



REPORT ON HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE

A Report on the Dialogues by SUHAKAM



REPORT ON HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE

A REPORT ON THE DIALOGUES BY
THE HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)



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Cetakan Pertama / First Printing, 2011

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Published in Malaysia by
THE HUMAN RIGHTS COMMISSION OF MALAYSIA
E-mail: humanrights@suhakam.org.my
URL: <http://www.suhakam.org.my>

Printed in Malaysia by
Gempita Maju Sdn. Bhd
7-1, Jalan 3/1, Taman Seri Merdeka
Ampang, SELANGOR
Tel: 03-4295 3010, 03-4296 3010
Fax: 03-4297 3010

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Perpustakaan Negara Malaysia

Cataloguing-in-Publication-Data

Report on human rights and access to equitable healthcare :

a report on the dialogues

ISBN 978-983-2523-70-3

1. Human rights--Health aspects--Malaysia. 2. Right to health care--Malaysia. I. Suruhanjaya Hak Asasi Manusia Malaysia.

341.48

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EXECUTIVE SUMMARY

On 5 November 2007, 8 January 2008 and 10 August 2008, the Human Rights Commission of Malaysia organised dialogues on “Human Rights and Access to Equitable Healthcare”. The dialogues were respectively held in Sarawak, Sabah and Kelantan.

The dialogues were structured based on the following aims:

- (i) to ascertain the concerns and views on improving the nation’s capacity to provide and sustain an equitable quality healthcare to the population with the emphasis on human rights; and
- (ii) to highlight areas which the government could take into consideration when implementing programmes in its efforts to provide and sustain an equitable quality healthcare, with particular focus on the marginalised and disadvantaged groups.

With emphasis on the human rights perspective to health and healthcare services, the dialogues entailed presentations and discussions on providing healthcare for all, in the context of Sarawak, Sabah and Kelantan; experiences of vulnerable groups; and moving towards equitable healthcare for all.

Steering in line with the objectives, the dialogues identified several issues concerning access to the right to health and healthcare services which include the following:

(i) Issues on Physical Accessibility to Facilities and Services

One of the main issues raised by participants at the dialogues pertained to inadequate physical access to clinics in rural and isolated villages. While the government has attempted to compensate this by implementing outreach programmes like mobile health teams and flying doctor service, several factors, such as bad weather, floods and inadequate number of staff and vehicles, have reduced the adequacy and effectiveness of these programmes.

For some other communities, while they had physical access to clinics, some were dilapidated and lacked basic facilities, such as electricity and clean water supply.

Besides physical access to clinics, the migration of many doctors from the public to the private sector has reduced access to certain medical specialties available in the public sector. This was particularly a concern for the poor who may not afford to obtain services from the private health sector.

Further, it was felt that Malaysia's health care system was not yet sufficient to cater for the health needs of the ageing population. In addition, early detection, appropriate healthcare and rehabilitation services for persons with disabilities were also lacking in the country. Besides healthcare services, current public amenities, such as public transportation and housing were also unequipped to cater for their mobility needs.

In addition, while Malaysia strives as an advanced developing country, there are groups and individuals in the country who remain without or have limited access to the underlying determinants of health.¹

There are many Malaysian citizens who did not possess identification/citizenship cards and birth certificates, especially those who have very limited contact with the mainstream society like the Penans in Sarawak. As a result, many found difficulties in obtaining government assistance and services, including healthcare services.

(ii) Issues on Affordability of Healthcare Services

While healthcare services in public healthcare centres are provided at very minimal fees, there were those who could not even afford this as they live in abject poverty.

Besides primary healthcare, the cost to obtain secondary and tertiary healthcare services may not be affordable to all in Malaysia. This is not limited to those classified as poor, but also among families earning medium income levels.

Other than the above, concerns were expressed over higher charges imposed by public hospitals and clinics towards migrant workers. As most of them earn very low income and were required to pay levies, such healthcare fees could burden them.

(iii) Concerns on the National Health Financing Mechanism

Participants expressed concern that information on the details of the government-proposed National Health Financing Mechanism (NHFM) was not made available in the public domain. In addition, despite their right to participation, public consultation, especially in Sabah and Sarawak was lacking. This had led to speculations that the NHFM would ultimately lead to privatisation of the healthcare in Malaysia.

¹ The United Nation's Economic and Social Council, in its General Comment on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, states that 'The right to health is an inclusive right, extending not only to timely and appropriate health care, including access to essential medicines, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation' as well as nutritious food, housing, healthy occupational and environmental conditions and access to health related information and education, including sexual and reproductive health.

(iv) Issues on the Current Healthcare System in Malaysia

Government allocation for healthcare in Malaysia is considered low and is below the WHO-recommended healthcare allocation of 5% of the national GDP, with Sabah and Sarawak receiving a small proportion of the total healthcare allocation.

Given the low budget allocation for healthcare development, some participants were displeased over its utilisation on facilities, which was perceived as wasteful. For instance, the building of million ringgit worth of sophisticated state-of-the-art healthcare facilities that could only serve the financial elites while there were those who lacked physical and economic access to the basic healthcare requirements. This, coupled with the promotion of medical tourism, gives the impression that health in Malaysia is being treated more as a commodity rather than as a basic human right.

Besides issues on the overall healthcare system, there were concerns over the lack of compassion shown amongst some healthcare providers towards patients. In addition, the tendency of doctors to dispense unnecessary drugs as the first treatment in response to several illnesses was also a concern.

(v) Public Awareness on the Rights and Responsibilities towards the Realisation of the Right to Health

There appears to be a lack of public awareness on the importance of and right to health as well as the fact that ensuring health was a shared responsibility and not solely the duty of the government. These include those who practice unhealthy lifestyles, including alcohol abuse, cigarette smoking, drug abuse and indiscriminate disposal of waste.

There were also concerns over those who appeared to be unaware of the importance of physicians' consultations and follow up. Many preferred to forego the cost for this and opted to purchase cheaper over-the-counter medicines from pharmacies. Without proper consultations, patients risk consuming unsuitable medicines.

SUHAKAM'S RECOMMENDATIONS

Based on observations made on the issues raised, SUHAKAM makes the following recommendations:

(i) Ensure Commitment to Health as a Human Right

SUHAKAM recommends that health, as a human right, be enshrined and guaranteed by the Federal Constitution of Malaysia.

To further strengthen its commitment to right to health, it is recommended that Malaysia ratifies the International Covenant on Economic, Social and Cultural Rights.

There is also the need for the government to ensure that policies and programmes to advance health and healthcare in Malaysia be anchored on the principles of human rights.

(ii) Increase Healthcare Budget Allocation

SUHAKAM recommends that the budget allocation for healthcare in Malaysia be increased, at least to the WHO-recommended level of 5% of the national GDP. Incremental increase to the existing budget allocations would be an ideal approach.

SUHAKAM further urges the government to ensure that adequate healthcare allocation be channelled to provide immediate access to health and healthcare especially for the poor, marginalised and those living in rural areas.

(iii) Ensure Physical Access to Healthcare for All in Malaysia

Ensure Physical Access

There is a need for the government to ensure that all persons in Malaysia have physical access to healthcare facilities, especially those in rural and isolated areas, as well as to ensure that healthcare facilities provide improved and comprehensive healthcare services to meet the current health needs and demands. Further, there is a need to recognise and promote indigenous healthcare and community healthcare practitioners in Malaysia.

Besides healthcare services, there is also a need to ensure that all persons in this country are provided with access to the underlying determinants of health, which include, among others, clean and safe drinking water, nutritious food, sanitation, and clean and safe environment. There is also an urgent need for the government to ensure that forest based indigenous peoples are not exposed to health threats such as pollution resulting from forest based activities like logging and plantations.

There is also a need for the government to ensure availability of public amenities for all – such as paved roads and public transportation – to bolster access to healthcare facilities. In doing so, it is necessary to ensure that amenities are disabled- and elderly-friendly.

As the provision of amenities like piped water, paved roads and public transport are under the jurisdictions of different agencies, an integrated approach amongst agencies is essential.

Ensure Economic Access

The government needs to ensure that all primary, secondary and tertiary healthcare services are affordable for all, particularly the poor. Economic access to such services could also be enhanced by ensuring that the society has the financial means. Thus, poverty eradication and income generating programmes could be further intensified for both the rural and urban poor.

In Malaysia, possession of Malaysian ICs is currently a requisite to whether a person is able to obtain subsidised healthcare services. Hence, the government would need to address the issue of undocumented Malaysian citizens including those amongst the indigenous peoples. Steps also need to be taken to encourage parent(s) of children born out of wedlock to step forward and register their children, by eliminating stigma as well as the risk of being apprehended by the relevant authorities.

(iv) Ensure the Right to Health of Migrant Workers in Malaysia

As the human rights law guarantees the right to health to all persons without distinction, the government is urged to take measures to ensure that migrant workers are able to enjoy their right to healthcare, in particular, economic access, given that migrant workers are already required to pay levies to be employed.

(v) Recommendations on the Government's Proposal for the National Health Financing Mechanism (NHFM)

It is recommended that information on the details of the NHFM be made available and accessible in the public domain. This is in line with the right to freedom of information as enshrined in article 19 of the UDHR.

SUHAKAM further urges the government to ensure that widespread consultations are conducted to enable the public to express their anxiety and apprehension as well as aspirations on the NHFM. This would realise the public's right to participate in the process and decision making in the development of the NHFM whose implementation would impact on each individual.

(vi) Implement Strict Monitoring

SUHAKAM strongly recommends that the government implements strict monitoring to ascertain the effectiveness of current programmes in meeting the population's health needs and expectations.

It is fundamental to ensure that basic and essential services contributing to health and wellbeing of all peoples are, in reality, available and easily accessible at all times, especially during emergencies.

CONCLUSION

Malaysia has achieved an impressive status on health and health coverage. It is therefore important for Malaysia to move forward by addressing the remaining pockets in the communities which are still deprived of their right to health. SUHAKAM's dialogues on Human Rights and Access to Equitable Healthcare, has provided an indication on groups in dire need of the government's attention. In addressing these, the government is urged to approach health as, first and foremost, a fundamental human right. To enable this, health as a human right, needs to be guaranteed by the law, in particular the Federal Constitution. This would reflect the commitment of the government to ensure that every person, without distinction, is able to enjoy their inherent right to health.

Appreciation

SUHAKAM expresses its utmost appreciation to all participants of the dialogue and other relevant agencies, organisations and individuals for rendering their invaluable assistance and insight on right to health.

PART I

BACKGROUND ON SUHAKAM'S DIALOGUES ON HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE

A. INTRODUCTION

Health is a basic human right, inherent to all peoples irrespective of their civil, political, economic, social and cultural background.

The World Health Organisation (WHO), in the preamble of its Constitution affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, and economic or social condition. Additionally, Article 25 (1) of the United Nations (UN) Universal Declaration of Human Rights (UDHR) states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

In addition, the United Nations Economic and Social Council in its General Comment on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) on the Right to the highest attainable standard of health states that one of the fundamental elements of the right to health is access to healthcare services. It proscribes discrimination on any grounds; emphasises equality and the special obligation of States to provide to those who do not have sufficient means with the necessary health insurance and healthcare facilities.

In this respect, the Human Rights Commission of Malaysia (SUHAKAM), via its Economic, Social and Cultural Rights Working Group (ECOSOC), has committed some of its time to look into issues affecting the right to health in Malaysia. Various seminars, dialogues and meetings were held resulting in the production of several reports on either the right to health per se, and others that encompass a number of socio-economic issues, including health. **SUHAKAM's reports on its Public Forum on Right to Health: Achieving Health MDGs; Ageing with Dignity: Rights of Older Persons; The Human Rights Approach to the Millennium Development Goals (MDGs); Penan in Ulu Belaga: Right to Land and Socio-Economic Development; Hak Asasi Orang Asal; and Hak Masyarakat Asli Sarawak**, are some examples of activities and reports by SUHAKAM which include issues affecting right to health and access to healthcare services.

Apart from the above, SUHAKAM has received complaints and memoranda relating to the right to health. These, in particular, called for the government to ensure the realisation of right to health which, among others, include ensuring equality in terms of access to healthcare services. Particular concerns centred on the economically and socially disadvantaged groups such as the poor, indigenous and rural communities especially those in Sabah and Sarawak, who appear to be extremely disadvantaged, as well as migrants in Malaysia. These concerns consequently raised the issue of the role played by the government as the primary duty bearer to respect, protect and fulfil human rights and consequently the peoples' right to health.

The government's plan to implement the National Health Financing Mechanism (NHFM)¹ has also been in SUHAKAM's agenda pertaining to the right to health. After receiving a memorandum by a coalition of health professionals and related groups, SUHAKAM worked closely with various social and non-governmental groups as well as government agencies to ensure that the grouses of the complainants reach and receive feedback from the government, as well as to ensure that the government takes into account human rights considerations, particularly on equality and non-discrimination in the delivery of, and access to health and healthcare services. The role of SUHAKAM in this was further enhanced when it was invited by the Ministry of Health (MOH) Malaysia to be a member to the Technical Committee of the Consultation Project for the National Health Financing Mechanism or *Projek Konsultasi Mekanisma Pembiayaan Kesihatan Negara* (NHFM).²

In view of the inherent right to health, the public's right to participation and SUHAKAM's commitment to ensure that the human rights of the poor and marginalised are not neglected, SUHAKAM decided to organise dialogues to have an on field look on health related issues as well as to obtain the views of the public on the current scenario of right to health and access to healthcare services in their localities.

SUHAKAM'S DIALOGUES ON HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE

As echoed by SUHAKAM and the participants of its previous meetings which discussed the right to health, this time, SUHAKAM decided to focus on the issues affecting health and healthcare services of the people in less developed states in Malaysia, namely, Sarawak, Sabah and Kelantan, especially those in rural and isolated locations as well as other economically and socially disadvantaged groups in the states.

- 1 The New Straits Times (NST) on 'Looking for a Healthy Compromise', on 8 April 2006. The NST reported that the government proposed the NHFS because of the following reasons: (i) Overwhelming workload in government Hospitals- There are only 25%-30% medical specialists working in government hospitals. However, they have to handle 75% of admissions; (ii) Cost borne by the government – When a person visits a government polyclinic, he or she only has to pay RM1 for treatment and up to two weeks to a month's worth of medication. However, the real cost, according to government study, is RM45 per visit, which is currently covered by the government. The NHFS has several components, which include the National Health Fund, Mandatory Monthly Contribution, Essential Health Benefits Packages (EHBP), Restructured MOH Hospitals and Clinics, Private Sector, Private Insurance for Extra Coverage and the National Health Financing Authority (NHFA). The aim of the NHFS is to split the burden of provisioning between stakeholders (public and private hospitals). However, the MOH has promised that both the NHFS as well as the NHFA – which oversees the operation of the NHFS – will be non-profit and will not be privatized. The NHFS will also transfer the burden of payment to the society through the mandatory monthly premiums. However, the amount of the monthly premium has not been decided by the government. The NHFS will cover payment for medical treatment for conditions specified in the Essential Health Benefits Packages (EHBP) in public hospitals but only covers a portion of the cost for treatment of conditions listed under the EHBP in Private hospitals.
- 2 SUHAKAM accepted the invitation and named Datuk Dr. Raj Karim to represent SUHAKAM to the Technical Committee of the Consultation Project to the NHFM.

In line with this focus, the “Human Rights and Access to Equitable Health” dialogues in Sarawak, Sabah and Kelantan were respectively held on 5 November 2007, 8 January 2008 and 10 August 2008.

Objectives

The dialogues were structured based on the following aims:

- (i) to ascertain the concerns and views on improving the nation’s capacity to provide and sustain an equitable quality healthcare to the population with the emphasis on human rights; and
- (ii) to highlight areas which the government could take into consideration when implementing programmes in its efforts to provide and sustain an equitable quality healthcare, with particular focus on the marginalised or disadvantaged groups.

SUHAKAM is pleased with the public response at all three dialogues in Sarawak, Sabah and Kelantan. Discussions were lively, fruitful and most importantly, frank. Speakers and participants were able to debate healthily on the issues affecting the people in the states as well as understanding the factors impeding state agencies from ensuring right to health and equal access to the relevant services in the states.

B. THE HEALTH SCENARIO IN MALAYSIA

Attributed by a relatively strong healthcare system, Malaysia has reached a rather high standard of health, comparable to several developed countries.

TABLE 1: POPULATION AND VITAL STATISTICS MALAYSIA, 1999, 2006 & 2008

	1999	2006	2008
Land Area (Sq Km)	330,113	330,252	329,960*
Population ('000)*	22,712.0	26,640.2	27,728.7
Population Density (Sq Km)*	69	81	84
Population by Age Group ('000)*			
Below 15 Years	7,618	8,632	8,876.2
15-64 years	14,234	16,858.6	17,620.2
65 years & above	860	1,149.5	1,232.3
Annual Population Growth Rate (%)*	2.3	1.5 ^P	2.0 ^P
Crude Birth Rate (per 1000 population)	25.4	18.7 ^P	17.5 ^P
Crude Death Rate (per 1000 population)	4.6	4.5 ^P	4.5 ^P
Still Birth Rate (per 1000 total births)	3.9	4.3 ^P	4.5 ^P
Perinatal Mortality Rate (per 1000 total births)	7.9	7.3 ^P	7.3 ^P
Neonatal Mortality Rate (per 1000 live births)	5.2	3.9 ^P	3.9 ^P
Infant Mortality Rate (per 1000 live births)	8.5	6.6 ^P	6.3 ^P
Toddler Mortality Rate (per 1000 Toddler population)	0.7	0.5 ^P	0.4 ^P
Maternal Mortality Rate (per 1000 live births)	0.3	0.3 ^P	0.3 ^P
Percentage Distribution of Live Births by Birth weight (Peninsular Malaysia)			
Under 2.5kg	9.7	10.1 ^P	10.5 ^P
2.5kg & above	90.3	89.9 ^P	89.5 ^P

Note: ^P Provisional

* In 2009, the total population of Malaysia was projected at 28,306,700 person (below 15 years [31.9%]; 15-64 years [63.6%]; 65 years and above [4.5%]. Population density was 86 persons per sq km. Annual population growth rate was 2.1.

Source: Ministry of Health, Malaysia website at http://www.moh.gov.my/v/stats_si
Department of Statistics, Malaysia

The population size of Malaysia has reached to more than 27 million in 2008, with the largest proportion being those between the ages of 15 - 64 years old. Following the trend of developed countries, the crude birth rate for Malaysia has also decreased. This may be attributed to increased knowledge of the population on family economics and planning.³

3 See WHO on Promoting Family Planning at http://www.who.int/reproductive-health/family_planning/index.html

Life Expectancy at birth

TABLE 2: MALE AND FEMALE LIFE EXPECTANCY AT BIRTH, 1999, 2006 & 2008

	1999	2006	2008
Life Expectancy at Birth (in Years) :			
Male	69.9	71.8 ^P	71.70 ^P
Female	74.9	76.3 ^P	76.46 ^P

Note: ^P Provisional
Source: Ministry of Health, Malaysia website at http://www.moh.gov.my/v/stats_si
* Department of Statistics, Malaysia

The life expectancy at birth for both male and female in Malaysia has gradually increased. This is one of the many other contributors that have improved Malaysia’s Human Development Index (HDI) standing.

TABLE 3: LIFE EXPECTANCY AT BIRTH, MALAYSIA, 2003 - 2008

Year	Level of HD	Malaysia HDI Rank	Life Expectancy at Birth
HDR 2003	Medium	58	72.8 (2001)
HDR 2004	Medium	59	73.0 (2002)
HDR 2005	Medium	61	73.2 (2003)
HDR 2006	High	61	73.4 (2004)
HDR 2007/2008	High	63	73.7 (2005)

Note: HD: Human Development; HDI: Human Development Index.
Source: UNDP’s Human Development Reports for years 2003-2007/2008. <http://hdr.undp.org/en/>

Maternal and Child Mortality

Malaysia’s report on its achievement vis-à-vis the Millennium Development Goals (MDGs) also showed outstanding performance in the reduction of maternal and child mortality.

Child Mortality

The infant and toddler deaths in Malaysia have impressively decreased. In 1963, the infant mortality rate was 55.5 deaths per 1,000 live births (LB), while in 2008 it was 6.3 per 1,000 LB.⁴

4 See Malaysia’s Department of Statistics Reports on Vital Statistics Time Series, Malaysia, 1963-1998; Vital Statistics Time Series, Malaysia, 2003; Malaysia Year Book of Statistics 2005. See also the Ninth Malaysia Plan 2006-2010. Since 1980, toddler deaths (aged 1-4) are by place of residence. Data prior to 1980 are by place of occurrence.

TABLE 4: INFANT AND TODDLER DEATHS (NUMBER AND RATE) IN MALAYSIA, VARIOUS YEARS

YEAR	INFANT DEATHS		TODDLER DEATHS ^(b)	
	Number	Rate (per '000 live births)	Number	Rate (per '000 toddlers)
1963	18,870	55.5	7,837 ^a	n.a
1970	13,873	39.4	5,814	n.a
1980	10,142	23.8	3,252	2.1
1990	6,629	13.1	1,853	0.9
2000	3,578	6.8	1,282	0.6
2002	3,124	6.5	1,124	0.5
2005 ^(p)	-	5.8	-	0.5

Note: ^(p) As reported in the Ninth Malaysia Plan 2006-2010, p.12
^a Peninsular Malaysia and Sabah
^b Since 1980, toddler deaths (aged 1-4) are by place of residence. Data prior to 1980 are by place of occurrence
- Not Available

Source: Vital Statistics Time Series, Malaysia, 1963-1998. Department of Statistics, Malaysia
Vital Statistics, Malaysia 2003. Department of Statistics Malaysia
Malaysia Yearbook of Statistics 2005. Department of Statistics, Malaysia
Department of Statistics, Malaysia
Ninth Malaysia Plan , 2006-2010

Maternal Mortality

The maternal mortality rate for Malaysia has gradually decreased over the years from 2.1 in 1963 to 0.3 in 2008.⁵

TABLE 5: MATERNAL MORTALITY (NUMBER AND RATE), MALAYSIA, VARIOUS YEARS

	1963	1970	1980	1990	2000	2002	2008
Maternal Deaths	702	496	240	94	167	158	-
Maternal Mortality Rate (Per '000 live births)	2.1	1.4	0.6	0.2	0.3	0.3	0.3 ^p

Note: Per 1,000 live births
Source: Ministry of Health, Malaysia website at http://www.moh.gov.my/v/stats_si
Vital Statistics Time Series, Malaysia, 1963-1998. Department of Statistics, Malaysia
Vital Statistics, Malaysia 2003. Department of Statistics, Malaysia

Communicable Diseases

In terms of communicable diseases, Malaysia has reported significant reduction in a majority of incidences and deaths caused by certain diseases especially childhood immunisable diseases such as poliomyelitis, diphtheria and measles.

5 Ibid

TABLE 6: INCIDENCE RATE AND MORTALITY RATE OF CERTAIN COMMUNICABLE DISEASES
(PER 100,000 POPULATION) MALAYSIA, 1999, 2006 & 2008

	1999		2006		2008	
COMMUNICABLE DISEASES	INCIDENCE RATE	MORTALITY RATE	INCIDENCE RATE	MORTALITY RATE	INCIDENCE RATE	MORTALITY RATE
AIDS	5.30	3.97	6.91	3.66	3.39	3.25
HIV Infections (All forms)	23.00	-	21.88	1.43	13.31	0.54
Chancroid	0.03	-	0.00	0.00	0.00	0.00
Cholera	0.60	0.001	0.89	0.01	0.34	0.01
Dengue Fever	30.20	-	64.37	0.01	167.76	0.02
Dengue Haemorrhagic Fever	1.80	0.16	4.10	0.25	10.16	0.38
Diphtheria	-	0.001	0.00	0.00	0.01	0.00
Dysentery (All Types)	2.00	-	0.39	0.01	0.33	0.00
Food Poisoning	36.60	0.02	26.04	0.01	62.47	0.01
Leprosy	0.90	-	0.89	0.00	0.84	0.00
Malaria (per 10,000?)	57.20	0.15	19.87	0.08	2.67 ¹	0.01 ¹
Measles	27.90	0.03	2.27	0.00	1.20	0.01
Plague	-	-	0.00	0.00	0.00	0.00
Poliomyelitis (Acute)	-	-	0.00	0.00	0.00	0.00
Rabies	-	-	0.00	0.00	0.00	0.00
Relapsing Fever	-	-	0.00	0.00	0.00	0.00
Syphilis (All Forms)	7.70	-	3.06	0.01	3.16	0.00
Tetanus Neonatorum	0.09	-	0.04	0.01	0.03 ²	0.00 ²
Tetanus(Adult)	0.09	-	0.06	0.00	0.06	0.00
Tuberculosis	67.80	5.83	62.56	5.37	63.10	5.49
Typhus	0.20	-	0.06	0.00	0.05	0.00
Viral Encephalitis	0.40	0.03	0.09	0.01	0.07	0.01
Whooping Cough	0.18	-	0.02	0.00	0.04	0.00
Yellow Fever	-	-	0.00	0.00	0.00	0.00
Hand, Foot and Mouth Disease	-	-	19.30	0.02	56.13	0.02
Ebola	13.60	0.03	0.00	0.00	0.00	0.00

Source: Extracts from Health Facts (various years) Ministry of Health, Malaysia website at http://www.moh.gov.my/MohPortal/health_fact.jsp

Note: (-) Data Not Available

¹ per 10,000 population

² per 1,000 live births

PROGRAMMES ATTRIBUTED TO THE HEALTH PROGRESS AND STATUS OF HEALTHCARE IN MALAYSIA

Malaysia's progress is attributed to the comprehensive policies and strategies implemented through various health and healthcare related programmes by the government. Malaysia had also invested in a wide network of health infrastructure and rural health such as maternal and child health, immunisation, nutrition, prevention of communicable diseases and non-communicable diseases, occupational safety and health, food safety and quality, water supply and environmental health, and other related programmes to address and improve primary, secondary and tertiary healthcare.

In terms of reaching remote populations and vulnerable groups, programmes such as the flying doctor service (FDS), mobile health teams and community clinics (*klinik desa*) were designed to reach communities residing in difficult to reach locations such as the Penans who live in the remote interiors of Sarawak. Government subsidy for healthcare services has enabled the poor to obtain services for a small RM1-RM5 fee. Exemptions or discounts of bills and payments are given for those earning less than RM300, persons with disabilities, and students. The steady establishment of new clinics throughout Malaysia has increased physical accessibility especially for the rural and urban poor.

ACCESS TO HEALTHCARE SERVICES AMONGST VULNERABLE GROUPS IN MALAYSIA

Ensuring access to healthcare amongst vulnerable groups, such as poor communities in rural and isolated areas, is an important aspect prioritised in the Malaysian Social-economic Development Plans. In line with this goal, various programmes have been implemented by the government including outreach programmes to ensure health for all.

The official data which shows overall national data on health status in Malaysia portrays that the country has done extremely well in ensuring access to healthcare services.

However, detailed analysis of disaggregated data reveals inequity in terms of access and level of access to healthcare services, such as between the rural and urban areas. Socially and economically disadvantaged groups also appear to be marginalised due to physical or financial inaccessibility to health service.

SUHAKAM's dialogues in Sarawak, Sabah and Kelantan clearly verify the issue of inequity in terms of access to healthcare services. The issues and concerns raised were further strengthened as those who spoke were among persons with disabilities, native and rural communities, as well as other vulnerable and disadvantaged groups.

While various government programmes were mentioned and appreciated, concerns still remained on inequitable access to healthcare services amongst vulnerable groups, especially those in lesser developed states like Sarawak Sabah and Kelantan. According to the WHO, health facilities in Malaysia were distributed equitably, with the exception of Sarawak and Sabah. These two states suffer from low densities in rural population with geographical disadvantage in access to services.⁶

For instance, while the FDS is provided to ensure access to healthcare services for those living in the interior of Sabah, Sarawak and Kelantan, factors such as bad weather and safety have made the delivery of this service irregular. Additionally, while there are medical assistants placed in villages, they lacked drugs and supplies and therefore were unable to deliver healthcare services effectively to the people. This scenario was encountered by the Penan community in Long Singu, Ulu Belaga Sarawak, who were told to obtain relevant medical services at Sungai Asap, Belaga, Sarawak which is about 3 hours away by vehicle. Given the socio-economic status of the Penan, and given that emergency services like ambulance services were limited, most would have to depend on chartered vehicles which could cost up to RM700 per trip.⁷

Besides physical access, some groups and individuals are unable to access healthcare services because of the direct and associated cost to obtain healthcare services especially for treatment of chronic diseases. The poor and even middle income households are affected as for instance, treatment for leukaemia would cost about a quarter of RM1million not including follow-up treatment⁸. This concern was heightened with the government's plan to implement a national health financing scheme (NHFM⁹); whether the scheme would protect the rights of vulnerable groups towards health and whether the scheme would encompass chronic illnesses.

Besides having inadequate physical and economic access to healthcare services, some communities lack access to healthcare related information such as information on available services and where to obtain such services¹⁰.

6 See WHO (Regional Office for the Western Pacific) website at <http://www.wpro.who.int/countries/>

7 See SUHAKAM's report on 'Penan in Ulu Belaga: Right to Land and Socio-Economic Development'. The report is available at SUHAKAM's website at www.suhakam.org.my

8 See answer by Dr. David Quek in the discussion relating to the NHFM during Session 2 of the dialogue in Kuching, Sarawak on 5 November 2007, p. 57

9 The NHFM was proposed by the government i) the overwhelming workload in government hospitals; (ii) the high cost borne by the government. See report by New Straits Times (NST) on 'Looking for a Healthy Compromise', on 8 April 2006. The NHFM would require monthly contributions from the society which is similar to that of insurance premiums. Information on how this contribution would be calculated has yet to be determined along with some other components of the NHFM. However, the NHFM has been put on hold. See feedback by Datuk Dr. Raj relating to the status of the NHFM during Session 1 of the dialogue in Kuching, Sarawak 5 November 2007, p.49.

10 See presentation by Dr. David Quek on "Equitable Access to Healthcare for All: Is this still a Pipe Dream for Malaysian? A Medical Professional's perspective" during Session 2 of the dialogue in Kuching Sarawak, 5 November 2007, attached as Annexure 5.

Following these concerns, local human rights advocates have emphasised the human right to health for all in Malaysia especially states like Sarawak and Sabah. It also emphasises the obligations of the government as the primary duty bearer to respect, protect and fulfil the human rights of its people and to ensure affirmative action is in place for the purpose of advancing the human rights of vulnerable and disadvantaged groups. This is to ensure that they are able to enjoy their right to health as enjoyed by the mainstream society in Malaysia.

C. RIGHT TO HEALTH OF DISADVANTAGED AND VULNERABLE GROUPS

"Our greatest concern must always rest with disadvantaged and vulnerable groups. These groups are often hidden, live in remote rural areas or shantytowns and have little political voice."

Dr Margaret Chan
WHO Director-General

Throughout the world, the right to health remains a distant goal for some individuals and groups. While unintentional, some countries have failed to ensure their health related legislations, policies and programmes do not discriminate and reach all vulnerable and disadvantaged individuals and groups who require special attention including, among others, the poor, women, children and adolescents, persons with disabilities, the elderly as well as those living in rural and remote locations¹¹.

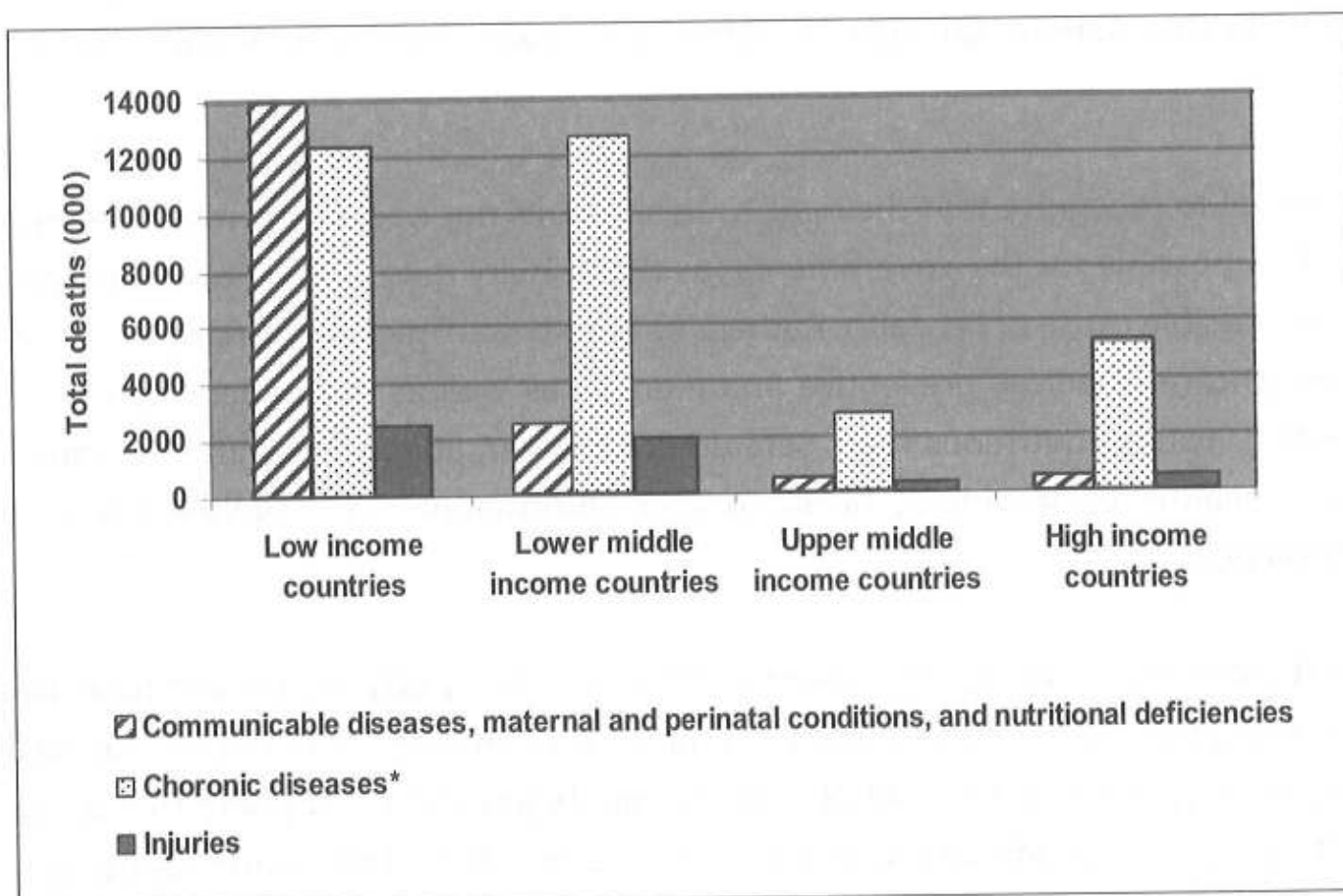
Following their inability to enjoy their right to the highest attainable standard of health, vulnerable or disadvantaged groups tend to encounter various health problems¹². According to the WHO, analysis of health data from poor and vulnerable population groups for 2005 invariably reveals higher-than-average instances of disease, premature mortality, maternal mortality, or HIV/AIDS infection rates¹³. This is illustrated in Graph 1.

11 See the General Comment (GC) 14 on Article 12 on the ICESCR on The Right to the Highest Attainable Standard of Health. The GC could be found at [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument)

12 See WHO report on '25 Questions & Answers on Health & Human Rights'. The report is available at http://www.who.int/hhr/information/25_questions_hhr.pdf.

13 See also WHO Report on 'Human Rights, Health and Poverty Reduction Strategies'. The Report is available at http://www.who.int/hdp/publications/human_rights.pdf.

GRAPH 1: PROJECTED DEATHS BY MAJOR CAUSE AND WORLD BANK INCOME GROUP, ALL AGES, 2005



Source: WHO brochure on "Working for Health: An Introduction to the World Health Organisation". http://www.who.int/about/brochure_en.pdf

THE LINKAGES OF HUMAN RIGHTS AND HEALTH

The right to the enjoyment of the highest attainable standard of health was enshrined for the first time in the Preamble of the World Health Organisation (WHO) Constitution 1946 and later, reaffirmed in the Alma-Ata Declaration on primary healthcare in 1978.¹⁴

This right is also guaranteed by the Universal Declaration of Human Rights (UDHR). Article 25(1) of the UDHR states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

¹⁴ See '25 Questions and Answers on Health and Human Rights at http://www.who.int/hhr/information/25_questions_hhr.pdf. See also WHO report on 'Human Rights, Health and Poverty Reduction Strategies at http://www.who.int/hhr/news/HHR_PRS_19_12_05.pdf

Other international human rights instruments that repeat this entitlement includes the International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).

It is fundamental to recognise that the right to health does not necessarily mean the right to be healthy¹⁵. It is impossible for the governments (as the primary duty-bearer) to ensure protection against every possible cause of ill-health. Rather, 'right to health' means the right to access/obtain adequate healthcare (medical, preventive and mental) as well as the underlying determinants of health which includes nutritious food, safe drinking water, adequate sanitation, safe working conditions, a healthy environment, health related information and abolishment of harmful traditional practices.¹⁶

An important component of the government's obligation to respect, protect and fulfil the human rights of their people is to ensure equality and non-discrimination. In the aspect of health, the government is obligated to ensure all persons within its jurisdiction are able to equally obtain and enjoy their rights to health and healthcare services. Article 2 of the UDHR clearly states that everyone is entitled to the rights set forth by the UDHR without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, as well as on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

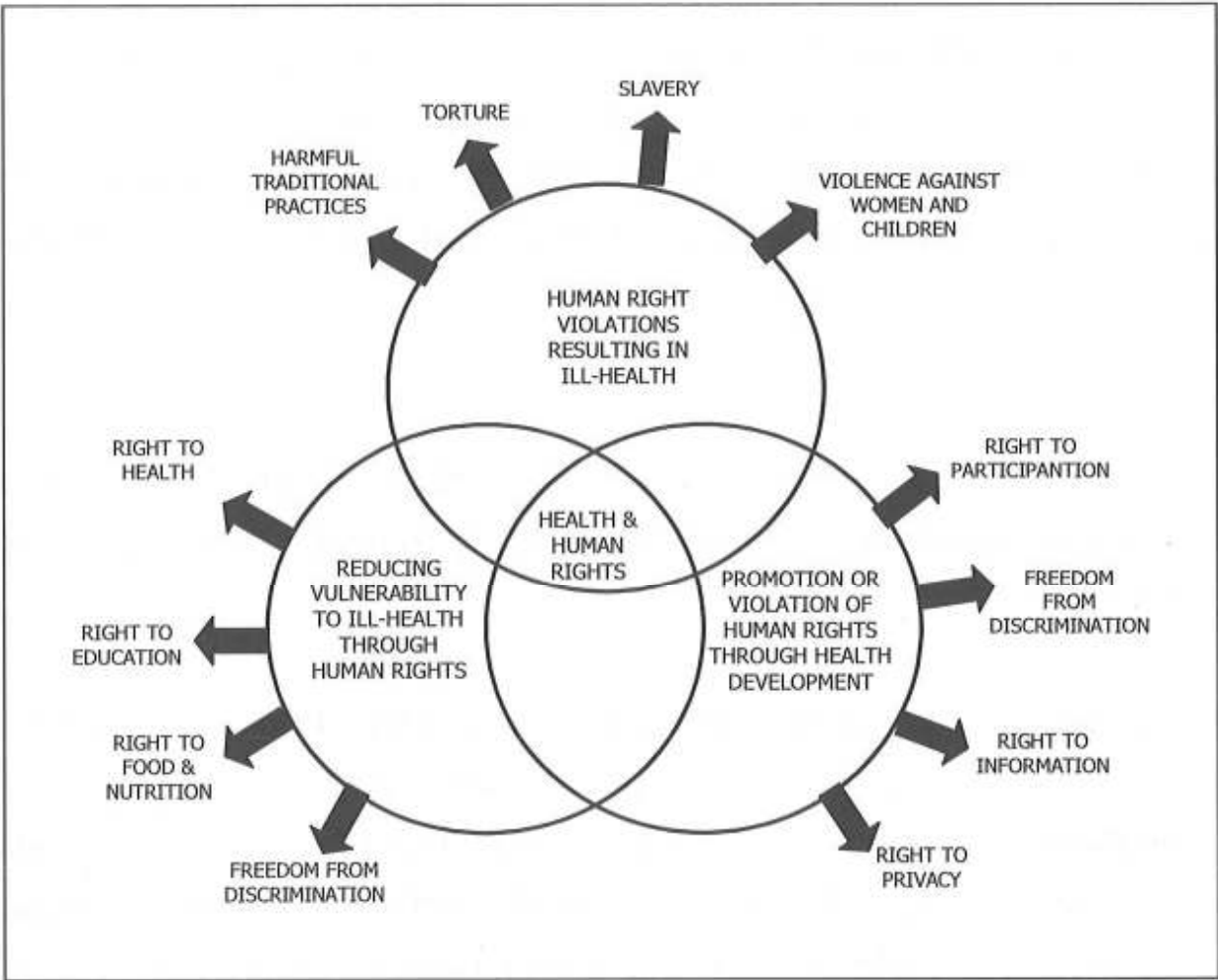
Besides being a human right itself, according to the WHO, the promotion and protection of health is inextricably linked to respecting, protecting and fulfilling other human rights as follows:

- Violation or lack of attention to human rights can have serious health consequences;
- Health policies and programmes can promote or violate human rights in their design or implementation;
- Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights.

15 See Para. 116 of the "Draft Guidelines: The Human Rights Approach to Poverty Reduction Strategies". Document is available at <http://www.unhchr.ch/development/povertyfinal.html>. See also Para 8 of the General Comment (GC) 14 on article 12 of the ICESCR on 'The right to the highest attainable standard of health', (E/C.12/2000/4.)

16 Ibid. See also Para. 17 & 18 of the Report of the Special Rapporteur, Paul Hunt on 'The rights of everyone to the enjoyment of the highest attainable standard of physical and mental health' (E/CN.4/2004/49/Add.1). See also the Centre for Economics and Social Rights Website at <http://cesr.org/health/resources>

EXAMPLES OF LINKAGES BETWEEN HEALTH AND HUMAN RIGHTS



Source: WHO Report on Human Rights, Health and Poverty Reduction Strategies. See http://www.who.int/hhr/news/HHR_PRS_19_12_05.pdf

Besides being influenced by the progress of other human rights, health could also influence the achievement of other human rights. To illustrate, health is a core component of the Millennium Development Goals (MDG). The eight MDGs are interdependent whereby the progress of one goal depends on the other. For instance, the promotion and protection of health is very important to ensure the people’s well-being as well as to ensure that they lead a dignified life. Poor health contributes to reduced educational achievement and work productivity, thus reducing access to adequate income and thus leads to poverty.¹⁷

ELEMENTS OF RIGHT TO HEALTH

The Committee on Economic, Social and Cultural Rights (CESCR) on the International Covenant on Economic, Social and Cultural Rights (ICESCR) maintains that right to health includes availability, accessibility, acceptability and quality, which, application of these elements depends on the current conditions of State Parties to ICESCR.

17 Brigit C.A. Toebes, 'The Right to Health as a Human Right in International Law', School of Human Rights Research Series Volume 1.

Availability

State parties to ICESCR must ensure availability and in sufficient quantity of functioning public health and healthcare facilities, goods and services, as well as programmes. Although the nature of these facilities, goods and services may vary – depending on various factors, including a country's development level - they must, however, be equipped with the basic determinants of health, such as clean and safe drinking water, sanitation, clinics as well as trained medical and professional human resource.

Accessibility

State parties to the ICESCR must ensure that everyone within its jurisdiction should have adequate access to health facilities, goods and services. Accessibility to health facilities, goods and services has four coinciding facets:

- **Non-discrimination** – health facilities, goods and services should be accessible to every person without discrimination. This is especially important amongst members of vulnerable groups.
- **Physical accessibility** – facilities, goods and services should be within safe physical reach for all especially members of the vulnerable groups. This includes the basic determinant of health such as sanitation and potable water. It is also important to ensure that facilities, goods and services are adequately accessible amongst persons with disabilities.
- **Economic accessibility** – health facilities, goods and services as well as the basic determinants of health should be affordable to all. This is important so as to ensure good health among people living in poverty. Principles of equity should be the underlying foundation to ensure health services, whether privately or publicly provided, are provided to all. Thus, poorer household are not disproportionately burdened with health expenses as compared to the richer households.
- **Information accessibility** – every person has the right to seek, obtain, and communicate any information related to health issues. However, this should not affect a person's right to have his or her personal data confidential.

Acceptability

Health facilities, goods and services should be provided in ways that respect medical ethics as well as are culturally appropriate. According to the CESC, this includes respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality

States must also ensure that health facilities, goods and services are of good quality. To realise this, skilled medical workers, scientifically approved and appropriate drugs and hospital equipment, adequate sanitation and safe and potable water should be adequately supplied.

D. SUHAKAM'S DIALOGUES ON HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE

SUHAKAM is particularly concerned over unprotected rights towards health and equal access to healthcare services. As outlined in the objectives of SUHAKAM's dialogues on Human Rights and Access to Equitable Healthcare, SUHAKAM aspired that the dialogues would provide a perspective on the issues confronted by communities in Sarawak, Sabah and Kelantan, with regard to their human rights to health, as well as their rights to equality and non-discrimination in obtaining healthcare.

Working in line with these objectives, SUHAKAM worked with the relevant state government agencies, medical professional groups, social groups, NGOs and members of the public in the conduct of these dialogues.

The dialogues began with the Opening Session, which heard the welcoming remarks and introduction to the dialogue by SUHAKAM Commissioners.

The two following sessions heard presentations by distinguished speakers followed by a discussion. During the sessions, speakers spoke of the progress of the states with regard to health status, the human rights perspective to health, and the experiences of vulnerable and marginalised groups.

The final session was a discussion, in which active discussions took place and recommendations were put forward to improve access to health in the states, and Malaysia as a whole.

PART II

ISSUES AND SUHAKAM'S OBSERVATIONS AND RECOMMENDATIONS

A. ISSUES AND SUHAKAM'S OBSERVATIONS

This section contains SUHAKAM's observations based on the issues raised during the open discussion session at SUHAKAM's Dialogues on Human Rights and Access to Equitable Healthcare in Sarawak, Sabah and Kelantan.

The objective of this section is not intended to provide the general health status and situation in Malaysia. Rather, it is a reflection of the issues faced by attendees of the dialogues in Sarawak, Sabah and Kelantan, including those who represent a number of social groups and organisations.

1. PHYSICAL ACCESSIBILITY

(i) *Physical Access to Hospitals, Clinics and other Healthcare Facilities*

The dialogues in Sarawak, Sabah and Kelantan heard similar concerns on the lack of physical access to healthcare facilities especially amongst those who reside in rural and isolated areas, including the indigenous peoples. Difficult terrain as well as distance between villages and healthcare facilities has made physical access to healthcare facilities considerably low.

For some communities, access road was unavailable and people depended on riverboats to get from one point to the other, including getting to the nearest hospital.

A previous research by SUHAKAM on the Penan in Ulu Belaga found a similar scenario to the above concern. The research found that some Penan villagers in Ulu Belaga had to travel three hours by vehicle to get to the clinic in Sungai Asap in the Belaga District of Sarawak. As they do not have personal vehicles, they hitchhiked timber lorries that travel on dangerously muddy and slippery logging tracts. Some depart from their villages via small handmade canoes to reach the logging tracts.¹⁸

18 See SUHAKAM's Report on Penan in Ulu Belaga: Right to Land and Socio-Economic Development. The Report is available online at www.suhakam.org.my



SUHAKAM's delegation attempted to reach Kampung Telaga, Pitas, Sabah for a dialogue with the villagers in January 2008, but had to turn back after two of the 4WD vehicles got stuck in thick mud. The delegation decided to take a boat ride and travel along a crocodile-infested river to reach the village.



Klinik Desa in Kampung Beladin, Pusa District, Sarawak, visited by SUHAKAM in February 2008.

(ii) Are healthcare facilities equipped to cater for the local communities' needs?

Concerns were also raised on the physical condition of clinics and limited services provided by clinics/polyclinics in rural areas. While hospitals in the urban areas have gone through changes and upgrades, polyclinics and other clinics in rural areas have not been upgraded and thus services offered remained the same despite increasing demand for other forms of medical services.¹⁹ According to some participants, some rural clinics do not even have electricity and clean water supply.

(iii) Is access to healthcare services easily available in all states?

To compensate for underserved rural and isolated villages, the government has implemented outreach programmes such as community nurses, mobile health teams, Flying Doctor Service (FDS) and community health representatives. However, for various reasons, some of the programmes have not been implemented effectively or services have not been regular.

- *Flying Doctor Service*

For reasons of safety of health personnel, teams were forced to cancel trips to villages during unfavourable weather, which had previously resulted in a number of crashes and fatalities. In Kelantan, the Health Department would request the assistance of the PDRM for helicopters to reach isolated villages especially during emergencies.

¹⁹ See feedback by Dr. Andrew Kiyu, the Director of Health, Sarawak, during the discussion for Session 2 of the dialogue in Kuching, Sarawak on 5 November 200, on the issue of Upgrading Rural Polyclinics, p. 56

- *Mobile Health Teams*

Similar to the FDS, visits by Mobile Health Teams to rural and isolated villages in the states were irregular. Visits by the teams were highly dependent on the availability and condition of their vehicles, availability of designated staff, the weather and road conditions. This issue was raised at the dialogues in Sarawak, Sabah and Kelantan.

- *Community Nurses*

Community nurses, while were in place, were required to assist patients residing within a 12-kilometre radius from the main office. Communities that reside outside the 12-kilometre radius, like some Penan communities in the interior of Sarawak, were, therefore, unable to access services provided by community nurses.

- *Ambulance Service*

Ambulance service was either scarce or unavailable for some communities living in the rural and isolated areas in Sarawak, Sabah and Kelantan.

For instance, at a previous meeting with the relevant district and state agencies in Sarawak, SUHAKAM was informed by a representative from the Miri Health Office that ambulance service was limited with one ambulance and a driver to cover a large area in Belaga. For this area, any emergency cases are referred to the Bintulu Hospital which is about three hours away from Belaga. In a scenario where there are two emergency calls at once, only one could be attended.²⁰

- *Community Health Representatives*

With regards to community health representatives, SUHAKAM was made to understand that while they were available, some could not function effectively as they lacked medicine supplies.

(iv) *Is there proportionate doctor-patient ratio in the public and private health sectors in Malaysia?*

Due to obvious factors such as brain drain and better remuneration in the private sector, many medical specialists have migrated to practise in the private sector, thus reducing the availability of expertise in the public sector. It was noted that there were about 25%-30% of medical specialists working in government hospitals who had to handle 75% of the total admissions in Malaysia.²¹ The latter would include those who could not afford to obtain healthcare services in the private health sector as charges were more expensive.

20 See SUHAKAM's Report on Penan in Ulu Belaga: Right to Land and Socio-Economic Development. The Report is available at www.suhakam.org.my

21 Source: New Straits Times (NST) on 'Looking for a Healthy Compromise', on 8 April 2006.

(v) Is there adequate access to nutritious food, clean and safe drinking water and adequate sanitation in the states?

Besides inadequate access to healthcare services, some rural and isolated villages lacked nutritious food, safe drinking water, proper sanitation, a healthy environment and health related information. Due to their location, some villages are not connected to the main towns which made it difficult for delivery of services. Further, many of the isolated villages in all the three states, especially in areas where indigenous communities lived were exposed to the impact of logging, oil palm plantations and other forest based development projects that affected their main source of water, food and environment.

There were concerns over the lack of information dissemination and public awareness programmes on the types and locations of available medical services. This could be a reason why some people do not avail themselves of health services until it is too late.



The villagers in Kampung Beladin, Pusa, Sarawak, depended on the poor quality rain water for consumption.



Similar to the villagers in Kampung Beladin, Sarawak, the Kampung Telaga villagers in Pitas, Sabah, depended on rain water for consumption. They also took water from a sump for consumption (picture), and the water from both sources was found to be unclean.

(vi) Is there an adequate healthcare and rehabilitation services for Persons with Disabilities?

Programmes and facilities for persons with disabilities were very limited in the rural areas. The Community Based Rehabilitation Programmes were only available for children below the age of eight.

In addition, rehabilitation and care for persons with mental disability, those with learning difficulties and personality disorders were lacking. This was not only limited to rural areas but also in some of the more developed areas in the states. Concerns were also raised over the lack of protection programmes to prevent sexual abuse of persons with disabilities.



Two disabled children from Kampung Beladin, Pusa, Sarawak, who were registered under the Social Welfare Department and were provided with the Orang Kurang Upaya (OKU) Cards. With this card, they are eligible to obtain free medicine and the food basket programme.

In addition to limited programmes and assistance for persons with disabilities, other concerns were the followings:

- *Early Detection of Disability*

Discussions pertaining to persons with disability, in majority of times, tend to overlook an important aspect of early detection of disability. In some other cases ailments that create risk of permanent disability but could be prevented with early detection and treatment went undetected until it was too late.

- *Facilities for Persons with Disabilities*

Besides healthcare related matters for persons with disabilities, the dialogues also observed that disabled-friendly facilities, such as disabled friendly buildings, health facilities, public transport and other public amenities were insufficient. While Malaysia is fast approaching a 'developed country' status, its public amenities and facilities especially for those with disabilities, have yet to reach the optimal standard such as those provided in developed countries.

(vii) Is there sufficient medical services and care for the elderly?

There were also concerns over the fact that Malaysia was unequipped to cater for the needs of the ageing population. Currently there are limited number of doctors who specialise in geriatrics and rehabilitative medicine for the elderly. Some were of the opinion that such disciplines were unpopular and unrewarding as the health of the elderly, even with any medication, would ultimately deteriorate.

(viii) Is there equitable access to healthcare for foreign migrants?

Bearing in mind that the right to health is an entitlement for all without distinction, concerns were raised on hindered access to healthcare services amongst illegal immigrants.

It was said that due to their fear that doctors might report their presence to the Immigration Department, undocumented immigrants avoid going to hospitals even when they require medical attention. This had created the risk of undetected diseases, including communicable diseases that could lead to the spread of infectious diseases, as well as increase mortality and morbidity. The insurgence of diseases such as Tuberculosis and Malaria was also raised.

2. AFFORDABILITY

Besides concerns over inequitable physical access to healthcare facilities and services, the issue of affordability of services provided was also discussed. The poor, undocumented persons and migrant workers were the main groups of concern.

In addition to disadvantaged groups, certain expensive but limited medical treatment and services were also identified as another factor which reduces economic access to health and healthcare.

(i) *Are healthcare services adequately accessible amongst economically disadvantaged groups and individuals?*

Participants of the dialogues in Sarawak, Sabah and Kelantan have raised concerns over the issue of inadequate access to healthcare amongst economically disadvantaged groups. It was said that while medical fees or charges in public hospitals were minimal, it should be noted that there were those who live in abject poverty and could not even afford to pay those minimal charges.

(ii) *Are secondary and tertiary healthcare services affordable to all?*

In addition to the poor, medium income earning families might also encounter problems in accessing medical treatment and care, in particular, for chronic diseases such as treatment and care for cancer patients. It was said that most would utilise their entire life savings for the above purpose, and at the same time, further reducing their purchasing power.

Concerns were also raised over the inadequate access to affordable services to care for the elderly. While there were some institutions which provided services such as home care nurses, they could only be accessed by those with strong financial standing.

(iii) *Are migrant workers enjoying their right to healthcare?*

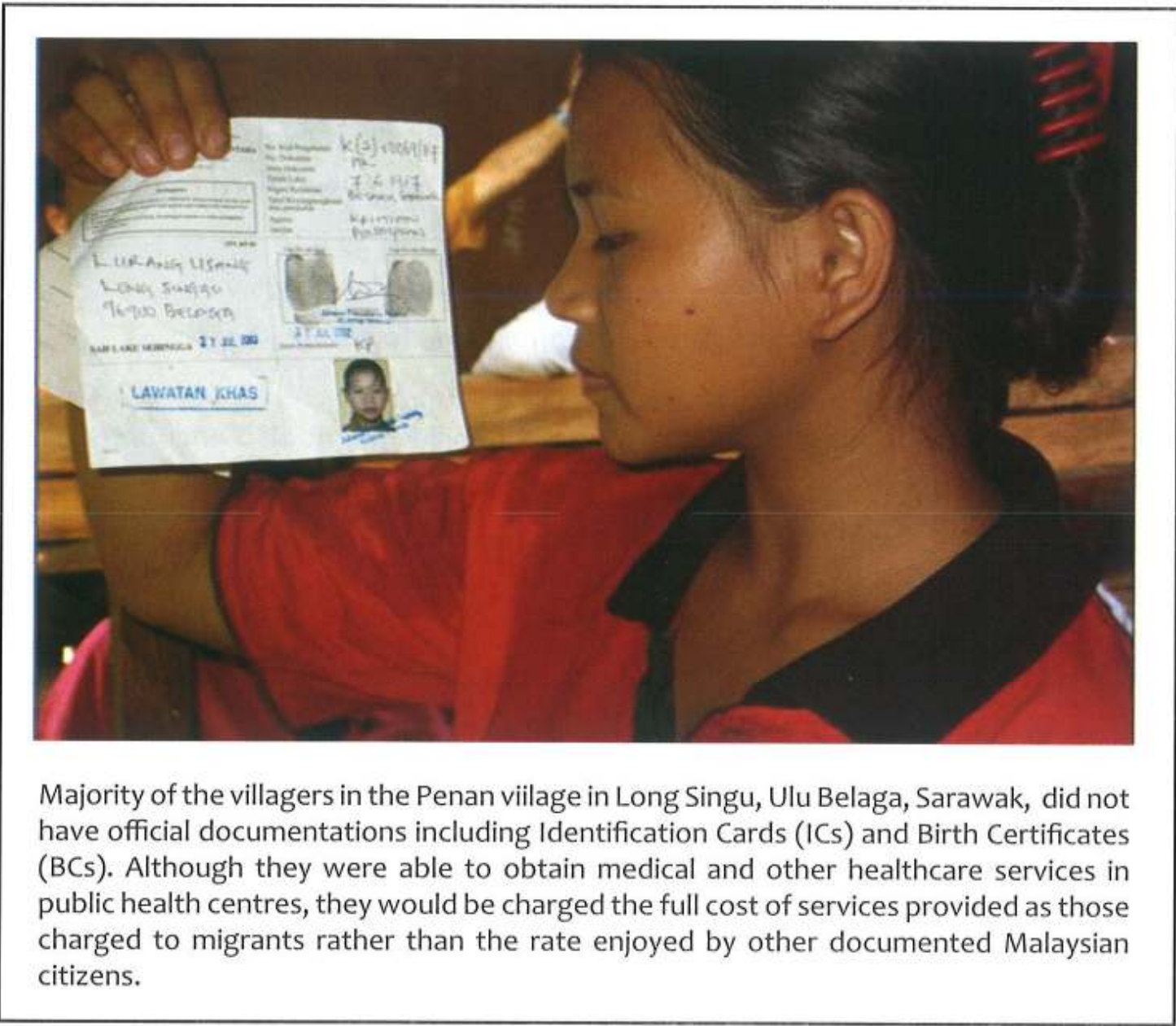
The dialogues noted that a majority of migrant workers in Malaysia worked as labourers in estates, plantations and construction sites and were remunerated with very low salaries/wages.

While the human rights law guarantees that all peoples are entitled to their right to health without distinction, in Malaysia, migrant workers are charged with higher fees for treatment compared to charges on local patients.

(iv) *Do undocumented locals have equitable and affordable access to healthcare services in Malaysia?*

There were Malaysian citizens who do not possess Identification Cards (ICs) and Birth Certificates (BCs), such as indigenous peoples residing in isolated villages. In terms of healthcare services, these identification documents were essential, especially for Malaysian citizens, in order to obtain subsidised healthcare services provided at public healthcare centres.

In a previous study by SUHAKAM on the Penans in Ulu Belaga, Sarawak, in 2006, SUHAKAM found that a majority of the villagers encountered were undocumented. Later, SUHAKAM was made to understand by a representative from the relevant state agency that while undocumented Penan were able to access healthcare services in public healthcare facilities, they would be charged the full cost of treatment such as those charged to foreigners.



3. THE GOVERNMENT-PROPOSED NATIONAL HEALTH FINANCING MECHANISM

The discussions on human right and access to equitable healthcare prompted questions on whether the government-proposed National Health Financing Mechanism (NHFM) would ensure equal access in both economic and physical aspects. Discussions on the NHFM heard participants, in particular, at the Sarawak dialogue, who expressed their anxiety over the government’s approach in developing the NHFM.

(i) Is there sufficient community participation in the development of the NHFM?

The main concern that was repeatedly expressed by participants of the dialogue in Sarawak was the issue on the unavailability of information on the details of the NHFM in the public

domain. Participants did express anxiety over the fact that consultation on the NHFM in Sarawak and Sabah was unheard of by participants.

During the dialogues, participants have sought clarification on whether the mechanism would ensure the right to health amongst vulnerable groups such as the poor; whether treatments for chronic diseases would be covered under the NHFM; whether the NHFM would cover persons who were self-employed; and the method that would be used by the NHFM to determine the quantum or premium which the public has to contribute under the scheme.

(ii) *Would the NHFM lead to Privatisation?*

Following unavailability of information on the details of the NHFM, participants further expressed their apprehension on whether the implementation of the NHFM would also bring about the privatisation of healthcare in Malaysia. Privatisation would mean higher healthcare costs and consequently would further reduce economic access especially amongst economically disadvantaged groups and individuals.

Some expressed preference on the current private-public system. The private would serve the healthcare needs of those with financial access while the public healthcare sector would serve as a safety net for the general public, especially the poor.

4. CONCERNS OVER THE CURRENT HEALTHCARE SYSTEM IN MALAYSIA

Concerns over the impact of the NHFM on the healthcare system also prompted participants to assess the strength and weakness of the current healthcare system in Malaysia. The discussions heard critiques made by participants and speakers, particularly on the budget allocation and subsidy as well as management and delivery of services provided in healthcare centres in Malaysia, especially those in the public sector.

(i) *Is the current amount of national budget allocated for healthcare sufficient to meet the current healthcare needs in Malaysia?*

Concerns were raised on the low allocation for healthcare budget in Malaysia and moreover on the fewer portion allocated for healthcare in Sabah and Sarawak. According to the World Health Organisation (WHO) Report entitled World Health Statistics 2007, in 2004, Malaysia's total health expenditure on health was 3.8% of the country's Gross Domestic Product (GDP), still short from the recommended 5% of GDP by WHO.

Participants questioned the amount of allocation from the overall national budget allotted to other sectors which they viewed as lesser priority compared to vital healthcare services.

(ii) *Is the budget allocation for healthcare in Malaysia being utilised appropriately to meet the basic health requirements of the population?*

Participants expressed uneasiness over the utilisation of healthcare budgets on healthcare facilities that seemed less in importance when compared to ensuring access to vital healthcare facilities and services for all in Malaysia. An example was the spending of billions of Ringgit for state-of-the-art healthcare facilities in the urban areas which could only be accessed by the elite few, when some rural and isolated communities do not even have access to basic healthcare services. For some other communities, while they had access to community clinics, some facilities were without electricity and clean water supply.

(iii) *Is subsidy the best option for healthcare in Malaysia?*

While some participants were of the opinion that the budget allocation for healthcare in Malaysia should be increased, others felt that extreme dependency on subsidy by the healthcare sector could bring about negative impact. Members of the public were seen as too accustomed to cheap healthcare costs made possible by subsidies, that any plan to decrease the amount of subsidy was seen as politically inexpedient. However, it was critical for the public to realise that maintaining subsidies to keep the public healthcare sector afloat could lead to the bankruptcy of the country, in view of the escalating cost of healthcare throughout the globe.

According to a government study, the actual cost of service per patient in a government clinic/hospital was RM45. However, patients of these facilities were only required to pay RM1 while the rest is subsidised by the government.²²

(iv) *Public access to certain scheduled drugs and poisons*

Certain scheduled drugs and poisons were widely and easily accessible in pharmacies. Participants were concerned that access to such items could lead to misuse of substances by some.

(v) *Use of drugs as first medical response*

There were concerns over the tendency of many medical professionals who prescribe drugs as primary response to many forms of illnesses.

²² Source: New Straits Times (NST) on 'Looking for a Healthy Compromise', on 8 April 2006

(vi) Are healthcare providers compassionate to patients?

It was highlighted that there were many complaints received by both private and public hospitals on dissatisfaction on the attitude of healthcare personnel towards patients. It was said that this attitude was moulded by the general Malaysian culture which, in contrast to what had been claimed, was not entirely compassionate.

5. PUBLIC AWARENESS ON THE RIGHTS AND RESPONSIBILITIES TOWARDS THE REALISATION OF RIGHT TO HEALTH

Following the issues discussed during all discussion sessions, participants began to question the level of awareness of all in Malaysia - including the government, healthcare providers and the public - on the fact that health is a human right and the duties of all, especially the principal duty bearer, to respect, protect and fulfil this right.

(i) Health - Is it recognised as a human right in Malaysia?

It was said that health in Malaysia appeared to be driven more by commercialisation rather than human rights.

To illustrate, health tourism was being promoted by Malaysia to foreigners despite the fact that there remain disparities in access to healthcare, especially amongst those in the rural and interior areas. Another example was given by a participant from the dialogue in Sarawak who accounted a scenario whereby a female migrant worker was asked to pay for the cost of a caesarean section which she crucially needed. The operation would not be carried out until payment was made.

(ii) Is the public aware of health as a human right and their duties to promote and protect this right?

While it was noted that the government has the primary role as the main duty bearer to respect, protect and fulfil the right to health of its people, it was highlighted that the public too had the rightful duty to ensure they promote and protect their own health.

In this light, there were concerns that there were some within the Malaysian society who seem unaware of their role to safeguard their health and hygiene. Besides contributing to indiscriminate waste disposal, there were those who consume alcohol, nicotine and drugs without considering affects to their health.



Indiscriminate waste disposal was apparent, and without access to proper sanitation and waste disposal services. The picture was taken by SUHAKAM during their visit to Kampung Beladin, Pusa, Sarawak

The lack of awareness amongst the public, including healthcare providers, on the right to and duties towards health had resulted in several problems in terms of the peoples' expectations and reactions such as the followings:

- *Unrealistic demand for immediate results*

Following inadequate knowledge on the provisions under the relevant international human rights documents - which allows for progressive realisation of human rights taking into consideration the constraints due to limitation of available resources - have led to unrealistic demands for immediate provisions, implementation and results in order to obtain cheap healthcare services.²³

- *Lack of Awareness on the importance of physician's consultation*

It was felt that some members of the public were unaware of the importance of physicians' consultations. For reasons of costs, some had resorted to self-medication without a doctor's consultation to avoid paying the related consultation fees. They would also obtain medicines

²³ Article 2 (1) of the ICESCR states that Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. See also Para. 30 of the General Comment on Article 13 of the same Covenant for further explanation on its implementation.

from pharmacies which were sold at cheaper prices compared to those dispensed by doctors.

There were also concerns over the possibility of a person being wrongly medicated. While pharmacists could assist, they may not have the capacity or expertise to detect and diagnose certain ailments. This is especially risky for those who were unaware that they were suffering from ailments, which left untreated, could lead to fatality.

Further it was said that while some others realised the importance of such consultations, they expected them to be provided free of charge and amounts paid by them were solely for medicines.

B. SUHAKAM'S RECOMMENDATIONS

Malaysia is to be a nation of healthy individuals, families and communities, through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer friendly, 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.

***Vision for Health,
Ministry of Health, Malaysia***

Based on the observations made on issues raised by participants at the dialogues as well as field studies by SUHAKAM, and in view of the Health Vision of the Ministry of Health Malaysia, SUHAKAM makes the following recommendations:

1. ENSURE COMMITMENT TO HEALTH AS A HUMAN RIGHT

(i) Legal Recognition on Health as a Human Right

SUHAKAM strongly recommends that health as a human right be enshrined and guaranteed by the Federal Constitution of Malaysia.

Further, SUHAKAM recommends that the government ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR) that guarantees, among others, the right to health and determinants of health.

(ii) Ensure Human Rights Principles are Anchored in Policies and Programmes

SUHAKAM urges the government to ensure that all policies and programmes pertaining to health are anchored by the fundamental principles of human rights.

2. INCREASE HEALTHCARE BUDGET ALLOCATION

(i) Incremental changes to increase Budget allocation to 5% of GDP

SUHAKAM recommends that the budget for healthcare be incrementally increased to at least the WHO-recommended 5% of the national GDP.

(ii) Increase allocation to improve access to healthcare in rural and remote areas

SUHAKAM strongly urges the government to increase budget allocation to be channelled to overcome urgent access related issues, particularly in lesser developed states and rural and isolated areas and villages.

3. ENSURE PHYSICAL ACCESS TO HEALTHCARE FOR ALL IN MALAYSIA

(i) Ensure Physical Access - Healthcare Facilities and Services

- *Equality in Access to Healthcare Facilities and Services*

Much has been done by the government to expand access to healthcare for the rural population. However, there remain pockets of deprivation and the need for the government to ensure healthcare facilities and services are within easy reach for all. Emphasis is to be given to ensure access to healthcare services amongst those residing in the more remote and isolated areas and areas inhabited by indigenous peoples.

Access should include not only physical access to clinics and health centres, but also an improved and comprehensive healthcare service in view of disease patterns and increasing health demand. For instance, rural and community clinics that only provide services for maternal and child care should be reviewed to include other essential healthcare services, such as treatment of communicable diseases like dengue and malaria.

Besides the above, ensuring physical access would also include recognising and promoting indigenous healthcare such as indigenous medicines as well as recognising community healthcare practitioners such as midwives, shamans and herbalists. In countries like Vietnam, the people have the option to obtain either modern or traditional/indigenous healthcare services.

- *Ensure Access to the Underlying Determinants of Health*

Besides access to healthcare facilities and services, there is the need for the government to ensure that, as far possible, all persons in Malaysia have physical access to the underlying determinants of health including access to nutritious food, clean and safe drinking water, sanitation, clean environment and access to health information.

There is also the urgent need for the government to ensure disadvantaged communities, particularly communities in rural and isolated villages, like the indigenous peoples, are not exposed to further health threats contributed by forest based activities like logging and plantations which bring about pollution to their main sources of water from rivers and lakes, as well as their environment. Such communities should not be put at risk in the name of development.

In addition, there is also the need for the government to ensure access to health related information especially those who lack interaction with the mainstream society and could not enjoy modern technology such as the internet. Information could include, among others, on the causes, symptoms and management of common diseases, as well as information on the types and locations of available healthcare services.

- *Ensure Availability of other Basic Amenities*

SUHAKAM is of the view that the Health Vision of the Ministry of Health, could be achieved by ensuring availability of basic amenities, such as access roads and public transportation that would bolster delivery of government services, especially to communities in rural and isolated areas.

- *Ensure disabled- and elderly-friendly facilities and basic amenities*

SUHAKAM strongly recommends that the government takes into consideration the needs of persons with disabilities and the elderly when structuring all healthcare facilities in Malaysia. For instance, ramps for wheelchairs and signage for those with hearing impairment should be provided.

There is the need for the government to ensure that public amenities like public transportations and pedestrian facilities are provided to bolster physical access to healthcare facilities and that services are disabled- and elderly friendly.

- *The Need for an Integrated Approach*

SUHAKAM notes that while access to healthcare facilities is very much dependent on the availability and accessibility of the underlying determinants of health, the responsibility to ensure these were being addressed are shouldered by different agencies. For instance the

health field is under the Ministry of Health, access to roads by the Public Works Department, access to clean water supply by the Ministry of Energy, Water and Communication.

SUHAKAM thus recommends that the government strengthens the multi-agency integrated approach to ensure that public infrastructure such as roads and transport are in place to encourage better access to health and other facilities.

(ii) Ensure Economic Access to Healthcare Services

- *Affordable Healthcare for All*

SUHAKAM urges the government to ensure that healthcare services are affordable to all in Malaysia. This not only includes primary healthcare, but also secondary and tertiary healthcare services. There is the need to ensure healthcare is provided as a basic human right and a public good rather than as a profit making commodity.

- *Intensify Poverty Eradication Programmes*

SUHAKAM recognises the significant effect of the government to eradicate poverty, specifically among the hardcore poor. SUHAKAM recommends that poverty eradication programmes are reviewed to ensure programmes reach and are benefited by communities who are the poorest of the poor, such as indigenous peoples residing in interior and isolated areas and people residing in areas with difficult geographical terrains.

There is also a need for the government to intensify programmes to eradicate urban poverty as the urban poor lack healthcare services due to their limited income and the escalating cost of healthcare.

- *Review the issue of Health Care Access to Undocumented Malaysians*

Although, access to public healthcare services for Malaysian citizens may be one of the most subsidised throughout the world, proof of citizenship – through possession of Malaysian ICs and birth certificates – is required to enable a person to obtain those inexpensive services.

To ensure all Malaysians have equal access to healthcare, it is, therefore, fundamental for the government to identify undocumented Malaysians through field operations and to urgently register them and issue ICs and birth certificates.

In addition, parent(s) of children born out of wedlock should be encouraged to register their newborns. At present, they are afraid of being apprehended by relevant authorities.

4. ENSURING THE RIGHT TO HEALTH OF MIGRANTS IN MALAYSIA

In Malaysia, migrant workers are unable to enjoy full access to healthcare services as to the extent enjoyed by citizens. They are required to pay for the full cost of healthcare services despite having paid levy for their work permit.

Among the important pillars of human rights is the right to equality and non-discrimination. These principles are enshrined in almost all human rights instruments, mirroring their significance in realising human rights for all, including migrants.

5. RECOMMENDATIONS ON THE GOVERNMENT'S PROPOSAL FOR A NATIONAL HEALTH FINANCING MECHANISM (NHFM)

(i) Ensure Public Access to information on the NHFM and hold widespread consultation

SUHAKAM urges the government to provide information to the public on the NHFM, to encourage public participation and to consult stakeholders and the public. This will allow for effective dialogue and concerns of the public can be addressed.

(ii) NHFM must include Coverage for Healthcare for the Poor and Vulnerable

SUHAKAM strongly recommends that the government ensures that the NHFM caters for the healthcare needs of the poor and vulnerable. Besides this, the NHFM must also take into consideration the fact that middle income families may not afford the cost of secondary and tertiary healthcare services.

6. IMPLEMENT STRICT MONITORING

SUHAKAM urges the government to implement a strict monitoring system to ascertain the effectiveness of current programmes in meeting the population's growing health needs and demands.

It is fundamental to ensure that health programmes and services listed by the authorities as contributing to Malaysia's laudable health coverage are, in reality, readily available and easily accessible at all times, especially during emergencies.

C. CONCLUSION

Malaysia's healthcare status has improved greatly over the years and healthcare coverage has reached more than 90% of the total Malaysian population. Malaysia is widely known as an advanced developing country, while its healthcare system is comparable to that of some developed countries, and serves as a model for other developing countries.

The ideal move forward, therefore, would be for the government to address the remaining pockets of inequity and deprivation within its society. SUHAKAM's Dialogues on Human Rights and Access to Equitable Healthcare gave clear indication of the prevailing issues and underserved groups whose health rights require dire attention from the government.

In addressing the above, it is imperative to view the advancement of health as not only an asset to boost human capital which would, in turn, contribute to the country's economic development, but also to recognise health as, first and foremost, a fundamental human right. Thus, this right needs to be guaranteed by the law, in particular, the Federal Constitution of Malaysia.

The fundamental human rights principles of equality, non-discrimination and justice are among the important pillars to ensure the right to health for all. Malaysia's Vision of Health which, among others, includes ensuring 'equity' to healthcare carries the same notion of these human rights principles.

Without discounting the duty of the public towards their health and the health of others, legal recognition by the Federal Constitution, coupled with Malaysia's Vision for Health would enable further health progress. These give rise to the core obligations of the government to ensure equality and non-discrimination of every person in accessing their right to health.

PART III

**REPORT ON THE PROCEEDINGS OF SUHAKAM'S DIALOGUES ON
HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE
IN KUCHING, SARAWAK; KOTA KINABALU, SABAH;
AND KOTA BHARU, KELANTAN**

A. DIALOGUE IN KUCHING, SARAWAK ON 5 NOVEMBER 2007

1. AGENDA

The dialogue in Kuching, Sarawak, followed the following agenda:

TIME	AGENDA		
0800 - 0900	Registration of Participants		
OPENING SESSION			
0900 - 0915	OPENING REMARKS by Dr. Mohammad Hirman Ritom Abdullah SUHAKAM Commissioner/ Resident Commissioner in SUHAKAM Sarawak Office		
0915 - 0935	INTRODUCTION TO THE DIALOGUE by Datuk Dr. Raj Abdul Karim SUHAKAM Commissioner		
0935 - 0950	Refreshments		
SESSION 1 : TOWARDS EQUITABLE HEALTHCARE FOR ALL			
0950 - 1120	Paper 1:	TOWARDS EQUITABLE HEALTHCARE FOR ALL - PROVIDING HEALTHCARE TO THE RURAL AREAS OF SARAWAK by Dr. Andrew Kiyu Director, Public Health Division, Sarawak Health Department	Moderator: Ustaz Mohammad Uthman El-Muhammady, SUHAKAM Commissioner
	Paper 2:	TOWARDS EQUITABLE HEALTHCARE FOR ALL - A HUMAN RIGHTS PERSPECTIVE by Datuk Dr. Teoh Siang Chin Chairman, Medical Association of Southeast Asian Nations (MASEAN)/Past President, Malaysian Medical Association	
		DISCUSSION SESSION	
SESSION 2: ACCESS TO EQUITABLE HEALTHCARE SERVICES: EXPERIENCE OF VULNERABLE/MARGNIALISED GROUPS			
1120 - 1250	Paper 1:	EQUITABLE ACCESS TO HEALTHCARE FOR ALL: IS THIS STILL A PIPE DREAM FOR MALAYSIA? A MEDICAL PROFESSIONAL'S PERSPECTIVE by Dr. David K.L. Quek Committee Member, Malaysian Medical Association	Moderator: Dr. Mohammad Hirman Ritom Abdullah, SUHAKAM Commissioner
	Paper 2:	ACCESS TO EQUITABLE HEALTHCARE SERVICES: EXPERIENCE OF DISABLED PERSONS (PWDS) by Mr Donald Law Member, Pertubuhan Orang Cacat Sarawak	
		DISCUSSION SESSION	
1250 - 1400	Lunch Break		
SESSION 3: DISCUSSION SESSION			
1400 - 1600	DISCUSSION SESSION ON MOVING TOWARDS EQUITABLE HEALTHCARE FOR ALL		Moderator; Datuk Dr. Raj Abdul Karim, SUHAKAM Commissioner
1600	Tea Break / End of Programme		

2. SUMMARY OF PROCEEDING

(i) Opening Session

Welcoming Remarks

SUHAKAM Commissioner, Dr. Mohammad Hirman Ritom Abdullah, in his opening remarks, welcomed all participants to the dialogue. The dialogue was seen as an arena for input from participants from various backgrounds on the issue of access to equitable healthcare. These issues would be forwarded to the government towards contributing and strengthening the future national health policy. Emphasis would be given to human rights to ensure that the general population are able to enjoy their right to health.

He concluded by expressing his gratitude to all those present at the dialogue.²⁴

Introduction to the Dialogue

SUHAKAM Commissioner Datuk Dr. Raj Abdul Karim began her Introduction on the Dialogue by quoting article 25(1) of the UDHR which guarantees every person's right to health, including the entitlement of special care and assistance in motherhood and childhood. On 10 October 2006, the WHO and UNHCHR, had together decided on common areas, based on which a plan of action would be developed, to include, among others, safe motherhood, elimination of discrimination especially amongst persons living with HIV/AIDS and health rights of detained psychiatric patients.

The dialogue would hopefully discuss access to equitable healthcare, taking into account the human rights principles of universality, indivisibility, interdependence and interrelatedness. For instance, the right to health is intrinsically linked with other human rights such as right to life, non-discrimination as well as benefits from scientific progress.

She continued by defining the right to health as specified by international human rights laws and UN general comments which include the components and determinants of health. It is important for governments to take measures, such as a national public health strategy or plan of action to ensure all these are included for the purpose of realising every person's right to health.

The Speaker concluded by saying that the dialogue would ascertain the related concerns which need to be addressed by the government and particular attention should be give to disadvantaged and marginalised groups. All these should take into account the human rights perspective.²⁵

²⁴ The full text of the Welcoming Remarks by SUHAKAM Commissioner Dr. Mohd. Hirman Ritom Abdullah at the dialogue in Kuching, Sarawak on 5 November 2007 is attached as Annexure 1.

²⁵ The Introduction to the Dialogue presented by Datuk Dr. Raj Abdul Karim at the Dialogue in Kuching, Sarawak on 5 November 2007 is attached as Annexure 2.

(ii) Session 1: Towards Equitable Healthcare for All

Paper 1: Providing Healthcare to the Rural Areas of Sarawak

Dr. Andrew Kiyu, the Director of the Sarawak State Health Department, began by highlighting that the current demand for quality, technology, affordability, competent personnel and zero error is a challenge facing the current health system of Malaysia. The factors such as increasing cost of healthcare, health threats resulting from population growth, deforestation, rapid urbanisation, intensive farming practices, environmental degradation and irrational use of antimicrobials as well as rapid international spread of infectious agents and their vectors are also the causes of concern.

He continued by focusing on the challenges faced by the Sarawak Department of Health (SDH), as well as current services provided and strategies adopted in their attempt to reach all in Sarawak. These include scattered communities who live in isolated areas who could not be easily accessed due to the rough terrain. Despite these, the strategies adopted by the department had enabled them to achieve almost total coverage by emphasising rural health services and hospital care. As a result, Sarawak records very low maternal as well as infant and toddler mortality rate and a good immunisation coverage which is reflected in Malaysia's achievement to the MDGs.

To make all these possible, the SDH adopted a set of philosophies which among others, included recognising that health is a human right, enabling affordable economic access and emphasising healthcare services in rural areas.

He continued by highlighting the services currently provided in the rural areas, including those implemented to reach scattered and isolated communities, such as the Flying Doctor Service (FDS), *Wakil Kesihatan Kampung* (WKK), Village Health Team (VHT) and Klinik Kesihatan (rural clinics). These facilities are established in ways that fit the population size and service expectation.

The rural clinic or Klinik Desa in particular, is a one-stop centre which provides promotive, preventive, curative and rehabilitative care. In some areas, such as the Penan areas, the rural clinic is equipped with a Penan hut in order to ensure facilities are socio-culturally 'friendly'.

He had also highlighted the methods adopted by the Department to overcome communication challenges and to ensure competency of staff, supervision and guidance of rural health facilities. Additionally, participation of villagers is welcomed by the Department. For instance, VHPs are amongst local villagers who are trained and later returned to serve their communities.

Dr. Andrew Kiyu said that new developments which were being looked into by the Department to improve the delivery of healthcare services, especially for rural and isolated villages.

In conclusion, he reminded participants that the current healthcare system in Malaysia is highly subsidised by the government. The government is currently in the final process of detailing the mechanism for the national health financing scheme for Malaysia.²⁶

Paper 2: Towards Equitable Healthcare for All - A Human Rights Perspective

Datuk Dr. Teoh Siang Chin, the Chairman of the Medical Associations ASEAN focused his presentation on the right to health, and the issues, challenges and opportunities in Malaysia.

He began his presentation by highlighting international laws and declarations which guarantee every person's right to enjoy the highest attainable standard of health. They include, among others, the WHO Constitution 1946, UDHR, Declaration of Alma Ata 1978, Millennium Declaration, and other International Human Rights Instruments.

He had highlighted the human rights perspective to health which includes right to healthcare and goes beyond to encompass the underlying determinants of health. He also outlined the components of right to health which include accessibility availability, acceptability and quality.

Today, the main global challenges to health include neglected diseases and populations. The former refers to tropical diseases such as tuberculosis and kala-azar, and the later includes the poor and powerless living in rural areas. Some diseases are life threatening and inflict economic burden. Ill health also contributes to the poverty cycle.

The speaker went on to highlight the UN appointed Special Rapporteur (SP) on the right to the highest attainable standard of health, Prof. Paul Hunt, as well as his role, issues in focus, activities and reports submitted to the UN General Assembly.

Datuk Dr. Teoh had also focused his presentation on the issues on health in Malaysia, including the issues of brain drain, migration of skills from public to private sectors and remuneration and incentives for health personnel. According to him, It was essential to ensure human rights knowledge amongst health personnel. At the very least, all health personnel should receive education on human rights of patients including their right to health, health related human rights of vulnerable groups and their own human rights. He exemplified the Malaysia Medical Association Annual General Meeting Resolutions 1999 which emphasise human right to health, namely the right to be free from torture and ill treatment, the right to care for disadvantaged groups and the right to care for prisoners.

²⁶ The Presentation on Providing Healthcare to the Rural Areas of Sarawak presented by Dr Andrew Kiyu at the dialogue in Kuching, Sarawak on 5 November 2007 is attached as Annexure 3.

He had also highlighted the major health challenges in Malaysia, which includes, among others, the level commitment of policy holder towards human rights, human rights and health is seen as a relatively new area of work, increasing inequality in access to healthcare and health outcomes and weaker rural health systems which have bigger impact on the poor.

The speaker later put in view a list of international human rights instruments having significant effect in viewing health as human rights, which Malaysia is or not a state party to. He later listed some attributes which could help Malaysia to further improve the enjoyment of this inherent entitlement.

In conclusion, the speaker said that the right to the highest attainable standard of health is the global standard and necessary to achieve health for all as it gives a framework for the government to meet its moral obligations. It is necessary for organisations to come together and advocate for the accession of the ICESCR.²⁷

Discussion for Session 1

- **Registration of Newborns**

A participant from SUHAKAM enquired about the system adopted by the Sarawak State Health Department (SHD) to ensure completeness in the recording of details of newborn. She said that in some cases, details were incomplete and exemplified her experience during a visit by SUHAKAM to a community in Baram, Sarawak. She explained that during her visit, they found that one of the children met, while having possessed a birth certificate, had no information on the date of birth. This section was recorded as 'unknown' despite the fact that the birth certificate recorded that birth was at Long San Clinic in Baram.

Dr. Andrew Kiyu responded by saying that the responsibility of the registration of newborns for the purpose of birth certificates and ensuring its completeness is borne by the National Registration Department (NRD). He, however, added that the information of births at government clinics, was also recorded in the Child Health Card (CHC). This information is available at the SHD and is accessible and could be obtained to the NRD. The CHC has complete information not only on place and date of birth, but also time of birth, weight and others.

In addition to the CHC, officers of the SHD, in arrangement with NRD, would assist in recording basic information on a newborn in certain areas. Officers from SHD, at other times would assist patients in their clinics, to travel to the nearest registration office for the purpose of applying birth

²⁷ The Presentation on Towards Equitable Healthcare for All – A Human Rights Perspective presented by Datuk Dr. Teoh Siang Chin at the dialogue in Kuching, Sarawak on 5 November 2007 is attached as Annexure 4.

certificates. This, however, would take a significant amount of time and lead to the persisting issue of late registration, for instance, amongst the Penan. In turn, this community for example, had put the blame on the health department for not bringing the relevant documents properly which had led to non-documentation. Therefore, he emphasised that recording by the health department is solely for the registration of births and not meant to determine citizenship. The latter is the responsibility of the NRD and not the SHD.

- **Programmes for Combating Thyroid for the Penan**

A participant from SUHAKAM made a specific reference on the presentation by Dr. Andrew Kiyu on hypothyroidism. She asked on the available programmes specifically for the Penan, who may be iodine deficient since they lack salt in their diet.

Dr. Andrew Kiyu said that for villages identified as goitre prone areas, salt would be delivered via the Flying Doctor Service (FDS). Once areas were identified, salt sold or delivered must be iodised to a certain level. However, the number is significantly small and he foresaw this programme to be halted as communities have increased access to salt. For instance, the Kelabit in Bario produce salt from salt springs. The product, which is called Kelabit or Bario Salt, contains iodine at levels enough for the Kelabit's needs.

With regards to the Penan, he said that salt has in fact become part of their diet due to heightened access to the product. The Penan's economic and trade activities with other communities such as the Kayan, Kenyah and Kelabit as well as access to small village shops have made this possible.

- **Privatisation of Healthcare**

A participant from UNIMAS raised concerns on privatisation and possible effects to the disadvantaged or marginalised groups. He said that the government has to be forth coming and transparent in any plans to change the current healthcare system. As citizens and taxpayers, all should be involved in the process.

Datuk Dr. Teoh replied by saying that there were many who share the same views. However, based on the theme of the dialogue, the concerns raised by the participant should be highlighted in a different forum. This dialogue on Access to Equitable Health looks mainly at the right to health.

Nonetheless, the Speaker said that those concerns which related to the government's proposal for the National Health Financing Mechanism (NHFM) had been raised to the government. He said he had assisted in enabling a meeting between the Coalition Against Healthcare Privatisation (GMPPK) with the Australian Consultant appointed.

- **Status on the NHFM**

Datuk Dr. Raj Abdul Karim added by informing participants on SUHAKAM's efforts in addressing issues concerning the NHFM which includes bringing the concerns of the GMPPK to the government's attention and giving SUHAKAM views to be included in the NHFM including right to health and priority for the poor and marginalised.

She added that the report by the said Australian Consultant had been put on hold by the MOH. The main issue arising from this scheme also relates to equitable access especially amongst the poor. As today's dialogue looks at the issue of equity, concerns and views would be forwarded to the government for consideration.

- **Allocation of the National Budget for Healthcare in Malaysia**

Reference was made to the statement made by both speakers on scarce resources. A participant said that Malaysia is a rich country and the problem was not the issue of scarce resources, but in fact, a misallocation of the national budget. He drew attention to the spending of billions of Ringgit worth of submarines and air fighters. The submarines for instance, were later found to be unsuitable for the shallow straits of Malacca and could easily be detected by satellite. He was of the opinion that these allocations could instead be used to improve the delivery of healthcare services, include better remuneration and training of health personnel.

Datuk Dr. Teoh said that there was the need for participants to understand the government's constraints and rationale in deciding the proportion of allocation for the sectors. For instance, the submarines, while they are not needed and unsuitable for the Straits of Malacca, it was, however, necessary for security in the Sulu Sea which was currently poor. To overcome the minimal allocation for the health sector is by seeking additional funds or incremental changes to the overall funds available.

He added that it was necessary for both government and social groups to address this diplomatically between each other and not to adopt an antagonistic approach.

While this issue was not in line with the theme of the dialogue, the speaker said he was ready to discuss the NHFM with the participant in a separate meeting.

Following this discussion, another participant enquired on the actual amount of government allocation for the healthcare sector.

In response, Datuk Dr. Teoh said that this equals to about 3.2% of the total Gross Domestic Product (GDP). This is including for both the public (1.8%) and private (1.7%) sectors. The Ninth Malaysia Plan 2006-2010 specifies the total budget of about RM10 billion for the Plan period. However, it

should be noted that the health sector would need approximately RM10 billion for operational costs for one year alone. However, he explained that the responsibility to ensure the availability of the components of health was shared by a few other agencies. For instance, the local council is responsible to ensure access to sanitation which is a component of health.

Nonetheless, he said he shared the same concerns on the budget allocation for the development of healthcare in Sabah and Sarawak. He reiterated his previous statement that incremental changes be made to increase the current allocation rather than obtaining them from the budget provision/ allocation apportioned for other sectors.

- **Integrated Healthcare System**

In response to the comment that Malaysia needed to have an integrated primary, secondary and tertiary healthcare to ensure equity, Dr. Andrew Kiyu agreed and said that Malaysia's current primary healthcare is integrated with its tertiary healthcare. This was planned by the government to ensure, as far as possible, equity in healthcare.

- **Programmes for the Care of Persons with Disabilities**

Another participant asked on programmes to care for persons with disabilities amongst those who reside in the rural and isolated areas in Sarawak. She said that during her time as a public health nurse, Community Based Rehabilitation (CBR) was only available for children aged 7 years old and below. Those above this age-group did not have access to any sort of rehabilitation programmes near their villages and were cared by their families. There was only one centre in Long Laput, Baram Sarawak that catered for these children. The centre was run by NGOs in collaboration with the State Welfare Department. She felt that more of such centres should be established to help those youths.

In response, Dr. Andrew Kiyu emphasised that the responsibility to care for children/youths with disabilities did not solely fall on the government and is the responsibility of all. With regard to the care of children with disabilities, he said that the current situation was better than before. The MOH has implemented several programmes to ensure the availability of rehabilitation services for children with disabilities in Sarawak. A good example is the facility in Sibu Sarawak, which is multidisciplinary with neurologists, paediatricians and orthopaedic as some of them would require surgery and needed an integrated care approach.

With regard to the CBR, Dr. Andrew said that it was under the purview of several ministries including the MOH, Ministry of Education (MOE) and the Social Welfare Department (SWD). Currently, the CBR catered not only for children with disabilities, but also for the elderly. He said that there were cases where some elderly were left in longhouses without any assistance. The CBR would cater for their special needs.

Nonetheless, his concern centred on the care of children after the age of 12 years as the current system only catered for children below the age of 12. He also said that the protection of youths with mental disabilities was important as there were a number of cases relating to sexual abuse of mentally disabled persons.

- **Access to Disabled-Friendly Amenities and Facilities**

In terms of access to disabled-friendly amenities and facilities, Dr. Andrew Kiyu said that Malaysia had not reached the standard as those in developed countries such as Japan. In some less developed areas in Malaysia, these were scarce. It is an area which needs further attention by all and not just the Ministry of Health.

- **Medical Attention and Care for the Elderly**

On the care and medical attention for the elderly, Dr. Andrew Kiyu said that Malaysia was now in the infancy stage of developing extra medical disciplines to meet the special needs of some groups such as the disciplines to care for the elderly. Currently, there was only one geriatrician and one rehabilitation medicine specialist to cater to the medical needs of the elderly and the aging population throughout the State. This was because such disciplines were viewed as unpopular and unrewarding as it was perceived that the health of the elderly would inevitably deteriorate. To overcome this, he said that the government was providing scholarships for these disciplines to encourage higher enrolment.

(iii) Session 2: Access to Equitable Healthcare Services: Experience of Vulnerable/ Marginalised Groups

Paper 1: Equitable Access to Healthcare for All: Is this Still a Pipe Dream for Malaysia? - A Medical Professional's Perspective

Dr. David K.L. Quek noted that while Malaysia has a good health system that is reflected in the increase of life expectancy and globally renowned primary healthcare, there are some who are unable to access these facilities as reported in various media.

He had illustrated some issues relating to the health system and access to healthcare services in Malaysia, such as availability and accessibility of medical funds, low allocation of the Nation's GDP for health related development, doctor-patient ratio; lack of necessary manpower for numerous modern facilities, and defects of newly built million-dollar facilities. He said that in some instances, state-of-the-art hospitals were built so that full paying patients could be charged with higher fees. This triggered protests which they saw as decreasing access to healthcare services especially amongst marginalised groups and individuals. Additionally, the Full Paying Patients Concept had mixed reviews. Some commended the move which was seen to discourage migration of doctors,

while others claimed that this could lead to preferential favouritism when dealing with full paying patients and highly subsidised patients.

Based on a recent report by the Joint Medical Consultative Council and the National Health Service (NHS), Dr. David K.L. Quek listed the modern expectations of patients towards healthcare services. These include, among others, fast access and reliable; affordable quality and effective treatment; participation in decision; respect for privacy; continuity of care; and smooth transition.

He also illustrated the pros and cons of health funding mechanisms adopted by other countries such as the United States of America and Taiwan. On the new National Health Financing Scheme proposed by the MOH, while it was viewed enthusiastically in the earlier stage, amendments made to the scheme created some concerns and drew criticism from a large proportion of the population. Among others, concerns related to the accessibility to healthcare for all, the quantum of coverage, and coverage for ailments requiring high costs of treatment.

In conclusion, he emphasised the need for common ground on a system that could meet the needs of all, including the government. There was the need for the process to be transparent and made available in the public domain. Despite these, the speaker was optimistic that Malaysia would adopt a system that was anchored on human rights for its citizens.²⁸

Paper 2: Access to Equitable Healthcare Services: Experience of Disabled Persons

A representative from the Pertubuhan Orang Cacat Sarawak (POCS), Mr Donald Law began his presentation by defining the terms 'disability' and 'disabled person'. Based on data by the WHO, 5%-10% of the total population comprise of people with disabilities. He had focussed on the total number of registered disabled persons in Malaysia and Sarawak which were 197,579²⁹ persons and 11,920³⁰ persons respectively.

He had also specified the categories of disabled persons and possible causes of those disabilities; explained the effects of disability on a person, who, therefore would need assistance, support and proper treatment and rehabilitation and later specified the strategies for the care of disabled person.

28 The Presentation on Equitable Access to Health Care for All: Is this still a Pipe Dream for Malaysia? A Medical professional's Perspective presented by Dr. David K.L. Quek at the dialogue in Kuching, Sarawak on 5 November 2007 is attached as Annexure 5.

29 The Speaker stated that this data is based on the number of those registered under the Jabatan Kebajikan Masyarakat Malaysia (as at 31 December 2006)

30 The Speaker stated that this data is based on the number of those registered under the Jabatan Kebajikan Masyarakat Negeri Sarawak (as at 31 December 2006)

After defining the right to health as given by the World Health Organisation (WHO), the speaker explained that the basis of justification for access to equitable healthcare for disabled persons is enshrined in numerous international human rights laws and declarations such as the UDHR, ICESCR, CRC, UN Convention on the Rights of Persons with Disabilities, and Declaration on the Rights of Disabled Persons. In Malaysia, a Persons With Disabilities Bill was currently being drafted by the Ministry of Women, Family and Community Development.

The speaker had highlighted the obstacles in ensuring access to equitable health for all which include poverty, environment and lack of access to information and communication.

He concluded by proposing several strategies to ensure access to equitable healthcare for Persons with Disabilities which include ensuring the role of the government as signatories to international human rights instruments; the role of the public, including persons with disabilities, to complement the work of the government; and the corporate social responsibility of the private sector towards persons with disabilities.³¹

Discussion for Session 2

- **Addressing Persons with Mental Disabilities**

Starting off the discussion for Session 2, a participant from the Sarawak AIDS Council Society commented that some institutions in Sarawak still use the term 'retarded'. She felt that this term was inappropriate and the use of the term should be stopped.

- **Care and Assistance for Persons with Disabilities**

Mr. Donald Law emphasised that all human beings, including those with disabilities have human rights. He also reminded participants that disability was not only caused by defects before birth, but could also be brought about later in life such as physical disabilities caused by accidents and illnesses. Therefore, he felt that all persons, young and old, as well as future generations, should understand the importance to ensure access to facilities and to endeavour towards ensuring facilities, care and assistance for persons with disabilities.

- **Early Detection and Protection for Children with Disabilities**

A participant said that in discussions pertaining to persons with disabilities, an important aspect that was usually overlooked was early detection. There were cases where conditions have been cured with early detection and treatment. If such conditions were not identified early and treatment was not given in time, this resulted in illness becoming serious and led to permanent disabilities.

31 The talking points on Access to Equitable Healthcare Services: Experience of Disabled Persons (PWDs) presented by Mr. Donald Law at the dialogue in Kuching, Sarawak on 5 November 2007, is attached as Annexure 6.

treatment. Contribution paid to the NHFM would be used to pay a portion of the actual costs of treatment.

He added that in some cases in Malaysia, healthcare facilities were available but without adequate manpower. He mentioned the Serdang Hospital in Selangor, whose opening was delayed because of insufficient manpower. This was an issue that should be addressed by the government. Therefore, instead of building new facilities, funds obtained should be channelled to address all accessibility related issues. Additionally, fast action must be taken by the government to fill in the vacuum left by doctors who migrate to the private sector.

Dr Andrew Kiyu agreed that a mechanism had to be in place to address the increasing cost of healthcare in Malaysia. This is necessary as a large portion of the actual healthcare services provided was currently being paid by the government through subsidies. Maintaining this could drain out allocations and lead to the bankruptcy of the country. He opined that the scheme would avoid this and at the same time the system could look into sustainability and equitable access of healthcare services for all in Malaysia.

(iv) Session 3: Discussion Session on Moving towards Equitable Healthcare for All

- **Public Awareness**

The representative from UNIMAS felt that dissemination of information and public awareness programmes on types of medical services available needed to be improved. This would also include awareness raising on the seeking correct channels to obtain such services.

Dr. Andrew Kiyu responded by saying that due to rapid development of Malaysia and its people, some have assumed that every person in this country was aware of available health facilities. At the same time, some others took for granted and did not avail themselves to the services until it was too late. Awareness raising programmes were continually done by SDH. For instance, the CBR gives health related talks every week. This week's talk focuses on asthma. In addition to the talks, the SHD also has a monthly radio service.

- **Concerns on the Government's proposal for a National Health Financing Mechanism (NHFM)**

Status of the NHFM

A participant enquired on the current status of the NHFM and what had been done by the government, and particularly the MOH in this regard.

The Moderator of the Session explained that the process of developing the NHFM was halted recently and implementation postponed. She said that the government had not identified the most suitable method and source for the purpose of individual contribution to the NHFM. For instance either calculated based on Value Added Tax (VAT) or community rated. There were also concerns on whether the NHFM would cover those who were self-employed and whether the mechanism would cover treatment for chronic diseases. Coverage for the poor in terms of treatment for chronic diseases was also questioned.

Widespread Consultation to shape the NHFM

A participant from UNIMAS said that was the need for a widespread consultation to shape the NHFM. This would provide the society with an arena to voice out their concerns as well as to make recommendations on a system and its financing which were suitable and accepted by all. The relevant government agencies and other organisations such as the MMA and SUHAKAM could work together and lead the consultation process with all stakeholders.

Dr. David Quek concurred and emphasised the importance of a widespread consultation. He viewed positively the postponement of the NHFM as this would give more time and opportunity for the people to influence the direction of the NHFM.

NHFM or Privatisation

A participant expressed his concern that the NHFM would also mean the privatisation of healthcare. The latter would lead to increased cost for healthcare and consequently lower accessibility especially for economically disadvantaged groups and individuals.

In response, Dr. David Quek said that in line with the demands of current times, it was difficult to maintain cheap healthcare. The speaker reminded participants that the government had been subsidising healthcare costs for a long time and majority of patients only have to pay RM1-RM5 out of the actual cost of service obtained. This, in his opinion, was a strong reason that the people tend to forget the actual cost of healthcare.

Dr. David Quek highlighted that a person's healthcare need throughout his or her life could amount to about 20%-30% of his/her life savings. He explained that with a form of health insurance in place such as the NHFM, a portion of the actual cost of healthcare would be covered by the NHFM. The larger the population contributing to the NHFM, the lesser treatment fees would be.

He later explained that while the quantum of contribution was yet to be determined, he felt that it should not be expensive. He exemplified the healthcare scheme currently adopted by Australia. The former required the population to contribute about 1.4% of their earnings, and recently, there

was a plan to increase this to 1.9%. This increase was still affordable for the Australian population. For those earning less than a stipulated income level, contribution would be 1%. He later informed participants that he was involved in the discussions with the Ministry of Health Malaysia (MOH) on the quantum of contribution. After much deliberation, a quantum that was preliminarily identified at that time was about 2.5%-5.5% for employers' contribution and 3% for the employee.

Nonetheless, he felt that the public health sector must remain and act as a safety net for the poor. However, to some of Malaysians, the public health sector should be accessible to others in higher income levels. They have the opinion that government funds obtained from taxes was not appropriately apportioned. They felt that as healthcare was important, it should be prioritised and should receive more allocation. This was a reason why people were reluctant to the idea that the public had to contribute more than what they have already contributed through the current taxes.

Dr. David Quek agreed to the explanation by the moderator and said that the details of the NHFM were unclear. Another concern that was raised was whether the contribution would cover family member including among others, uninsured parents or only for him/her.

Dr. Andrew Kiyu later shared two guidelines which the MOH had practised. He explained that as mentioned in the Malaysia Plans, one of the government's philosophies was to have a district hospital in every district. However, the Eighth and Ninth Malaysia Plans did not enshrine this philosophy. A reason, in the context of Sarawak, was because districts could be created in any point of time, making the philosophy unpractical. To overcome inaccessibility of facilities was by way of consolidating and having good communication to ensure any cases could be referred to the relevant centre in any point of time. The use of IT was a good method.

Dr. Andrew said that the idea behind the NHFM was one of the MOH's service goals which was for the MOH to put in place a system that could enable a patient with a specific ailment to continuously get treatment interchangeably in both the public and private sectors without any boundaries such as the cost in the private health sector.

Proposal to Maintain the Current Mixed System

A representative from SUHAKAM felt that the current mixed system of the private and public sectors was an ideal system. The private sector could be driven for those who were able or could afford the associated costs while the public sector could cater for the health needs of disadvantaged groups such as the poor like the Penan in Sarawak. In terms of funds for the public health sector, he said that this was clearly the task of policy makers but taking into consideration of concerns and recommendations by the general public.

- **Physical Access for Some Communities**

A participant from SUHAKAM raised concerns over the lack of physical accessibility of healthcare facilities for some communities in Sabah and Sarawak. He felt that instead of the flying doctor service, healthcare facilities should be made available in isolate villages.

In response, Dr. Andrew Kiyu stated that ambulance was a form of access to healthcare services. It was however important for the public to understand that ambulance service was not only provided by the government, but also by other private healthcare providers and telephone numbers were different. There were times when private ambulances had arrived late to the scene which resulted in deaths, the public would mistakenly blame the government. Following this the government decided on the use of one general telephone number which is 999 for both public and private ambulance and calls would be diverted to the provider nearest to the scene. Currently not all private providers are included but it was hoped that all would be included in the future.

- **Increase the Number and Expand the Use of Ambulance Service**

Adding to this, another participant from UNIMAS said that there was the need for the government to ensure easy access to ambulance service for all communities as this was crucial for emergency cases. Ambulance service could also be used to transport patients who suffer from stroke and for the elderly.

Dr. Andrew Kiyu said that currently there was no provision for this purpose. However, this suggestion could be explored as he agreed that some patients discharged, for instance, those who underwent surgery following stroke, could not sit up or stand. This would be especially difficult for patients who depend on motorcycles to travel. In the context of communities in isolated villages in Sarawak, for example the Penan, he said that the SDH would provide transportation, including airlifts, of patients from their village to the hospital. However, no transportation was provided for patients to return to their villages. He agreed that this would create difficulty for the Penan as they were extremely economically disadvantaged and may not know the way back. Previously, funds for transportation of the Penan were available and managed by the relevant District Office. This facility was however, discontinued. He later agreed to the participant and said recommendations would be made to the relevant parties.

For the context of Sarawak, the department provided transportation for patients, such as the Penan, from their villages to the hospitals, including airlifts. However no transportation was provided for them to return to their villages. He understood the participant's concern and said that some communities may not know the way back and not have money to charter vehicles. He said that this was not confined to communities in rural areas, but also for some in the urban. For the Penan, previously there were funds allocated by the government and managed by the district office. However, this was not available now and agreed that this issue be addressed and the SDH would make recommendations to explore the possibility.

He also said that there were home based nurses available for discharged patients, but this was not totally dependable as it depended on the availability and free time of nurses.

- **Lack of Access to Healthcare by Undocumented Migrants**

A participant from SUHAKAM drew attention on the lack of access to healthcare amongst undocumented migrant workers in Malaysia. He emphasised the right to health for all but undocumented migrants fall outside of the safety net in Malaysia. He reminded participants that undocumented migrant workers form a percentage of those who suffer from contagious diseases and would infect Malaysians. This issue needed to be addressed.

On the other hand, he said that Malaysia was burdened by the cost of healthcare incurred by undocumented migrants. He explained that some only paid an initial RM50 to obtain treatment, but later left without paying the remaining outstanding bill. The Minister of Health recently mentioned that illegal immigrants in Malaysia owe the government between RM2million to RM3million. Despite this, they would still access healthcare facilities in the country.

Dr. David Quek said that this was a worldwide phenomenon. Malaysia had continually maintained that undocumented migrants had utilised facilities that were meant for local Malaysians. However, the fact remained that these people serve a function in the country as they were doing jobs which the Malaysians do not want. Therefore, he was of the opinion that the Malaysians give something back. He reminded participants that migrants, legal or otherwise, are human beings with inherent human rights, which include the right to health. Hence, they should be given access to this right. He suggested that at the very least, employers of foreign migrants should be required to provide insurance for their foreign employees.

- **Prioritise Patients' Survival and Well-being rather than Payment**

A participant from UNIMAS said that doctors should prioritise the survival and well-being of patients rather than payment. She exemplified a situation she had heard of where a female migrant worker in Sarawak who needed a caesarean section was asked to pay the fee which was around RM3000 before the operation could be done. She explained that most female migrants in Sarawak were working in timber plantations and sawmills. Their salaries were very low and may not have RM3000 in hand. She directed her question to the Speaker from MMA on what advice the Speaker would give to his fellow doctors who expect payment of fees before a critical operation could be done.

In response Dr. David Quek emphasised medical etiquette in such scenarios and in that particular scenario, he said it was clear that there had been a breach of conduct. He emphasised that patients health should come first.

- **Budget Allocation for Health**

The participant from UNIMAS, while referring to the previous discussion of the allocation of the national budget for health, said that there needed to be prioritisation. As health is a clear fundamental human right, it should be prioritised.

In terms of the amount of allocation for healthcare in Malaysia, he said that other sources could be sought to increase the amount. For instance the annually increased tax for cigarettes and alcohol drinks are amongst two major cause of ill health could be in turn used in healthcare. Another source could be obtained by increasing higher taxes on industrial activities that cause pollution.

Dr. Andrew Kiyu responded by saying that the Parliament of Malaysia had recently approved the setting up of the Health Promotion Board. A portion of the taxes imposed on cigarettes and alcohol drinks would be channelled to the Health Promotion Board to run various health promotion related activities such as health promotion campaigns.

With respect to the Health Promotion Board, Dr. David Quek explained that the syntax started in Australia and proved successful in that country. He was aware of the establishment of the said Board in Malaysia, however sensed that the quantum of allocation could be quite small. He expressed hope that Malaysia moves towards this while allocations spent in line with its objectives for health promotion and not merely utilised for payment of salaries while execution of activities were weak.

With regard to the issue of tax spending, Dr. David Quek said that the public had to question on how it was spent and what the public was getting in return to ensure there was minimised wastage.

- **Unequal Deployment of Doctors and Specialists in Public vs. Private Hospitals**

The moderator of the session commented on the existing inequality in the deployment of doctors and specialists in the public and private sectors. Due to some 'push and pull' factors, the number of doctors and specialists was higher in the private sector. As a result, access to certain healthcare services in public hospitals was limited. Since most of the services were only available in the private sector, the public could only obtain them at a higher cost, while services may be totally inaccessible to the poor.

Dr. David Quek said that doctors practicing in the public and private sector as well as in limited private wings were first proposed by SCOMOS. University Malaya (UM) was the first to start a public health facility University of Malaya Medical Centre (UMMC) with a limited private wing University of Malaya Specialists Centre (UMSC). There were concerns on this type of set up but some viewed the set up optimistically. Doctors were able to balance their roles in both public and private sector without short-changing the public sector.

- **Compassion Amongst Medical Staff**

Commenting on the issue of compassion amongst medical staff which was raised in the previous session, Dr. David Quek agreed that there was the need to change the mindset of some doctors. It was necessary for healthcare providers to revert back to a compassionate care provider that we are.

- **Drug Dispensing**

Dr Andrew Aeria raised his concern on the amount of drugs used as a cure for ailments. He felt that drugs were easily accessible to consumers in Malaysia and that an alternative and more rational approach should be sought.

Dr. Andrew Kiyu responded by saying that the National Medicine Use Survey was done to see the pattern of antibiotics and drug usage in the public and private health sectors. The nationwide study had been completed and findings were currently being analysed. Since it was in analysis stage, no comments would be made as yet.

Dr. Quek added that the said survey currently being done was actually the second survey to ascertain the types, pattern and amount of drugs being used. While he viewed positively on the survey done, he felt that analysis of findings, as demonstrated in the first survey, was not done well. He felt that more could be done based on the survey rather than only understanding the pattern of drug usage without any follow-up action.

With regards to the issue of access to drugs, Dr. David Quek noted that Malaysia was the only country which makes drugs widely available and accessible to the public. He agreed to the participants and said that some parties such as pharmacists should not be allowed to dispense scheduled drugs and poisons.

On the other hand, he felt that the public seemed to think that consultation by doctors should be free and the amounts paid by patients were solely for the medicines. He believed that following this, patients tended to get their medicines in pharmacies without the necessary consultation. There could be cases where patients continued to get the same medicine at pharmacies without knowing that their illness had become more serious and a different kind of medicine or higher dose would be necessary. As pharmacists were not trained as doctors, they would not be able to diagnose this. Awareness raising was needed to inform the public on the limitations of pharmacists and the importance of doctors' consultations and thus patients should pay for the service provided to them.

- **Health Tourism**

In response to concerns towards health tourism and its possible effect to the public healthcare system, Dr. David Quek said that he understood the public's perception of the government's inability to provide equitable access for their own people, but were ready to provide healthcare tourism for foreigners. Nonetheless, he said that there was a huge push factor to get foreigners to use the healthcare facilities in Malaysia. He exemplified Singapore, Thailand and India who promoted healthcare tourism and said that they appeared to be doing well. He felt that therefore, health tourism should be maintained.

He also felt that access to healthcare in Malaysia had enhanced and would continue to do so. Total healthcare coverage was not a distant goal. He believed that a problem was that the public tend to demand access to healthcare for each and everyone in this country immediately.

He also drew attention to some possible reasons leading to the glut of healthcare facilities in Malaysia. They include long waiting list that could run to two months as well as the fact that not all in Malaysia has the financial ability to access available services. Nonetheless, he emphasised that access to healthcare in Malaysia today was much better compared to 20 years ago.

- **Efforts by Social Organisations and NGOs**

A participant from the Sarawak Thalassemia Society said that there were a number of social organisations and NGOs who had implemented various activities for children with cancer and thalassemia.

The participant said that the main challenge faced by parents of these children was the medical and treatment cost involved. For instance, a full medical treatment for thalassemia costs about RM5000 a month. Until two years ago, medicines for thalassemia patients were not subsidised by the government. This had prompted NGOs and other social groups to find ways to raise funds to purchase those drugs to be subsidised to the patients. He explained that response was good and about 90% of the medical costs were subsidised and the patients were only required to pay RM100 to obtain the medicine. NGOs and social groups have spent a huge amount of time to speak to the previous and current Minister of Health. Thankfully, this was taken over by the current Minister which he said tremendously helped the NGOs and social organisations.

However, he said that such activities taken up by NGOs and other social groups to raise funds were more like stopgap efforts. Due to various constraints, organisations were able to ensure continued access to medicines for all. He expressed hope that the government would take over such responsibilities which he said was theirs in the first place.

Dr. Andrew Kiyu said that while the government had the main responsibility to ensure the rights of its people, it was important for participants to understand that the care of vulnerable individuals and groups is a shared responsibility for both government and public. For instance, when the session talked about the lack of care for the elderly, he said that this was a weakness not only of the government but also the society. There was the role to care for other family members which he said, was missing in many family institutions.

- **Human Rights Driven Value System**

The participant from the Sarawak Thalassemia Society emphasised that the extent of the realisation of health and healthcare could only be determined based on the value system. He explained that if the value system of the country recognised that health was indeed an entitlement, it was therefore the responsibility of the government to ensure the enjoyment of this right. However, he felt that the current value system in Malaysia was driven more by commercialisation rather than human rights. As a result, problems manifest while health is traded as a commodity which was evident in health tourism.

Dr. David Quek agreed to the previous statement by Dr. Andrew Kiyu and said that there were many things to be done including changing the value system of the country. At the same time, the public must be proactive and voice out their concerns and aspirations to the government. He pointed out that there were a lot of people who were aware of the scenario but have kept it to themselves. These are the silent majority.

- **Improve Access to Healthcare Services for Persons with Special Needs**

Mr. Donald Law said that there was the need to improve access to healthcare services for persons with special needs such as the elderly and persons with disabilities.

He said that in some scenarios, such persons were forced to wait in hospitals before their turn. There should be a system where persons with special needs are given priority for medical attention, including those who are in life and death situations like persons who had suffered from a stroke. He suggested a system which would require hospital/clinic patrons to fill in forms which would entail the specification of their ailment or special needs and later would be immediately sent to the relevant doctors. This he thought, could improve waiting time.

This was added by another participant who exemplified the triage³² system in United Kingdom. This system entails assessment by nurses on patients at the point of entry. The nurses would determine

32 Triage is a process of prioritizing patients based on the severity of his/her condition as to treat as many as possible when resources are insufficient for all to be treated. The term comes from the French word triage, meaning "sorting process." There are two types of triage: simple triage and advanced triage. <http://en.wikipedia.org/wiki/Triage>

which doctors would be consulted. This system cut waiting time especially significant for patients who need immediate medical attention.

Dr. Andrew Kiyu responded by saying that at the moment there was a kind of triage system in Sarawak which is the A&E (Accident & Emergency). However, as indicated by its term, this system prioritises patients with serious illness or injury that requires immediate attention. Additionally, the existing polyclinics in urban areas, in some aspects, adopt the triage system whereas patients with specific medical need would be directed to the specific hospital section. For instance, patients who need wound dressing would be directed to the dressing room. The hospital system also had a green lane for persons with special needs such as the elderly including those aged 60 years and above. On the other hand, a full-fledged Triage System would automatically be in place for cases of outbreaks such as the recent avian influenza outbreak whereby patients would be assessed before they enter a hospital to reduce the risk of infecting others.

With respect to the suggestion by Mr. Donald Law, this would be taken up by the SDH. He said that this suggestion could initially be tested in some polyclinics and the SDH would assess whether this could reduce waiting time.

3. CONCLUSION

The session ended by a note of thanks to the speakers and participants by the moderators. She said that the session was informative and stimulating and that the main issues would be taken up with the relevant government department.

B. DIALOGUE IN KOTA KINABALU, SABAH, 8 JANUARY 2008

1. AGENDA

The dialogue in Kota Kinabalu, Sabah, followed the following agenda:

TIME	AGENDA		
0800 - 0900	Registration of Participants		
OPENING SESSION			
0900 - 0915	WELCOMING REMARKS by Tan Sri Datuk Seri Panglima Simon Sipaun Vice Chairman of SUHAKAM		
0915 - 0935	INTRODUCTION TO THE DIALOGUE by Datuk Dr. Raj Abdul Karim SUHAKAM Commissioner		
0935 - 0950	Refreshments		
SESSION 1 : TOWARDS EQUITABLE HEALTHCARE FOR ALL			
0950 - 1120	Paper 1:	GOVERNMENT'S EFFORTS TOWARDS EQUITABLE HEALTHCARE FOR ALL by Dr. Christina Rundi Principal Assistant Director, Public Health Division, Sabah Health Department	Moderator: Dr. Mohammad Hirman Ritom Abdullah, SUHAKAM Commissioner
	Paper 2:	TOWARDS EQUITABLE HEALTHCARE FOR ALL - A HUMAN RIGHTS PERSPECTIVE by Datuk Dr. Teoh Siang Chin Chairman, Medical Association of Southeast Asian Nations (MASEAN)/Past President, Malaysian Medical Association	
		DISCUSSION SESSION	
SESSION 2: ACCESS TO EQUITABLE HEALTHCARE SERVICES: EXPERIENCE OF VULNERABLE/MARGNIALISED GROUPS			
1120 - 1250	Paper 1:	PERKONGSIAN PENGALAMAN PACOS: ORANG ASAL & PERKHIDMATAN KESIHATAN DI LUAR BANDAR by Ms. Moilin M. Unsing Member, PACOS Trust	Moderator: Tunku Datuk Nazihah Tunku Mohamed Rus, SUHAKAM Commissioner
	Paper 2:	EQUITABLE ACCESS TO HEALTHCARE FOR ALL: IS THIS STILL A PIPE DREAM FOR MALAYSIA? A MEDICAL PROFESSIONAL'S PERSPECTIVE by Dr. David K.L. Quek Committee Member, Malaysian Medical Association	
		DISCUSSION SESSION	
1250 - 1400	Lunch Break		
SESSION 3: DISCUSSION SESSION			
1400 - 1600	DISCUSSION SESSION ON MOVING TOWARDS EQUITABLE HEALTHCARE FOR ALL		Moderator; Datuk Dr. Raj Abdul Karim, SUHAKAM Commissioner
1600	Tea Break / End of Programme		

2. SUMMARY OF PROCEEDING

(i) Opening Session

Welcoming Remarks

The Vice Chairman of SUHAKAM, Tan Sri Datuk Seri Panglima Simon Sipaun, in his welcoming remark, conveyed his gratitude to all speakers and participants for joining the dialogue. He had highlighted one of the cornerstones of the UDHR which guarantees the every person's right to life, liberty and security. Among others, it represents the right to health which is essential to maintain life with dignity. Governments are obligated to ensure this right is realised.

He noted that the WHO Constitution was the first to provide the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being irrespective of race, religion, political belief, and economic or social condition. Despite international human rights provision of equality, not all in Sabah are able to enjoy adequate access to health.

He went on to explain the two most notable factors, with the first being the unusually large illegal immigrant population in the State. They account for many contagious and communicable diseases. A significant number possess forged identity cards which were used to take advantage of minimal or no fee for healthcare services meant for Malaysians in Sabah. As government allocation for healthcare services only take into account the health needs of Malaysians in Sabah, utilisation of the services by illegal immigrants would also mean less for the genuine Malaysians.

Poverty, which is the second factor, remains high in Sabah, especially amongst those in rural areas. As poverty and health are interrelated, the poor are caught in a vicious cycle. In addition to health, poverty adversely affects access to education. Some are not aware of the importance of good hygiene and proper healthcare. In some places, infrastructure and other basic facilities that could enhance access to health care are not available.

In conclusion, he expressed his hope that the dialogue would enable the generation of recommendations to address the issues in relation to healthcare in Sabah.³³

Introduction to the Dialogue

Datuk Dr. Raj Abdul Karim, in her presentation said that as part of its consultation activities with various agencies, organisations and other groups, SUHAKAM would hear concerns and recommendation with regard to the issue of inequality in healthcare in the context of Sabah. As follow-up, a report would be published by SUHAKAM to be forwarded to the Ministry of Health.

³³ The texts of the Welcoming Remarks by Tan Sri Datuk Seri Panglima Simon Sipaun at the dialogue in Kota Kinabalu, Sabah on 8 January 2008 is attached as Annexure 7.

All concerns and recommendation would be included, and therefore, reflected participation of interested groups and individuals and a transparent approach by SUHAKAM.

She continued by highlighting relevant international human rights laws which guarantees every person's right to health, and the obligation of governments to ensure this right is realised via legislation, policies and programmes. She further explained the components and determinants of health which were inalienable in ensuring the enjoyment of the health entitlement.

By way of conclusion, Datuk Dr. Raj said that Malaysia had a good healthcare system, with about 90% of coverage in Malaysia. It is therefore, timely for Malaysia, to move further to address and fulfil the health needs of the remaining deprived groups and individuals within the society.³⁴

(ii) Session 1: Towards Equitable Healthcare for All

Paper 1: Government's Efforts towards Equitable Healthcare for All

Dr. Christina Rundi, after providing an introduction on international declarations related to health and equitable distribution to it, gave an account of measures taken by the government to ensure healthcare for all in Sabah. They include measures to ensure both geographical and cost access. These were implemented to cater for the needs of rural and isolated communities as well as those living in poverty.

The speaker then shifted her focus to the Wellness Paradigm which dimensions include physical fitness and nutrition; emotional well-being; intellectual well-being; social, family, community and environment; occupational and vocational aspects; and spiritual, values and ethics.

Related to the wellness paradigm in the context of Malaysia was tele-health which the speaker said could encourage more integration, equitable and accessible services. It would further advance the participation of individuals and institutions in managing their health.

Dr. Christina Rundi concluded by highlighting several issues to exclusively ensuring equitable access to health which include what access meant to different people; barriers and stages of access; and measuring equity in access.³⁵

Paper 2: Human Rights and Health

Dr. Teoh Siang Chin's paper mirrored his presentation at SUHAKAM's dialogue on the same topic in Kuching, Sarawak on 5 November 2007.

³⁴ The Introduction to the Dialogue presented by Datuk Dr. Raj Abdul Karim at the dialogue in Kota Kinabalu, Sabah on 8 January 2008 is attached as Annexure 8.

³⁵ The presentation on Government's Efforts towards Equitable Healthcare for All presented by Dr. Christina Rundi at the dialogue in Kota Kinabalu, Sabah on 8 January 2008 is attached as Annexure 9.

After he briefed participants on the international perspective on human rights and health and the issues related to access to healthcare in Malaysia - which included distribution of doctor, migration of skills and incentives to encourage equitable distribution of healthcare. Dr. Teoh proceeded to focus on the factors leading to unequal access to healthcare. They include, among others, disparities in resources in Sabah as well as the lack of knowledge on health as a human entitlement amongst the society as well as health providers and professionals.

After highlighting the national challenges to ensure equitable access to health in Malaysia, he listed down several opportunities that could encourage progress towards equal access to health for all.

He concluded by underscoring the need for Malaysia to accede the relevant international human rights treaties to further strengthen the society's entitlement to healthcare.³⁶

Discussion for Session 1

- **Undocumented Migrants' Utilisation of Facilities meant for Locals**

A participant raised concerns on the phenomena of undocumented migrants in Sabah who he said were using healthcare facilities meant for Malaysian citizens.

In response, Dr. Christina Rundi said that while she acknowledged the undocumented migrant phenomenon in Sabah, she reminded participants that all migrants, legal or otherwise, have their human right to health.

Datuk Dr. Teoh agreed to the statement by Dr. Christina Rundi. He added that the issue on the amount charged on migrants, legal or otherwise, was being mentioned in the Parliament.

Datuk Dr. Teoh said that undocumented migrants were afraid to come to hospitals because they feared that doctors would report their presence to the Immigration Department. This created the risk of undetected diseases, possibly contagious diseases, mortality and morbidity. He said that while Malaysia had laws, the human rights to health and life should be prioritised.

- **Access to Healthcare Services amongst the Poor**

A participant from the Persatuan Orang-Orang Sungai Sabah said that access to healthcare in Sabah was very much affected by the community's economic status. He said that according to a report by the Economic Planning Unit (EPU) about 32,000 people in Sabah were living in absolute poverty, who earned about RM200 a month.

36 The presentation on Towards Equitable Healthcare for All – A Human Rights Perspective presented by Datuk Dr. Teoh Siang Chin at the dialogue in Kota Kinabalu, Sabah on 8 January 2008 is attached as Annexure 10.

In response, Dr. Christina Rundi said that while there were those who live in poverty in Sabah, the Ministry of Health would still provide healthcare services for them.

- **Lack of Clean Water Supply**

In addition to limited access because of poverty, the participant from Persatuan Sungai Sabah said that limited physical access to healthcare services was also an issue, especially amongst those who live in isolated areas. He exemplified the villagers in Kinabatangan, who could reach healthcare facilities via roads and riverboats, but nonetheless, these were not totally dependable. He explained that during floods, the roads would be submerged while the river was unsafe.

Another issue which forms a fundamental determinant to health was clean water supply. This was lacking in some rural villages in Sabah. While villages in hilly areas would be able to obtain fresh water, some villages on lower grounds on the other hand, depended on river water that was polluted following disposal of waste from oil palm plantations. He added that even in some clinics, clean water supply was unavailable.

Dr. Christina Rundi responded by reminding participants that in Malaysia, the duty to ensure health and its components did not solely lie on the MOH. Rather it is shared by a number of ministries. For instance, the responsibilities to ensure availability of clean water supply, sanitation and access road lies with other ministries, while the responsibility to ensure availability of clinics and other health facilities were with the MOH. Based on the visits, she was unable to concur that the health clinics did not have clean water supply.

- **Physical Access for Isolated Villages**

A participant recommended that each constituency area be provided with a clinic. He exemplified his experience when his wife contracted malaria a few years back, they had to rely on the FDS. The nearest clinic to their village was the clinic in Kampung Batangan which was two hours away, while the nearest hospital was in Kudat which was seven hours away by speed boat.

Dr. Christina Rundi, in response said that the State Health Department has carried out many visits to healthcare facilities in various areas including those built in isolated locations. She explained that the establishment of clinics would depend on the concentration of people in an area. The idea was to, as far possible, maximise patrons in the clinics.

- **Resolution on Right to Health**

A participant from the Department of National Unity recommended that based on the findings of the dialogue, SUHAKAM could prepare a resolution. The resolution was to include a target to ensure healthcare facilities are available in all areas inhabited by communities. This should be accomplished by the relevant ministry and agency by the end of 2008. Based on this resolution, assessment could be done in the year 2009 to ascertain whether this has materialised.

Datuk Dr. Teoh said that a resolution could be made. On the other hand, the speaker said that this must come with awareness on the part of the public on how the ministry functions. The public must bear in mind that it was impossible for the government to accomplish such target in only one year. Also, the public had to be aware that realisation of the right to health and its components require the implementation of tasks by other responsible Ministries including the MOH, the Ministry of Rural Development and the Works Ministry, together with other NGOs, media and other relevant organisations.

(iii) Session 2: Access to Equitable Healthcare Services: Experience of Vulnerable/ Marginalised Groups

Paper 1: Perkongsian Pengalaman PACOS: Orang Asal dan Perkhidmatan Kesihatan di Luar Bandar (Sharing the Experience of PACOS: The Indigenous People and Healthcare Services in the Rural Area)

Ms. Moiling Unsing began by explaining that PACOS TRUST stands for Partners for Community Organisations (Rakan Membangun Masyarakat). It is a voluntary organisation registered under the Trustees Ordinance Chapter 148. She had listed down the objectives of PACOS which generally centred on assisting in raising the quality of life of indigenous communities.

She went on to specify the main native groups in Sabah which include Kadazan Dusun, Murut, Rungus and Sungai. She said that generally access to healthcare services amongst native villagers in the deep interior and isolated locations was poor. Among the factors that have led to this were their location, economic status, communication and availability of healthcare facilities near their villages.

While the main problem related to the availability and accessibility of healthcare facilities, others, while had access, encounter problems in terms of attitude amongst health personnel towards them; some healthcare facilities lacked basic amenities such as electricity and ambulance; and there was limited sessions to see the doctors as doctors would only come to the villages a few times in a month.

The speaker had informed participants on cooperation between PACOS and other voluntary organisations such a MERCY Malaysia and the Rotary Club. Together, they reached and brought healthcare services to several isolated villages in Sabah.

Ms. Moilin concluded by giving two recommendations. The first was for the government to provide training for native villagers in rural and isolated areas on basic medical or paramedic related skills.

The second recommendation was to encourage the use of traditional medicines and treatments.³⁷

Paper 2: Equitable Access to Healthcare for All: Is this Still a Pipe Dream for Malaysians? A Medical Professional's Perspective

Steering his presentation based on his first presentation at SUHAKAM's dialogue on access to equitable healthcare in Sarawak on 5 November 2007, Dr. David K.L. Quek inserted in his presentation on specific issues affecting the people of Sabah.

He raised several concerns on healthcare which include issues of delivery of services to vulnerable and marginalised groups; non-recognition of health as a human right; identification of the said groups and their healthcare needs; and access to urban and tertiary healthcare as well as financial concerns.

While various programmes to reach vulnerable and marginalised groups were implemented by the government, limitations in terms of availability and access for all throughout Malaysia, cost associated with new technology, specialist medical centres and expertise, as well as operational matters, has made them difficult to obtain.

Another issue brought up by the speaker was concerning the amount of budget allocated for healthcare in Sabah. Additionally, he said that while access to information and communication have heightened in Malaysia which at the same time increased expectations and demands, Malaysia's budget for healthcare expenditure remained low at 3.8% of Malaysia's total Gross Domestic Product (GDP).

Further, while state-of-the-art facilities were rapidly built, collapsed ceiling and leakages as well as other structural defects had brought about criticism towards the government particularly on wastage of resources. Availability of up-to-date and state-of-the-art facilities also raised the question of whether all, including the poor, would benefit from these expensive facilities and services.

On the other hand, the speaker commented on the negative perception of the public towards any plans to decrease subsidies and increase public contribution. The speaker said that the current public healthcare sector was heavily subsidised. The Malaysian public had been made accustomed to the extent that any adjustment or increase of fees to be borne by the public was seen as politically inexpedient.

37 The presentation on Perkongsian Pengalaman PACOS: Orang Asal dan Perkhidmatan Kesihatan Luar Bandar presented by Ms Moilin M. Unsing at the dialogue in Kota Kinabalu, Sabah on 8 January 2008 is attached as Annexure 11.

Dr. David K.L. Quek moved on to focus on healthcare financing where he underscored the threat of delays and bankruptcy leading from unaffordable healthcare. He later referred to the government's plan for a national health financing scheme for Malaysia. He highlighted a few concerns relating to uncertainties in the schemes including, among others, the quantum of contribution, coverage for family members, premiums for self-employed persons, as well as types of ailment (non-serious and/or catastrophic illnesses) covered under the scheme. These concerns must be addressed before the scheme is implemented.

He said that Malaysia must strive to identify a common ground for a system that was suitable for all in Malaysia.³⁸

Discussion for Session 2

- **Awareness on the Importance of Health and Hygiene**

A participant commented on the presentation by the speakers regarding the lack of awareness of the importance of health and hygiene amongst the local rural communities. He said that in some instances, it was found that the locals were responsible of disposing wastes along alleys and stairways.

In addition, local villagers consume alcohol which they said was part of their culture, despite the fact that alcohol drinks threatened health. Moreover, alcohol drinks were available for purchase in shops and marts.

This was agreed by the speakers. Ms. Moilin Unsing added that PACOS, in cooperation with other organisations and agencies, have carried out various activities concerning various health issues including awareness programmes on the importance of health and the threat of alcohol to health.

- **Provide more Allocation for the Development of the People of Sabah**

A participant commented on the budget allocation for the purpose of healthcare in the country. He said that a portion of the country's income was obtained from Sabah and, therefore, a significant portion should be given back to the state for the healthcare and the development in Sabah.

He later likened the situation of healthcare in Sabah with the proverb '*kera di hutan disusukan anak di rumah mati kelaparan*' and enquired on whether migrants, both legal and illegal, working in plantations had access to healthcare facilities. If affirmative, where do they obtain this and whether this was provided by the company they are working with.

³⁸ The presentation on Equitable Access to Health Care for All: Is this still a Pipe Dream for Malaysia? A Medical Professional's Perspective presented by Dr. David K.L. Quek at the dialogue in Kota Kinabalu, Sabah on 8 January 2008 is attached as Annexure 12.

Dr. David Quek said that the State Government had the right to demand for more allocation for the purpose of setting up health facilities and for the maintenance of the current facilities.

In respect to the question on migrant workers in plantations, Dr. David Quek said that in some plantations owned by large companies such as Guthrie, plantation clinics were provided for their workers. He understood the participant's point and said that it was unfortunate that the local Sabahans were left out.

- **Education on the Peoples' Right to Choose types of Development**

Ms. Moilin Unsing explained that PACOS has implemented various activities to educate the rural communities on their right to decide what types of development programmes suitable for them. In some cases, local villagers were made to understand by other interested parties that the opening of estates could help in the rural peoples' development. However, after the estates were established, rural villagers found themselves further marginalised. They lost their ancestral land, their source of food and ultimately affected their health and wellbeing.

Now, rural people have learned their right to development and were able to consider projects and reject those deemed not suitable for them. Unfortunately, their rejections were seen as anti-government. Villagers were sidelined for other development programmes.

Ms. Moilin Unsing said that there was the need for the relevant parties to recognise and respect the people freedom of expression without being marginalised later on.

(iv) Session 3: Discussion Session on Moving towards Equitable Healthcare for All

- **Recommendation for a Working Paper**

A participant from the Persatuan Orang-Orang Sungai Sabah recommended that based on the dialogue, a working paper be prepared. This working paper should be circulated to the relevant government agencies, which would hopefully lead to response activities by relevant agencies to improve health and healthcare services in Sabah.

He added that the government must ensure that even small villages have adequate access to healthcare facilities as enjoyed by those in the urban areas. He recommended that community clinics (klinik desa) be made available in all rural villages. He added that basic amenities such as electricity, clean water source (piped water) and tarred road must be in place for the rural communities. While it has been 50 years of independence, the scenario had led him feel otherwise.

- **An Integrated Approach to Address Health Issues**

Dr. Christina Rundi said that while the Ministry of Health had the main responsibility to address health issues in Malaysia, some underlying factors such as clean water supply, sanitation, and electricity, were beyond the said Ministry. Therefore, to ensure the overall issue of health is adequately dealt with, the speaker said that there was the need for an integrated approach and cooperation between ministries.

- **Employment of Foreign Doctors**

A participant gave an account of his previous experience when he tried to obtain healthcare service from a foreign doctor. He was shocked to find that the doctor could not speak Malay or local language well. He made a complaint to relevant Department. He emphasised that Sabah lacked both adequate and appropriate facilities and services.

- **Conduct Spot-Checks to Rural Health Facilities**

A participant recommended that the relevant Agency or even Ministry to carry-out unannounced spot-checks to the rural health facilities in Sabah. He felt that when monitoring visits were earlier announced, the persons in charge in the rural facilities would make everything appear fine, even though in reality, they were not. He said that the current monitoring was different than before when unannounced spot-checks were carried out.

- **Ensure Safe Environment**

Another subject closely linked to health is the issue of environment. A participant said that the country's development had simultaneously brought about pollution. Besides the environment, rivers, which were once the main source of fresh water of rural communities, could no longer be consumed. It was therefore, necessary to ensure these underlying determinants of health are addressed and protected.

With regards to the quality of water, the participant said that communities today were aware of their duty and rights to the environment. Water is important to our daily lives. With this in mind, communities have made water catchments with the help of some organisations. However, the problem was that communities could not obtain approval from the government to alienate the catchments. He claimed that this was a result of actions by some parties who had prevented the plans from materialising. This, he felt was clear, as later those areas were leased out or sold to private companies. While communities had opposed to this, their objections were unheeded. As a result, communities were forced to depend on polluted water sources. He was of the view that the MOH should be one of the entities that should support such community efforts and their right to health.

- **Healthcare Status in Malaysia thus far**

Dr. Christina Rundi said that one of the popular issues which was brought up at the dialogue related to access to healthcare facilities. She explained that it was difficult for the government to realise all the different demands by the people. However, she reminded participants that the healthcare coverage in Malaysia was around 90% which she felt was good. She explained that in Sabah, the total number of community clinics was 268 clinics which she said was a big number for such a small state.

CONCLUSION

The session ended by a note of thanks to the speakers and participants by the moderators. She said that the session enabled the identification of current critical issues affecting equality in accessing right to health in Malaysia. These issues would be raised by SUHAKAM to the relevant government department.

C. DIALOGUE IN KOTA BHARU, KELANTAN, 10 AUGUST 2008

1. AGENDA

The agenda of the dialogue held in Kota Bharu, Kelantan on 10 August 2008 was as follows:

TIME	AGENDA		
0800 - 0900	Registration of Participants		
OPENING SESSION			
0900 - 0915	WELCOMING REMARKS by Datuk Dr. Denison Jayasooria SUHAKAM Commissioner & Chairperson to the Economic, Social and Cultural Rights (ECOSOC) Working Group of SUHAKAM		
0915 - 0935	INTRODUCTION TO THE DIALOGUE by Datuk Dr. Raj Abdul Karim SUHAKAM Commissioner		
0935 - 0950	Refreshments		
SESSION 1 : TOWARDS EQUITABLE HEALTHCARE FOR ALL			
0950 - 1120	Paper 1:	HEALTH SCENARIO IN KELANTAN: PROGRESS, OPPORTUNITIES & CHALLENGES by Dr. Lila P. Mohammed Meeran Kelantan Health Director, Department of Health , Kelantan	Moderator: Datuk Dr. Denison Jayasooria SUHAKAM Commissioner/ Chairperson to the ECOSOC Working Group of SUHAKAM
	Paper 2:	HEALTH SCENARIO IN KELANTAN: CURRENT STATUS FROM THE HUMAN RIGHTS PERSPECTIVE by Dr Rosniza Abd. Aziz Department of Medical Education Universiti Sains Malaysia, Kelantan	
SESSION 2: ACCESS TO EQUITABLE HEALTHCARE SERVICES: VOICES REPRESENTING THE VULNERABLE/MARGNIALISED GROUPS			
1030 – 1130	Paper 1:	HUMAN RIGHTS AND EQUITABLE HEALTHCARE AMONGST THE POOR IN KELANTAN by Hajjah Zabidah Binti Ismail Managing Director, Amanah Ikhtiar Malaysia	Moderator: Dr. Mohammad Hirman Ritom Abdullah, SUHAKAM Commissioner
	Paper 2:	HUMAN RIGHTS AND EQUITABLE HEALTHCARE AMONGST PERSON WITH DISABILITIES IN KELANTAN by Assoc. Prof. Dr. Tiun Ling Ta President, Persatuan Orang-Orang Cacat Anggota Malaysia (POCAM)	
	Paper 3:	HUMAN RIGHTS AND EQUITABLE HEALTHCARE AMONGST ORANG ASLI IN KELANTAN by Dr. Saiah Bt. Abdullah Director, Health and Medicine Department of Orang Asli Affairs (JHEOA)	
SESSION 3: DISCUSSION SESSION			
1130– 1245	DISCUSSION SESSION ON ISSUES RELATING TO HUMAN RIGHTS AND EQUITABLE HEALTHCARE AND THE WAY FORWARD		Moderator; Datuk Dr. Raj Abdul Karim, SUHAKAM Commissioner
1245	End of Programme / Lunch		

2. SUMMARY OF PROCEEDING

(i) Opening Session

Welcoming Remarks

In his welcoming remarks, the Chairperson of the Economic, Social and Cultural Rights (ECOSOC) Working Group of SUHAKAM, Datuk Dr. Denison Jayasooria, said that side by side to the more popularly debated civil and political rights are the economic, social and cultural rights. An within the economic, social and cultural rights context there exists various equally important rights as those in civil and political rights, which includes, among others, right to health. He proceeded to highlight one of the several important elements of right to health, which was access to equitable healthcare services.

He explained the different Working Groups established under SUHAKAM which includes among others, the ECOSOC Working Group, and the function of this group to engage with the civil society via various dialogues to obtain their views and concerns on various economic, social and cultural rights related issues.

He then emphasised the influence of health towards the quality of life and sustainable livelihood, capacity building, and even poverty, as well as the influence of an individual's state of health towards him/herself, the economies of his/her family and consequently the nation's.

He highlighted that while Malaysia had generally achieved commendable levels in healthcare and public health, there remain pockets of deprivation which need for the government's targeted addressal. And it was within this context that the series of dialogues were being held by SUHAKAM, in order to identify the vulnerable groups in several areas in Malaysia and the health related issues affecting them. The output of the dialogues would be consolidated in a report which would include SUHAKAM's recommendations to the issues identified, to be forwarded to the government for consideration.³⁹

Introduction to the Dialogue

Datuk Dr. Raj Abdul Karim, in her presentation began with a brief overview on the definition of right to health as given by the World Health Organisation (WHO) and what constitutes the right to health as specified by the United Nations (UN). She went on to highlight the different UN Conventions that embed the right to health and further spelt out the elements of right to health which includes availability, accessibility, acceptability and quality. Accessibility, in particular further includes non-discrimination, physical access, economic access and access to the related information.

³⁹ The texts of the Welcoming Remarks by Datuk Dr. Denison Jayasooria at the dialogue on Kota Bharu Kelantan on 10 August 2008 is attached as Annexure 13

She continued by highlighting the work done by SUHAKAM which focused on the right to health, which include various public forums, dialogues and research that looked at vulnerable groups in Malaysia.

She demonstrated Malaysia's achievement in terms of health, based on general and disaggregated data, which depicts that while Malaysia had generally achieved a laudable level in terms of health, concerns remain on issues concerning access to health and healthcare services, with particular focus on groups rendered vulnerable because of their economic, social and cultural background and even their geographical location.

She exemplified some issues which were identified during the first two dialogues on Human Rights and Access to Equitable Health, which were earlier held in Sabah and Sarawak. The issues identified include *inter alia*:

- Poor physical access to clinics;
- Lack of equipment and facilities in rural clinics to cater the evolving health needs of local communities;
- Lack of access to several underlying determinants of health such as nutritious food, safe drinking water, adequate sanitation, a healthy environment, and health related information;
- Lack of awareness of local communities on the importance of health and maintaining hygiene;
- Increasing cost associated to obtain healthcare services;
- Lack of community participation in planning and implementing health related programmes;
- Services provided in public healthcare centres were deemed poor in quality;
- Lack of awareness on available healthcare services provided and the procedures to obtain such services.

In her conclusion, Datuk Dr. Raj Abdul Karim reiterated the current need to target remaining pockets of deprivation within the Malaysian society to ensure every person is able to fully enjoy their right to health. The dialogue would give valuable insight on the issue of right to health in Kelantan, and these would be forwarded to the relevant authorities for their consideration.⁴⁰

(ii) Session 1: Towards Equitable Healthcare for All

Paper 1: Health Scenario In Kelantan: Progress, Opportunities & Challenges

Dr. Lila P. Mohammed Meeran, the Kelantan Health Director began her presentation by citing Malaysia's vision for health and the mission of the Ministry of Health, Malaysia. She went on to brief the participants of the dialogue on the background of the Kelantan and its population.

⁴⁰ The Introduction to the Dialogue presented by Datuk Dr. Raj Abdul Karim at the dialogue in Kota Bharu, Kelantan on 10 August 2008 is attached as Annexure 14.

Dr. Lila focused her presentation on the health status of Kelantan. All maternal, toddler, infant and prenatal mortality rates have shown significant declines for the year 1985 and between the years 1990 to 2006. Also on the decline were the incidence rates of Malaria, Cholera and Hepatitis A. On the other hand, the incidence rates of dengue, tuberculosis and HIV and AIDS cases have shown increases. There was a large increase in cases of food poisoning in Kelantan in several years with the two highest numbers of cases in 2007 and 2008. She further presented data on other chronic diseases in the state, and also the statistics on water supply coverage and sanitary latrines for the year 2007.

Dr. Lila continued by highlighting the opportunities of the State Health Department that had improved efforts to progress to better health status in Kelantan. These include the available human resource of the Department, increased operating expenditure, the number of available health facilities and specialists in Kelantan as well as the upgrading and locations of those facilities. New progress for HIV and AIDS programmes were also identified as part of the health opportunities in Kelantan.

While statistics show the decreased mortality rates and the prevalence of some diseases, these cases, along with the other increased prevalence of diseases, were still higher than the national average. Other important challenges include low coverage of treated water supply; inadequate solid waste disposal system; inadequate basic facilities in public areas; and mushrooming of unlicensed food stalls. Dr. Lila also said that the high expectation and dependency of the public towards government aid, coupled with the poor attitude of the public towards health and hygiene practices were also causes for concern. The increased number of drug addicts and influx of illegal foreigners would further contribute to the increase number of HIV and AIDS and malaria cases. Additionally, the escalating healthcare cost in Malaysia and misdistribution of allocated resources would affect the current healthcare coverage in Malaysia.⁴¹

Paper 2: Health Scenario in Kelantan: Current Status from the Human Rights Perspective

The presentation by Dr. Rosniza Abdul Aziz from the Universiti Sains Malaysia focused on the current health status in Kelantan viewed from a human rights perspective, in particular the issues pertaining to the delivery of healthcare services to vulnerable and marginalised groups; the rights of marginalised groups towards health and healthcare services and to identify vulnerable/marginalised groups and their health needs which require consideration by the government when implementing policy and programmes to ensure equitable healthcare for all.

She started off by defining the principles of Bioethics and Autonomy which generally highlights the rights of the public to participate in the planning of their healthcare, and the duties of healthcare

⁴¹ The presentation on Health Scenario in Kelantan: Progress, Opportunities & Challenges presented by Dr. Lila P. Mohd Meeran at the dialogue in Kota Bharu, Kelantan on 10 August 2008 is attached as Annexure 15

providers to benefit the patients. She further delved into the principle of Autonomy by taking into account the Western and East Asian perspectives on it and exemplified with the findings of her previous research on Principles of Patient Autonomy from Malaysian Perspectives.

The speaker focussed on the issue concerning patients' consent before any medical intervention and listed down the different types of consent which includes tacit consent, implicit or implied consent, presumed consent, and informed consent.⁴²

(iii) Session 2: Access to Equitable Healthcare Services: Voices Representing the Vulnerable/Marginalised Groups

Paper 1: Human Rights and Equitable Healthcare amongst the Poor in Kelantan

Hajjah Zabidah Binti Ismail, the Managing Director of Amanah Ikhtiar Malaysia (AIM) presented the first paper for the session entitled Human Rights and Equitable Healthcare Amongst the Poor in Kelantan.

The Speaker started off by giving participants a brief background, vision and objective behind the establishment of the AIM. She went on to give the definition of poverty and presented the Poverty Line Income (PLI) as adopted by AIM and in comparison with Malaysia's official PLI for the states in Peninsular Malaysia and Sarawak and Sabah.

The Speaker then elucidated participants on the programmes that were implemented by the AIM which began in the Peninsular Malaysia and later expanded to Sarawak and Sabah.

The Speaker said that the programmes implemented by the AIM had major positive impact towards the society, namely the improved financial capacity of poor families as well as impact towards non-monetary aspects such as access to piped water, electricity and toilet facilities, improvement to physical housing conditions and others.

She presented the programmes which were implemented and their impacts towards the people of Kelantan. Following the programmes, many were able to increase their financial capacity which in turn, had improved their access to other basic necessities, including healthcare.

Under the Welfare and Wellbeing Fund, the AIM had spent more than RM2 million for health related benefits, namely payment for the costs of ward admissions and treatment for chronic diseases with more than 11,000 persons have benefited from these.⁴³

42 The presentation on Health Scenario in Kelantan: Current Status from the Human Rights Perspective presented by Dr. Rosniza Abdul Aziz at the dialogue in Kota Bharu, Kelantan on 10 August 2008 is attached as Annexure 16

43 The presentation on Human Rights and Equitable Healthcare amongst the Poor in Kelantan presented by Hajjah Zabidah Binti Ismail at the dialogue in Kota Bharu, Kelantan on 10 August 2008 is attached as Annexure 17.

Paper 2: Human Rights and Equitable Healthcare amongst Person with Disabilities in Kelantan

Prof. Madya Dr. Tiun Ling Ta, who was attached to the School of Social Science of Universiti Sains Malaysia and also the President of the Persatuan Orang-Orang Cacat Anggota Malaysia (POCAM), was the second speaker of the session.

In his presentation entitled "*Hak Asasi Manusia dan Kesaksamaan Akses Persekitaran dan Penjagaan Kesihatan dalam Kalangan OKU*", the speaker emphasized that persons with disabilities (PWD) were part of the society and citizens of Malaysia, and therefore, have the right to enjoy facilities as enjoyed by others in the country.

He continued by highlighting the challenges faced by PWDs in Malaysia which related to PWDs being perceived as liability, third world mentality, stereotyping, enforcement as well as mobility issues.

The speaker said that while, in general, Malaysia has achieved well in terms of providing for PWDs, there was still room for improvement, in particular, through prevention and early detection programmes, as well as nutrition and healthcare programmes, which awareness he said was less than favorable amongst some guardians.

The speaker went on to highlight issues relating to access to healthcare and rehabilitation services for children and adults with disabilities. Whether access to these were adequate or otherwise, could be determined by several factors, including, among others, the availability of disabled friendly public transportation system; extent of self medication through traditional medicine and over the counter drugs; and availability of supporting equipment and trained personnel to meet the needs of PWDs.

Before concluding, the speaker had listed several recommendations to healthcare services to be adequately accessibility amongst PWDs which include ensuring access to healthcare services for all forms of disabilities, including securing the services of specialists; establishing a rehabilitation centre for those suffering from spinal injury; encouraging telemedicine for PWDs; increasing the number of trained healthcare personnel as the number of PWDs was also increasing; and ensuring the provision of healthcare services to PWDs be provided in the law.⁴⁴

Paper 3: Human Rights and Equitable Healthcare amongst Orang Asli in Kelantan

The presentation by Dr. Sa'iah bt Abdullah began with an overview of the Administrative Centres of the Department of Orang Asli Affairs (JHEOA) in Kelantan. She went on to brief on the number and background of the Orang Asli population in Kelantan.

⁴⁴ The presentation on Human Rights and Equitable Healthcare amongst Persons with Disabilities in Kelantan presented by Assoc. Prof. Dr. Tiun Ling Ta at the dialogue in Kota Bharu, Kelantan on 10 August 2008 is attached as Annexure 18.

She gave an account of the health premises that were set up by the JHOEA throughout Kelantan, as well as other health related project that was carried out by the Department in the State. The speaker then listed the healthcare facilities that cater for the health needs of the Orang Asli including hospital, clinics, transit centres and medical posts.

The Gombak Hospital is one of the above facilities and includes several units including the Out-Patient Unit, Maternal and Child Unit, TB Control Unit, Leprosy Control Unit, Malaria Control Unit, Dental Health Unit, Health Education Unit, and the Mobile Health Unit.

Dr. Sa'iah then illustrated the health related activities carried out by the Units for the Orang Asli through visuals and later focused her presentation on maternal and child health and mortality, and sexual and reproductive health. She explained that maternal mortality amongst the Orang Asli population in Pahang, Selangor and Perak, had shown significant reduction from nearly 600 deaths per 100,000 live births in 1998, to about 100 deaths per 100,000 live births after four years. However, during the same period, the combined infant mortality rate in the States had shown increase.

The incidences of Tuberculosis, Malaria and Filariasis cases amongst the Orang Asli in Peninsular Malaysia, on the other hand, have shown decreases, while the incidence of Leprosy remained at 10 cases between 1998 and 2001, and later increased to 20 cases in 2002 and dropped back to 10 cases in 2003.

The Speaker continued by saying that the main challenge to ensure adequate access to healthcare services amongst the Orang Asli was their location. Mobile Health Teams have to journey difficult, and sometimes, dangerous terrain to reach the communities. The weather, for some areas, was an important determinant on whether the communities could be reached or otherwise.

Dr. Sa'iah continued by briefing on future facilities which was planned to be set up in the Hendrop Post, Aring 5 Post and Pasik.

She concluded by outlining several recommendations which included the setting up of clinics in Interior posts of Orang Asli villages where schools already exists; increasing the number of vehicles for the health mobile teams; placement of trained personnel at transit and treatment centres; and encourage further collaboration between the JHEOA and the MOH.⁴⁵

⁴⁵ The presentation on Human Rights and Equitable Healthcare amongst Orang Asli in Kelantan presented by Dr. Saiah Bt. Abdullah at the dialogue in Kota Bharu, Kelantan on 10 August 2008 is attached as Annexure 19.

(iv) Session 3: Discussion Session on Issues Relating to Human Rights and Equitable Healthcare and the Way Forward

- **Coordination between Agencies**

A representative from SUHAKAM sought clarification from the Director of the Department of Health (DOH), Kelantan, on the extent of coordination which exists between the Department of Orang Asli Affairs and the Ministry of Health (MOH) in order to improve access to healthcare services and facilities amongst the Orang Asli.

Dr. Lila responded by saying that in terms of the coordination of activities, cooperation between the two said agencies were very good where programmes were jointly organised to improve access to healthcare services and facilities to the Orang Asli. On the other hand, she clarified that in terms of the construction of new clinics, coordination would be at the state level as the state would have jurisdiction on state land for the construction of new clinics.

- **Physical access to healthcare services for the Orang Asli and Rural Communities**

The participant from SUHAKAM inquired on whether the Gombak Hospital was the only healthcare facility that specifically caters for the healthcare needs of the Orang Asli or whether the MOH or DOH, would have any other programmes to ensure healthcare services are brought to the Orang Asli villages, granted their distant and remote villages' locations. If so, the participant asked on the current level of assistance accorded to the Orang Asli. The participant also inquired on the MOH's long-term plan to ensure Orang Asli communities had easy and adequate access to healthcare facilities and services in the future.

He added that in previous dialogues held by SUHAKAM which were participated by Indigenous Communities, many expressed concern to the fact that the involvement of Orang Asli in any planning process was scarce, if not none. He highlighted the importance of the Orang Asli's involvement in the process of determining programmes suitable for their unique economic, social and cultural background, and thus, in structuring such plans or any other relevant plans, the Orang Asli should be given ample opportunity to be involved in the process.

Dr. Lila explained that the emphasis on marginalised groups, including the Orang Asli and many others like estate workers, was contained in the Ninth Malaysia Plan (9MP). She continued by saying that in terms of healthcare facilities for the Orang Asli and other rural communities, various efforts had been taken by the government to, as far possible, ensure marginalised communities were provided with adequate access to healthcare facilities and services. She exemplified with the Gua Musang Hospital which catered for the healthcare needs of the Orang Asli, as well as the health mobile teams that were deployed to reach villages in remote and distant locations.

Adding to Dr. Lila, a participant from the Gua Musang Health Office briefed on the services provided by his office to cater for the health needs of the Orang Asli. He explained that the Office had a specially designated health mobile team to reach and provide healthcare services in Orang Asli villages. However, the team had only one vehicle for this purpose and had more than 110 Orang Asli posts to visit. Nonetheless, if this designated vehicle broke down, the team could be lent with other vehicles from the Health Office. On the other hand, since the team consists of specifically designated but limited number of members, the team would be forced to skip visits when any member of the team was on leave or assigned with other tasks such as attending courses. However, he had personally directed the team to visit all posts at least once every month.

The representative from the Gua Musang Health Office added that another constraint facing the team was the rainy season from July to December every year, whereby the team would not be able to reach certain villages as access road to those villages would be either submerged by water or become slippery and dangerous. As a result, some of these villages could not be reached for up to 3 months.

In some Orang Asli villages, clinics were unavailable. Therefore, the team would spend the night in villages that could be reached after a whole day's journey.

For the past two weeks, the Health Offices had cooperated with the Royal Malaysian Police (RMP) to reach several isolated villages. The Inspectorate Unit which consisted of medical assistants and health inspectors would follow the RMP by helicopter to go to Orang Asli posts. Assistance for the PDRM helicopter would also be requested by the Health Office when there are reported cases of epidemics and outbreaks in isolated villages.

While such assistance could be obtained from the PDRM, the representative from the Gua Musang Health Office maintained that ensuring regular and consistent provision of healthcare services for the Orang Asli, especially those residing in isolated locations and those that could only be reached via difficult terrain, remains an issue, in view of the right to health of the indigenous peoples and safety of healthcare personnel.

- **Overcrowding of Community Clinics and irregular visits by Mobile Health Teams**

Based on previous field observations made during grassroot programmes, the participant from the Kelantan Association of Reproductive Health commented on overcrowding in some community clinics. She explained that while mobile teams were available, the frequency of their visits was subject to various factors such as the weather and the condition of the teams' vehicles. As a result, visits were irregular and for some villages, the gaps between visits could reach to several months. Consequently, when the teams eventually visited the villages after the few months, the clinics were overcrowded with patrons who had fallen sick or were in need of assistance since after the last visit.

- **Locations of healthcare facilities**

Dr. Sa'iah emphasised that while community clinics have tremendously improved the health of the Orang Asli, there were Orang Asli communities, such as those in Bala Post, who could only access the clinic through a long stretch of logging tract. While noting that the Bala Post had a school, she recommended that a community clinic be established in the same area.

In response to the suggestion that health clinics be constructed in areas where schools were available, Dr. Lila said that ensuring the suitable locations for healthcare centres was a problem. At times, a certain area is selected, even if it was deemed unsuitable, as they were unable to acquire better location for reasons such as the land was a private individual property and proposal to acquire the land was not approved by the State for various reasons. But as far possible, the Department would try to establish clinics near local populations.

The participant from the Gua Musang Health Office added by saying that in some areas where schools were available, clinics were already set up. He exemplified with the clinics in Kuala Betis and Lebir Posts and the planned clinic to be set up in the Brooke Post where schools were also available.

Another participant from the Gua Musang Health Office explained that they had proposed for the setting up of clinics in several other areas, but due to the reduction of budget for the year 2008, many of these have been shelved.

He added that while setting up clinics in the areas was an ideal step forward, an issue that would require attention was related to permanent staff placement at the clinics, especially those with catchments of populations of 200 people or less.

Dr. Mohd Hirman noted that it would not be cost effective to put up clinics in rural villages with 200 villagers or less. As an alternative, the State Health Department could explore the possibility of placing trained or semi-trained health personnel at the villages. This could cost much less and placement is necessary, especially during health or medical emergencies. Prevention activities could also be done at the villages.

- **Social responsibility of the private sector**

Dr. Hirman also noted earlier concerns over the cost that may need to be incurred to set up clinics in rural and isolated villages. He said that this may be overcome by roping in private companies in the State such as logging companies whose activities usually affects the lives of the Orang Asli. With profits reaching millions of ringgit, the government could impose that such companies were to ensure that a fraction of the profit be returned to the communities by way of providing decent access roads, healthcare facilities and others.

In addition, he suggested that the MOH and State Health Departments could come up with a national action plan to intensify efforts to improve the health outlook of rural communities, thus, addressing their needs in a targeted manner.

- **Resources must be improved to meet the public's healthcare needs**

Another participant from the Gua Musang Health Office said that the capacity of the health offices to cater the healthcare needs of the Orang Asli could be improved by expanding human resource. With this, the frequency of visits could be further improved.

The participant also proposed that the number of vehicles for the health mobile teams could be increased. The current budget for the vehicle maintenance should also be reviewed as vehicles used to journey through difficult terrain could require expensive repairs and service.

- **Information and services on Family Planning for the Orang Asli women**

The participant from the Kelantan Association of Reproductive Health said that Orang Asli women, being homemakers, were responsible to care for their children. For some, the number of offspring could reach 16 to 18 children. When asked on their possibility of practising family planning, most would say that they could not persistently practise these following irregular visits by the health mobile teams who would bring the relevant medical and other supplies only during visits. In addition to this, the participant said that the services of community clinics were limited to services such as post- and ante-natal checkups, and it appeared that no family planning advice or services were provided.

- **Ensuring Disabled-friendly healthcare centres**

The speaker from the School of Social Science (SSS), USM, commented that many public healthcare centres lacked facilities for persons with disabilities. For instance, many healthcare centres in Kelantan were without signage to assist those with hearing disabilities. Additionally unavailable sign language interpreters in such centres may affect their understanding on advises given by doctors during consultations.

In terms of signage in healthcare centres, Dr. Lila welcomed the suggestion by the speaker. In terms of sign language interpreters, she explained that there was no move by the Department towards that yet.

With regards to the physical design of clinics, she explained that the standard construction plan of clinic was given by the MOH and the MOH would be the agency responsible to plan and decide any changes in the design of healthcare centres. Recent constructions of public hospitals might have designs which cater persons with certain disabilities. However, old clinics were not equipped.

She added that the *Klinik Desa* (community clinics) in particular, were meant for maternal and child healthcare, and those centres receive very few pregnant women with disabilities. She added that the Department has not received any complaint on this.

Adding to Dr. Lila, a participant from the Gua Musang Health Office said that the basic design of some clinics were alleviated from ground and were thus unsuitable for some persons with disabilities. However, he recently heard that according to the Planning and Development Division of the MOH, a new design was determined whereby the clinics would be two-storey with the lower level on the ground floor, would be the area to receive patients. In addition, it was necessary to ensure that toilets in the facilities were accessible to persons with disabilities as well.

- **Obtaining informed consent from patients with low mental capacity**

Building to the comment made by the speaker from the SSS-USM the opportunity for persons with disabilities to understand medical advices given during consultations, Dr. Sa'iah Hj. Abdullah touched on the issue of informed consent, especially amongst patients with reduced mental capacity or those who lack decision making capacity. She explained that doctor would be able to obtain substitute judgement, which would be from the patient's next of kin or guardian. For patients whom doctors were unsure of their mental capacity, Dr. Sa'iah said that the Mini Mental State Examination (MMSE) could be run. The MMSE was a simple psychiatric examination to assess the mental capacity of patients. If it was found that patients were mentally incapable of making decisions, doctors could assess the risk of the treatment or medical intervention towards the patient. Dr. Sa'iah opined that if the treatment was low risk but would benefit greatly, a marginally lesser level of competence was considered acceptable.

The representative from the Kelantan Association of Reproductive Health told of her experience during a field programme in one Orang Asli post during which their team organised a talk which touched on Pap smear. They were, however, advised by the personnel from the clinic in the village to avoid from speaking on this. In view of this, it raised a question on informed consent of those patients who were to undergo Pap smear without having ample information on what the procedure entailed.

The representative from Gua Musang Health Office in Kelantan explained that consent from patients to do Pap smear is obtained verbally only.

He opined that many women were uncomfortable to speak and undergo the Pap smear procedure. However, he said that it may be worthwhile for the Kelantan Association of Reproductive Health to ascertain the reasons through a study that the Association could carry out. This was agreed by the Chairperson of the Session who added that studies could be made on HIV/AIDS, cancer screening and sexual reproductive health with focus on Kelantan.

He added that while Kelantan has shown improvement in terms of Pap smear coverage when compared to its status 10 years ago, it was still considerably low when compared to the other states in Malaysia. Various programmes were implemented by the state to persuade villagers to take the Pap smear test, but many still refuse to do so. He opined that the approaches taken by the health department and its district offices must be suitable and sensitive to encourage acceptance and participation of local communities on such matters.

The Director of the Kelantan Health Department added that the Department and its offices had implemented many innovative approaches to deal with health issues that might be perceived as sensitive or embarrassing by some. One of the approaches includes house visits by the Department's personnel. During a visit to a house, the neighbours would be invited to join, and the personnel would speak on the importance of Pap smear. During the visit, services for Pap smear would also be made available. While the programme proved to be effective, it had to be halted due to insufficient manpower.

The Chairperson of the session added that one of the strategies as mentioned by Dr. Rosniza was to obtain the assistance of a person with experience to speak on her/his experience.

- **Differentiating rights and privileges**

A representative from the Kuala Krai Hospital sought clarification on what was meant as Orang Asli's rights as opposed to privileges. She explained that she was a doctor at the Kuala Krai Hospital which receives, among others, Orang Asli patients. She went on to say that a few weeks before SUHAKAM's dialogue, she was approached by two Officers from the JHEOA who told her that the Kuala Krai Hospital was responsible to ensure that escorting family members of the Orang Asli patients were provided with food. They said that in the event that complaints were made on this, the Hospital would have to take responsibility. Based on her experience, the participant explained that in one given Orang Asli patient admission, he/she could be escorted by more than 5 Orang Asli family members. This posed a problem to the Hospital as ration was insufficient to cover the patient's family members.

Dr. Sa'iah responded by saying that whenever an Orang Asli patient was admitted in hospitals or transit centres under JHEOA, the responsibility to ensure the escorting family members were provided with food lies with the JHEOA. In addition to food, the JHEOA would also be responsible to ensure that they are provided with other necessities including clothes, hair combs, talcum powder, soap, slippers, among others. Financial allocation was provided by to JHEOA from the Federal Government for the above purpose. In addition, vehicles to transport food and necessities were also available.

Dr. Sa'iah noted that the MOH was without such allocation. Only registered patients were provided with food. Therefore, Dr. Sa'iah established that the JHOEA was able to assist those hospitals by

providing food and other necessities not only for the Orang Asli patient(s) but also their escorting family members. She exemplified Orang Asli patients who were admitted at the Gombak Hospital following referral from the Kuala Lumpur General Hospital. The JHOEA would follow-up by providing food and other necessities to the patients and their escorting family members.

En. Rahim from the JHEOA concurred to this. However, he expressed concern when many family members escort one Orang Asli patients.

To this, Datuk Dr. Raj Abdul Karim suggested that the matter be taken up by the JHEOA to ensure clear coordination between agencies.

In view of the above discussion, the representative from the Kuala Krai Hospital said that there was the need to differentiate rights from privileges. While the former must be accorded, the latter has to have limits as hospitals might not have the capacity to accord such assistance to the escorting family members.

In contrast, Datuk Dr. Denison opined that given their economic, social and cultural backgrounds, the Orang Asli must be encouraged to expose themselves to available facilities, and that providing such assistance to escorting family members could be a form of encouragement. Absence of such assistance could discourage them, and in turn, could lead to increased ailments, mortality and morbidity amongst them. Datuk Dr. Denison suggested that hospitals could follow-up by applying for additional allocations for the above purpose.

The Director of the Kelantan State Health Department said that providing food for the escorting family members should not be seen as a problem as the cost would not be too expensive. She welcomed the suggestion by Datuk Dr. Denison and said that this would be highlighted to the MOH so that ways could be sought to ensure escorting family member were provided with food as they (Orang Asli) might not have the financial capacity to do so.

However, she expressed concern over some hospitals who had registered the escorting family members as patients, in order for the family members to obtain food. She explained that if something were to happen to those family members, the hospital could be held responsible.

- **Public awareness of the importance of hygiene**

SUHAKAM Commissioner, Tunku Datuk Nazihah recounted her experience during a visit by SUHAKAM to three villages in Kelantan, Based on her observation, two of the villages appeared to be unsanitary. She emphasised that sanitation was an important aspect to encourage health and prevention of certain diseases.

A participant from the Kelantan State Health Department concurred to this concern and explained that he had previously worked in hospitals in other states like Sarawak and Pahang. He observed that the level of cleanliness in Kelantan was still very poor when compared to the other states. This could be amongst other reasons why the State Health Department was unable to effectively eradicate endemics such as water and food borne diseases in Kelantan.

He further explained that the State Health Department had initiated various programmes to ensure a clean environment such as *gotong-royong* with village communities. Initiatives were done in both proactive and reactive manners. The former relates to activities to avoid endemics, while the latter includes actions taken by the Department after outbreaks such as dengue.

He felt that the Kelantan people were too dependent on the Department and other relevant state authorities to maintain a clean environment, and that people did not view this as a shared responsibility. To overcome this, the Department had to introduce an incentive programme whereby the Department would buy garbage from the people. While this programme was effective, the cost was expensive.

In view of the above, he suggested that SUHAKAM could initiate public awareness programmes on maintaining cleanliness and hygiene.

- **SUHAKAM's role on issues regarding health**

Dr. Kamarulzaman from the Tengku Anis Hospital enquired on the role of SUHAKAM in comparison with the role held by the Public Complaints Bureau and as the public may be aware, any complaints on the services of hospitals would be directed to the hospital or the ministry. He inquired whether SUHAKAM had the same role in handling health related issues.

In response, SUHAKAM Commissioner Dr. Mohd. Hirman Ritom said that in terms of health issues, the Commission would look at matters regarding rights which includes, among others, the components of right to health like accessibility and others. Therefore, when a person is denied access to healthcare services or other related facilities, he or she can lodge a complaint to SUHAKAM.

On the other hand, complaints relating to the delivery of healthcare services by relevant institutions would be a matter to be addressed by the MOH or other authorised agencies. Nevertheless, if there was an agency which failed to take the necessary action, a complaint could be lodged to SUHAKAM to investigate the alleged inaction.

Dr. Mohd. Hirman further reminded participants that SUHAKAM was without prosecution powers or to force an agency to take action. Instead, SUHAKAM was only mandated to make recommendations until the existing SUHAKAM Act is amended to give SUHAKAM such power.

- **Duties of the Orang Asli**

Dr. Mohd. Hirman lauded the efforts taken by the Kelantan State Health Department and hospitals to ensure access to healthcare facilities for the Orang Asli as well as accommodating their family members when Orang Asli patients were admitted to hospitals. However, he noted that the Orang Asli communities themselves must move forward and carry out their responsibility towards their health because human rights also emphasises duties. Therefore, the Orang Asli community should be exposed not only on information on their rights, but also their duties.

3. CONCLUSION

The session ended by a note of thanks to the speakers and participants by the moderators. She said all issues raised by participants would be brought to the attention of the relevant government department.

PART IV

ANNEXURES

ANNEXURES PART A

SPEECHES AND PRESENTATIONS

**BY SPEAKERS AT SUHAKAM'S DIALOGUE ON HUMAN RIGHTS AND
ACCESS TO EQUITABLE HEALTHCARE IN KUCHING, SARAWAK**

5 NOVEMBER 2007

ANNEXURE 1

WELCOMING REMARKS

BY DR. HIRMAN RITOM ABDULLAH

COMMISSIONER, HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)

Fellow Commissioners of the Malaysian Human Rights Commission,
Honourable guests and speakers,
Participants for today's dialogue,
Ladies and Gentlemen.

A very good morning to all.

On behalf of the Malaysian Human Rights Commission (SUHAKAM), in particular, its Sarawak Office and its Economic, Social and Cultural Rights Working Group (ECOSOC), I would like to extend a very warm welcome to all present, especially to the Speakers, who have willingly agreed to be with us today, despite their very busy schedules.

Tan Sri-Tan Sri, Datuk-Datuk, Ladies and gentlemen,

As you are all aware, the subject matter of the dialogue today is on Human Rights and Access to Equitable Healthcare. Needless to say that we all know that health is an engine which affects, and is also a concern of the whole family of the human society; be it the individual himself, or his family unit, the community and state.

But ladies and gentlemen, besides being a right itself, health is also a very crucial foundation to the fulfilment and enjoyment of all other components of what we understand as human rights.

Today we will have the opportunity to hear from our esteemed and knowledgeable panel of speakers from the public and private health sectors, as well as neighbours of civil society who will share with us their views and concerns pertaining to the human rights and access to equitable healthcare, and perhaps more important for us in this hall today, with respect to the State of Sarawak which all of us know has its peculiarity with regards to health needs.

ANNEXURE 1

Ladies and gentlemen,

SUHAKAM has taken pains to make the efforts to be as inclusive as we can in extending our invitation for today's deliberation. Amongst you, there are academics, dedicated representatives of various health-related and community based NGOs, doctors as well as allied health professionals. We believe that your ideas through the subsequent discussions will help to provide the necessary input to the government through the Ministry of Health in order to help strengthen and consolidate our existing, and in the future national health policy as well as implementation and delivery of the mechanism, with special emphasis on the human rights of the general population.

Ladies and gentlemen,

I will not prolong my presence here on this stage as it falls on my fellow Commissioner Datuk Dr. Raj Karim who will then introduce the subject on the human rights perspective to health, which would hopefully become the basis of our discussion this morning.

Before I end, I would like to extend our heartfelt thanks to all our guest speakers, my fellow commissioners, all present here this morning and to the Secretariat from Kuching, Sarawak as well as Kuala Lumpur, and to all those who have contributed to the preparation of today's dialogue. I would especially like to single out the contribution from the Director of Medical Services, of the Department of Health Sarawak, Dr. Andrew Kiyu and his staff; Ms. Gill rajah from UNIMAS, the Sarawak Development Institute for the input they have given us in preparation for this dialogue and also to all those who have contributed in whatever form, be it their ideas or their time and effort. If we have unintentionally curbed some quarters by either our omissions or actions, please accept our sincere apologies.

So ladies and gentlemen, with this, thank you very much and a very happy deliberation for the rest of today.

Thank you.

ANNEXURE 2

INTRODUCTION TO THE DIALOGUE

BY DATUK DR. RAJ ABDUL KARIM

COMMISSIONER, HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)

Assalamu'alaikum and good morning to all of you.

Dr Andrew Kiyu and colleagues from Sarawak Health Department,

Fellow commissioners,

Honourable speakers,

Ladies and gentlemen.

The United Nations Declaration of Human Rights has stated that every one has the right to a standard of living adequate for the health and wellbeing for himself and of his family including food, housing, clothing, and medical care, and necessary social services and the right of security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood, in circumstances beyond his control. It also state that motherhood and childhood are entitled to special care and assistance and all children whether born in or out of wedlock shall enjoy the same social protection.

The rights based approach to health programme and planning is in its infancy stage. It is really very new, and it was only on Oct 10 2006, exactly one year ago that the World Health Organisation (WHO) and UN Office of Human Rights got together to decide on what are the common areas they would like to work on to have a plan of action on health as a human rights and some aspects were mentioned such as maternal mortality or safe motherhood, discrimination especially against HIV/ aids, and the imprisonment of psychiatric persons in jails. These were a few areas that have been identified & I guess many more will come.

The right to health is intrinsically linked to other basic rights including the right to life, non-discrimination, privacy, work, education, and to enjoy the benefits of scientific progress. We all know that human rights are universal, indivisible, interdependent, and inter-related and this is in the Vienna declaration and plan of action 1993 and that human rights are inspired by moral values such as dignity, equality and access to justice. This is what we are discussing today. They are not moral entitlements but they are legal entitlements and therefore must be legally guaranteed.

ANNEXURE 2

The right to health does not mean the right to be healthy. The right to health means that the government must generate conditions in which everyone can be as healthy as possible. Such conditions range from ensuring availability of health services, healthy and safe working condition, adequate housing, and nutritious food.

The right to health has been enshrined in numerous international and regional human rights treaties as well as international constitutions all over the world. Some of the UN human rights treaties are the international covenant on economic, social & cultural right 1966 especially article 11 & 12, CEDAW, CRC.

The WHO Constitution also states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political believe, socio-economic condition. Additionally, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states that steps for the realization of the right to health including to reduce infant mortality; to ensure the healthy development of the child; to improve environment and industrial hygiene; to prevent, treat & control epidemic, endemic, as well as other diseases; and to create conditions to ensure access to health care for all. To ensure that this is progresses in countries, the ICESCR adopted the general comment on the right to health in 2006 which says that the right to health extends not only to timely and appropriate healthcare, but also to underline determinants of health including safe and clean water supply, sanitation, food, nutrition, housing and others. Another important component is the right to sexual and reproductive health.

According to the general comment, the right to health contains several elements including availability, accessibility (including physical and economic accessibility), acceptability and quality.

The right to health also has 3 obligations which are imposed to all counties or state parties which includes respect (whereby state parties should not interfere with the enjoyment of the right to health), protect (this means ensuring state parties do not infringe upon the enjoyment of the right to health), and fulfil (which means that state parties need to take positive steps to realize the right to health). Additionally, the general comment on right to health also outlines the core contents of right to health including minimum essential and nutritious food, sanitation, safe and potable water and essential drugs, which Malaysia has done very well.

Another core obligation is the adoption and implementation of a national public health strategy and a plan of action. Besides the national health policy to be included in the Ninth Malaysia Plan, the government of Malaysia also wants to come up with a national healthcare financing scheme.

ANNEXURE 2

These must address the health concerns of the whole population and be devised on the basis of a participatory and transparent process.

Today's dialogue session would look into the national health policy proposed financing scheme to ensure participation of all sectors its development. It must take into account the needs of vulnerable and marginalised groups and must contain certain indicators and benchmarks which can be monitored.

We have done well and Malaysia has been commended by the WHO and many other international agencies in our attempt to provide comprehensive basic health care using the primary healthcare approach. We have also been successful in including health within socio-economic development such as in rural development and poverty alleviation. But new challenges are approaching such as privatization. We have a withdrawing public health sector and growing urbanisation that comes with emerging health issues like HIV/AIDS, health of migrants and displace people, health of adolescents, sexual violence and reproductive health and many other ethical issues.

We need new approaches, new way of thinking, new ways of doing things, and above all we need to ensure that human rights is part of the health plan and that equity to ensure that health becomes a reality for all of us Malaysian.

Thank you.

ANNEXURE 3

TOWARDS EQUITABLE HEALTH CARE FOR ALL – PROVIDING HEALTH CARE TO THE RURAL AREAS OF SARAWAK

BY DR. ANDREW KIYU

DIRECTOR, PUBLIC HEALTH DIVISION, SARAWAK HEALTH DEPARTMENT

**Towards Equitable Health Care
For All**

Presented by
Dr. Andrew Kiyu - Director
Sarawak State Health Department
At the Dialogue on the Malaysia National Health Policy
Kuching Hilton
5 November 2007

Perspectives of Rural Medicine in the Asia-Pacific Region :
**Providing Health Care to the
Rural Areas of Sarawak**

Dr Andrew Kiyu
Dr Flora Ong
Dr Kamaliah Mohd Noh
Dr Jamilah Hashim
Dr Mohd Rais

Presented at the
International Conference on Rural Medicine,
Kota Kinabalu, Sabah
29-31 October 2007

Questions and comments to: andrew.kiyu@sarawak.health.gov.my

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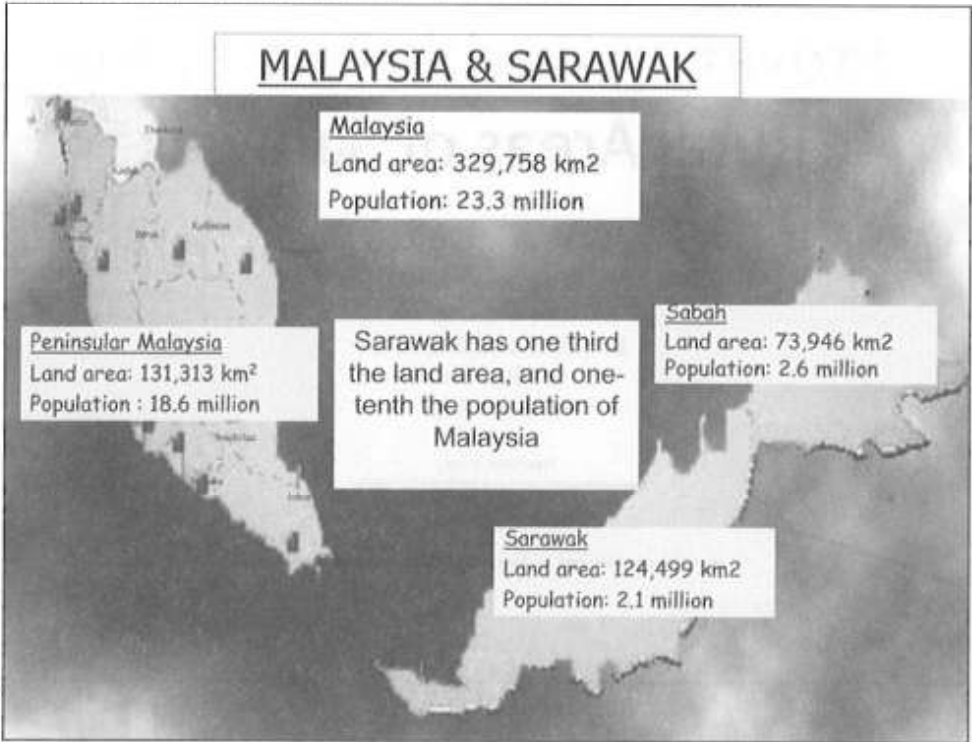
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Outline of Presentation

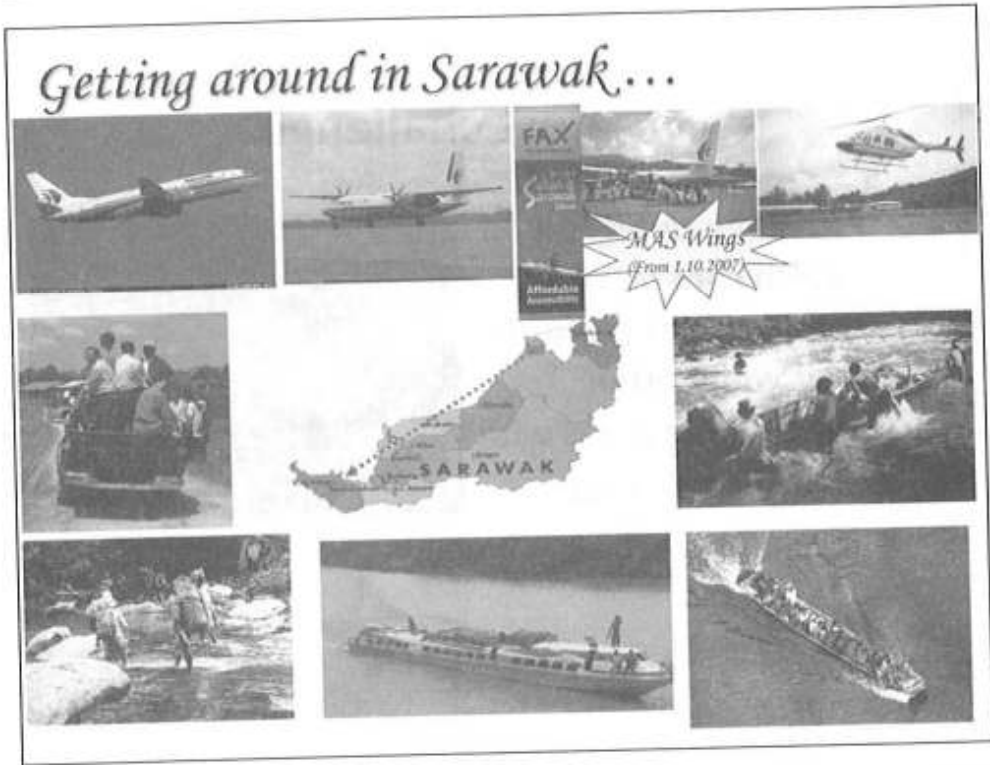
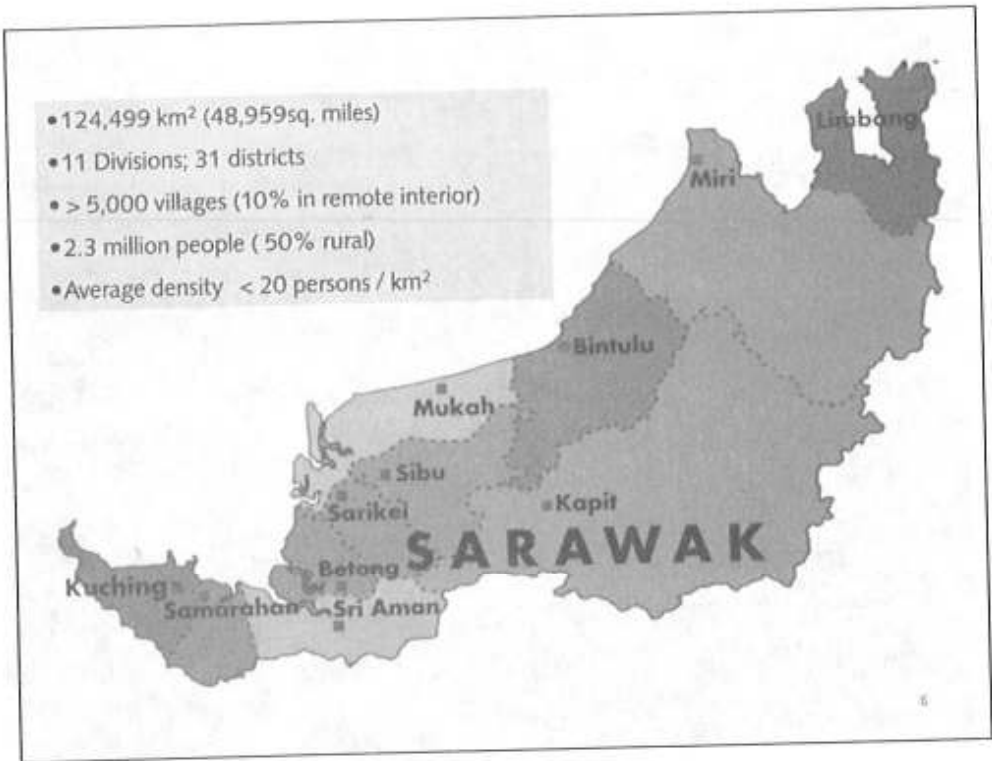
- 1. Challenges
- 2. Strategies
- 3. Organization
- 4. Health care delivery system
- 5. Overcoming communication challenges
- 6. Staffing
- 7. Community participation
- 8. Volunteer groups
- 9. New developments
- 10. Funding

Challenges

- Rising demand by consumers for high quality, high technology, and affordable medical care; free from errors and incompetence; delivered by healthcare professionals who are caring, competent, compassionate and trustworthy
- Increasing cost of healthcare
- Global public health threats resulting from population growth, deforestation, rapid urbanisation, intensive farming practices, environmental degradation & irrational use of antimicrobials
- Rapid international spread of infectious agents & their vectors
 - New diseases emerging at rate of one per year
 - Airlines transport more than 2 billion passengers every year



ANNEXURE 3



Challenges to health care delivery

- Large land area (124,499 sq. km)
- Scattered population – low population densities in rural areas
- Rough terrain making road development slow

Greatest challenge

- Providing **universal health care** to small communities scattered over wide, often inaccessible areas with – limited resources



10

Greatest achievement

- Almost total health service coverage achieved despite these odds
- Made possible by the State Health Department placing **equal emphasis** on rural health services & hospital care

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ANNEXURE 3

Impact of health care system

- Low maternal mortality
- Good immunisation coverage
 - Low incidence of immunisable diseases
- Low infant & toddler mortality rates
- 7 out of 8 health related Millenium Development Goals achieved

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Outline of Presentation

1. **Challenges**
2. **Strategies**
3. Organization
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10. Funding

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2.1. Philosophy

- Health is a human right
 - Aim: The best possible health
- Health is a means to better health
- No discrimination
 - Inequity is an issue of access, and not discrimination
- Almost free primary health care
 - Access and lost days of work
- Must actively focus on rural people
 - Otherwise forgotten

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2.2. Causes of Causes

- Rural Health Improvement Scheme of the early 1970s to Environmental Sanitation, & now BAKAS (Bekalan air dan Kesihatan Alam Sekitar)
- Healthy settings: Healthy village, Healthy Clinics, etc



1. Gotong royong for gravity feed
2. Rain water tank
3. Pour flush latrine
4. Healthy Village in Kapit



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2.3. Prioritise – (1/3) (Because of limited resources)

- Carry out activities and programmes that had the most impact
- Take care of vulnerable groups
 - Age and physiology
 - Socioeconomic status
 - Know the community
 - Village Health survey
 - family folders
 - Penans



2.3. Prioritise – (3/3) (Because of limited resources)

- Tackle diseases and conditions that cause high morbidity &/or mortality through:
 - Childhood immunisations
 - Maternal care
 - child growth monitoring
 - Applied Nutrition Programme
 - Hard core poverty programme
 - Malaria control programme
 - Iodine Deficiency Disorders



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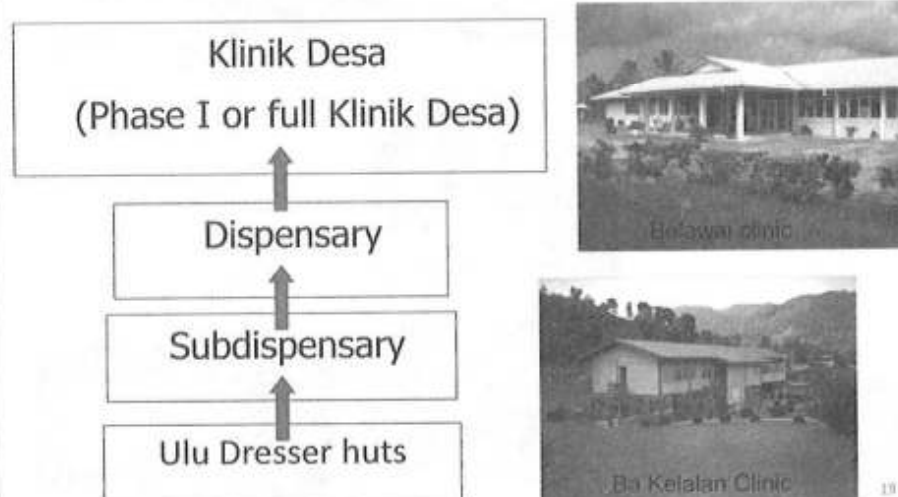
ANNEXURE 3

Outline of Presentation

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3.3. Fitting the Correct Clinic to the Population Size and Service Expectations

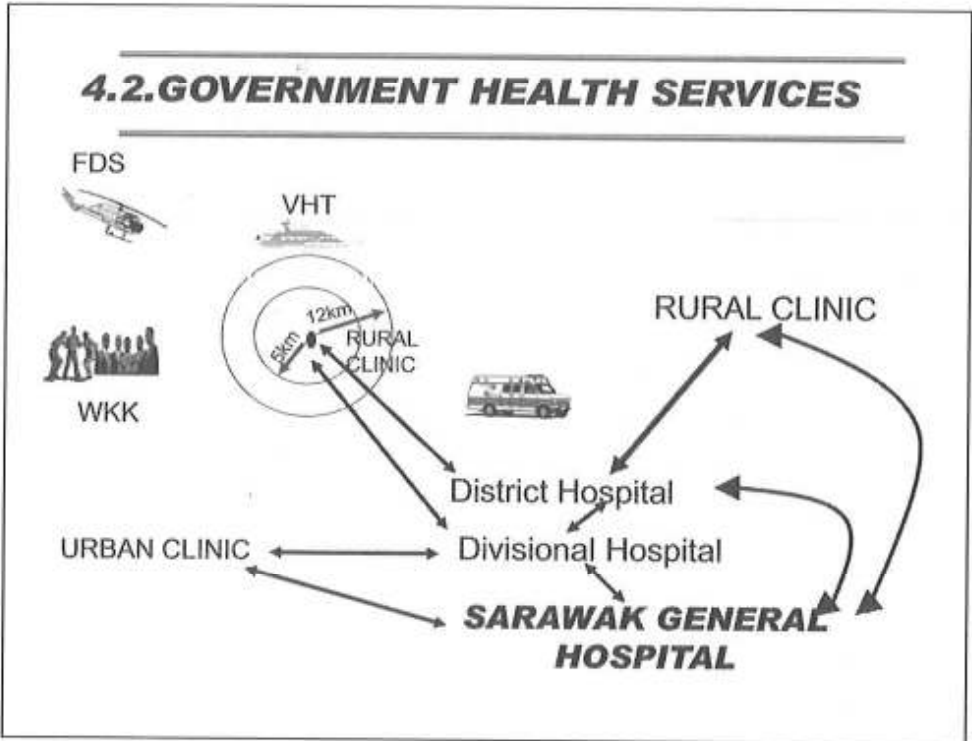


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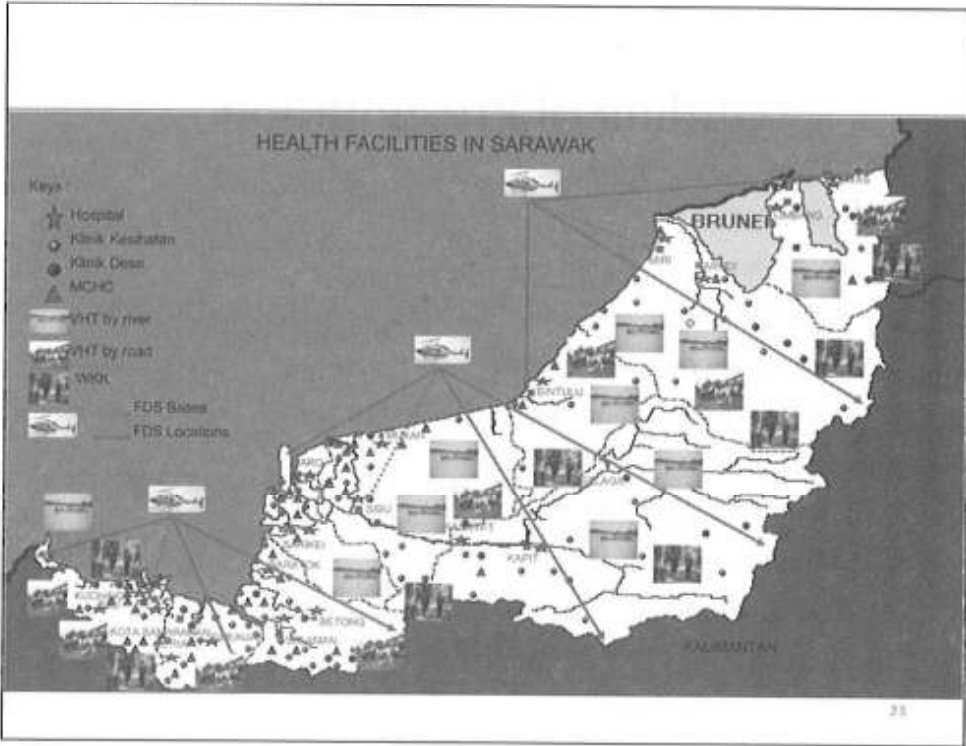


4.3. Health Service coverage

90% coverage in primary health care achieved through :

- 239 health clinics
- 125 mobile health teams
- 173 FDS locations
- 22 hospitals

The collage includes images of: English Clinic, Song; Flying Doctor Service; Village Health Team; Kapit Polyclinic, Kapit; Community Health Volunteers (pink); Serapi Hospital; Sarawak General Hospital; and Remote-based Health Units.



ANNEXURE 3

4.5. Current Klinik Desa

- “one-stop” health centre providing promotive, preventive, curative care & rehabilitative care
- Staffed by medical assistants, community nurses & public health assistants
- Has rest beds, delivery rooms, patient’s kitchen & food for in-patients
- Design has changed over years to meet changing needs of population

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4.5. Current Rural Clinics

- Now all called “Klinik Kesihatan”



Bario KK



Batu Lintang KK



Belawai KK

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4.5.1. Physical features

- Delivery room
- OPD
- MCH
- Postnatal room
- Admission beds
- Kitchen
- Penan huts nearby (in Penan areas)



Delivery room



Rest beds in Klinik Kesihatan

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4.5.2. Services

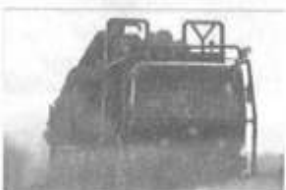
- MCH
 - Midwife/JM
 - Birth incentives
- Outpatient
 - JHA/MA
- Environmental sanitation
 - RHS/PKA



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4.5.4. Mobile teams to overcome transport problems

- Roads
 - Rent transport
- Rivers
- Foot
- FDS
 - FDS
 - MEDEVAC
 - Cargo run
 - Outbreak



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4.5.4.2. Flying Doctor Service

- Aims to provide health care to people in remote areas
- Pilot project in 1973; permanent service in 1975
- Operates with 3 helicopters based in Kuching, Sibuan and Miri
- FDS team comprises a medical officer, a medical assistant, and two community nurses
- Provides outpatients and MCH services
- Emergency medical evacuation (MEDEVAC)
- Cargo runs
- Outbreak investigation & control (eg measles outbreak in Belaga)



ANNEXURE 3

4.5.5. Referral and consultation system

- 2-way referral:
- up to the highest level of care, if needed
- Downwards for follow-up of patients
- Drug list for Medical Assistants
- "Protocol" drugs: to be prescribed to patients on follow-up and to follow the protocol for use of the drug

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Outline of Presentation

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5.0. Overcoming communication

- Satellite phone too expensive
- Tele-Primary Care
- Universal Service Provider
- FDS
- Logging Camp phones



Radio call sets



Broad-band VSat

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Outline of Presentation

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6.1. Right kind of staff and right kind of training and knowledge and skills

- Extra training of Medical Assistants (Assistant Medical Officers)
- Junior Hospital Assistants
 - Stopped training in mid 1980s
- Community nurse or “JM”
 - Started in 1976
- Rural Health Supervisor/Public Health Worker (PKA) and Health Inspector (now called Assistant Environmental Health Officer)
 - For environmental sanitation



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6.2.1. “Remote” supervision

- Supervision despite distances
 - Klinik Kesihatan manual
 - Village Health Promoter manual
 - Regular visits by supervisors
 - Supervision checklist
 - Extra training for medical assistants
 - Ensure that right kind of staff get right kind of training in knowledge & skills
 - Internet connections to access the Web for continuing education

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ANNEXURE 3

6.2.2. Supervision & Guidance

- “Klinik Desa” Manual
- Village Health Promoter manual
- Supervision checklist
- Supervisors very important

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Outline of Presentation

1. Challenges
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7.1. Working with Community

- Rural Health Improvement Scheme
- Village Health Promoter project
- Birth incentives for mothers who deliver in our clinic
- Village Health survey
 - To understand community
- Healthy settings



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ANNEXURE 3

7.2. Village Health Promoters

- community-based village health volunteer programme
- launched in 1983 to improve access to basic health care in under-served areas
- volunteers undergo two weeks of training in basic health care & return to serve their communities

— 17 Penans



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Outline of Presentation

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7. Community participation
8. **Volunteer groups**
9. New developments
10. Funding

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8.1. Volunteer groups

- Volunteer groups
 - Mercy Malaysia
 - Rotary Club, Lions Club
 - Religious organisations etc
- Often organise special visits to provide health care to rural communities
- Complement our services

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ANNEXURE 3

Outline of Presentation

1. Challenges
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8. Volunteer groups
9. **New developments**
10. Funding

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9.1. New developments

- Reaching the unreachable
- Re-emphasise importance given to health care compared to hospital care
- Role of IT
 - Tele-Primary Care
 - Bridging digital divide
- Upgrading services in KK
 - Oxygen

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Outline of Presentation

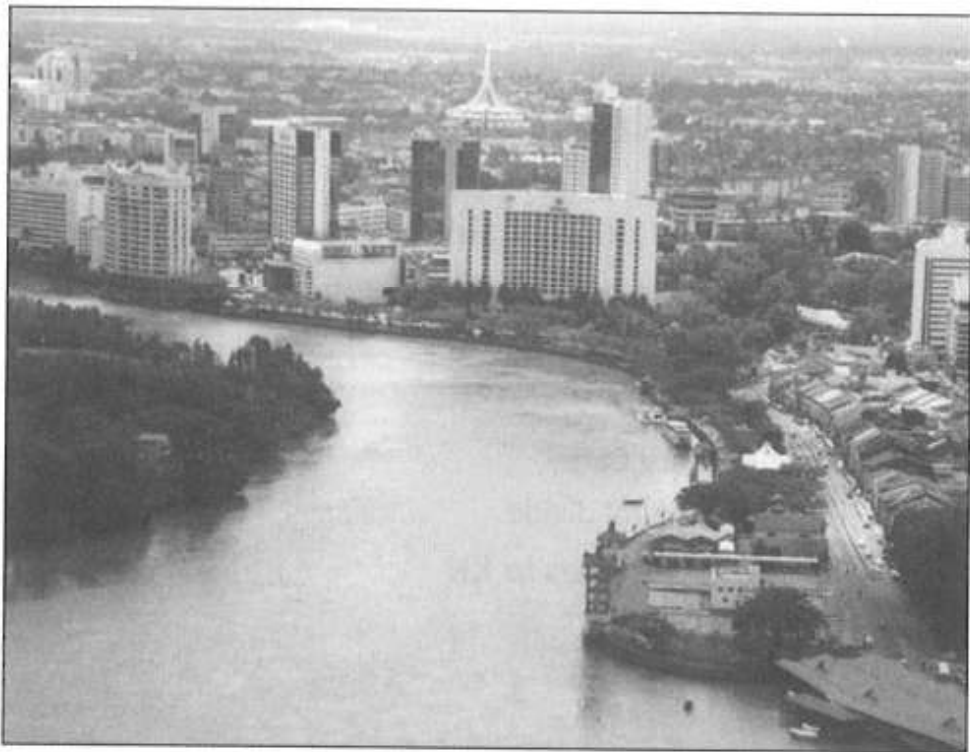
1. Challenges
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7. Community participation
8. Volunteer groups
9. New developments
10. **Funding**

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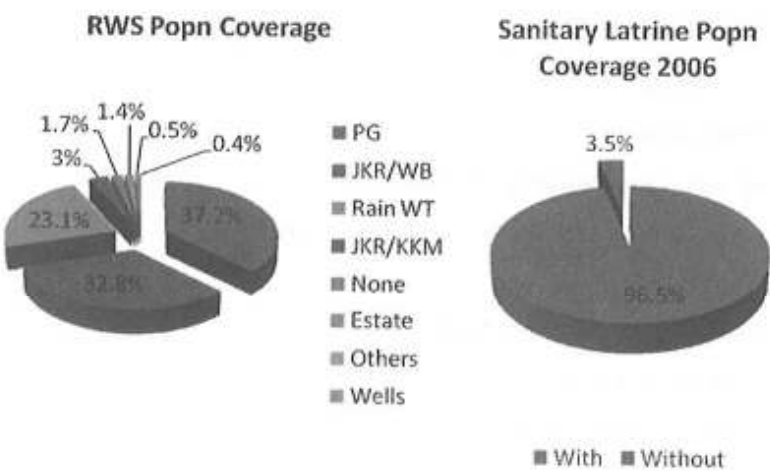
ANNEXURE 3

Funding for Health Services

- Highly subsidised by Govt at min. or no cost at any level of health service
- Exemption process in payment system
- Fees collected 3 – 5% of MOH annual budget
- Details of mechanism for national health insurance still being finalised



Rural Water Supply & Sanitary Latrines



ANNEXURE 4

TOWARDS EQUITABLE HEALTHCARE FOR ALL - A HUMAN RIGHTS PERSPECTIVE

BY DATUK DR. TEOH SIANG CHIN

CHAIRMAN, MEDICAL ASSOCIATION OF SOUTHEAST ASIAN NATIONS (MASEAN)/PAST PRESIDENT, MALAYSIAN MEDICAL ASSOCIATION

SUHAKAM

**HUMAN RIGHTS COMMISSION MALAYSIA
TOWARDS EQUITABLE HEALTH CARE FOR
ALL - A HUMAN RIGHTS PERSPECTIVE**

5th November 2007
KUCHING, SARAWAK

Datuk Dr TEOH Siang Chin
MBBS, MSc HHSM, LFOM, PgDp Sp Med

Immediate Past President: MMA
Chairman: MASEAN
Medical Associations ASEAN



BAREFOOT MEDICINE IN MERGUI, MYANMAR

Outline of presentation

1. Introduction Human Rights & Health
2. Global Approach in HR & H
3. Status and Issues HR & H Malaysia
4. Challenges and Opportunities



ANNEXURE 4

Introduction: Human Rights

HR: freedoms and entitlements concerned with protection of the inherent dignity and equality of every human being.

- Include Civil, Political, Economic, Social & Cultural rights
- HR inspired by moral values - dignity, equality & access to justice
- More than moral entitlements: they are legally guaranteed
- Enshrined in various international treaties & declarations

3

International law: Right to health

1. WHO Constitution in 1946:

'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.

Defines health as "a state of complete physical and social well-being and not merely the absence of disease or infirmity".

2. In 1948 the Universal Declaration of Human Rights included the right to health as:

'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services'.

4

HEALTH & HUMAN RIGHTS

3. World Health Assembly 1970

- WHA = Supreme decision-making body, which meets in May each year, and is attended by delegations from the 193 Member States.
- Recognized the right to health as "a fundamental human right" and set out that "the health aspect of human rights is within the competence of the WHO".
- Established the DG mandate to participate in coordination arrangements of the UN system to assure WHO's "full contribution to the overall effort to attain for all peoples the full enjoyment of their economic, social and human rights".

4. World Health Assembly 1973

- Adopted the Health for All Policy.
- Acknowledged health "as a basic human right".

5

ANNEXURE 4

HEALTH & HUMAN RIGHTS

5. Declaration of Alma Ata 1978

- States that "health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right".

6. World Health Declaration 1998

- Sets out a framework for the Health-for-All Policy for the 21st century.
- Reaffirms WHO Member States' commitment to the principle that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".

6

INTERNATIONAL AGREEMENTS

7. UN Reform Program 1997

- Sets out that human rights are cross-cutting ALL UN activities and urges mainstreaming across the UN system.

8. Millennium Declaration 2000 and MDGs

- Explicitly places both human rights commitments and development goals at the centre of the international agenda for the new millennium.

9. World Summit 2005

- The GA adopted Resolution 60/1 2005 which calls upon "all parts of the UN to promote human rights and fundamental freedoms in accordance with their mandates".

10. International Human Rights Instruments

- Each of the 193 WHO Member States is party to at least one HR treaty that endorses the right to health.

7

What is the right to the highest attainable standard of health?

- The right to the highest attainable standard of health is codified in numerous legally binding international and regional human rights treaties.
- The right is also enshrined in numerous national constitutions

Right to highest attainable
standard of health does NOT
mean right to be healthy

8

Beyond just health care:

While the right to health includes the right to *health care*, it goes beyond health care to encompass the *underlying determinants of health*. i.e.

safe water, sanitation, education, shelter etc..

- The right includes *freedoms* – of want; to pursue choice; to move; or satisfy hunger
- It also includes *entitlements* – obligations – legal national constitution
- The right requires an effective, inclusive *health system* of good quality
- The assessment of the provision of this right to Health is the Triple A Q or the AAAQ analysis

9

A 1 : Availability

Availability means that functioning public health and health-care facilities, goods and services, including essential drugs and programmes, have to be available in sufficient quantity within State Parties. The precise scale and nature of the facilities, goods and services will vary depending on numerous factors, including the State party's development level. However, regardless of the development level, the health facilities, goods and services must include:

- The underlying determinants of health, such as safe and potable drinking-water and adequate sanitation facilities;
- Hospitals, clinics and other health-related buildings;
- Trained health professionals receiving domestically competitive salaries; and;
- Essential drugs, as defined by the WHO Action Programme on Essential Drugs.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

10

A 2 : Accessibility

Accessibility requires that health facilities, services and goods, including essential drugs, must be accessible on the basis of:

Non-discrimination:

Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility:

Health facilities, goods and services must be within safe physical reach of

margin * **Access to information*** 15
popula
with disabilities and persons living with HIV/AIDS.

Economic accessibility or affordability:

Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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ANNEXURE 4

A 3 : Acceptability

Acceptability means all health facilities, goods and services must be respectful of medical ethics and culturally appropriate. In practice, health facilities, goods and services must:

- Be respectful of the culture of individuals, minorities, peoples and communities;
- Be sensitive to gender and life-cycle requirements;
- Be designed to respect confidentiality; and
- Improve the health status of those concerned.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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Q: Quality

Quality means health facilities, services and goods must be scientifically and medically appropriate and of good quality. That requires, for instance:

- Skilled medical personnel;
- Scientifically approved and unexpired drugs and hospital equipment; and
- Safe and potable water and adequate sanitation.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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2.Global Approach Health & HR



ANNEXURE 4

Global Challenges: Neglected Diseases & Populations

Diseases that burden the poor: affect almost exclusively poor, powerless people living in rural parts of low income countries – impact about 1 billion people

- Include tropical diseases : kala-azar, tuberculosis, filariasis, dengue
- Some are life threatening & high morbidity with severe disabilities
- Inflict enormous economic burden on communities – lost productivity & opportunity cost of long term care
- Contribute to poverty cycle and ill-health for neglected people
- Attribute it to the low profile of affected population
- research maybe sidelined by big Pharma & Urban bias of health care.



The UN Special Rapporteur on the right to the highest attainable standard of health

- A UN Special Rapporteur is an independent expert appointed to promote and protect human rights.
- For many years, the UN appointed Special Rapporteurs to focus on the classic civil and political rights, like freedom of religion and the prohibition against torture
- Recently the UN has appointed experts to focus on economic, social and cultural rights, the first being the Special Rapporteur on the right to education who was appointed in 1998
- In 2002, the UN decided to appoint a Special Rapporteur on the right to the highest attainable standard of health

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UN Special Rapporteur

The Rapporteur is asked to help States, and others, better promote and protect the right to the highest attainable standard of health.

Appointed Prof Paul Hunt 2003

The first report of the SR identified three key objectives:
(Focussed on poverty & discrimination)

- to promote – and encourage others to promote – the right to health as a fundamental human right;
- to clarify the scope of the right to health;
- and to identify good practices for the operationalisation of the right to health at the community, national and international levels

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ANNEXURE 4

SR Reports:

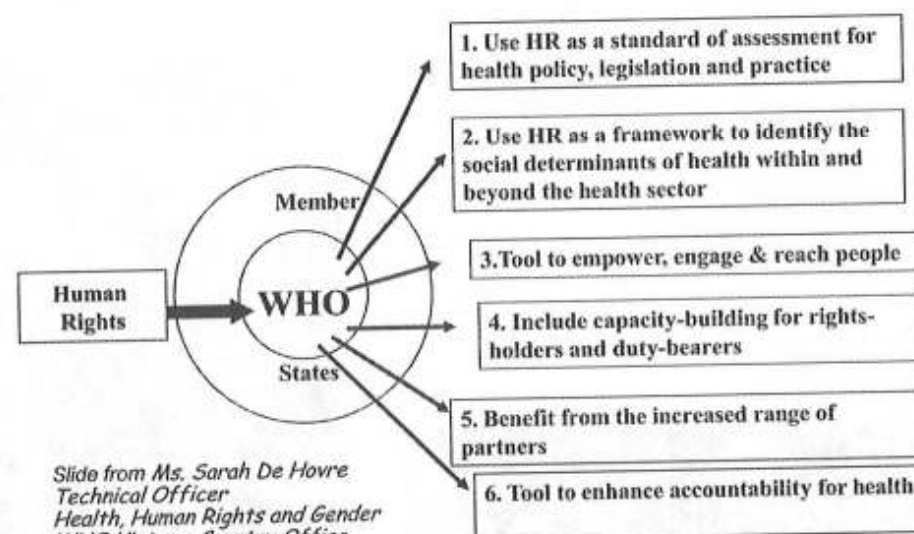
Each year the SR submits written and oral annual reports to the UN General Assembly and another to the UN Human Rights Council

- To date, these annual reports have looked at a range of issues, including the health-related Millennium Development Goals:
- the skills drain of health professionals,
- access to medicines,
- maternal mortality,
- sexual and reproductive health rights,
- indigenous peoples,
- mental disability, and others



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How WHO uses a Human Rights approach



19

3. MALAYSIA :



COUNTRY ISSUES

HEALTH & HUMAN Rights



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ANNEXURE 4

DOCTOR: POPULATION RATIO BY STATE 2004						
	Public Sector ¹			Private Sector	Total	Ratio of Doctor to Population
	MOH	Non MOH	Total			
Wilayah Persekutuan ²	1,115	918	2033	1,779	3,812	1: 401
Pulau Pinang	630	9	639	841	1,480	1: 975
Malaka	299	25	324	333	657	1: 1,066
Negeri Sembilan	440	6	446	320	766	1: 1,214
Selangor	911	90	1001	2,053	3,054	1: 1,511
Perak	626	22	648	802	1,450	1: 1,534
Kelantan	358	385	723	168	891	1: 1,628
Perlis	93	1	94	36	130	1: 1,702
Johor	788	12	800	874	1,674	1: 1,810
Pahang	458	1	459	311	770	1: 1,818
Kedah	501	6	507	447	954	1: 1,901
Sarawak	684	24	708	362	1,070	1: 2,115
Terengganu	311	0	311	144	455	1: 2,177
Sabah	714	3	717	348	1,065	1: 2,765
MALAYSIA	7,928	1,482	9,410	8,836	18,246	1: 1,402

Notes :
¹ Includes Ministry of Health, other government agencies, local authorities and universities
² Includes Kuala Lumpur, Putrajaya and Labuan

Table Four: Distribution of Health Resources in Malaysia 1999

	Hospital Public	Hospital Private
Admissions	1,500,000	500,000
C.T. Scan*	19	67
Specialists*		
- Medical	33%	67%
- Surgical	34%	66%
- O&G	20%	80%

Source: Eight Malaysia Plan. Pg 486

We now have a situation where 75% of the admissions are still to the government hospitals, but 75% of the specialists are in private hospitals. The distribution indicates that high tech facilities are much easier to avail in the private sector over-stretched government sector.



DISTRIBUTION
& DISPARITIES

ANNEXURE 4

Medical Human Resource Migration

SLOWING DOWN THE BRAIN DRAIN: ARE WE DOING ENOUGH?



ACCESS – DISTRIBUTION OF DOCTORS

Doctors are extremely high-cost, valuable and highly skilled professionals making difficult decisions daily; and who through their individual interventions, greatly determine health outcomes and health care expenditure

MIGRATION OF SKILLS

- Public to Private
- General Practitioner to Specialist
- Specialist to Interventional specialist
- Across Political borders

??? Public health ???

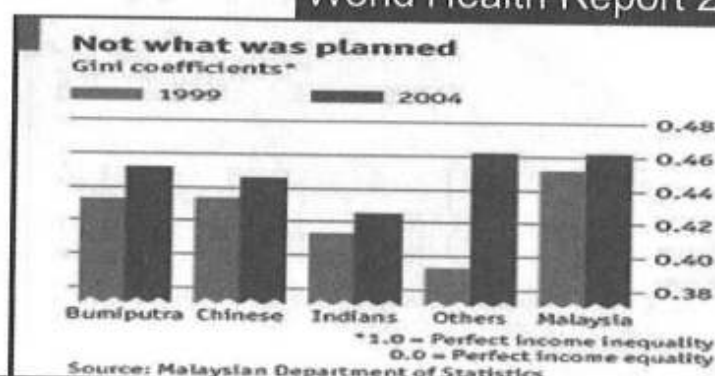


ANNEXURE 4

Incentives to encourage equitable distribution of health care workers

Both financial and non-financial incentives can also reduce geographical imbalances in the distribution of health workers. For example, in Indonesia, a bonus of as much as 100% of the normal salary attracted medical graduates from Jakarta to the outer islands (33). Recruitment and training of people from remote areas, who are committed to their region of origin, have also been proposed.

World Health Report 2003



4. Challenges and Opportunities

- Health Professionals and HR
- NMA's and HR
- Action by Society & Individuals



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Health Professionals & Human Rights

- *Human rights education* is an essential starting point for equipping health professionals with the knowledge and tools to empower them to protect and promote human rights
- The value of educating health professionals in human rights has been widely endorsed by states and the health and human rights communities worldwide
- What the health professionals need to know, to some extent will depend upon the country they work in and also their area of specialisation
- At a minimum all health professionals should receive education on human rights of patients including their right to health, health related human rights of vulnerable groups and their own human rights

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ANNEXURE 4

MMA AGM RESOLUTIONS 1999
On health and human rights

▪ **The right to be free from torture and ill treatment**

The MMA believes that all persons have the right not to be subjected to torture or to cruel, inhuman or downgrading treatment or punishment and not to be subjected to medical or scientific treatment without free and informed consent.

▪ **The right to care for disadvantaged groups**

The MMA believes that the disadvantaged and vulnerable groups have the right to medical care. The obligation of the physician to provide medical care for disadvantaged and vulnerable groups must be upheld. Physicians should endeavour to identify causes of ill health in such groups and should draw attention to the need to alleviate them.

▪ **The right to care for prisoners**

The MMA believes that attendance by physicians on persons in custody, prison and those held in detention must always be conducted in the best interests of their health.⁶

Challenges - National

1. H&HR = relatively new area of work

2. Misunderstanding - " Rights are for lawyers and not for health professionals"

3. Senior management / policy commitment to HRs

4. HRs and civil society are seen as a threat.

5. Ministry of Health have core priorities - aligned politically and by literate and vocal electorate

6. National public health budget is low.

7. Health data are not always reliable.

8. Increasing inequalities in access to health care and health outcomes.

9. Weaker rural health systems, which have a bigger impact on the poor.

Abbreviation	Full name	When?	No of countries?	Right to health?	Malaysia as signatory
ICCPR	International Covenant on <u>Civil and Political</u> Rights	1966	156		NO
ICESCR	International Covenant on <u>Economic, Social and Cultural</u> Rights	1966	153	Yes Art.12	NO
CERD	International Convention on the Elimination of All Forms of <u>Racial Discrimination</u>	1965	170		NO
CEDAW	Convention on the Elimination of All Forms of Discrimination against <u>Women</u>	1979	182	Yes Art.12	YES 4 TH AUG 95
CAT	Convention against <u>Torture</u> and Other Cruel, Inhuman or Degrading Treatment or Punishment	1984	141		NO
CRC	Convention on the Rights of the <u>Child</u>	1989	192	Yes Art. 24	YES 19 TH MAR 95
ICRMW	International Convention on the Protection of the Rights of All <u>Migrant Workers</u> and Their Families	1990	34		NO

ANNEXURE 4

Opportunities - Malaysia

- Good relations with government & privileged contacts at high level
- Strength at policy level
- Sound system of health indicators
- Some excellent tools have been developed
- Good network of H&HR colleagues across the world with different areas of expertise
- Increasing interest among colleagues
- Use the MDG's to introduce human rights
- Use the national Constitution and legislation that guarantee the right to health
- SUHAKAM, partnerships with MMA/ Bar & NGOs

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Summary

- The right to the highest attainable standard of health is the global standard for health and human rights professionals to strive and work with the government to achieve health for all.
- Human rights approach is the framework to provide standards and mechanisms to encourage government to meet its moral and legal obligations (provision of AAAQ healthcare)
- In Malaysia, the priority is for all agencies to unite under the leadership of SUHAKAM and convince the Government of the righteousness and benefits of signing the ICESCR

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ANNEXURE 5

EQUITABLE ACCESS TO HEALTH CARE FOR ALL: IS THIS STILL A PIPE DREAM FOR MALAYSIA? A MEDICAL PROFESSIONAL'S PERSPECTIVE

BY DR. DAVID K.L. QUEK

COMMITTEE MEMBER, MALAYSIAN MEDICAL ASSOCIATION

**Equitable Access to Health
Care for All:**

**Is this still a Pipe Dream for Malaysians?
A Medical Professional's Perspective**

Dr David KL Quek, KMN,

*MBBS (Mal), MRCP (UK), FRCP (Lon), FAMM (Mal), FNHAM (Mal),
FASCC (ASEAN), FCCP (USA), FACC (USA)*

**Suhakam's "Human Rights & Access to Equitable
Healthcare" Dialogue,**

Hilton Kuching, Sarawak, 5 Nov 2007

- "The availability of good medical care tends to vary inversely with the need for the population served.
- This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.
- The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."

* Julian Tudor Hart: 'The Inverse Care Law.' The Lancet, 1971

- “The reason we don’t know that we know things is that they conflict with more powerful ideas, and so we see them but fail to recognise them.
- The idea that inequality is a sign of economic health and social vigour is too compelling to permit serious engagement with the idea that inequality is anti-social and a cause of illness.
- We need to be told what we know, instinctively, about what makes a good society.”

Marek Kohn, in Prospect magazine, September 2005, when reviewing a book by Richard Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier*, Routledge, London, 2005

A Good 50 Years for Human Capital Development, but we can achieve far more...

- Malaysians in general have had a sterling achievement in terms of advancement of human capital development, for the past 50 years since independence.
- Our life expectancy at birth has risen from 55.8 years and 58.2 years for men and women respectively in 1957, to 71.8 years and 76.3 years, as of 2006. Infant and maternal mortality rates have markedly decreased to current levels, which equal those of developed nations.[1]
- Our primary health care service especially the rural health service has long been the envy and role model for other developing countries around the globe to emulate, deservedly endorsed by various agencies of the World Health Organization.

[1] Merican MI, *Medicine and Healthcare in 2020*. Berita Academi, 2007, Vol 16;3, Pg.2.

Begging for Alms for medical treatment...

- Yet, when one turns the pages of our daily newspapers, we are invariably accosted with pleas and requests for financial help to pay for some expensive, supposedly urgent life-saving medical services—particularly heart-rending stories when they involve babies and young children.[1],[2],[3] This constant ‘begging’ for alms to help defray medical therapies and surgeries is unbecoming of a nation which aspires to be a fully developed one by 2020, i.e. a mere 13 years away.

- [1] *Little Kin Wai hopes to walk tall-He needs funds to help him grow*, The Star, Saturday, 20 October, 2007, p N18.
- [2] *Single mum needs aid for kidney transplant in China*, The Star, Friday 19 October 2007, p N26
- [3] *In need of aid to treat his burns*, New Straits Times, Monday, 22 October 2007, p N17

ANNEXURE 5

Saturday September 1, 2007

Ex-International Michael needs help

PETALING JAYA: The National Sports Council (NSC) core sport's bowling officer Allan Lee has initiated a donation drive for former international Michael Chuah.

Michael, the 1983 AMF World Cup runner-up and the 1985 national Sportsman of the Year, has been diagnosed with pancreatic cancer and needs more than RM30,000 for medical treatment.

The Malaysian Tenpin Bowling Congress (MTBC) have started the rolling with a RM5,000 donation. Donors can make their contribution through the MTBC.

Wednesday October 11, 2007

Sharvin still short of RM16,000

JOHOR BARU: Young R. Sharvin is scheduled to go for surgery at the National Heart Institute but his single mother is still short of RM16,000 required for the operation.

Four days ago, The Star ran a story urging the public to help the two-year-old boy who was born with two holes in the heart.



Medical bill dilemma: Can you help Devi raise enough money for Sharvin's operation?

Factory worker O. Devi, 31, said she had withdrawn RM12,000 from her EPF savings but the entire medical bill costs RM28,000.

Medical Assistance Fund...

- A few years ago, Ministry of Health initiated a Medical Assistance Fund (MAF). Unfortunately, despite occasional injection of funds from public pledges and the government, the distribution of such monies have been painfully slow, pedantically bureaucratic, and sporadic—so much so that the deprived still resorted to direct pleadings via the mass media to implore some sympathetic charitable souls to help out.
- Recent press statement by our DG of Health Tan Sri Datuk Ismail Merican, this MAF is now topped up to RM 25 million, but this will only be available to requests for treatment at government and public institutions only, which effectively excludes those seeking treatment from the private sector or overseas.^[1]
- Another emergency fund launched by the Ministry of Health in collaboration with the National Welfare Foundation called "D'tik YKN" has been set up recently. It has received an initial allocation of RM 5 million. ("D'tik" is an acronym for *Dana Talian Insan Kritikal Yayasan Kebajikan Negara*.)
- This fund provides critically ill patients access to treatment within 24 to 72 hours, but is currently only available at Kuala Lumpur Hospital as its pilot medical facility to kick-start the programme.
- Surely there must be a better mechanism to address these clangorous but pitiful entreaties for help from among the less well-to-do, the underprivileged, or simply the uninsured, or underinsured.

[1] Annie Freeda Cruz, *Poor can apply to medical fund*, New Straits Times 17 Oct 2007

Why Now?

- Perhaps over the past 2 or 3 decades we have become exposed to the stupendous advancement of medical progress, such that once desperately untreatable conditions are now given new hope of cure or palliation? I believe this is the main reason, the public is now calling out for help—there is indeed greater awareness of what can be done and what can alleviate, even cure some of these previously 'fated' ailments.
- Better education, improved literacy level and increasing human self-esteem and the huge explosion of information accessibility, especially via the Internet, have clearly contributed to this knowledge dissemination.^[1] Greater wealth distribution has of course also added to this new empowerment for more perceived rights and entitlement as citizens.

[1] UNDP Human Development Report 2006. The Human Development Index ranks Malaysia 61st, with a literacy rate of 88.7%, Education index of 0.84, life expectancy index 0.81 and PPP GDP of USD 10,276. Malaysia spent some 8% of the GDP on education with the government spending some 28% of the total budget on education alone with 36.5% for tertiary education.
<http://hdr.undp.org/hdr2006/pdfs/report/HDR06-complete.pdf>. Pgs. 302, 320. Accessed 21 October 2007.

We are spending too little on Health Care...

- However, Malaysia's health expenditure remains contentiously low.
- A total of 3.8% of the nation's GDP is spent on health care, with the public sector (i.e. government spending) accounting for 2.2% and private funding 1.6%.
- On average per capita, we spent only 374 PPP-USD for health in 2003, and
- we have 70 physicians per 100,000 population (i.e. one doctor for every 1428 citizens).⁹

An incongruous mish-mash of private versus public health care sectors

- The public healthcare sector is heavily subsidized by the government, and caters to the huge civil service employees, as well as to the less well-off (it is almost free from co-payments), such that some 70% (perhaps as high as 75%) of the population actually utilize these services almost exclusively; because for most, this is all what many perceive is all they can afford to access any form of health care services, for themselves and their families

Are we doing enough?

- It is true that there are sporadic attempts to offer a greater array of affordable health services for the poor, but these are often fraught with uncertainties and limited scopes for the actual service rendered—it is not enough to simply offer advice and information—what is more important is that patients should also have access to what can be done—what treatment or surgery can be offered, without having to seek other alternative avenues of assistance.^[1]

^[1] Mazlinda Mahmood. *Affordable reproductive health services for the poor*, New Straits Times, Saturday, 27 October 2007, p N24.

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Costly modernization of facilities, but questionable manpower development

- However, Malaysians also expect modernization and better amenities of their health care services. Thus, huge amounts are allocated and have been spent on bringing up-to-date state-of-the-art equipment and facilities to nearly all of the major hospitals of every state or towns.
- For example, in terms of tertiary Cardiology care, public-funded cardiac catheterization laboratories are now available in nearly all the major cities of Malaysia—from the highly successful IJN, then Penang, JB, Kuching, Malacca, Kota Kinabalu, Serdang, Selayang, and now in Alor Star, Kota Bahru, Kuantan and later Ipoh—these to the tune of at least tens of millions of ringgit, each, in terms of hardware alone!
- These expensive set-ups are nearly all available and ready, but there is still some question on whether there is enough adequately-trained personnel or dedicated medical specialists.

Costly endeavours, but is it prudent?

- While such expenditure is laudable, there is a growing sense among the more discerning public, of possible wastage, less than spectacular structural excellence—from the outset many facilities (while futuristic and spectacular to look at from the outside), are beset (some before even being launched!) with ceiling leakages, mouldy infestations, structural defects, questionable fitness-to-operate certification, etc.
- These together with other dubious turn-key acquisition of costly equipment and beds, arguably make these hugely expensive facilities appear less than the best that they can be managed and/or run.
- ***We appear not to have achieved a bigger bang for the buck, so to speak.***

Restructured hospitals, pay more...

- When some of these new modern state-of-the-art hospitals (built and equipped to the tune of hundreds of millions of ringgit, e.g. Selayang and PutraJaya Hospitals) are re-structured so that full-paying patients can be charged for first class treatment—many protests were made, due to fears that the marginalized would once again be shortchanged and possibly neglected.^[1]
- It is not unreasonably feared that those who cannot pay may be made to wait unfairly long for therapies or surgeries which they need—that they might be preferentially sidelined by those who could afford to pay.^[2]

^[1] Subramaniam Pillay, *Can We afford to fall Sick?* Airan Monthly Vol 25 (2005): Issue 4

^[2] Jeyakumar Devaraj, *Health Is Not A Commodity*, Parti Sosialis Malaysia Press Statement: 8 June 2007

Full Paying Patients concept bearing fruit

The Star Friday September 28, 2007
By A. LETCHUMANAN



Not Everyone is happy...

- The Ministry of Health clearly views this option very differently, with the Minister Dato' Seri Dr Chua stating recently that patients are already enjoying the benefits, with some 103 patients paying some RM 116,000 as full-paying patients, with a small portion being disbursed to doctors.^[1]
- Also another recent opinion piece commended the Ministry's move, stating that allowing this practice at these private wings might help retain some senior specialists from either resigning to join the private sector or moonlighting as locum outside the public domain.
- In turn, these medical specialists can remain in the MOH and still contribute to looking after the poorer patients in the respective hospitals.^[2]

^[1] A. Letchumanan, *Full Paying Patients concept bearing fruit*, The Star, Friday, 28 September 2007

^[2] HT Chua, *Give Full Paying Patient scheme time to work*, The Star, Monday, 24 September 2007

Private Wings have problems...

- However, some other critics are less sanguine about this practice. There have been examples bandied about that certain private wings of university medical centres are already practicing such preferential favoritism when dealing with fee-paying versus subsidized patients—that specialist medical treatments are offered fee-paying patients almost without any waiting time, whereas the poor have been made to queue, which can run into months, perhaps even years!
- The uncomfortable truth is that, many of those in the queue have been told that they can always expedite their case when and once they have the requisite funds! Hence, the resorting to pleas for financial assistance from the public via the mass media, demeaning as this may be.

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The doctor's dilemma

Queues, Rationing & Delays...

Experienced staff continues to leave

- There is another problem—that of specialists and experienced staff leaving the public for the private sector.
- The usual cause for this 'senior staff hemorrhaging' is the financial 'pull' factor. Rightly or wrongly, the private sector is perceived of as being far more worthwhile, certainly more financially rewarding than the meagre public wages paid for slogging through the humdrum drudgery and thankless services for the masses.
- Bureaucratic and office politics are other 'push' factors for this migration to so-called greener pastures of the private health care sector.
- This has led to the incongruity where some 60% of all the nation's physicians (in the private sector) are looking after some 'privileged' 30% of the population, and vice-versa! The depleted public sector doctors (some 40%) have to manage the greater 70% of population!

Rising Health Care Cost : How Can We Cope?

- ***"Health care is an incredibly sensitive subject, which one cannot talk about sensibly without treading on very dangerous emotional and political ground..."***
- ***The trouble with health care is simple: it has become incredibly costly."***

Paul Krugman, World-Renown Economist

Some Poorer Patients find Private Health care expensive, unaffordable...

- But it is true that by and large, those who are uninsured and who are not public-paid civil servants, can find it expensive and in some cases unaffordable, when they seek private medical health care.
- Thus, their access to health care can be severely limited and some have resorted to self-delays or to seek cheaper alternative but probably ineffective therapies, which in the long run may endanger their health even further.
- Others sometimes think that they can afford private health care initially, only to be burdened by high charges which accrue when complications set it unexpectedly or when unforeseen.
- Unfortunately, there is no mechanism to assist such patients caught in such quandaries. However, most private medical facilities would offer discounts and even waive some of the extra charges, when they can after assessing the socio-economic background of the patients and their families.
- But some also had legal demands dumped on them to reimburse these hospital charges, which can bankrupt the unwary.



What do modern patients want in health care?

In a recent report (*A Clinical Vision of a reformed NHS*, 2007) by the Joint Medical Consultative Council (JMCC) and the NHS, it was reported that the following are what patients want from their health care experience:^[1]

- Fast access to reliable health advice
- Effective treatment delivered by trusted professionals
- Participation in decisions and respect for preferences
- Clear, comprehensive information and support for self-care
- Attention to physical and environmental needs
- Emotional support, empathy and respect
- Involvement of, and support for family and carers
- Continuity of care and smooth transitions

^[1] JMCC & NHS Confederation. *A Clinical Vision of a Reformed NHS*, London, 2007

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Which model is sustainable?

- This concept of universal access to health care is not easy to define or to delimit or more optimistically what it should embrace.
- Can it be a 'be all' and free for all comers, at every point of care?
- Clearly this is not a feasible nor reasonable option unless of course, we have a command economy (Cuba-style?) where every aspect of healthcare services is state-controlled and delivered via a system of one all-inclusive integrated services—there being no private sector or third party insurer or payer.

US model too expensive, ultimately unsustainable...

- Although many nations are increasingly looking toward the model of the NHS in UK, many are fully aware of its severe shortcomings and its rapidly evolving and chameleon-like shifts in practices and approaches.
- The *laissez faire* free-for-all system as now practiced by the United States is clearly flawed and far too expensive (15-16% of the national GDP!) and leave too many disadvantaged groups fully neglected or uninsured (some 46 million people!) including many children and elderly (although the latter is assisted by Medicaid).^{[1],[2]}

[1] Jacob S. Hacker, *Healing Our Sicko Health Care System*, N Engl J Med, 2007;357(8):733-5

[2] Garson Jr A. *Heart of the Uninsured*. Health Affairs, Jan-Feb 2007;26(1):227-31

Funding Mechanisms...

- Other highly dependent state-insured nations such as the Netherlands, New Zealand are smaller populated but richer nations which spend an inordinately high portion of their social taxes on health, social and individual taxes can reach 50 percent or more—something that our country simply cannot match as of this juncture.^[1]
- Germany for example, has a statutory health insurance system where 78% of the population contributes, the remainder being voluntary members or who pay private insurance; in 2003 88% of the population has social health insurance.¹⁹
- However, it is estimated that only 30% of our population is paying any form of income tax or provident fund savings—how then can we raise sufficient community-rated premiums to help defray the enormous cost of health care for all?

[1] Lewis R, Alvarez-Rosete A, Mays N. *How to Regulate Health Care in England*. London, Kings Fund 2006. pg 19-50

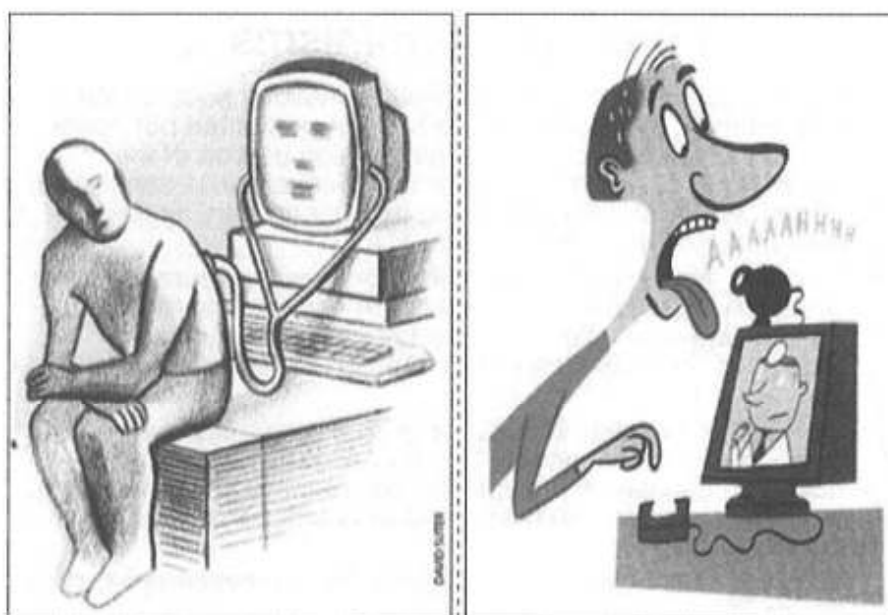
The Taiwan Model...

- Modified single insurer states such as Taiwan are facing serious financial crunches after grappling with an erstwhile successful model for the initial years—spiralling costs from more and more advanced treatment options are exhausting whatever reserves or spread of risks for its rapidly-ageing public.^[1]
- End-of-year credit squeezes and fund exhaustion (from DRG disbursements) are hampering high-cost surgical or medical procedures and therapies, thus elective procedural deferment and waiting times are increasing once again...

[1] JFR Lu, Hsiao WC. *Does Universal Health Insurance Make Health Care Unaffordable? Lessons From Taiwan*. Health Affairs, May-June 2003;22(3):77-88

The Public Sector as Safety Net?

- Our current model of private and public sector health care dichotomy is not without flaws, but is one that has provided reasonable access to health care for nearly everyone, with the public sector facilities serving as a fall-back safety net, whenever, higher costs therapies and surgeries preclude the patient from affording them.
- But this safety net is not sufficiently robust, and there are inevitable leakages and obstacles which can seriously hamper access for the hapless and financially-strapped.
- There is still this perception among public hospital personnel and administrators that once you have opted for care in the private sector, you should stay there and are not entitled to back-up care in the public sector.
- There is unspoken anger and discouragement for this bail-out mechanism for many a poor patient, who had unwittingly made some of these choices, but who crash out because they fail to foresee the potentially huge costs some illness can generate.



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Are we spending our Health Ringgit Correctly?

- Thus, perhaps this faulty model can be modified, tweaked and adapted so that we have a system which can work more efficiently with less wastage, despite our paltry expenditure as a whole.
- Although the health care budget is touted as some 5% of the GDP, actual government spending on health care and services amount to at most 2.6 to 3%, which is way below the number suggested by WHO and most health care advocates (which is around 8% of a nation's GDP).
- Imagine if we can allocate another 5% into the healthcare budget, we can clearly achieve so much more and provide even better care and hopefully more access to cover more of the population, rather than the recurrent hiccups we encounter almost daily, these days.
- We are spending hundreds of millions of Ringgit on infrastructure, facilities, equipment; what about more human development, patient centred access issues...??

A New National Health Care Financing Scheme and Authority— When and in What Form?

- For a long time the MMA through its National Health Policy and Planning Committee headed previously by past president Dato RS McCoy have advocated a single-payer National Health Plan, which was presented to the government in a comprehensive monograph titled "Health for All".^[1]
- We understand that large sections of our single-payer initiative proposal have been incorporated into the proposed scheme by the MOH in the National Health Care Financing Scheme (NHCFS).

^[1] MMA, *Health for All*, 2000

Rising Concerns on the proposed NHCFS

- Although in the beginning the MMA was enthusiastic about this development of the NHCFS, over the past few years, the very many alterations and distortions which have crept into the scheme, have created many concerns and doubts among those who had earlier favoured this approach.^[1]

^[1] Jeyakumar Devaraj, *Resolutions Adopted at the Forum on Health Care Financing in University Malaya on 25/3/07*

Flawed Model feared...

- A shared provident-insurance premium contribution is supposed to have been made by both employer and employee. What has not been agreed to, is the quantum of contribution, and whether this now dispenses with other health insurance incentives/benefits which employers now offer to many of their workers.
- Furthermore, additional coverage premiums for family members remain uncertain, and factoring in this additional deduction based on the number of dependents can clearly be difficult for a large segment of the public. What about the self-employed and the unemployed?
- *Then, there is the question of civil servants, the police and military personnel which the government has indicated that they would be provided for from the existing system, and that they would remain outside this new NHCFS!*

Proposed NHCFS excluding Civil Servants from Scheme, poses problems of parity and natural justice

- This has drawn huge criticism that a large proportion of the population (including their not unsizeable dependents) would therefore not be participating in this so-called 'national' health care financing scheme.
- Effectively, this defeats the purpose to community-rate the health care risk and insurance burden. Two separate systems would thus appear to remain, except that the private sector is now made to contribute to yet another provident-like fund!
- Thus, this could unfairly burden the private sector with a disproportionate yoke of the community-rated insurance scheme.

Which health care services should be readily accessible/available to everyone?

- This sounds clichéd but becomes the lynchpin of any health care service in the world. Most would agree that all medical emergencies should fall under this category, where any ill person should have and must have access to life-saving or limb-salvaging care at the most urgent and timely manner as possible.
- Still medical experts and regulators must identify specifically what should be the type and extent of health care which can be offered without due consideration as to costs and reimbursement.
- Clearly too, such often costly medical care must be insured upon (a central insurance mechanism or financing authority to reimburse claims to these cases) so that total coverage of an acceptable quantum can be disbursed to whichever sector is handling these emergencies—so that these would not bankrupt the system.

ANNEXURE 5

Public Health Catastrophes...

- Another very pressing issue of very great public concern, is that of catastrophic ailments such as major heart and brain affectations, public health disasters such as critical infections (Bird Flu!!!, HIV/AIDS; SARS, Nipah, Enterovirus-Coxsackie, Meningitis, poliomyelitis, etc) and cancers.
- These must also be very clearly enunciated and itemized so that they are covered for the ordinary citizen.

How Much Coverage?

Finite Resources, Infinite Needs...

- How much coverage and to which extent would also have to be delineated. Then there is the question of prioritization and rationing—invariably there will have to be some degree of waiting and queuing (the question is how long?), and triaging mechanisms for sicker patients who need treatment more urgently than others.
- How can we make our public understand that these are necessary evils, which takes place in a finite system of services with finite limited resources, no matter the allocation?
- Can we not allocate from all health care budget more towards access issues such as better trained doctors (not necessarily more), nurses, allied health workers, more readily available medications, early access to needed surgeries, cancer therapy?
- Can we not divert more reasonable funds to access issues rather than building monoliths where barriers continue to stall ready patient access?

Conclusion...

- However, there must be some common ground for which to agree upon a system that works for Malaysia.
- We believe the government and the Ministry of Health must engage all interested parties to fully dialogue on this very pressing issue, so that everyone's interests can be represented.
- A cut-and-paste approach behind several layers of closed doors and OSA dictates will only stifle rigorous and fair debate on this issue which involves and affects everyone.
- Ultimately there will have to be concessions and compromises. But, a user-friendly cost-effective and sustainable system beckons.
- I remain optimistic that we can foster a better system where the rights of every citizen to access reasonable, safe and excellent health care services, is guaranteed.

ANNEXURE 5

A More Benevolent Market Economics...

- "First, let us embrace market economics - yes - but also recognize that free market economics are passé. We need an active role of the state, to help the poorest to break free of the poverty trap, and to help narrow the inequalities of a high-income market society...
- Let us understand that economic solidarity is insurance for all, the poor and the rich...
- Let us resolve to honor our commitments in the fight against poverty, hunger, and disease.
- Our commitments are small compared with our vast wealth, and the benefits will be vast."

—Jeffrey Sachs, Economics Professor, Columbia University, New York, in the BBC World Service Reith Lecture, 2007.



ANNEXURE 6

ACCESS TO EQUITABLE HEALTHCARE SERVICES: EXPERIENCE OF DISABLED PERSONS

BY MR. DONALD LAW

MEMBER, PERTUBUHAN ORANG CACAT SARAWAK (POCS)

NOTES OF PRESENTATION

Introduction

1. Definition of “disability” and “disabled person”
2. Statistics on disabled persons varies according to definition of disability:
 - WHO, 5 - 10 % population comprise people with disabilities (600 million worldwide)
 - UN, about 650 million worldwide
 - Nos. of PWDs registered with Jabatan Kebajikan Masyarakat Malaysia: 197,579 (as at 31.12.2006)
 - Nos. of PWDs registered with Jabatan Kebajikan Masyarakat Negeri Sarawak: 11,920 (as at 31.12.2006)

Six (6) categories of disabled persons in Malaysia:

1. physical (66,250 persons)
2. blind/visual (18,258 persons)
3. deaf/auditory (29,522 persons)
4. cerebral palsy (887 persons)
5. learning difficulties (76,619 persons)
6. others/multiple disabilities (5,983 persons)

[Note: actual of PWDs in Malaysia not known, due to large nos. of those not registered].

Main causes of disability

1. accidents (roads, industrial, etc.)
2. injuries sustained in wars and conflicts, and natural disasters
3. disease or illness
4. congenital/hereditary
5. drugs, etc.

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Effects of disability on the individual

1. often associated with loss of bodily functions, weak limbs, etc.
2. affects mobility
3. results in loss of confidence, depression, etc
4. dependence on others, etc.

THEREFORE, PWDs need assistance, support, and proper treatment & rehabilitation

Strategies for care of disabled persons:

1. early detection
2. early treatment
3. early intervention/rehabilitation programmes
4. community based rehabilitation programmes
5. preventive measures

International Perspective

World Health Organisation (WHO) definition of health:

a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Basis or justification for access to equitable healthcare for disabled persons – as incorporated in International instruments and national policies, including the following:

1. United Nations Charter (1945)
universal respect for, and observance of, human rights ... for all without distinction... (i.e including disabled persons, as members of society)
2. Article 25, Universal Declaration of Human Rights (1948)
Everyone has right to a standard of living, adequate for the health and well being of himself and his family, including food, clothing, housing and medical care ...
3. Article 12, International Covenant on Economic, Social and Cultural Rights (ICESCR) defines the right to adequate health in a relative fashion – the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ...

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4. Declaration on Rights of Mentally Retarded Persons (1971)
reaffirms universal protection of right to adequate health, and mandates proper medical care and physical therapy, rehabilitation, etc to be provided
5. Declaration on the Rights of Disabled Persons (1975)
.....disabled persons have same fundamental rights as their fellow citizens
6. Convention on the Rights of the Child (1989)
7. Standard Rules on Equalization of Opportunities for Persons With Disabilities (1993)
Rules incorporates human rights perspective for disabled persons; aimed at eliminating obstacles to prevent them from exercising their rights and freedoms, so as to enable them to participate fully in the society
8. Biwako Millennium Framework For Action: Towards an inclusive, barrier-free and rights based society for disabled persons (2003 - 2012)
7 priority areas to be achieved: including access to built environment and transport; early detection, early intervention and education programmes; access to information and communication (including assistive technology for disabled persons)
9. UN Convention on Rights of Persons With Disabilities (2006)
Article 26 (health); and Article 27 (rehabilitation)
10. National Social Welfare Policy (1990)
designed to improve quality of life of disabled persons, including early detection, facilities for treatment, rehabilitation, education and training of disabled; to foster a caring culture
11. Proposed Persons With Disabilities Act (of Malaysia) - Bill still being drafted by federal Ministry of Women, Family and Community Development
 - provides basis for equal opportunities and full participation for PWD
 - to eliminate discrimination against PWDs
 - prevention and early detection of disabilities; rehabilitation, accessibility and support services, etc.

ANNEXURE 6

Obstacles or barriers to equitable healthcare

1. Poverty – unable to afford costs of transport, medical treatment, assistive devices & technologies
2. Environment (physical, attitudes, policies)
3. Lack of access to information and communication

Proposals and strategies to ensure access to equitable healthcare for PWDs:

1. Role of the Government – international instruments (listed above) imposed obligations on the Government to pass laws, formulate policies and set up appropriate agencies for implementing and monitoring; ensure adequate budget allocation for healthcare facilities, medical treatment and rehabilitation, education and training of staff; support services for disabled persons, etc
2. Role of voluntary and welfare organizations, including disabled groups – to complement Government efforts; promote spirit of volunteerism; advocacy, public awareness, etc.
3. Role of corporate and private sectors – sponsorship of healthcare programmes; research and development for cheaper drugs and other treatment, assistive devices and technologies, etc.
4. Role of individual members of society, including disabled persons themselves.

.....END.....

ANNEXURES PART B

SPEECHES AND PRESENTATIONS

**BY SPEAKERS AT SUHAKAM'S DIALOGUE ON HUMAN RIGHTS AND
ACCESS TO EQUITABLE HEALTHCARE IN KOTA KINABALU, SABAH**

8 JANUARY 2008

ANNEXURE 7

WELCOMING REMARKS

BY TAN SRI DATUK SERI PANGLIMA SIMON SIPAUN

VICE CHAIRMAN, HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)

Fellow Commissioners,
Moderators,
Paper presenters,
Participants,
Ladies and gentlemen,

On behalf of the Human Rights Commission of Malaysia (SUHAKAM) I am delighted and honoured to welcome each and every one of you to this dialogue and discussion on “Human Rights and Access to Equitable Healthcare in Sabah”. I wish to convey and record my gratitude and appreciation to all the paper presenters. I am fully aware that preparation of papers involves much time, energy and effort. I say thank you also to all moderators and participants for responding to SUHAKAM’s invitation.

Article 3 of The Universal Declaration of Human Rights states that “Everyone has the right to life, liberty and security of person”. This article represents the first corner stone of the declaration. The right to life and security is the mother of all rights because it is essential to the enjoyment of all other rights. It is not possible to sustain and maintain a life with dignity in the absence of basic health facilities which are the obligation and responsibility of the government to provide. The Preamble to the Constitution of the World Health Organization adopted 2 years before the Universal Declaration of Human Rights was approved by the General Assembly of the UN on 10/12/1948 emphasizes “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

I believe the provision of equitable healthcare in Sabah faces significant challenges. Two notable ones that come to mind are associated with the unusually large illegal immigrant population as well as geographical factors which greatly restrict human mobility.

It is common knowledge that Sabah is known for the large number of illegal immigrant population. I believe no one really knows the precise figures. This is expected because the number is changing all the time and most likely in an upward trend. There could be as many foreigners and possibly

ANNEXURE 7

more as there are Malaysians in Sabah. This guess is based on certain indicators. Time does not permit me to enumerate them. They are definitely changing the economic, social, cultural and political landscape of the State.

The Minister of health was reported in the Daily Express in its 9 July 2006 edition that Sabah hospitals were receiving the most number of foreigners amounting to about 30%. Some of them used forged identity cards to gain admission and leave without paying. They also account for many cases of contagious and communicable diseases. It was further reported in the Daily Express on 18 November 2007 that illegal immigrants occupy 80% of the Likas Maternity Hospital beds.

About 6 years ago during one of SUHAKAM's dialogue with government ministries SUHAKAM was informed by a representative of the Federal Economic Planning Unit that allocation of federal funds for the Malaysia Plan did not take into account the actual number of people living in Sabah. It only took into consideration the number of Malaysian citizens residing in Sabah. For example, if in 2007 Sabah has a total population of about 3.5 million and only 1.5 million are Malaysians this simply means that funds meant for 1.5 million people have to be shared by 3.5 million. At some stage in the past Sabah was one of the richest state in the country. Sadly now it is the poorest. It is possible that the large illegal immigrant population is a contributing factor.

You would have read the news which appeared in both national and local newspapers on 12 December 2007 that according to the United Nations Development Programme (UNDP) resident representative in Malaysia the indigenous communities of Sabah who are found mostly in the rural areas are among the poorest in the country. The most intense poverty is not among the Indians after all but right here in Sabah. Poverty and health are inter-related. Poor people cannot afford good and nutritious food which in turn has adverse effect on their health. When they get sick they cannot afford the best health care. When they are unhealthy they are unable to realize their best potential in terms of productivity and human development. Their life-span will be considerably shorter compared to the richer and more fortunate members of the community. They are caught in a vicious cycle. They suffer in silence.

Generally their literacy standard is low since they and their children have no or limited access to education. This being the case, they are not very aware of the importance of good hygiene and proper health care. To make matters worse more often than not they live without basic infrastructure facilities such as roads, water and electricity supply, hospitals, rural clinics and so on. Some of them could be reached by mobile health and flying doctor services but are often constrained by limited availability of funds as well as human resource.

ANNEXURE 7

There must be many more challenges/problems and other constraining factors associated with access to equitable healthcare and medical services peculiar to Sabah for which you are in a much better position to identify having regarded your qualification and varied and extensive experience. It is my sincere hope that this forum would be used to exchange knowledge, skills and experience and participants would come up with specific recommendations at the end of the dialogue and discussion.

With these remarks, ladies and gentlemen, I wish all participants interesting, fruitful and rewarding deliberations.

I thank you for your kind attention.

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INTRODUCTION TO THE DIALOGUE

BY DATUK DR. RAJ ABDUL KARIM

COMMISSIONER, HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)

Assalamualaikum and Good Morning to the Vice Chairman of SUHAKAM, Fellow Commissioners, Distinguished Speakers, Ladies and Gentlemen

I wish to express my gratitude to all present this morning. I am glad that we are able to meet and spend today to discuss a very important aspect on inequality in access to healthcare. The Vice Chairman of SUHAKAM, in his speech earlier, gave a good overview of the situation of access to healthcare in Sabah.

Sabah records the highest incidence of poverty in Malaysia. Those affected by poverty lack access to basic human rights, including healthcare. Today's dialogue, therefore, would attempt to look at the inequalities in the healthcare system and identify the gaps and unmet needs of the society towards healthcare. It would also identify those who are marginalised or suffer from some form of discrimination.

As all of you may be aware, in the Ninth Malaysia Plan 2006-2010, the Ministry of Health is planning to develop a national health strategy and a national health policy. They are currently at the consultation with stakeholders' stage.

In view of this, SUHAKAM is taking this to a more participatory and transparent process right down to the grassroot. SUHAKAM is in consultation with various groups including professional bodies, medical associations, government agencies, NGOs and other interested groups and individuals. This includes today's dialogue and the recent dialogue held in Sarawak on 7 November 2007 and another which would be held in Peninsular Malaysia. Following the consultations, a report would be produced to highlight the issues and SUHAKAM's recommendations to promote an equitable access to healthcare for all. This would be tabled to the Ministry of Health and the Government to be considered for inclusion in the national health policy.

As enshrined in the World Health Organisations Constitution, the Right to the enjoyment of a highest attainable standard of health is fundamental to every human being without distinction.

Additionally, according to the United Nations, right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and

ANNEXURE 8

reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

Therefore, the Government has to ensure the availability of, among others, healthcare services, healthy and safe working environment, adequate housing as well as nutritious food.

Article 25 of the Universal Declaration of Human Rights (UDHR) guarantees every person's right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. It further states that Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection

Article 24 of the Convention on the Rights of the Child (CRC) recognises every child's right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It further spells out the duty of state parties to ensure this and to pursue the full implementation of this right, including the necessary assistance to parents.

Additionally, article 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) provides that States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

We hope to get your valuable insights as much as possible, to be included in the report later. We look forward to your participation and contribution.

Thank you.

ANNEXURE 9

GOVERNMENT'S EFFORTS TOWARDS EQUITABLE HEALTHCARE FOR ALL

BY DR. CHRISTINA RUNDI
PRINCIPAL ASSISTANT DIRECTOR, PUBLIC HEALTH DIVISION,
SABAH HEALTH DEPARTMENT

**Government's Efforts Towards
Equitable Healthcare For All**

Dr. Christina Rundi
Sabah State Health Department

Outline

- Background
- Ministry of Health Vision
- Geographical Access
- Cost Access
- Wellness Paradigm
- Issues with access

ANNEXURE 9

Alma Ata Declaration 1978

- **International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978**
- New approach to health care
- **Primary health care (PHC), is**
- "essential health care based on practical, scientifically sound and socially acceptable methods and technology made **universally accessible** to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination"

"Our greatest concern must always rest with disadvantaged and vulnerable groups. These groups are often hidden, live in remote rural areas or shantytowns and have little political voice."

**Dr Margaret Chan
WHO Director-General**

MINISTRY OF HEALTH MALAYSIA – VISION FOR HEALTH

"Malaysia is to be a nation of healthy individuals, families and communities through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer-friendly with emphasis on quality, innovation, health promotion and respect for human dignity, and which promotes individual responsibility and community participation towards and enhanced quality of life."

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MINISTRY OF HEALTH MALAYSIA

- The development of health services has given priority to equity considerations of access in two important dimensions,

geographical access and cost access.

- The **Primary Health Care** approach has successfully improved the health services and would continue to be re-enforced for the effective and efficient health service delivery.

Geographical access

AREA HEALTH OFFICE - 11

- Health Clinic - 80



KK Pinangah



KK Pensiangan

Geographical access

AREA HEALTH OFFICE

- Maternal & Child Health Clinic - 19



KKIA Pekan



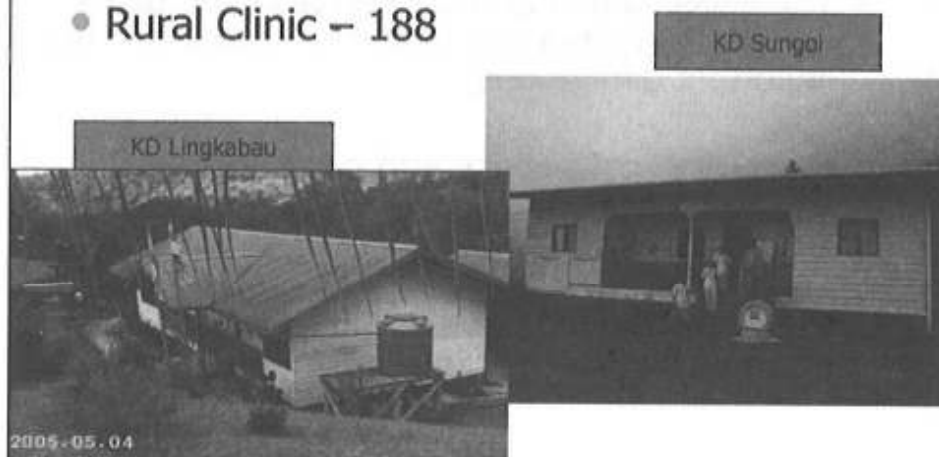
KKIA Beaufort

ANNEXURE 9

Geographical access

AREA HEALTH OFFICE

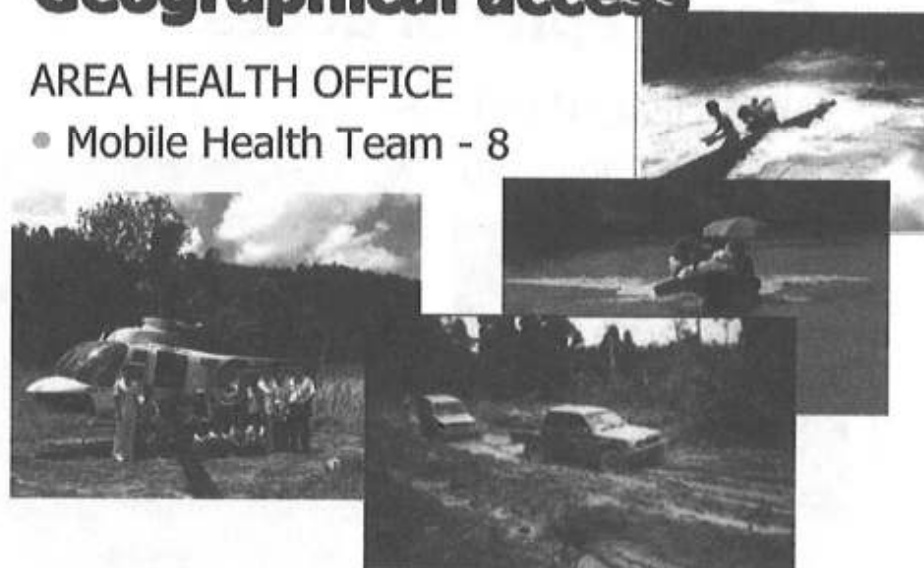
- Rural Clinic – 188



Geographical access

AREA HEALTH OFFICE

- Mobile Health Team - 8



Easier access to healthcare for all

THE STAR, Saturday November 3, 2007



- **SEGAMAT:** Healthcare will be more accessible with the deployment of more mobile clinics around the country.
- Health Minister Datuk Seri Dr Chua Soi Lek said the Cabinet had approved an additional 96 mobile clinics to the present 151. He said the 96 would be introduced in stages over the next three years. Dr Chua said that although the standard of healthcare in the country had improved considerably since independence, there were still those who did not have access to proper healthcare services, such as the rural folk and urban poor.
- "In some urban areas, development was so rapid that there was no land for us to build polyclinics or community clinics. The scenario especially applies to older developments, where there was no provision for the developer to reserve land for clinics," he said.

ANNEXURE 9

Hospital Charges

- Outpatient charges:

Malaysian	RM 1.00 (Kecemasan & "Locum")
Foreigner	RM 50.00 (Kecemasan)
Foreigner	RM 15.00 ("Locum")

- **Kategori Kelas 3**

Warganegara	RM3.00
Warganegara Asing	RM40.00
Kakitangan kerajaan	Percuma
Pesara Kerajaan	Percuma

WELLNESS PARADIGM

- The World Health Organisation defines health as "...a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."

WELLNESS PARADIGM – DIMENSIONS OF WELLNESS

- Physical fitness and nutrition
- Emotional well-being
- Intellectual well-being
- Social, family, community and environment
- Occupational and vocational aspects
- Spiritual, values and ethics

ANNEXURE 9

Problem with WHO definition of 'health'

- Total well-being
- 'happy' vs 'healthy'
- Individual's subjective experience of wellbeing
- Condition of 'completeness'

WELLNESS PARADIGM

- Telehealth is expected to make Malaysian healthcare system more integrated, equitable and accessible without compromising on quality services.
- Individuals, families and communities are empowered to play a major role in managing their health.
- The Telehealth Flagship Application comprises the following applications:
Lifetime Health Record (LHR), MyHEALTH portal, Continuing Professional Development (CPD), Teleconsultation (TC)

Issues with access

- Definitions – what it means to different people
- Barriers and stages of access
- Measuring equity in access



ANNEXURE 10

TOWARDS EQUITABLE HEALTHCARE FOR ALL - A HUMAN RIGHTS PERSPECTIVE

BY DATUK DR. TEOH SIANG CHIN

**CHAIRMAN, MEDICAL ASSOCIATION OF SOUTHEAST ASIAN NATIONS (MASEAN)/PAST
PRESIDENT, MALAYSIAN MEDICAL ASSOCIATION**

SUHAKAM

**DIALOGUE ON "HUMAN RIGHTS AND
ACCESS TO EQUITABLE HEALTHCARE"**

**TOWARDS EQUITABLE HEALTH CARE FOR ALL:
A HUMAN RIGHTS PERSPECTIVE**

8th Jan 2008
Kota Kinabalu SABAH

Dr TEOH Siang Chin
MBBS, MSc HHSM, LFOM (RCPI), PgDp Sp Med

Immediate Past President: MMA
Chairman: MASEAN
(Medical Associations ASEAN)

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Outline of presentation

1. Introduction Human Rights & Health
2. Global Approach in HR & H
3. Status & Issues Malaysia & Sabah
4. Challenges and Opportunities



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Introduction: Human Rights

HR: freedoms and entitlements concerned with protection of the inherent dignity and equality of every human being.

- Include Civil, Political, Economic, Social & Cultural rights
- HR inspired by moral values - dignity, equality & access to justice
- More than moral entitlements: they are legally guaranteed
- Enshrined in various international treaties & declarations

3

International law: Right to health

1. WHO Constitution in 1946:
'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.

Defines health as "a state of complete physical and social well-being and not merely the absence of disease or infirmity".
2. In 1948 the Universal Declaration of Human Rights included the right to health as:
'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services'.

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HEALTH & HUMAN RIGHTS

3. World Health Assembly 1970

- WHA = Supreme decision-making body, which meets in May each year, and is attended by delegations from the 193 Member States.
- Recognized the right to health as "a fundamental human right" and set out that "the health aspect of human rights is within the competence of the WHO".
- Established the DG mandate to participate in coordination arrangements of the UN system to assure WHO's "full contribution" to the overall effort to attain for all peoples the full enjoyment of their economic, social and human rights".

4. World Health Assembly 1973

- Adopted the Health for All Policy.
- Acknowledged health "as a basic human right".

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ANNEXURE 10

HEALTH & HUMAN RIGHTS

5. Declaration of Alma Ata 1978

- States that "health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right".

6. World Health Declaration 1998

- Sets out a framework for the Health-for-All Policy for the 21st century.
- Reaffirms WHO Member States' commitment to the principle that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".

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INTERNATIONAL AGREEMENTS

7. UN Reform Program 1997

- Sets out that human rights are cross-cutting ALL UN activities and urges mainstreaming across the UN system.

8. Millennium Declaration 2000 and MDGs

- Explicitly places both human rights commitments and development goals at the centre of the international agenda for the new millennium.

9. World Summit 2005

- The GA adopted Resolution 60/1 2005 which calls upon "all parts of the UN to promote human rights and fundamental freedoms in accordance with their mandates".

10. International Human Rights Instruments

- Each of the 193 WHO Member States is party to at least one HR treaty that endorses the right to health.

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What is the right to the highest attainable standard of health?

- The right to the highest attainable standard of health is codified in numerous legally binding international and regional human rights treaties.
- The right is also enshrined in numerous national constitutions

Right to highest attainable
standard of health does NOT
mean right to be healthy

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Beyond just health care:

While the right to health includes the right to *health care*, it goes beyond health care to encompass the *underlying determinants* of health: i.e. safe water, sanitation, education, shelter etc..

- The right includes *freedoms* – of want; to pursue choice; to move; or satisfy hunger
- It also includes *entitlements* – obligations – legal national constitution
- The right requires an effective, inclusive *health system* of good quality
- The assessment of the provision of this right to Health is the Triple A Q or the AAAQ analysis

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A 1 : Availability

Availability means that functioning public health and health-care facilities, goods and services, including essential drugs and programmes, have to be available in sufficient quantity within State Parties. The precise scale and nature of the facilities, goods and services will vary depending on numerous factors, including the State party's development level. However, regardless of the development level, the health facilities, goods and services must include:

- The underlying determinants of health, such as safe and potable drinking-water and adequate sanitation facilities;
- Hospitals, clinics and other health-related buildings;
- Trained health professionals receiving domestically competitive salaries; and;
- Essential drugs, as defined by the WHO Action Programme on Essential Drugs.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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A 2 : Accessibility

Accessibility requires that health facilities, services and goods, including essential drugs, must be accessible on the basis of:

Non-discrimination:

Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility:

Health facilities, goods and services must be within safe physical reach of all, including persons with disabilities and persons living with HIV/AIDS.

Economic accessibility or affordability:

Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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*** Access to information ***

ANNEXURE 10

A 3 : Acceptability

Acceptability means all health facilities, goods and services must be respectful of medical ethics and culturally appropriate. In practice, health facilities, goods and services must:

- Be respectful of the culture of individuals, minorities, peoples and communities;
- Be sensitive to gender and life-cycle requirements;
- Be designed to respect confidentiality; and
- Improve the health status of those concerned.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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Q: Quality

Quality means health facilities, services and goods must be scientifically and medically appropriate and of good quality. That requires, for instance:

- Skilled medical personnel;
- Scientifically approved and unexpired drugs and hospital equipment; and
- Safe and potable water and adequate sanitation.

Neglected Diseases : A human rights analysis Paul Hunt WHO 2007

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2.Global Approach Health & HR



ANNEXURE 10

Global Challenges: Neglected Diseases & Populations

Diseases that burden the poor: affect almost exclusively poor, powerless people living in rural parts of low income countries – impact about 1 billion people

- Include tropical diseases : malaria, kala-azar, tuberculosis, filariasis, dengue
- Some are life threatening & high morbidity with severe disabilities
- Inflict enormous economic burden on communities – lost productivity & opportunity cost of long term care
- Contribute to poverty cycle and ill-health for neglected people
- Attribute it to the low profile of affected population
- research maybe sidelined by big Pharma & Urban bias of health care.



UN Special Rapporteur

The Rapporteur is asked to help States, and others, better promote and protect the right to the highest attainable standard of health.

Appointed Prof Paul Hunt 2003

The first report of the SR identified three key objectives:
(Focussed on poverty & discrimination)

- to promote – and encourage others to promote – the right to health as a fundamental human right;
- to clarify the scope of the right to health;
- and to identify good practices for the operationalisation of the right to health at the community, national and international levels

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SR Reports:

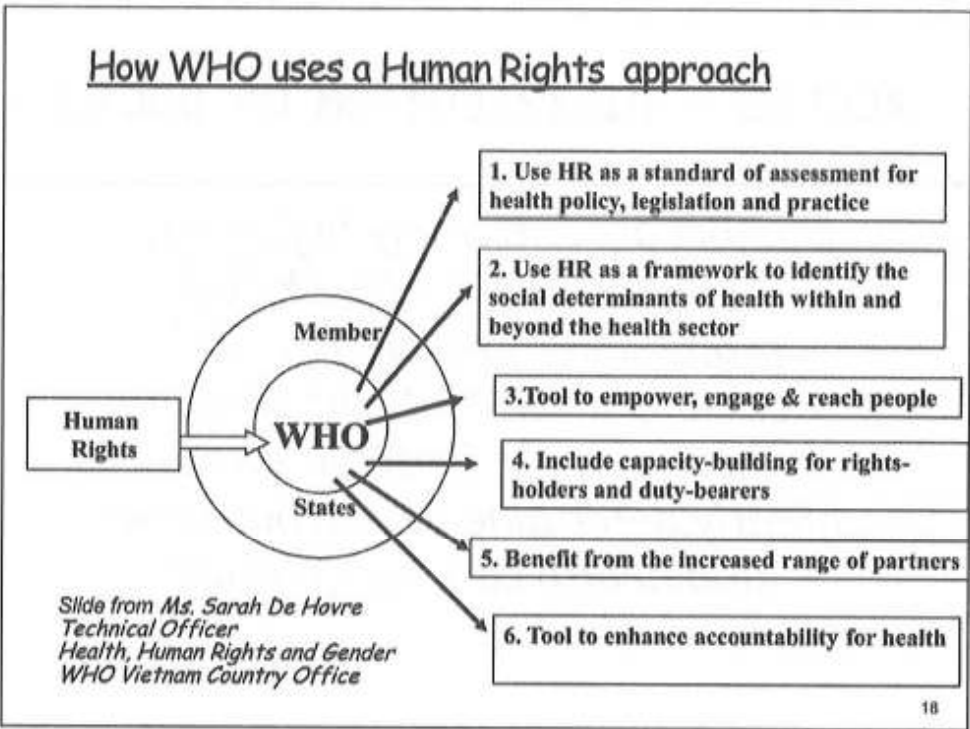
Each year the SR submits written and oral annual reports to the UN General Assembly and another to the UN Human Rights Council

- To date, these annual reports have looked at a range of issues, including the health-related Millennium Development Goals:
- the skills drain of health professionals,
- access to medicines,
- maternal mortality,
- sexual and reproductive health rights,
- indigenous peoples,
- mental disability, and others



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ANNEXURE 10



3. MALAYSIA :



COUNTRY ISSUES

HEALTH
& HUMAN Rights



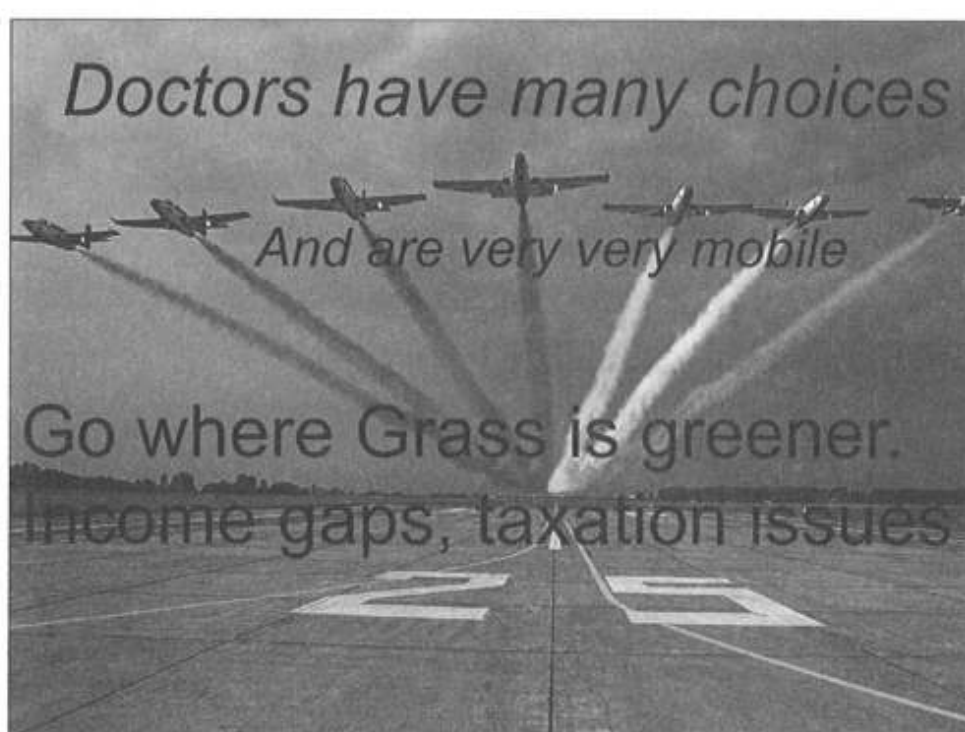
Medical Human Resource Migration

SLOWING DOWN THE BRAIN DRAIN: ARE WE DOING ENOUGH?



ACCESS – DISTRIBUTION OF DOCTORS

*Doctors are extremely high-cost,
valuable and highly skilled
professionals making difficult
decisions daily; and who through
their individual interventions,
greatly determine health outcomes
and health care expenditure*



MIGRATION OF SKILLS

- Public to Private
- General Practitioner to Specialist
- Specialist to Interventional specialist
- Across Political/ Geographical and Economic borders

? Public health ?



ANNEXURE 10

Incentives to encourage equitable distribution of health care workers

Both financial and non-financial incentives can also reduce geographical imbalances in the distribution of health workers. For example, in Indonesia, a bonus of as much as 100% of the normal salary attracted medical graduates from Jakarta to the outer islands (33). Recruitment and training of people from remote areas, who are committed to their region of origin, have also been proposed.

World Health Report 2003

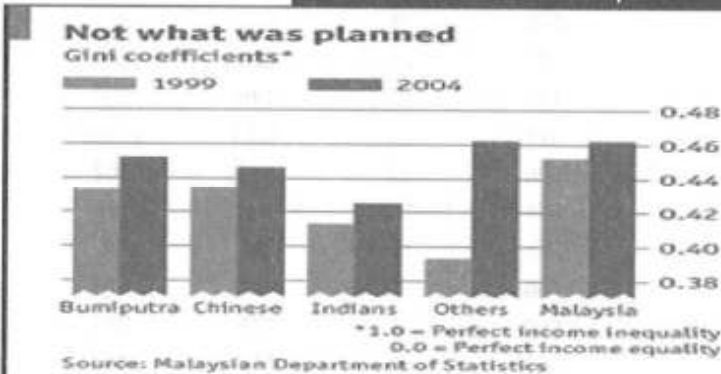


Table Four: Distribution of Health Resources in Malaysia 1999

	Hospital Public	Hospital Private
Admissions	1,500,000	500,000
C.T. Scan*	19	67
Specialists*		
- Medical	33%	67%
- Surgical	34%	66%
- O&G	20%	80%

Source: Eight Malaysia Plan. Pg 486

We now have a situation where 75% of the admissions are still to the government hospitals, but 75% of the specialists are in private hospitals. The distribution indicates that high tech facilities are much easier to avail in the private sector over-stretched government sector.



DISTRIBUTION & DISPARITIES

ANNEXURE 10

DOCTOR: POPULATION RATIO BY STATE 2004						
	Public Sector ¹			Private Sector	Total	Ratio of Doctor to Population
	MOH	Non MOH	Total			
Wilayah Persekutuan ²	1,115	918	2033	1,779	3,812	1: 401
Pulau Pinang	630	9	639	841	1,480	1: 975
Melaka	299	25	324	333	657	1: 1,066
Negeri Sembilan	440	6	446	320	766	1: 1,214
Selangor	911	90	1001	2,053	3,054	1: 1,511
Perak	626	22	648	802	1,450	1: 1,534
Kelantan	358	365	723	186	909	1: 1,628
Perlis	93	1	94	36	130	1: 1,702
Johor	788	12	800	874	1,674	1: 1,810
Pahang	458	1	459	311	770	1: 1,818
Kedah	501	6	507	447	954	1: 1,901
Sarawak	684	24	708	362	1,070	1: 2,115
Terengganu	311	0	311	144	455	1: 2,177
Sabah	714	3	717	348	1,065	1: 2,765
MALAYSIA	7,928	1,482	9,410	8,836	18,246	1: 1,402

Notes :

¹ Includes Ministry of Health, other government agencies, local authorities and universities

² Includes Kuala Lumpur, Putrajaya and Labuan

Sabah : Disparities in resources

- District hospitals : 2 to 6 MOs compared to vs 8 to 12 in equivalent hospitals in W Malaysia
- Higher Outpatient : poverty, less access to private sector
- More complex emergency procedures: LSCS and ectopics
- More difficult transfer for patients
- Unable to take leave, attend CPD programmes

Policy Actions:

1. Incentives for Sabah postings:
2. Easier Post graduate entry
3. Higher funding services – equipment and operational
4. Better implementation

ANNEXURE 10

4. Challenges and Opportunities

- Health Professionals and HR
- NMA's and HR
- Action by Society & Individuals



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Health Professionals & Human Rights

- *Human rights education* is an essential starting point for equipping health professionals with the knowledge and tools to empower them to protect and promote human rights
- The value of educating health professionals in human rights has been widely endorsed by states and the health and human rights communities worldwide
- What the health professionals need to know, to some extent will depend upon the country they work in and also their area of specialisation
- At a minimum all health professionals should receive education on human rights of patients including their right to health, health related human rights of vulnerable groups and their own human rights

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MMA AGM RESOLUTIONS 1999 On health and human rights

- **The right to be free from torture and ill treatment**

The MMA believes that all persons have the right not to be subjected to torture or to cruel, inhuman or downgrading treatment or punishment and not to be subjected to medical or scientific treatment without free and informed consent.

- **The right to care for disadvantaged groups**

The MMA believes that the disadvantaged and vulnerable groups have the right to medical care. The obligation of the physician to provide medical care for disadvantaged and vulnerable groups must be upheld. Physicians should endeavour to identify causes of ill health in such groups and should draw attention to the need to alleviate them.

- **The right to care for prisoners**

The MMA believes that attendance by physicians on persons in custody, prison and those held in detention must always be conducted in the best interests of their health.⁶

ANNEXURE 10

Challenges - National

1. H&HR = relatively new area of work

2. Misunderstanding - " Rights are for lawyers and not for health professionals"

3. Senior management / policy commitment to HRs

4. HRs and civil society are seen as a threat.

5. Ministry of Health have core priorities - aligned politically and by literate and vocal electorate

6. National public health budget is low.

7. Health data are not always reliable.

8. Increasing inequalities in access to health care and health outcomes.

9. Weaker rural health systems, which have a bigger impact on the poor.

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Abbreviation	Full name	When?	No of countries?	Right to health?	Malaysia as signatory
ICCPR	International Covenant on <u>Civil and Political</u> Rights	1966	156		NO
ICESCR	International Covenant on <u>Economic, Social and Cultural</u> Rights	1966	153	Yes Art.12	NO
CERD	International Convention on the Elimination of All Forms of <u>Racial Discrimination</u>	1965	170		NO
CEDAW	Convention on the Elimination of All Forms of Discrimination against <u>Women</u>	1979	182	Yes Art.12	YES 4 TH AUG 95
CAT	Convention against <u>Torture</u> and Other Cruel, Inhuman or Degrading Treatment or Punishment	1984	141		NO
CRC	Convention on the Rights of the <u>Child</u>	1989	192	Yes Art.24	YES 19 TH MAR 95
ICRMW	International Convention on the Protection of the Rights of All <u>Migrant Workers</u> and Their Families	1990	34		NO

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ANNEXURE 10

Opportunities - Malaysia

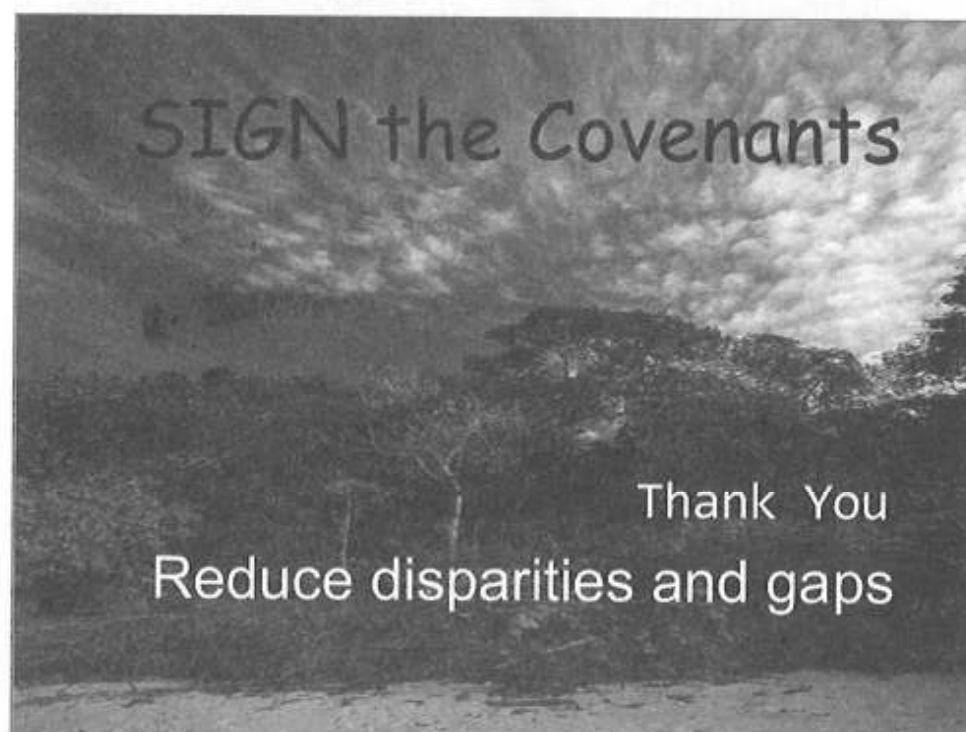
- Good relations with government & privileged contacts at high level
- Strength at policy level
- Sound system of health indicators
- Some excellent tools have been developed
- Good network of H&HR colleagues across the world with different areas of expertise
- Increasing interest among colleagues
- Use the MDG's to introduce human rights
- Use the national Constitution and legislation that guarantee the right to health
- SUHAKAM, partnerships with MMA/ Bar & NGOs

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Summary

- The right to the highest attainable standard of health is the global standard for health and human rights professionals to strive and work with the government to achieve health for all.
- Human rights approach is the framework to provide standards and mechanisms to encourage government to meet its moral and legal obligations (provision of AAAQ healthcare)
- To recognise disparities within Malaysia and enact policies to reduce or eliminate gaps in access and outcomes in health
- Priority is for all agencies to unite under the leadership of SUHAKAM and convince the Government of the righteousness and benefits of signing the ICESCR

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PERKONGSIAN PENGALAMAN PACOS : ORANG ASAL DAN PERKHIDMATAN KESIHATAN DI LUAR BANDAR

**BY MS. MOILIN M. UNSING
MEMBER, PACOS TRUST**





**PERKONGSIAN PENGALAMAN PACOS:
Orang Asal Dan Perkhidmatan Kesihatan
Di Luar Bandar**

Oleh:
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- 
1. Pengenalan PACOS
 2. Perkongsian: Orang Asal Dan Perkhidmatan Kesihatan Di Luar Bandar
 3. Kesimpulan

ANNEXURE 11

Pengenalan kepada PACOS

Rakan Membangun Masyarakat (PACOS TRUST) - sebuah organisasi sukarela yang didaftarkan di bawah Ordinan Amanah Bab 148 pada 1993.



Objektif penubuhan adalah untuk:

- 1. Menggalakan semangat berdikari di kalangan komuniti luar bandar;
- 2. Menggalakan persefahaman dan kerjasama di kalangan komuniti di Sabah menuju ke satu masyarakat penyayang;
- 3. Memulakan pusat pendidikan khusus untuk pembangunan masyarakat yang terpinggir di luar bandar;
- 4. Menyelaras dan menjalankan aktiviti pendidikan atau latihan untuk mencapai objektif yang ternyata di atas;
- 5. **Membina jaringan dan sokongan mana-mana organisasi yang mempunyai minat dan keperihatinan yang sama.**



Orang Asal Dan Perkhidmatan Kesihatan

Situasi 1

Tidak ada Pusat Kesihatan

Kehidupan Orang Asal

- ✓ Jauh dan terpencil
- ✓ Ekonomi



- ✓ Masalah perhubungan
- ✓ Akses terhadap perkhidmatan kesihatan terhad



Mempunyai Pusat Kesihatan

- ✓ Sikap kakitangan
- ✓ Kekurangan kemudahan (cth: ambulan, tiada bekalan elektrik)
- ✓ Masa rawatan terhad

Situasi 2



JARINGAN KERJASAMA PACOS

MERCY Malaysia (Pitas, Tongod, Gana, Inarad & Crocker Range)

Rotary Club (Kg. Batu Lunguyan, Sook)



ANNEXURE 11

Kesimpulan/Cadangan

1. Memberi latihan kepada masyarakat luar bandar tentang asas rawatan/pramedik
2. Galakkan penggunaan rawatan tradisional (pengetahuan tradisi) seperti penggunaan herba sebagai rawatan alternatif



EQUITABLE ACCESS TO HEALTH CARE FOR ALL : IS THIS STILL A PIPE DREAM FOR MALAYSIA? A MEDICAL PROFESSIONAL'S PERSPECTIVE

BY DR. DAVID QUEK

COMMITTEE MEMBER, MALAYSIAN MEDICAL ASSOCIATION

Equitable Access to Health Care for All:

**Is this still a Pipe Dream for Malaysians?
A Medical Professional's Perspective**

Dr David KL Quek, KMN,

MBBS (Mal), MRCP (UK), FRCP (London), FAMM (Mal), FNHAM (Mal),
FASCC (ASEAN), FCAPSC (Asia Pacific), FCCP (USA), FACC (USA)

Suhakam's "Human Rights & Access to Equitable
Healthcare" Dialogue,

Kota Kinabalu Sabah, 8 January 2008

NHS vs. Private Practice

- "The availability of good medical care tends to vary inversely with the need for the population served.
- "This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.
- "The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."

Julian Tudor Hart: 'The inverse care law.' *The Lancet*, 1971

ANNEXURE 12

Social Inequality breeds ill-health

- "The reason we don't know that we know things is that they conflict with more powerful ideas, and so we see them but fail to recognise them."
- "The idea that inequality is a sign of economic health and social vigour is too compelling to permit serious engagement with the idea that inequality is anti-social and a cause of illness."
- "We need to be told what we know, instinctively, about what makes a good society."

Marek Kohn, in Prospect magazine, September 2005, when reviewing a book by Richard Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier*, Routledge, London, 2005

International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12, ratified by 151 countries.

It provides as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Remarkable Improvements through 50 years...

- Malaysians in general have had a sterling achievement in terms of advancement of human capital development, for the past 50 years since independence.
- Our life expectancy at birth has risen from 55.8 years and 58.2 years for men and women respectively in 1957, to 71.8 years and 76.3 years, as of 2006. Infant and maternal mortality rates have markedly decreased to current levels, which equal those of developed nations.^[1]



^[1] Merican MI, *Medicine and Healthcare in 2020*. Berita Akademik, 2007, Vol 16:3, Pg.2.

Improving the health status

- Policies and programmes that provide improved health care for the poor and vulnerable groups, as well as for the growing number of older persons, need to be formulated and implemented.
- The poor must be excluded from user charges with increased privatization of health services.
- Reproductive health targets, including those for adolescents, should be set, to further improve maternal health.
- Sexual education in schools, as well as through civil society and religious organizations, should be intensified, to prevent health problems, such as the spread of the HIV/AIDS epidemic and pregnancy among youths.
- Country-specific MDG plus targets relating to mental health, heart disease, and cancer should be set and monitored.[1]

[1] SUHAKAM/UNDP. A Human Rights Perspective on MDGs and Beyond, 2006, Kuala Lumpur

Suhakam: some areas of concern

- issues pertaining to the delivery of healthcare services to the vulnerable and marginalised groups;
- the rights of vulnerable/marginalised groups to health/healthcare services; and
- to identify vulnerable/marginalised groups and their health needs which require consideration by the Government when implementing policy and programmes to ensure equitable healthcare for all.
- *Urban and tertiary health care access issues and financing concerns*

Still pockets of poor access for some Malaysians, too often, quite unbecoming...

- Yet, when one turns the pages of our daily newspapers, we are invariably accosted with pleas and requests for financial help to pay for some expensive, supposedly urgent life-saving medical services—particularly heart-rending stories when they involve babies and young children.[1],[2],[3]
- This constant 'begging' for alms to help defray medical therapies and surgeries is unbecoming of a nation which aspires to be a fully developed one by 2020, i.e. a mere 13 years away.

[1] *Little Kin Wai hopes to walk tall-He needs funds to help him grow*, The Star, Saturday, 20 October, 2007, p N18.

[2] *Single mum needs aid for kidney transplant in China*, The Star, Friday 19 October 2007, p N26

[3] *In need of aid to treat his burns*, New Straits Times, Monday, 22 October 2007, p N17

ANNEXURE 12

Saturday September 1, 2007

Ex-international Michael needs help

PEI LING JAYA: The National Sports Council (NSC) core sport's bowling officer Allan Lee has initiated a donation drive for former international Michael Chuah.

Michael, the 1983 AMF World Cup runner-up and the 1985 national Sportsman of the Year, has been diagnosed with pancreatic cancer and needs more than RM30,000 for medical treatment.

The Malaysian Tenpin Bowling Congress (MTBC) have started the rolling with a RM5,000 donation. Donors can make their contribution through the MTBC.

Wednesday October 17, 2007

Sharvin still short of RM16,000

JOHOR BAHRU: Young R. Sharvin is scheduled to go for surgery at the National Heart Institute but his single mother is still short of RM16,000 required for the operation.

Four days ago, The Star ran a story urging the public to help the two-year-old boy who was born with two holes in the heart.



Medical X-ray shows. Can you help Sharvin undergo surgery for Sharvin's operation?

Factory worker G. Devi, 31, said she had withdrawn RM12,000 from her EPF savings but the entire medical bill costs RM28,000.

> PENANG

Teenager with leukaemia seeks aid

GEORGE TOWN: When 15-year-old Muhammad Eerie Abdullah failed at his brother's leukaemia still six months ago, his family members did not realise that it was caused by a serious disease.

He was diagnosed as suffering from acute myeloid leukaemia but after being treated with a few cycles of chemotherapy at a hospital here, the disease is now in remission.

To prevent a relapse, he needs an urgent stem cell transplantation at the Hospital Universiti Kebangsaan Malaysia in Kuala Lumpur.

His brother Muhammad Eerie Abdullah, 23, who was killed in a traffic accident here, has been found to be a suitable donor for stem cells.

Stem cells will be taken from Eerie's body to help his bone marrow produce healthy blood cells.

The procedure will cost RM42,000, an amount which is beyond the means of his widowed mother Zahara Isahak, 47, a manufacturing assistant in a factory near a



Muhammad Eerie Abdullah with a letter from Hospital Universiti Kebangsaan Malaysia which states his need for financial assistance for stem cell transplantation.

basic pay of RM1,628 a month.

Eerie's father Abdullah Huda, who was a member of the Armed Forces, died in 2000 while still in service.

Eerie was unable to enrol for a course in business management at a college in Selangor because of his illness.

To help Eerie, cheques can be made payable to New Straits Times with his name written on the reverse side, addressed to The Cashier, Finance Department/Charity Unit, The New Straits Times Press (M) Bhd, Balai Berita, No. 21, Jalan Klang, 50100 Kuala Lumpur.

NST Tuesday 17 Nov 2007

Toddler, newborn in need of surgery



GEORGE TOWN: Fifteen-month-old Rohana Syukri is thin, pale and has frequent chest infections due to her heart condition.

She urgently needs RM28,000 for surgery which would be performed at the Glenagles Medical Centre here.

Her father, Syukri Isahak, 33, is a coffee shop assistant from Jitra, Kedah, who earns about RM600 a month. He has three other children, aged 4, 8 and 10, from a previous marriage.

Rohana's mother, Nurane Sumae, 21, is a housewife.

They cannot afford to pay for Rohana's operation and are appealing for donations.

Meanwhile, a 5-day-old girl who has yet to be given a name, also needs financial aid for surgery.

Her father, Chaw Min Chong, 32, appealed for donations as the operation at the same hospital was expected to cost RM20,000.

Chaw is an insurance agent who earns less than RM2,000 a month, while his wife, Neo Chia See, 29, is not working.

Those who wish to help them, can send cheques made payable in New Straits Times with the child's name written on the reverse side, addressed to The Cashier, Finance Department/Charity Unit, The New Straits Times Press (M) Bhd, Balai Berita, No. 21, Jalan Klang, 50100 Kuala Lumpur.

Fifteen-month-old Rohana Syukri, with her mother Nurane Sumae, Rohana suffers from chest infections.

Medical Assistance Fund

- A few years ago, when such pleas became too embarrassingly shameful to bear, the Ministry of Health initiated a Medical Assistance Fund (MAF).
- Unfortunately, despite occasional injection of funds from public pledges and the government, the distribution of such monies have been painfully slow, pedantically bureaucratic, and sporadic—so much so that the deprived still resorted to direct pleadings via the mass media to implore some sympathetic charitable souls to help out.
- From a recent press statement by our DG of Health Tan Sri Datuk Ismail Merican, this MAF is now topped up to RM 25 million, but this will only be available to requests for treatment at government and public institutions only, which effectively excludes those seeking treatment from the private sector or overseas.^[1]

[1] Annie Freeda Cruz, *Poor can apply to medical fund*. New Straits Times 17 Oct 2007

“D’tik YKN”

- Another emergency fund launched by the Ministry of Health in collaboration with the National Welfare Foundation called “D’tik YKN” has been set up recently. It has received an initial allocation of RM 5 million. (“D’tik” is an acronym for *Dana Talian Insan Kritikal Yayasan Kebajikan Negara*.)
- This fund provides critically ill patients access to treatment within 24 to 72 hours, but is currently only available at Kuala Lumpur Hospital as its pilot medical facility to kick-start the programme.



ANNEXURE 12

Surely there must be a better mechanism for greater access to such needs

- Surely there must be a better mechanism to address these clangorous but pitiful entreaties for help from among the less well-to-do, the underprivileged, or simply the uninsured, or underinsured.
- How is it that for so long we seemed to have weathered such demands in the past without these coming to the surface?
- Were there factually fewer cases requiring such special tertiary surgeries or therapies previously, say some 20-30 years ago?

Child healthcare issues appear to tug more at our heart strings.

Shouldn't we have a child health access/protection program?

washingtonpost.com

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Bush Signs Child Health-Care Extension Into Law

Insurance Program Is Funded Through March 2009, Without Expansion Democrats Sought

By Ben Feller
Associated Press
Sunday, December 30, 2007; A09

CRAWFORD, Tex., Dec. 29 -- President Bush signed legislation on Saturday that extends a popular children's health insurance program after having twice beaten back attempts to expand it.

The extension of the State Children's Health Insurance Program is expected to provide states with enough money to cover those enrolled through March 2009. Bush and some Republican lawmakers say the program will serve those that it should: children from families who earn too much to qualify for Medicaid but cannot afford private insurance.

"We're pleased that the program will be extended and that states can be certain of their funding," White House spokesman Tony Fratto said.

Many Democrats, with help from some Republicans, wanted to give the program a significant cash infusion and broaden coverage to an estimated 4 million more children.

They overwhelmingly supported a tobacco tax increase to pay for the expansion.

The matter came to dominate legislative debate and further sour relations between the Democratic leadership and Bush this year.

The Democratic-pushed bills would have expanded the program by \$35 billion. Bush said the proposals did not put the neediest children first.

He opposed the tax increase and, more broadly, fought against what he saw as a movement toward more government health-care coverage.

The joint federal-state program provides benefits to about 6 million people, mostly children. Democratic lawmakers still want to expand enrollment and are negotiating with some Republican leaders for another try.

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IMPACT

Foreign Workers healthcare access:
Another area of concern

16:30 PM NEWS

Foreign patients leave RM61m bill

By Tai Chai Chee
Health Correspondent

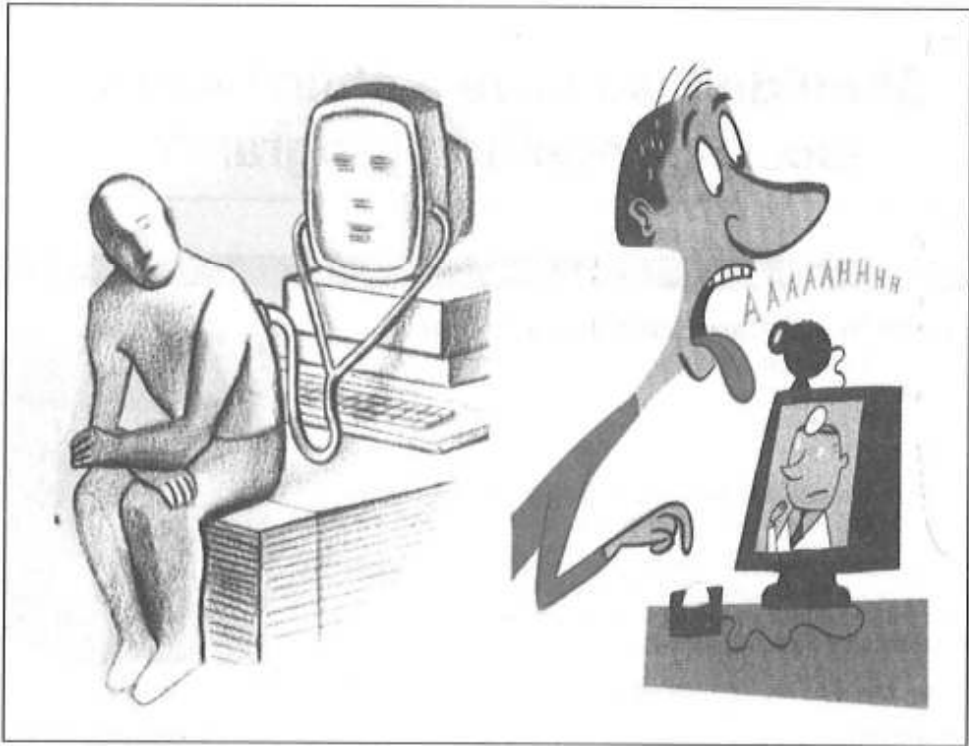
ALLEN LEMPIE, the incoming number of foreign patients who seek treatment in our public hospitals are leaving behind a RM61m bill.

From 2002 until October last year, foreign patients owed RM61.4 million to the government. In 2003 and 2002, they owed RM61.4 million to the government. In 2003 and 2002, they owed RM61.4 million to the government. In 2003 and 2002, they owed RM61.4 million to the government.

AMOUNT OWED TO PUBLIC HOSPITALS

Year	Malaysians (RM)	Foreign patients (RM)	Grand total (RM)
2002	10,000,000.00	5,000,000.00	15,000,000.00
2003	12,000,000.00	7,000,000.00	19,000,000.00
2004	15,000,000.00	10,000,000.00	25,000,000.00
2005	18,000,000.00	13,000,000.00	31,000,000.00
2006	21,000,000.00	16,000,000.00	37,000,000.00
2007 (partial)	24,000,000.00	19,000,000.00	43,000,000.00
TOTAL	100,000,000.00	61,000,000.00	161,000,000.00

Legal or illegal who should look after these marginalized who also contribute to our economy?



Information Explosion creates
greater demand for services...

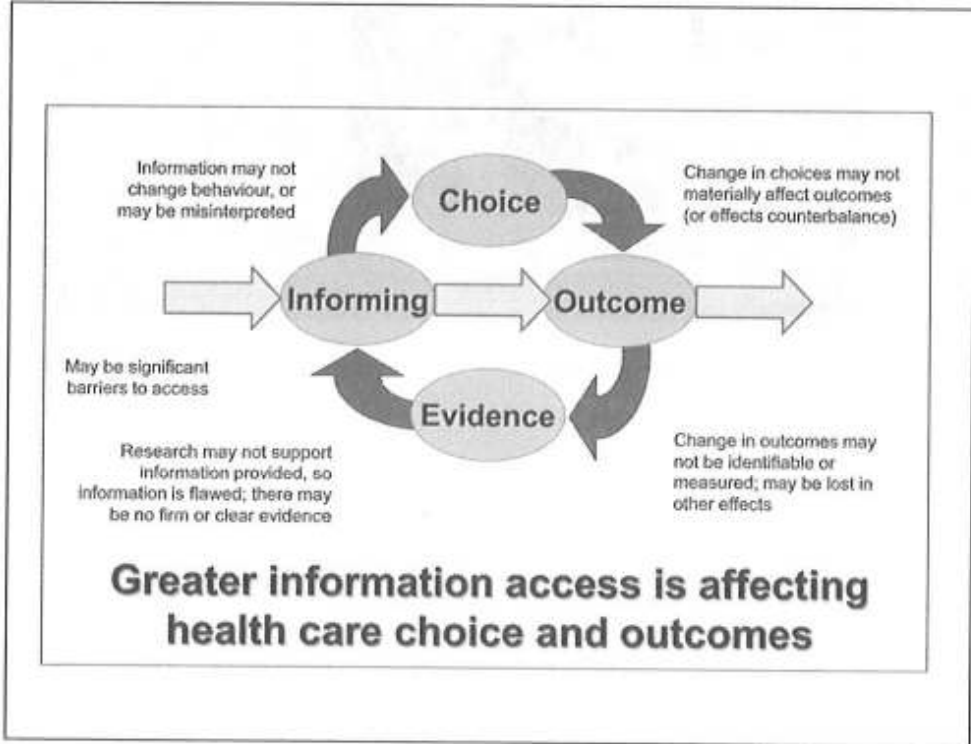
- Perhaps over the past 2 or 3 decades we have become exposed to the stupendous advancement of medical progress, such that once desperately untreatable conditions are now given new hope of cure or palliation?
- Better education, improved literacy level and increasing human self-esteem and the huge explosion of information accessibility, especially via the Internet, have clearly contributed to this knowledge dissemination.[1]
- Greater wealth distribution has of course also added to this new empowerment for more perceived rights and entitlement as citizens.

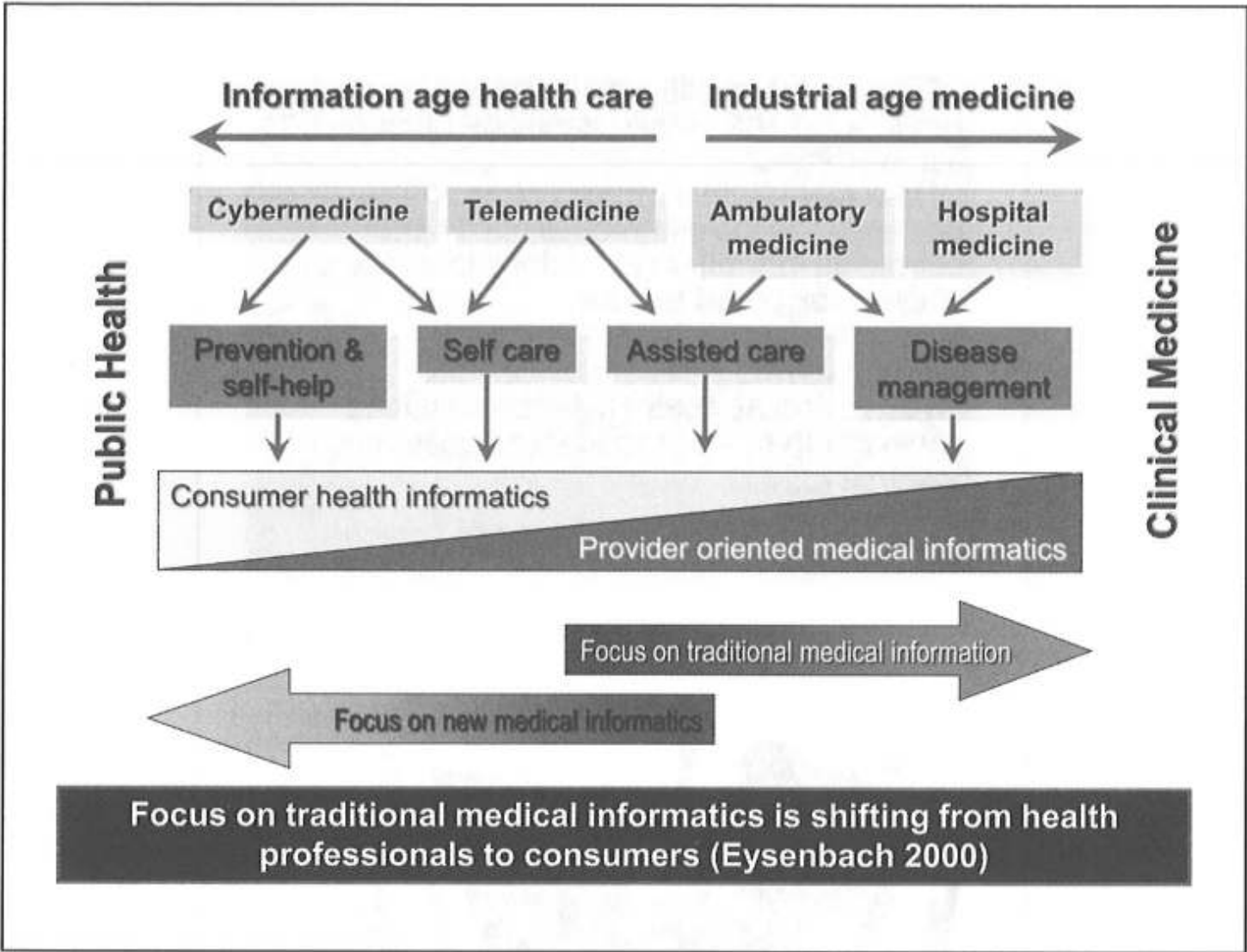
[1] UNDP Human Development Report 2006. The Human Development Index ranks Malaysia 61st, with a literacy rate of 88.7%, Education Index of 0.84, life expectancy index 0.81 and PPP GDP of USD 10,276. Malaysia spent some 8% of the GDP on education with the government spending some 28% of the total budget on education alone with 36.5% for tertiary education.
<http://hdr.undp.org/hdr2006/pdfs/report/HDR06-complet.pdf>. Pgs. 302, 320. Accessed 21 October 2007.

ANNEXURE 12

"The Internet will break the logjam that has slowed the development of competition among services.
Take medicine: Through chat rooms, patients can communicate with other people with similar conditions in a way that they never could before.
Word of mouth has gone global.
And patients have almost infinite information at their fingertips, making them much more formidable consumers of medical care.

—Hamish McRae in 20/20 Vision: The New Mass Market; Fortune Global, Nov 22, 1999, p.48.





ANNEXURE 12

Yet, despite greater information access, heightened expectations and demands, our budget for health care spending remains incongruously low

- Malaysia's health expenditure: A total of 3.8% of the nation's GDP is spent on health care, with the public sector (i.e. government spending) accounting for 2.2% and private funding 1.6%.
- Per capita, on average, we spent only 374 PPP-USD for health in 2003, and we have 70 physicians per 100,000 population (i.e. one doctor for every 1428 citizens).
- What is peculiar to Malaysia is that we have always had a rather mature dual system of health care service sectors—an incongruous dichotomy of private versus public health care sectors.
- There have been many presentations to try and assimilate and integrate these two sectors so that they complement rather than duplicate each other, but so far, little has been achieved despite common thoughts on sharing patient information and talk of portable (IT-savvy electronic) personal health records.

Huge Public sector subsidies are unrealistic & ultimately unsustainable

- The public healthcare sector is heavily subsidized by the government, and caters to the huge civil service employees, as well as to the less well-off (it is almost free from co-payments), such that some 70% (perhaps as high as 75%) of the population actually utilize these services almost exclusively; because for most, this is all what many perceive that they can afford to access any form of health care services, for themselves and their families.
- One ringgit for consultation and medicines as an outpatient is clearly an economic anomaly, if any, to be considered as a co-payment for any health care service available anywhere in the world.
- Yet, our Malaysian public has been made so accustomed to this paltry sum (this cannot even pay for a bus fare or a canned drink) that it would appear politically inexpedient if any such fee adjustments were to be made or suggested.
- So the government has to continue to appease the public and the electorate by staying this unsustainable course.
- Of course, one can argue that for basic and emergency health care, even the poorest can have access to treatment in most if not all of Malaysia's public health care sector—the question is what sort of quality, what standards, what about waiting times?

Health care planning too sporadic and not well-structured enough...

- It is true that there are sporadic attempts to offer affordable health services for the poor, but these are often fraught with uncertainties and limited scopes for the actual service rendered—it is not enough to simply offer advice and information—what is more important is that patients should also have access to what can be done—what treatment or surgery can be offered, without having to seek other alternative avenues of assistance.^[1]

^[1] Mazlinda Mahmood. *Affordable reproductive health services for the poor*, New Straits Times, Saturday, 27 October 2007, p N24.

Rising Expectations, modern infrastructure but delivery problems...

- However, Malaysians also expect modernization and better amenities of their health care services.
- Thus, huge amounts are allocated and have been spent on bringing up-to-date state-of-the-art equipment and facilities to nearly all of the major hospitals of every state or towns.
- While such expenditure is laudable, there is a growing sense among the more discerning public, of possible wastage, less than spectacular structural excellence— from the outset many facilities are beset (some before being launched, even!) with ceiling leakages, mouldy infestations, structural defects, questionable fitness-to-operate certification, etc.
- These together with other dubious turn-key acquisition of costly equipment and beds, arguably make these hugely expensive facilities appear less than the best that they can be managed and/or run.
- We appear not to have achieved a bigger bang for the buck, so to speak.

State-of-the-Art but who benefits?

- When new modern state-of-the-art hospitals (built and equipped to the tune of hundreds of millions of ringgit, e.g. Selayang and Putrajaya Hospitals) are re-structured so that full-paying patients can be charged for first class treatment— many protests were made, due to fears that the marginalized would once again be shortchanged and possibly neglected.^[1]
- It is not unreasonably feared that those who cannot pay may be made to wait unfairly long for therapies or surgeries which they need—that they might be preferentially sidelined by those who could afford to pay.^[2]

^[1] Subramaniam Pillay. *Can We afford to fall Sick?* Aliran Monthly Vol 25 (2005): Issue 4

^[2] Jeyakumar Devaraj, *Health Is Not A Commodity*, Parti Sosialis Malaysia Press Statement: 8 June 2007

Full Paying Patients concept bearing fruit

The Star Friday September 28, 2007

By A. LETCHUMANAN



Full-paying disquiet among some concerned with inequitable access...

- The Ministry of Health clearly views this option very differently, with the Minister Dato' Seri Dr Chua stating recently that patients are already enjoying the benefits, with some 103 patients paying some RM 116,000 as full-paying patients, with a small portion being disbursed to doctors.^[1]
- Also another recent opinion piece commended the Ministry's move, stating that allowing this practice at these private wings might help retain some senior specialists from either resigning to join the private sector or even to practice as locum outside the public domain.
- In turn, these medical specialists can help remain in the MOH and still contribute to looking after the poorer patients in the respective hospitals.^[2]

^[1] A. Letchumanan, *Full Paying Patients concept bearing fruit*, The Star, Friday, 26 September 2007

^[2] HT Chua, *Give Full Paying Patient scheme time to work*, The Star, Monday, 24 September 2007

Fee-paying versus subsidized patients—Differential services?

- However, some other critics are less sanguine about this practice.
- There have been examples bandied about that certain private wings of university medical centres are already practicing such preferential favoritism when dealing with fee-paying versus subsidized patients—that specialist medical treatments are offered fee-paying patients almost without any waiting time, whereas the poor have been made to queue, which can run into months, perhaps even years!
- The uncomfortable truth is that, many of those in the queue have been told that they can always expedite their case when and once they have the requisite funds!
- Hence, the resorting to pleas for financial assistance from the public via the mass media, demeaning as this may be.



Continuing experienced staff losses to private sector

- There is another problem—that of specialists and experienced staff leaving the public for the private sector. The usual cause for this 'senior staff hemorrhaging' is the financial 'pull' factor.
- Rightly or wrongly, the private sector is perceived of as being far more worthwhile, certainly more financially rewarding than the meagre public wages paid for slogging through the humdrum drudgery and thankless services for the masses.
- Bureaucratic and office politics are other 'push' factors for this migration to so-called greener pastures of the private health care sector.
- This has led to the incongruity where some 60% of all the nation's physicians (in the private sector) are looking after some 'privileged' 30% of the population, and vice-versa!
- The depleted public sector doctors (some 40%) have to manage the greater 70% of population!

Perceived private-public wage advantage

- The perceived discrepancy between the public and private sector doctors' wages remain an unresolved bone of contention. Being part and parcel of the public services, only special allowances can be allocated to improve the final take-home pay for doctors.
- Of course this has been made more attractive lately with the abolishing of taxes on some of these allowances.
- Still, some attrition to the private sector continues, and public sector shortages and congestion remain problems—which can affect timely and free access for poorer patients, using the system.
- The nearly-free treatment provided may sometimes be too much for the government to afford.
- Yet, despite these misgivings, our Malaysian public has also been led to believe that health care costs in Malaysia are exorbitant, i.e. the private sector is charging too much; that doctors are profiting unfairly at the expense of the unfortunate public.

Malaysian private medical costs are not as high as some of our neighbouring countries...

- Surprisingly but not always obviously exposed, when we compare private medical practice fees and medical costs in Malaysia, we are actually modestly inexpensive—largely because our doctor's professional fees are consistently lower than those in neighbouring countries.^[1]
- We are attracting foreign healthcare tourists because of our perceived modern facilities, greater technical and expert skills as well as affordability and cost-effectiveness. However, some people are unhappy as to this lopsided push for more tourist health dollars, which they feel may further disadvantage the poor.
- But it is true that by and large, those who are uninsured and who are not civil servants, can find it expensive and in some cases unaffordable, when they seek private medical health care.
- [1] Quek DKL. *Physician Fees-what's our rightful compensation?* (Editorial), MMA News August 2003, p 7.

ANNEXURE 12

Unaffordable health care can lead to delays and bankruptcies...

- Thus, their access to health care can be curtailed and they may resort to self-delays or seek alternative therapies, which in the long run may endanger their health even further.
- Others sometimes think that they can afford private health care initially, only to be burdened by high charges which accrue when complications set in unexpectedly or when unforeseen.
- Unfortunately, there is no mechanism to assist such patients caught in such quandaries.
- However, most private medical facilities would offer discounts and even waive most of the extra charges, when they can after assessing the socio-economic background of the patients and their families.
- But some also had legal demands dumped on them to reimburse these hospital charges, which can bankrupt the unwary.

What do modern patients want in health care?

- In a recent report (*A Clinical Vision of a reformed NHS, 2007*) by the Joint Medical Consultative Council (JMCC) and the NHS, it was reported that the following are what patients want from their health care experience:[1]
 - Fast access to reliable health advice
 - Effective treatment delivered by trusted professionals
 - Participation in decisions and respect for preferences
 - Clear, comprehensive information and support for self-care
 - Attention to physical and environmental needs
 - Emotional support, empathy and respect
 - Involvement of, and support for family and carers
 - Continuity of care and smooth transitions

[1] JMCC & NHS Confederation. *A Clinical Vision of a Reformed NHS*, London, 2007

What is “reasonable” health care costs?

- The public as citizens may be concerned with abstract notions of good service such as affordability—free at the point of care; universality and equity; safety and quality; and health protection and disease prevention.
- Although we do not have a similar survey conducted in Malaysia, I believe that many among the public would agree that the abovementioned features are what they too aspire our health care service to be.
- Most importantly, everyone expects to have ‘reasonable’ access to reliable effective and safe health care and advice.
- The problem is what is considered as ‘reasonable’?

Which health care financing model is sustainable?

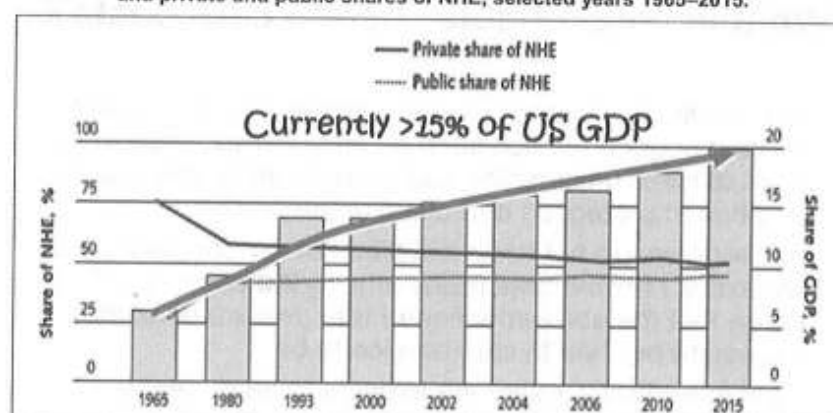
- This concept of universal access to health care is not easy to define or to delimit or more optimistically what it should embrace. Can it be a 'be all' and free for all comers?
- Clearly this is not a feasible nor reasonable option unless of course, we have command economy where every aspect of healthcare services is state-controlled and delivered via a system of one all-inclusive integrated services—there being no private sector or third party insurer or payer.
- Unless we adopt such a radical or revolutionary change, as that practiced by communist Cuba, then we have to find an alternative approach—one that melds the two divergent arms of the private and public sector into a coherent complementary system.

The UK NHS and the USA...

- Although many nations are increasingly looking toward the model of the NHS in UK, many are fully aware of its severe shortcomings and its rapidly evolving and chameleon-like shifts in practices and approaches.
- The *laissez faire* free-for-all system as now practiced by the United States is clearly flawed and far too expensive (15% of the national GDP!) and leave too many disadvantaged groups fully neglected or uninsured (some 46 million people!) including many children and elderly (although the latter is assisted by Medicaid).^{[1],[2]}

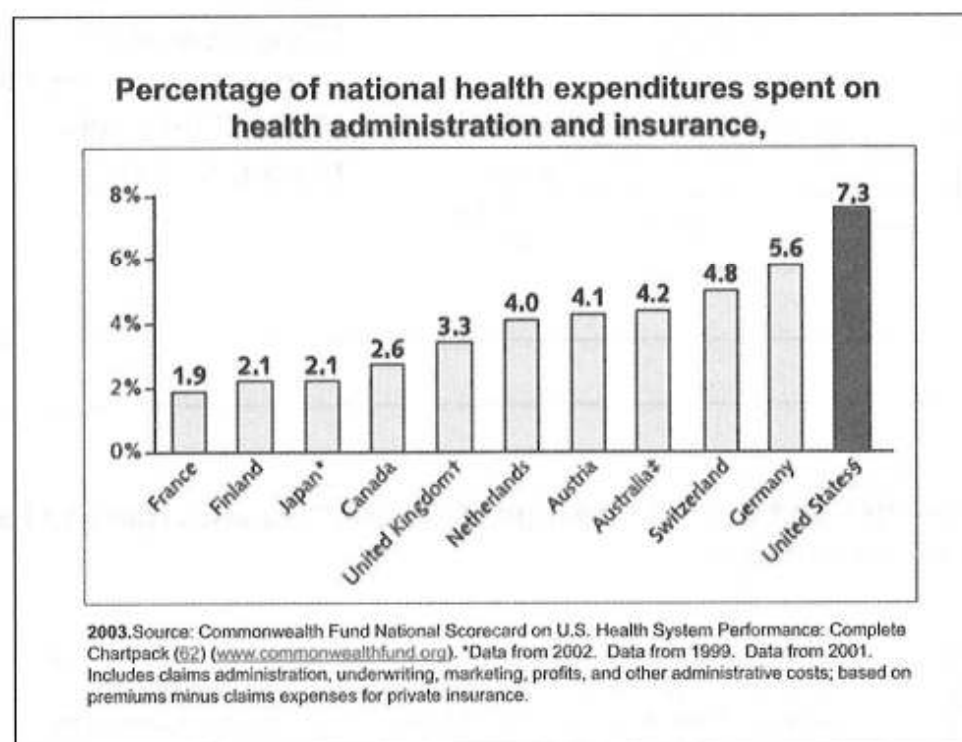
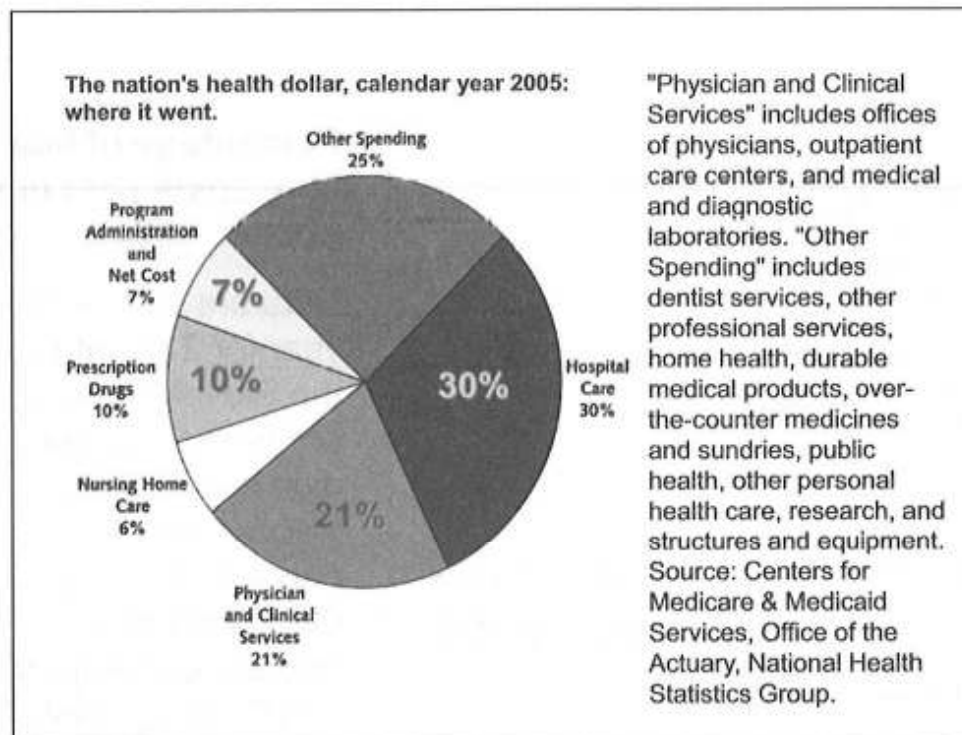
- ^[1] Jacob S. Hacker, *Healing Our Sicko Health Care System*, N Engl J Med, 2007;357(8):733-5
- ^[2] Garson Jr A. *Heart of the Uninsured*. Health Affairs, Jan-Feb 2007;26(1):227-31

U.S. national health expenditure (NHE) as a share of gross domestic product (GDP) and private and public shares of NHE, selected years 1965–2015.



Total NHE is the total amount spent in the United States to purchase health care goods and services during the year. Detailed definitions of the various components of NHEs can be found at www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-05.pdf. The left axis (public and private spending's share of NHE) relates to the 2 line graphs. The right axis (NHE share of GDP) relates to the bars. Data for 2006, 2010, and 2015 are projections. Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

ANNEXURE 12



NEWS

Downloaded from bnj.com on 4 January 2008

IN BRIEF

Reactor reopens after isotopes shortage: Canada's National Research Universal nuclear research reactor, whose shutdown in November caused a worldwide shortage of nuclear isotopes for medical purposes, was restarted on 14 December and is expected to resume full-scale production soon. Parkland's regulatory safety is regulated.

BMJ paper tops US medical journal charts: A study by the BMJ of the cardiovascular disease risk score used by the American Heart Association (see, *the heart*) as one of the top 10 advances of 2007.

Strike has knock-on effect for Israeli medical students: The closure of Israel's four medical schools means that unless the government swiftly resolves the two-month strike by senior lecturers in the country's universities, hundreds of medical students will be stuck in their preclinical studies and be unable to proceed to work in hospitals.

Motor neurone mortality rises: The death rate in people with motor neurone

US healthcare executive pays back \$600m in stock options

Justice Hopkins Times NEW YORK
William McGuire, former chief executive officer and chairman of the board of United Health Group, has agreed to return \$600 million to the company.

The US Securities and Exchange Commission said that Dr McGuire and other officers and directors of United Health Group had engaged in a "pattern of performance by secretly backdating stock options, the integrity of our markets is undermined. As demonstrated in this case, the commission is committed to holding those who engage in such illegal stock trading accountable."

McGuire "knew, or was reckless in not knowing," that several reports filed to the commission contained false information.

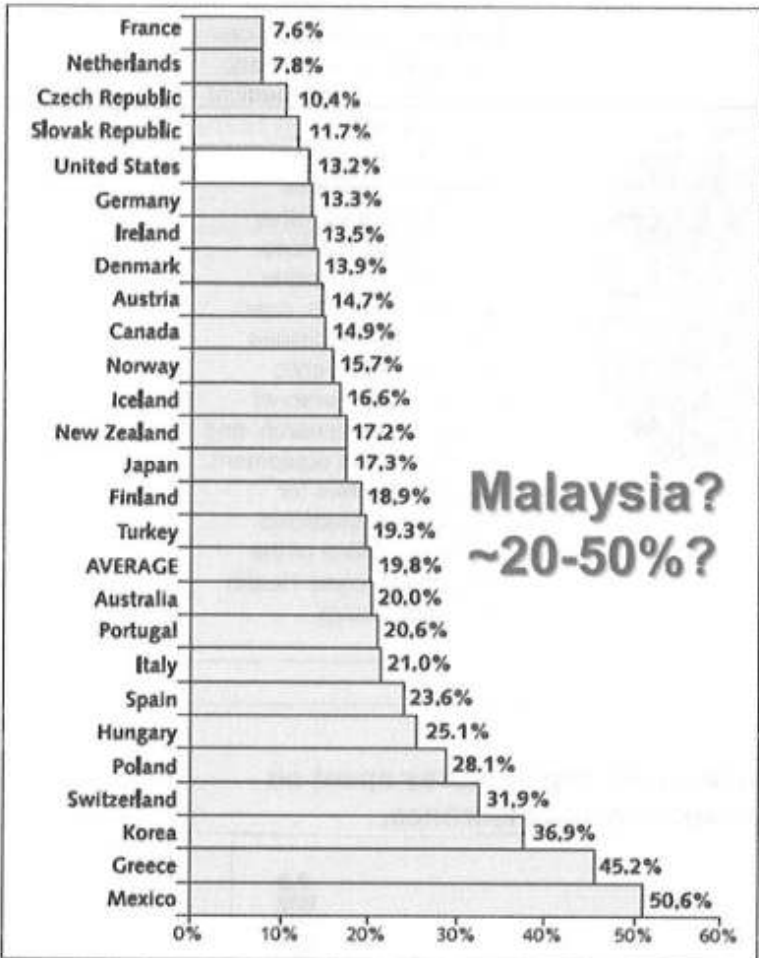
Stock options are valued at the day's market price, so by backdating the company's

United Healthcare Group paid 1.53 Billion USD compensation to its executives over 12 years!!!

HMO? Wasteful culture of administrative excesses

William McGuire

ANNEXURE 12



Percentage of health care costs paid out of pocket, 2004.

Data are from a previous year for 2 countries: For the Slovak Republic, data are from 2003; for Japan, data are from 2002. Recent data are available only for 26 of the 30 Organization for Economic Co-operation and Development (OECD) countries. Source: Congressional Research Service based on OECD Health Data 2006 (October 2006).

Commonwealth Fund overall rankings of 6 countries according to key indicators of performance.

Country Rankings

1.00-2.66
2.67-4.33
4.34-6.00

Source: Calculated by the Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard (65) (www.commonwealthfund.org). *Data from 2003.

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	\$2876*	\$3165	\$3005*	\$2083	\$2546	\$6102

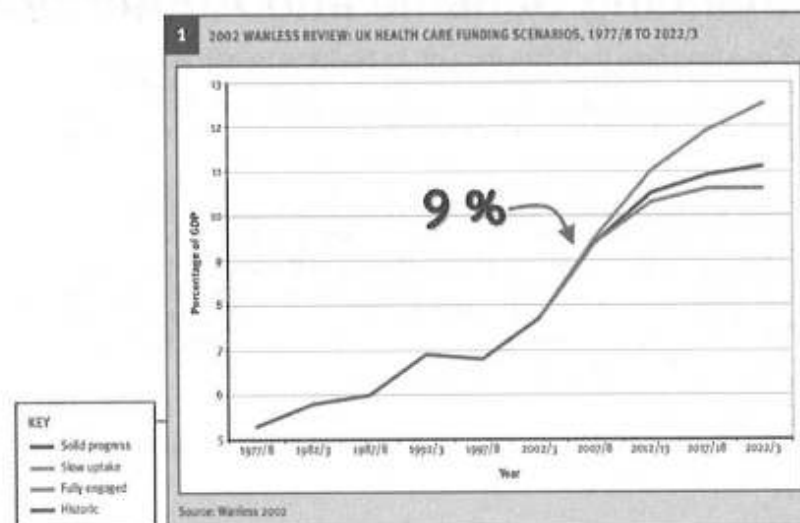
ANNEXURE 12

Other examples...

- Other highly dependent state-insured nations such as the Netherlands, New Zealand are smaller populated but richer nations which spend an inordinately high portion of their social taxes on health, social and individual taxes can reach 50 percent or more—something that our country simply cannot match as of this juncture.^[1]
- Germany for example, has a statutory health insurance system where 78% of the population contributes, the remainder being voluntary members or pay private insurance; in 2003 88% of the population has social health insurance.
- However, it is estimated that only 30% of our population is paying any form of income tax or provident fund savings—how then can we raise sufficient community-rated premiums to help defray the enormous cost of health care for all?

[1] Lewis R, Alvarez-Rosete A, Mays N. *How to Regulate Health Care in England*. London, Kings Fund 2006. pg 19-50

Health Care Cost will continue to escalate in the future, even in the UK...



The Taiwan Single Payer Insurance scheme...

- Modified single insurer states such as Taiwan are facing serious financial crunches after grappling with an erstwhile successful model for the initial years—spiralling costs from more and more advanced treatment options are exhausting whatever reserves or spread of risks for its rapidly-ageing public.^[1]
- End-of-year credit squeezes and fund exhaustion (from DRG disbursements) are hampering high-cost surgical or medical procedures and therapies, thus elective procedural deferment and waiting times are increasing once again...
- Co-payments are now being suggested as are rationing of certain forms of less than urgent or life-saving forms of therapies.
- In Germany, a physician fee of 10 euros is charged for a first visit to either GP or specialist, but free for other contacts within a quarter-year, if referred, to prevent doctor-hopping.

[1] JFR Lu, Hsiao WC. *Does Universal Health Insurance Make Health Care Unaffordable? Lessons From Taiwan*. *Health Affairs*, May-June 2003;22(3):77-88

Is our current Healthcare system so terminally bad, that it has to be totally overhauled?

- Our current model of private and public sector health care dichotomy is not without flaws, but is one that has provided reasonable access to health care for nearly everyone, with the public sector facilities serving as a fall-back safety net, whenever, higher costs therapies and surgeries preclude the patient from affording them.
- This model may be sufficiently robust as to be tweaked and adapted so that we have a system which can work more efficiently with less wastage, despite our paltry expenditure as a whole.
- Although the health care budget is touted as some 5% of the GDP, actual government spending on health care and services amount to at most 2.6 to 3%, which is way below the number suggested by WHO and most health care advocates (which is around 8% of a nation's GDP).⁹
- Imagine if we can allocate another 5% into the healthcare budget, we can clearly achieve so much more and provide even better care and hopefully more access to cover more of the population, rather than the recurrent hiccups we encounter almost daily, these days.

A New National Health Care Financing Scheme and Authority?

- For a long time the MMA through its National Health Policy and Planning Committee headed previously by past president Dato RS McCoy have advocated a single-payer National Health Plan, which was presented to the government in a comprehensive monograph titled "Health for All".^[1]
- We understand that large sections of our single-payer initiative proposal have been incorporated into the proposed scheme by the MOH in the National Health Care Financing Scheme (NHCFS).
- Although in the beginning the MMA was enthusiastic about this development of the NHCFS, over the past few years, the very many alterations and distortions which have crept into the scheme, have created many concerns and doubts among those who had earlier favoured this approach.^[2]

^[1] MMA, *Health for All*, 2000

^[2] Jeyakumar Devaraj. *Resolutions Adopted at the Forum on Health Care Financing in University Malaya* on 25/3/07

Many uncertainties remain with the new proposal...

- This plan was earlier mooted as a single community-rated insurance scheme, which will provide mandatory and statutory cover for every Malaysian, through a central-collection and distribution system.
- Regional trust authorities were to be formed which act as gatekeepers as well as disbursers of funds and allocation of resources, so that healthcare costs can be contained; and excesses, wastage and duplication of services and testing are prevented or reduced.
- A shared provident-insurance premium contribution is supposed to have been made by both employer and employee.
- What has not been agreed to, is the quantum of contribution, and whether this now dispenses with other health insurance incentives/benefits which employers now offer to many of their workers.
- Furthermore, additional coverage premiums for family members remain uncertain, and factoring in this additional deduction based on the number of dependents can clearly be difficult for a large segment of the public.
- What about the self-employed and the unemployed?

ANNEXURE 12

Why is there *another* parallel system for civil servants?

- Then, there is the question of civil servants, the police and military personnel which the government has indicated that they would be provided for from the existing system, and that they would remain outside this new NHCFS.
- This has drawn huge criticism that a large proportion of the population (including their not unsizeable dependents) would therefore not be participating in this so-called 'national' health care financing scheme.
- Thus, this could unfairly burden the private sector with a disproportionate burden of the community-rated insurance scheme.
- There is fear that there might be cross-subsidies to the public healthcare sector because the available public sector healthcare facilities would still be offering their services to privately-insured citizens, and hence be receiving reimbursement from this same financing authority.
- Separation of costs and services would become an unmanageable reality, and privately-insured citizens paying such additional insurance premiums could be paying far more than his or her fair share.

Concerns of the new NHCFS that must be addressed, before implementation...

- Although the NHCFS has been suggested as an all-embracing model, the manner of implementation appears fragmentary and less than convincing towards a health care system which offers universal access for all Malaysians. Interestingly after some review and counterproposals from yet another Health Care Commission (Karol), the implementation of this NHCFS has been deferred to the next 10th Malaysia Plan.
- I don't pretend to have all the answers, but clearly if we are to revamp our health care services so drastically as to have a "National Health Care Financing Scheme" then clearly this should be one that encompasses every citizen, and not piecemeal adaptation which only helps to complicate the practical issues on the ground.
- The very large segment of the population that comprises the civil services, must also fall under this category, otherwise the system would fail, as costs cross-coverage would surely be unavoidable and difficult to control.

**Incentive to self-insure or budget for health;
Coverage of specified illnesses must be regulated**

- Rather perhaps we could instill a newer mandated approach where each employed person be given incentives to insure himself and his family, and that a reasonable raft of healthcare services available should always be made accessible—either through some co-payment (Medicare model) or Medicaid when even the most indigent cannot afford.
- This must cover some regulated and specified diseases or ailments, and must include catastrophic illnesses which can often bankrupt even the most modestly middle-class of the citizens.

Which health care services should be readily accessible/available to everyone?

- This sounds clichéd but becomes the lynchpin of any health care service in the world.
- Most would agree that all medical emergencies should fall under this category, where any ill person should have and must have access to life-saving or limb-salvaging care at the most urgent and timely manner as possible.
- Still medical experts and regulators must identify specifically what should be the type and extent of health care which can be offered without due consideration as to costs and reimbursement.
- Clearly too, such often costly medical care must be insured upon (a central insurance mechanism or financing authority to reimburse claims to these cases) so that total coverage of an acceptable quantum can be disbursed to whichever sector is handling these emergencies—so that these would not bankrupt the system.

DRG (Diagnosis-Related Groups)

- Would the DRG (Diagnosis-Related Groups) model work, and if so, have sufficient means testing been done to determine what the actual average costs are?
- Clearly in many countries where this is practiced, constant revision and meticulous attention to constantly shifting details and changes (socioeconomic, medical advances and newer techniques and technology costs and skills development, etc.); are a must.
- Still having said this, most DRG models utilize their allocated funds within shorter periods than have been projected, with unavoidable delays and deferments toward the end of each fiscal year.

Epidemiological infections & Catastrophic diseases must be centrally defined and managed

- Another very pressing issue of very great public concern, is that of catastrophic ailments such as major heart and brain affectations, critical infections (HIV/AIDS; SARS, Nipah, Enterovirus-Coxsackie, Meningitis, poliomyelitis, etc) and cancers.
- These must also be very clearly enunciated and itemized so that they are covered for the ordinary citizen.
- How much coverage and to which extent would also have to be delineated?

ANNEXURE 12

The public must be educated as to rationing delays and prioritization

- Then there is the question of prioritization and rationing—Invariably there would be some degree of waiting and queuing and the question of how long, and triaging sicker patients who need treatment more urgently than others.
- How can we make our public understand that these are necessary evils, which takes place in a finite system of services with finite limited resources, no matter the allocation?
- If we allow a free-for-all access to all-comers whenever and wherever, then clearly costs will balloon and easily reach stratospheric levels of exorbitance and wastes.
- Perhaps the role of the National Health Care Financing Scheme would be able to encompass all such concerns and address these in models, which are not too bureaucratic or doctrinaire, where access can be stymied.

PUBLIC HEALTH ACTIVISM

Past campaigns can inspire future strategies, says Virginia Berridge



BMJ 2007;335:1310-12

A better health care system calls for greater interaction and input from larger segments of society, not secrecy and bureaucracy...

- However, there must be some common ground for which to agree upon a system that works for Malaysia.
- We believe the government and the Ministry of Health must engage all interested parties to fully dialogue on this very pressing issue, so that everyone's interests can be represented.
- A cut-and-paste approach behind several layers of closed doors and OSA dictates will only stifle rigorous and fair debate on this issue which involves and affects everyone.
- Ultimately there will have to be concessions and compromises. But, a user-friendly cost-effective and sustainable system beckons.

Free market health care must be tempered with social justice...

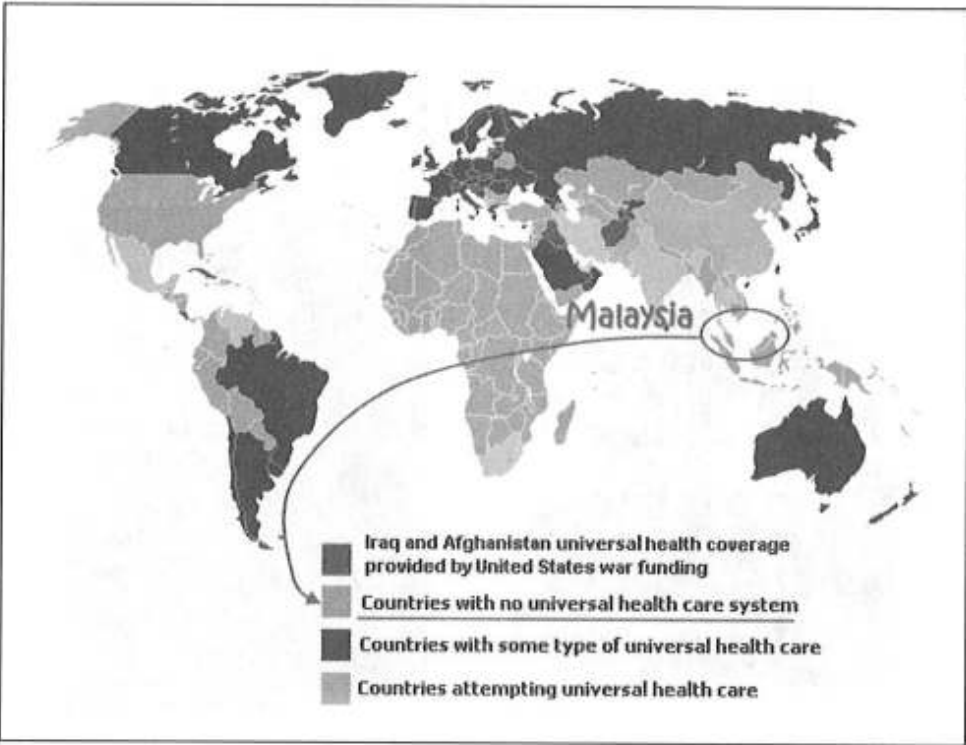
"First, let us embrace market economics - yes - but also recognize that free market economics are passé.

"We need an active role of the state, to help the poorest to break free of the poverty trap, and to help narrow the inequalities of a high-income market society...

"Let us understand that economic solidarity is insurance for all, the poor and the rich...

"Let us resolve to honor our commitments in the fight against poverty, hunger, and disease. Our commitments are small compared with our vast wealth, and the benefits will be vast."

—Jeffrey Sachs, Economics Professor, Columbia University, New York, in the BBC World Service Reith Lecture, 2007.



BMJ

HEALTH IN AN UNEQUAL WORLD

Mexican public health insurance and blood pressure control
Halved mortality from childhood malaria in Guinea-Bissau
Rapid tranquillisation in psychiatric emergencies in India and Brazil

The Global Human Right to Health

What is possible?

Edited by ...

Thank You

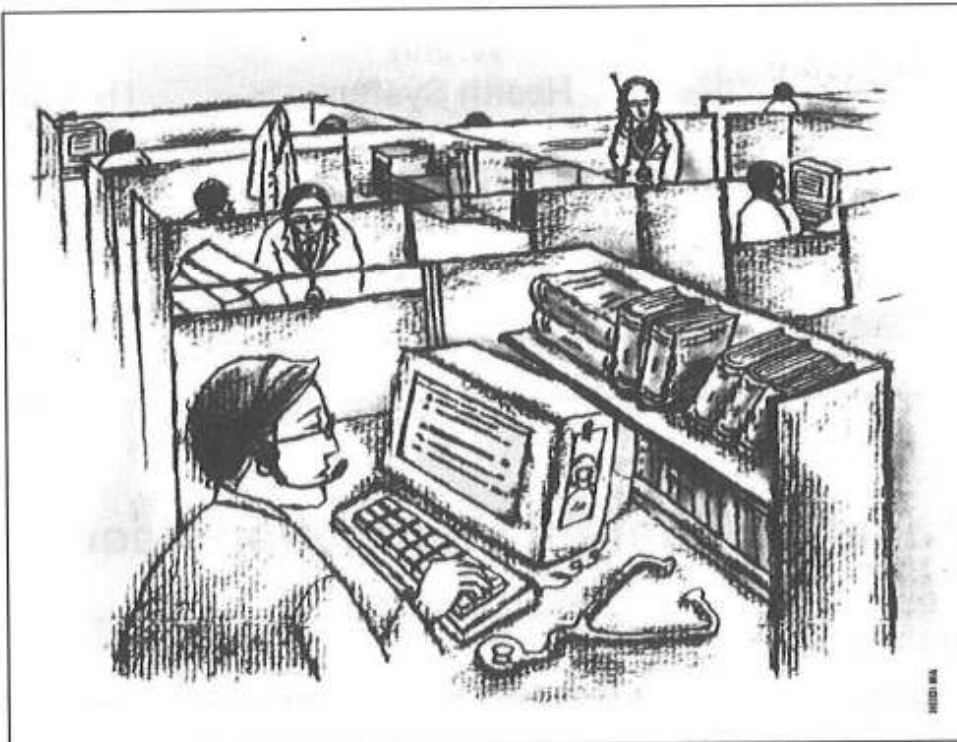
ANNEXURE 12

Eventually, rankings of doctors by success rates (how many patients survive surgery?) and customer satisfaction (how long are patients kept waiting?) will be widely available.

In short the medical establishment is losing control of information.

The result will be to pressure doctors to standardize and deliver the best practice—around the world.*

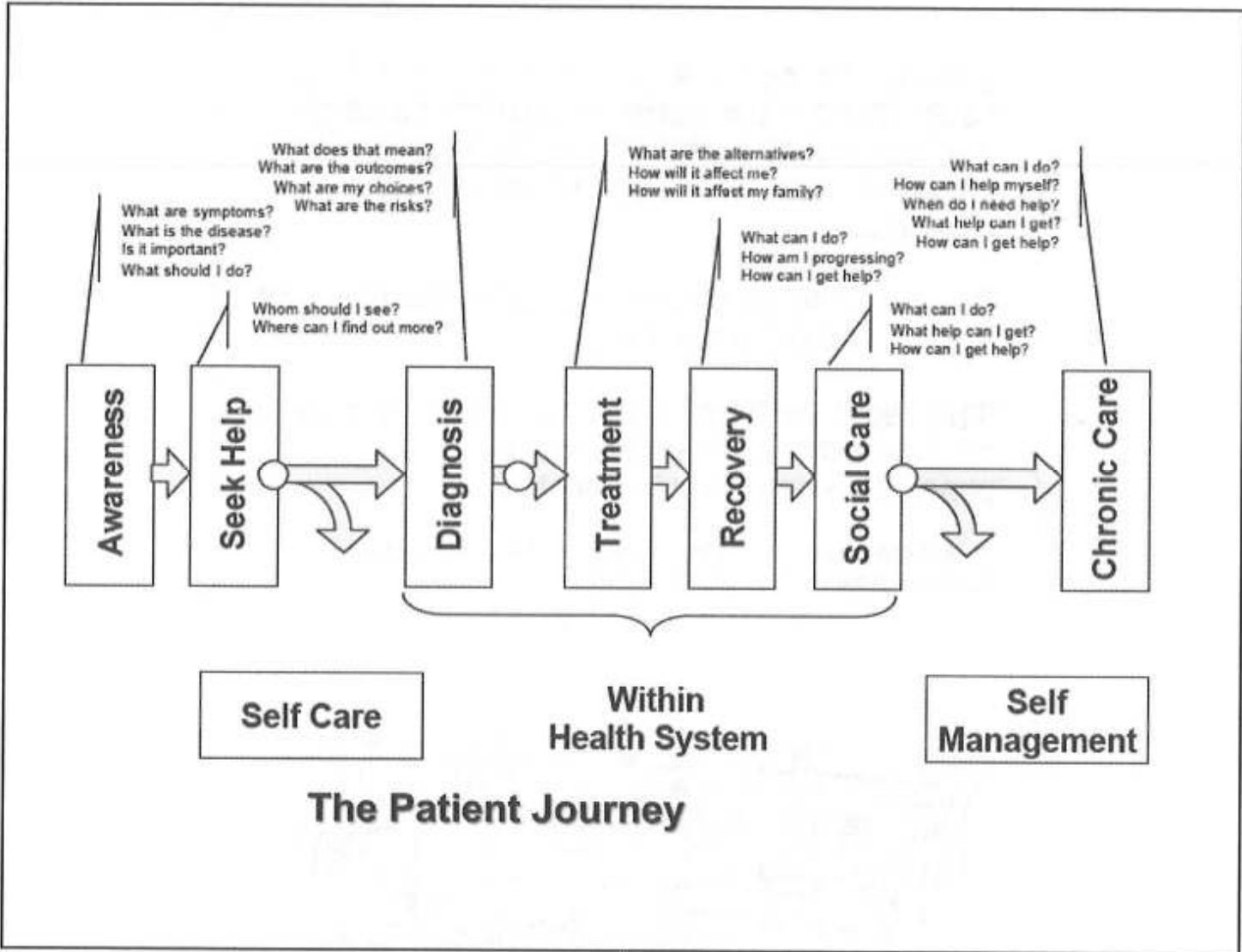
—Hamish McRae in *20/20 Vision: The New Mass Market*; *Fortune Global*, Nov 22, 1999, p48.



2004 Paul Sieghart Memorial Lecture,
Baroness Hale of Richmond:

"... human dignity is all the more important for people whose freedom of action and choice is curtailed, whether by law or by circumstances such as disability. The Convention* is a living instrument ... We need to be able to use it to promote respect for the inherent dignity of all human beings but especially those who are most vulnerable to having that dignity ignored. In reality, the niceties and technicalities with which we have to be involved in the courts should be less important than the core values which underpin the whole Convention."

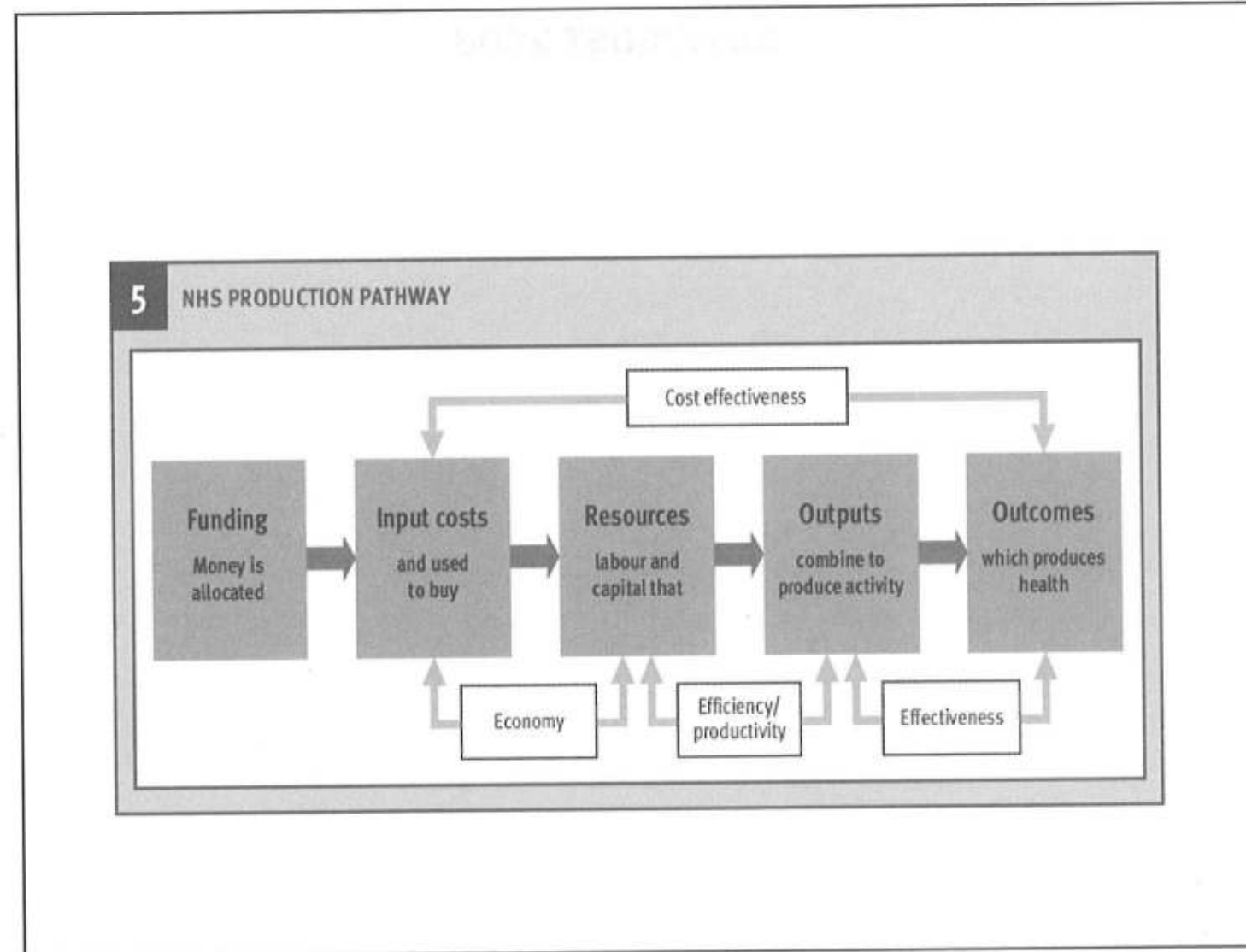
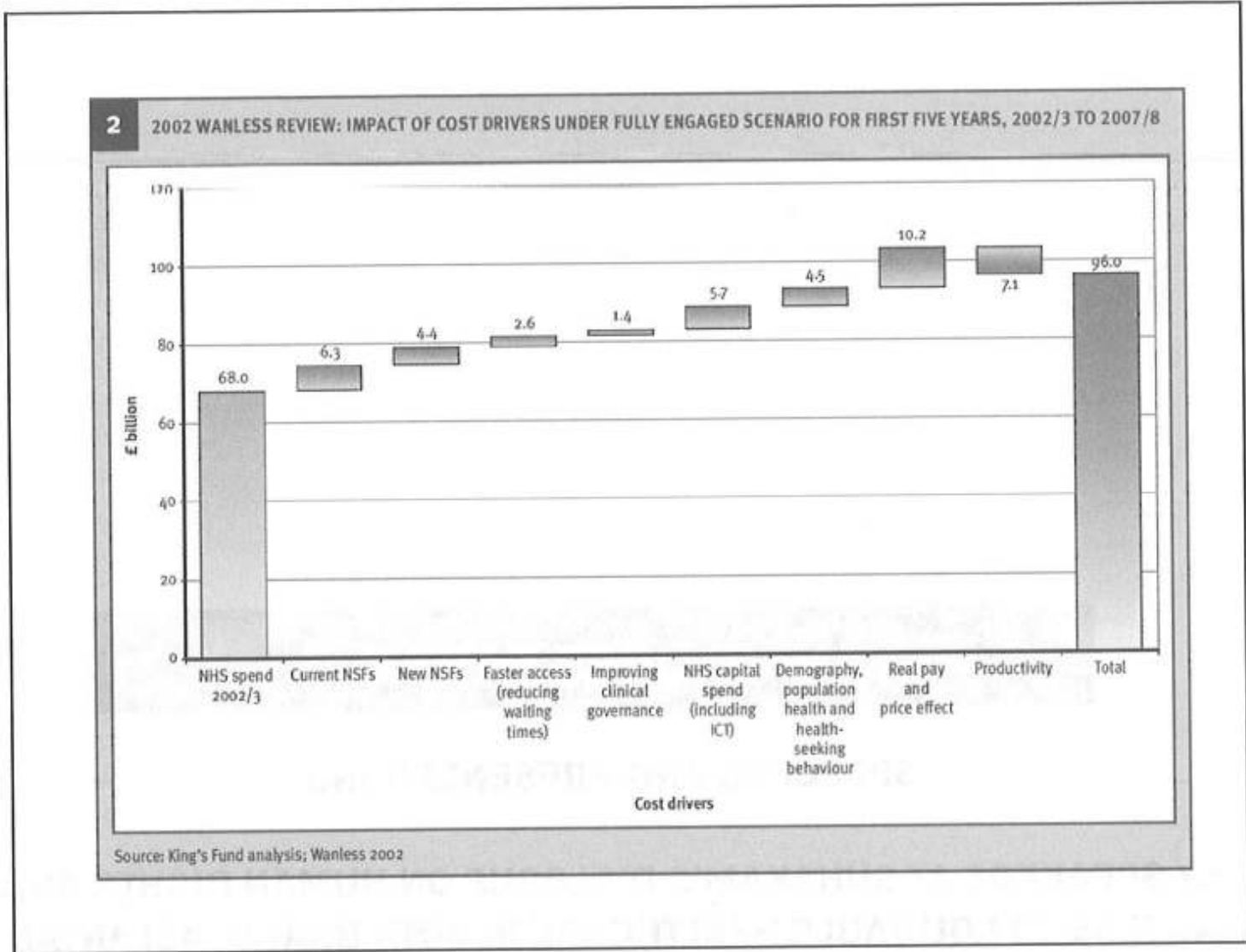
*refers to the European Court of Human Rights, Article 8



Model of Different Information Needs

Information about:	Need
Disease/symptoms	To know that there is a problem, that the condition is treatable
Access to the health system	Where to go, whom to see, what to ask for – should one call/see ambulance, GP, specialist, pharmacist, or alternative healer?
Disease/prognosis	What does the disease mean – what are the outcomes without treatment?
Treatment options	What different treatments are available? Which are covered under public funding, insurance, or need to be paid for privately?
Outcomes	What are likely outcomes? What will they mean in terms of recovery and future life?
Personal involvement	What will patient need to do – either in adherence to the agreed treatment or in future lifestyle to remain healthy?
Lifestyle	How do I live with the condition or disability?
Support options	Where do I seek social care and what technologies are available to help me cope with the condition?
Self-management education	Can I self-treat? This is the basis of the UK 'Expert Patient' initiative.

ANNEXURE 12



ANNEXURES PART C

SPEECHES AND PRESENTATIONS

**BY SPEAKERS AT SUHAKAM'S DIALOGUE ON HUMAN RIGHTS AND
ACCESS TO EQUITABLE HEALTHCARE IN KOTA BHARU, KELANTAN**

10 AUGUST 2008

ANNEXURE 13

WELCOMING REMARKS

BY DATUK DR. DENISON JAYASOORIA

**COMMISSIONER, HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)/
CHAIRPERSON, ECONOMIC, SOCIAL AND CULTURAL RIGHTS WORKING GROUP
(ECOSOC)**

Selamat pagi, salam sejahtera dan juga salam perpaduan.

Bagi pihak pasukan Suruhanjaya Hak Asasi Manusia (SUHAKAM) Malaysia, Datuk Dr. Raj Abdul Karim, Dr. Mohammad Hirman Ritom Abdullah, dan saya sendiri, ingin mengalu-alukan kedatangan semua para hadirin ke sesi Dialog kita pada hari ini.

Para hadirin sekalian,

Biasanya, bila kita berbincang mengenai hak asasi manusia, perbincangan yang amat popular merupakan hak-hak berkaitan sivil dan politik seperti hak-hak untuk bersuara, berhimpun dan sebagainya.

Walau bagaimanapun, perlu diketahui, hak asasi manusia juga berkaitan dengan hak kepada ekonomi, sosial dan kebudayaan. Dan dalam konteks ini, hak kepada kesihatan dan akses kepada perkhidmatan kesihatan yang saksama, merupakan aspek-aspek penting kepada hak ekonomi, sosial dan kebudayaan, dimana isu-isu berkaitan akan dibincangkan pada hari ini.

Para hadirin sekalian,

SUHAKAM telah menubuhkan beberapa kumpulan kerja. Salah satu daripada Kumpulan Kerja tersebut adalah Kumpulan Kerja Hak Ekonomi, Sosial dan Kebudayaan ataupun, *Economic, Social and Cultural Rights Working Group (ECOSOC)*. Antara lain, Kumpulan Kerja ini telah menganjurkan pelbagai dialog seperti ini bagi mendapatkan pandangan, serta mendapatkan isu-isu yang dihadapi oleh masyarakat. Bagi dialog ini, Datuk Dr. Raj, semasa pembentangannya, akan memberi penerangan lanjut tentang aspek yang kita akan bincangkan nanti.

ANNEXURE 13

Bila kita melihat kepada topik kesihatan, kita perlu sedar bahawa tahap kesihatan seseorang memberi kesan kepada kualiti kehidupan (*quality of life*) serta mata pencarian yang mampan (*sustainable livelihood*) seperti pekerjaan dan membasmi kemiskinan, dan kesihatan juga penting untuk membina kapasiti (*capacity building*). Oleh kerana yang demikian, tahap kesihatan seseorang, samada baik atau sebaliknya, akan memberi kesan, bukan sahaja ekonomi keluarga, tetapi juga ekonomi negara.

Tuan-tuan dan puan-puan,

Sekiranya kita berbincang mengenai hak kepada kesihatan di Malaysia, adalah jelas pada peringkat umumnya bahawa Malaysia telah mencapai tahap kesihatan yang amat memuaskan jika dibandingkan dengan 50 tahun dahulu. Ini termasuk liputan penjagaan kesihatan asas, pendidikan kesihatan dan sebagainya.

Walau bagaimanapun, masih terdapat isu-isu yang berkaitan hak kepada kesihatan dan akses kepada perkhidmatan penjagaan kesihatan yang masih perlu ditangani oleh pihak kerajaan dan rakyat secara umumnya.

Dialog ini akan memberikan peluang kepada semua yang hadir pada hari ini untuk memahami apa yang dimaksudkan dengan hak kepada kesihatan dan membincangkan isu-isu yang berkaitan didalam konteks negeri Kelantan. Semasa dialog ini, kita akan mendengar pembentangan kertas kerja mengenai kesihatan dari perspektif umum dan seterusnya isu-isu kesihatan berkaitan kumpulan-kumpulan yang spesifik di Kelantan termasuk masyarakat asli, orang kurang upaya dan golongan miskin. Hasil daripada dialog ini, SUHAKAM akan menyediakan satu laporan yang akan memasukkan segala topik perbincangan dari dialog pada hari ini. Laporan ini juga akan memasukkan segala syor-syor yang dibuat pada hari ini, serta syor-syor SUHAKAM, yang seterusnya akan dimajukan kepada pihak Kerajaan untuk pertimbangan.

Adalah harapan SUHAKAM agar dialog pada hari ini akan mendengar pandangan yang terbuka dan interaksi yang baik. Spesifik bagi dialog SUHAKAM ini, yang penting adalah kita berfikir dan membincangkan isu-isu kesihatan dari perspektif hak asasi manusia. Ini adalah merupakan usaha kita untuk mengenalpasti langkah-langkah yang boleh diambil semua pihak, untuk memperbaiki tahap kesihatan di Kelantan khususnya, dan Malaysia umumnya.

Terima kasih

ANNEXURE 14

HAK ASASI MANUSIA DAN KESIHATAN

BY **DATUK DR. RAJ ABDUL KARIM**

COMMISSIONER, HUMAN RIGHTS COMMISSION OF MALAYSIA (SUHAKAM)

**HAK ASASI MANUSIA DAN
KESIHATAN**

**Datuk Dr. Raj Abdul Karim
Pesuruhjaya
Suruhanjaya Hak Asasi Manusia (SUHAKAM)**

DEFINISI KESIHATAN

● WORLD HEALTH ORGANISATION

'Kesihatan' bermakna **sihat** daripada **aspek** fizikal, mental dan sosial, dan **bukan** sekadar terbebas daripada penyakit, kecacatan dan kecederaan sahaja;

KESIHATAN SEBAGAI HAK ASASI MANUSIA

❶ WORLD HEALTH ORGANISATION

Menikmati kesihatan **ditahap** tertinggi yang boleh dicapai merupakan **hak** asasi setiap manusia tanpa **mengira** bangsa, agama, fahaman politik dan keadaan ekonomi dan sosial;

❷ PERSATUAN BANGSA-BANGSA BERSATU

Hak kepada kesihatan **merangkumi** faktor-faktor sosio-ekonomi yang luas. Faktor-faktor ini menggalakkan keadaan yang membolehkan setiap manusia menjalankan **hidup** yang sihat. Ini termasuk penentu asas (underlying determinants) kepada kesihatan seperti makanan dan **nutrisi**, perumahan, akses kepada air yang selamat dan boleh diminum, sanitasi yang wajar, keadaan pekerjaan yang selamat dan sihat, serta alam persekitaran yang sihat.

UNDANG-UNDANG HAK ASASI MANUSIA ANTARABANGSA YANG BERKAITAN KESIHATAN

❶ Hak kepada Kesihatan dijamin oleh undang-undang hak asasi manusia antarabangsa:

- Artikel 25.1 Perisytiharan **Deklarasi** Hak Asasi Manusia **Sejagat** (UDHR);
- Artikel 12 Kovenan Antarabangsa berkenaan Hak Ekonomi, Sosial dan Kebudayaan (ICESCR);
- Artikel 11.1 (f) dan 12 Konvensyen mengenai Penghapusan Segala Bentuk Diskriminasi terhadap Wanita (CEDAW);
- Artikel 24 Konvensyen mengenai Hak Kanak-Kanak (CRC);
- Artikel 5 (e) (iv) Konvensyen Antarabangsa berkenaan Penghapusan Segala Bentuk Diskriminasi berasaskan Bangsa (ICERD).

❷ Malaysia merupakan negara ahli (state party) kepada CEDAW dan CRC.

ELEMEN-ELEMEN HAK KEPADA KESIHATAN

❶ Ketersediaan (Availability)

❷ Mudah diperolehi (Accessibility)

- Tiada Diskriminasi (Non-Discrimination)
- Akses fizikal (Physical Access)
- Akses Ekonomi (Economic Access)
- Akses kepada maklumat yang berkaitan (Information Accessibility)

❸ Boleh terima (Acceptability)

❹ Mutu (Quality)

ANNEXURE 14

**KERJA-KERJA SUHAKAM YANG
BERKENAAN HAK KEPADA KESIHATAN (1)**

- Seminar dan Laporan Human Rights Approach to the Millennium Development Goals(MDGs) - Matlamat MDGs ke 4, 5 & 6 berkaitan dengan kesihatan;
- Forum Umum dan Laporan "Ageing with Dignity: Rights of Older Persons";
- Forum Umum dan Laporan "The Right to Health: Achieving Health related MDGs";
- Kajian dan Laporan "Penan in Ulu Belaga: Right to Land and Socio-Economic Development";
- Mesyuarat bersama NGO dan Mesyuarat bersama KKM untuk membincangkan isu-isu berkaitan perancangan kerajaan untuk melaksanakan Mekanisma Pembiayaan Penjagaan Kesihatan Negara (National Health Financing Mechanism).

**KERJA-KERJA SUHAKAM YANG
BERKENAAN HAK KEPADA KESIHATAN (2)**

- Kerja – Kerja Semasa
 - Kajian terperinci bertajuk "The Human Rights Approach to the MDGs: Malaysia's Achievement on Health related MDGs 4, 5 & 6;
 - Kajian "Mengaplikasi Matlamat Pembangunan Milenium ke atas komuniti mikro di Malaysia:
 - Kg. Beladin, Pusa, Sarawak;
 - Kg. Telaga, Pitas, Sabah;
 - Perkampungan di Kelantan
 - Dialog "Human Rights and Access to Equitable Healthcare"

**PENCAPAIAN UMUM
KESIHATAN DI MALAYSIA**

JANGKA HAYAT
SEMASA KELAHIRAN DI MALAYSIA

Jangka hayat semasa lahir di Malaysia menunjukkan peningkatan.

Tahun	Tahap HD	Kedudukan HDI Malaysia	Jangka Hayat semasa Kelahiran
HDR 2003	Medium	58	72.8 (2001)
HDR 2004	Medium	59	73.0 (2002)
HDR 2005	Medium	61	73.2 (2003)
HDR 2006	High	61	73.4 (2004)
HDR 2007/2008	High	63	73.7 (2005)

HD: Pembangunan Manusia (Human Development)
HDR: Laporan Pembangunan Manusia (Human Development Report)
HDI: Indeks Pembangunan Manusia (Human Development Index)

Sumber: Human Development Report, various years

PETUNJUK KESIHATAN TERPILIH

Peratusan kematian bayi, kanak-kanak dan ibu mengandung juga menurun

TABLE 1: SELECTED INDICATORS OF HEALTH STATUS, 2000 AND 2005

Indicator	2000	2005
Life Expectancy at Birth (in years)		
Male	70.0	70.6
Female	75.1	76.4
Crude Birth Rate (per 1,000 population)	24.5	21.0
Crude Death Rate (1,000 population)	4.4	4.5
Infant Mortality Rate (per 1,000 live births)	6.6	5.8
Toddler Mortality Rate (per 1,000 toddler population)	0.6	0.5
Maternal Mortality Rate (per 1,000 live births)	0.3	0.3
Perinatal mortality Rate (per 1,000 total births)	7.5	6.8
Neonatal Mortality Rate (per 1,000 live births)	3.8	3.8

HASIL UMUM SUHAKAM BERKENAAN ISU KESIHATAN DI MALAYSIA

- Kajian SUHAKAM yang membawa pendekatan hak asasi manusia terhadap Matlamat Pembangunan Milenium @ Millennium Development Goals (MDGs) telah mendapati:
 - Secara umumnya, tahap kesihatan di **Malaysia** adalah memberangsangkan;
 - Walaubagaimanapun, terdapat kumpulan-kumpulan terpinggir - seperti Orang Asli/Asal, masyarakat dan keluarga yang hidup dalam **kemiskinan, masyarakat yang hidup di kawasan terpencil, warga emas, ibu tunggal, orang kurang upaya, serta rakyat asing, dan 'pelarian' - yang tidak mempunyai akses, ataupun peluang untuk mengakses** perkhidmatan kesihatan;
 - Kini, Malaysia perlu bergerak ke hadapan untuk memastikan semua individu di negara ini, terutamanya yang terpinggir, mendapat akses kepada kesihatan yang sempurna,

DIALOG "HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE"

DIALOG "HUMAN RIGHTS AND ACCESS TO EQUITABLE HEALTHCARE"

- Dialog SUHAKAM bertajuk "Human Rights and Access to Equitable Healthcare" merupakan aktiviti **lanjutan** SUHAKAM daripada kajian yang membawa pendekatan hak asasi manusia terhadap **Matlamat** Pembangunan Milenium @ Millennium Development **Goals** (MDGs):
 - MDG 1: Membasmi kemiskinan dan kelaparan;
 - MDG 2: Mencapai pendidikan rendah yang universal;
 - MDG 3: Meningkatkan kesaksamaan gender dan memperkasakan wanita;
 - MDG 4: Mengurangkan mortaliti kanak-kanak;
 - MDG 5: Memperbaiki kesihatan ibu bersalin;
 - MDG 6: Mencegah HIV/AIDS, malaria dan lain-lain penyakit;
 - MDG 7: Memastikan alam sekitar yang mampan;
 - MDG 8: Mewujudkan perkongsian global untuk pembangunan.

**OBJEKTIF DIALOG “HUMAN RIGHTS AND
ACCESS TO EQUITABLE HEALTHCARE”**

● **OBJEKTIF**

- Untuk mendapatkan pandangan dan pendapat umum dalam mempertingkatkan kapasiti negara untuk menyediakan **perkhidmatan** kesihatan **yang** bermutu, mampan dan samarata untuk populasi **negara** dengan menekankan kesihatan **sebagai** hak **asasi** manusia;
- Untuk mengenalpasti **aspek-aspek** yang boleh di **ambilkira** oleh **kerajaan** semasa melaksanakan program **dalam** usahanya untuk menyediakan perkhidmatan **kesihatan** yang bermutu, mampan dan samarata, **dengan** menekankan hak kumpulan-kumpulan terpinggir.

**DIALOG “HUMAN RIGHTS AND
ACCESS TO EQUITABLE HEALTHCARE”**

- Dialog pertama – Kuching, Sarawak
(5 November 2007);
- **Dialog kedua** - Kota Kinabalu Sabah
(8 Januari 2008);
- Dialog ketiga – Kota Bharu, Kelantan
(10 Ogos 2008)

**HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (1)**

- **Akses fizikal dan ekonomi kepada perkhidmatan dan fasiliti kesihatan yang serba kurangan, terutama dikalangan penduduk kawasan pedalaman serta masyarakat miskin dikawasan pedalaman dan bandar;**



Klinik Desa di Kampung Beladin, Pusa, Sarawak, yang dilawat SUHAKAM pada bulan Februari 2008.

ANNEXURE 14

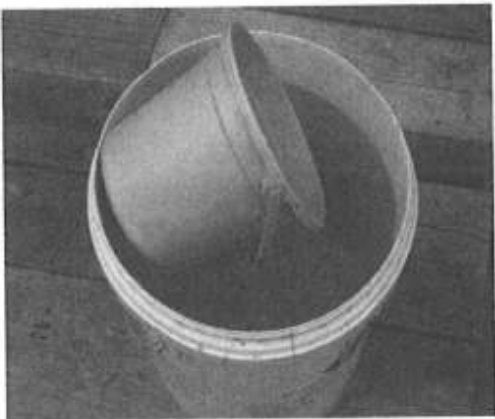
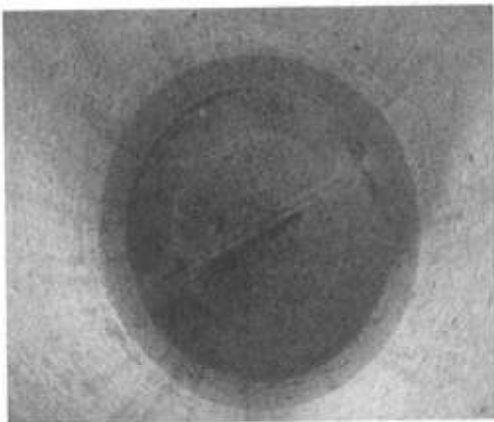
TABLE 3: FACILITIES PROVIDED BY MINISTRY OF HEALTH, 2000 AND 2005

Type of Facility	Number		Ratio of facilities to population	
	2000	2005	2000	2005
Rural Health Facilities				
Community Clinics	1,924	1,900	1:4,640	1:5,085
Health Clinics	474	495	1:17,506	1:19,520
Mobile Units ¹	204	200	1:43,764	1:48,312
Mobile Dental Clinics	8	30		
Urban Health facilities				
Health Clinics ²	473	462	1:30,797	1:35,638
Patient Care Services				
Hospitals	119	128	1:197,436	1:204,140
Total Beds	34,573	35,210	1:679	1:742
Dental Units ³	2,597	3,340	1:9,047	1:7,823

Source: Ninth Malaysia Plan, 2006-2010
Notes: 1 Refers to dispensary services, village health teams, flying doctor services and mobile dental services.
2 Includes maternal and child health clinics
3 Refer to dental chairs in Government clinics

HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (2)

- Terdapat masyarakat kampung, terutamanya dikawasan terpencil yang tidak mempunyai akses yang sempurna kepada penentu asas (underlying determinants) kesihatan.



Lawatan SUHAKAM ke Kampung Beladin, Pusa, Sarawak, mendapati penduduk kampung menggunakan air hujan untuk di minum (kiri). Walaupun terdapatnya bekalan air paip, kualiti air adalah sangat rendah (kanan)

**HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (3)**

- Terdapat perkampungan yang tidak mempunyai akses yang lengkap kepada perkhidmatan kesihatan dan rehabilitasi untuk anak-anak kurang upaya.



**HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (4)**

- Kurang kesedaran umum mengenai kepentingan kebersihan dan peranan masyarakat dalam menjaga kesihatan;



Kampung Beladin, Pusa, Sarawak, yang dilawat SUHAKAM pada bulan Februari 2008

**HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (5)**

- Peningkatan kos perkhidmatan kesihatan;
- Peruntukan Belanjawan Kerajaan untuk kesihatan adalah rendah;
- Perkhidmatan pakar yang terhad di sektor awam berkaitan disebabkan perpindahan pakar perubatan dari sektor awam ke sektor swasta;

**HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (6)**

- Terdapat sesetengah yang berpendapat perkhidmatan kesihatan yang disediakan di sektor awam adalah bermutu rendah. Ini termasuk fasiliti serta layanan terhadap pesakit / pengguna;
- Kurang pengetahuan mengenai perkhidmatan yang disediakan di pusat-pusat kesihatan dikalangan masyarakat;
- Masyarakat tidak mempunyai akses kepada maklumat mengenai intipati Mekanisma Pembiayaan Perkhidmatan Kesihatan Negara;
- Kekurangan penglibatan atau peluang untuk melibatkan masyarakat umum dalam proses perancangan dan pembentukan program dan polisi berkaitan kesihatan;

**HASIL AWAL/PENDAPAT
DIALOG SABAH DAN SARAWAK (7)**

- Peningkatan Kes-Kes Jangkitan HIV/AIDS dan stigma dikalangan orang-orang yang dijangkiti HIV/AIDS;

	1986 - 2004			2005			1986 - 2005		
	HIV	AIDS	MATI	HIV	AIDS	MATI	HIV	AIDS	MATI
Perlis	851	347	185	129	50	27	980	397	212
Kedah	4,180	560	354	268	9	3	4,448	569	357
P Pinang	2,537	539	350	251	50	50	2,788	589	400
Perak	4,325	901	775	399	99	77	4,724	1,000	852
Selangor	8,622	611	406	829	173	130	9,451	784	536
W Persekutuan	4,531	1,659	1,418	518	411	162	5,049	2,070	1,580
N Sembilan	5,848	577	426	195	77	48	6,043	654	474
Melaka	2,108	555	486	154	31	19	2,262	586	505
Johor	11,986	1,341	928	671	108	66	12,657	1,449	994
Pahang	6,543	846	944	786	76	68	7,329	922	1,012
Terengganu	6,448	535	440	486	42	32	6,934	577	472
Kelantan	5,639	622	433	1,239	0	255	6,878	622	688
Sarawak	448	195	79	104	50	24	552	245	103
Sabah	373	113	34	91	45	23	464	158	57
MALAYSIA	64,439	9,401	7,258	6,120	1,221	984	70,559	10,622	8,242

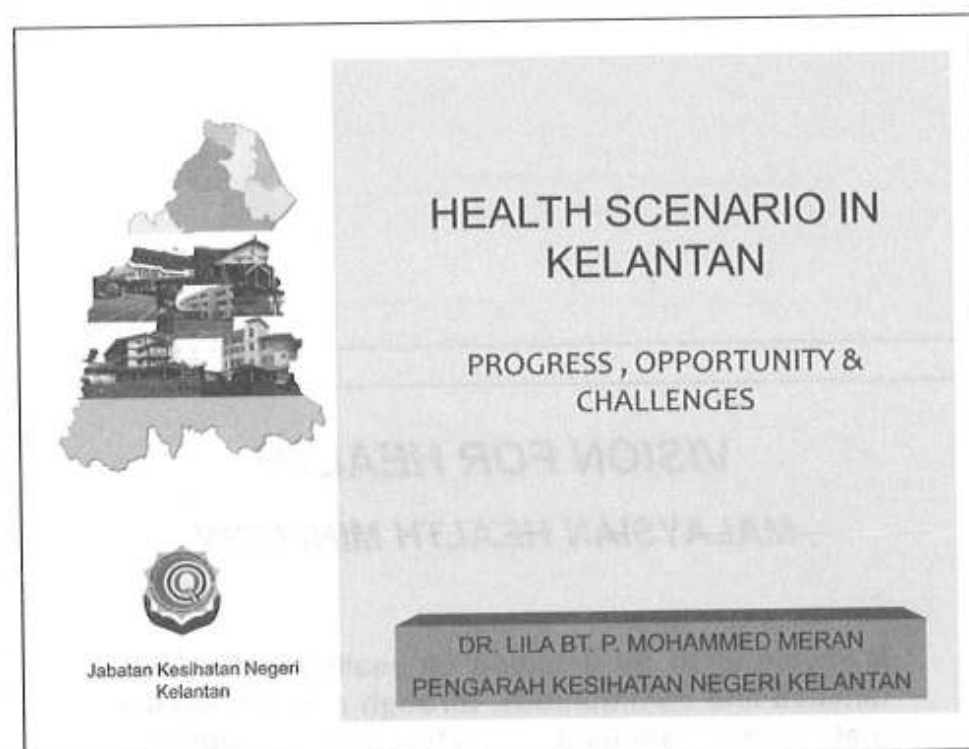
KESIMPULAN

- Walaupun Malaysia telah mencapai tahap kesihatan umum **yang memberangsangkan, kini, fokus harus diberikan kepada kumpulan dan individu terpinggir diseluruh Malaysia untuk memastikan setiap orang dapat menikmati hak kepada kesihatan dan perkhidmatan yang berkaitan;**
- Dialog SUHAKAM bertajuk “Human Rights and Access to Equitable Healthcare” akan memberikan peluang kepada masyarakat umum untuk mengenalpasti kumpulan-kumpulan **terpinggir tersebut serta mengutarakan pendapat berkaitan langkah-langkah yang boleh diambil oleh kerajaan untuk menangani isu-isu berkaitan kesihatan;**
- Semua input yang diberikan oleh peserta Dialog akan **dimajukan kepada pihak kerajaan.**

ANNEXURE 15

HEALTH SCENARIO IN KELANTAN - PROGRESS, OPPORTUNITIES AND CHALLENGES

BY DR. LILA BT. P. MOHAMMED MERAN
DIRECTOR, KELANTAN HEALTH DEPARTMENT



CONTENT

- Introduction
- Health status
 - Mortality and morbidity
 - Progress
 - Opportunities
 - Challenges
- Conclusion

INTRODUCTION

VISION FOR HEALTH MALAYSIAN HEALTH MINISTRY

Malaysia is to be a nation of healthy individuals, families and communities, through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer friendly, 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.

3/28/2011

4

MISSION OF MALAYSIAN HEALTH MINISTRY

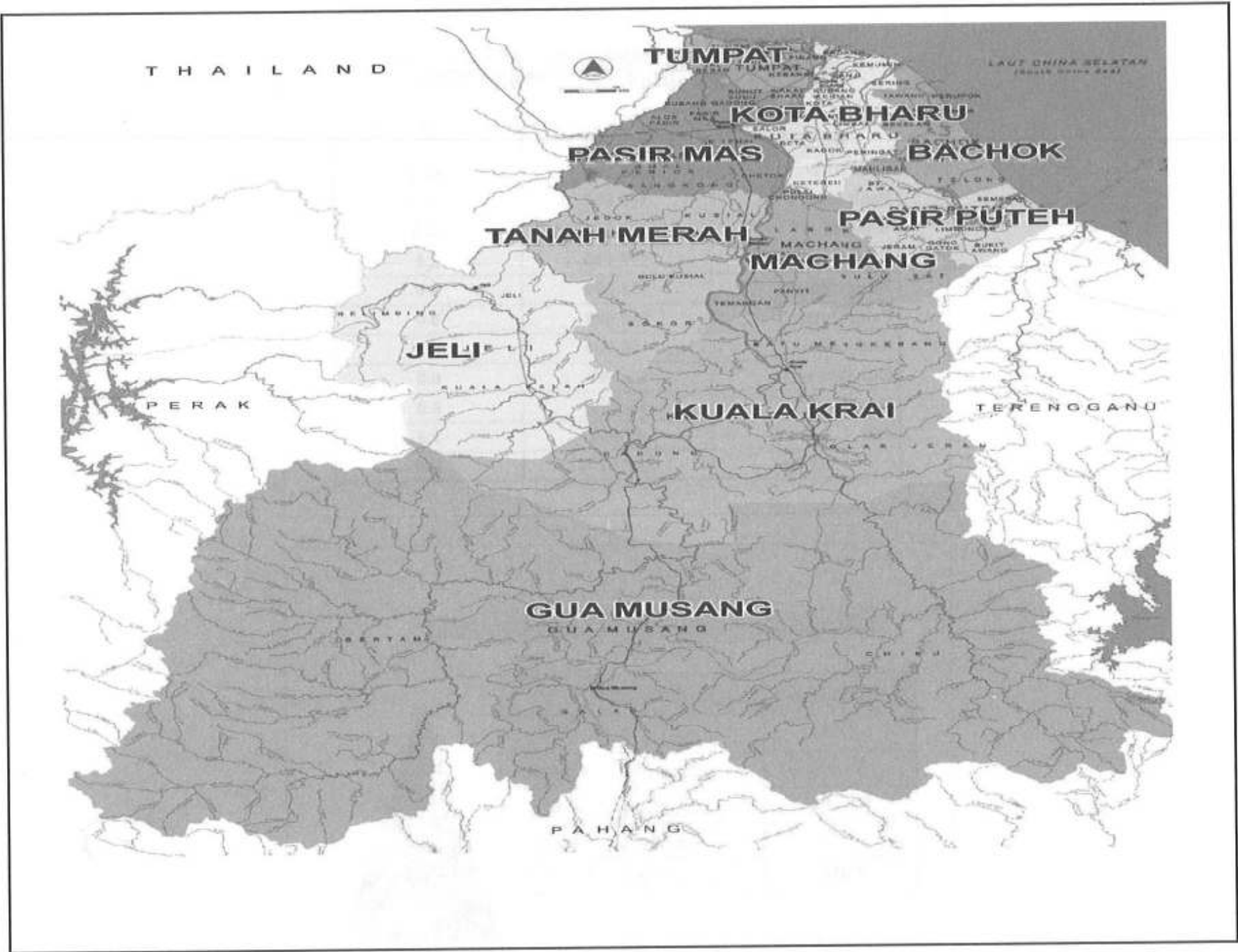
The mission of Ministry of Health is to build partnership for health to facilitate and support the people to:

- Attain fully their potential in health.
- Motivate them to appreciate health as a valuable asset.
- Take positive action to improve further and sustain their health status to enjoy a better quality of life.

3/28/2011

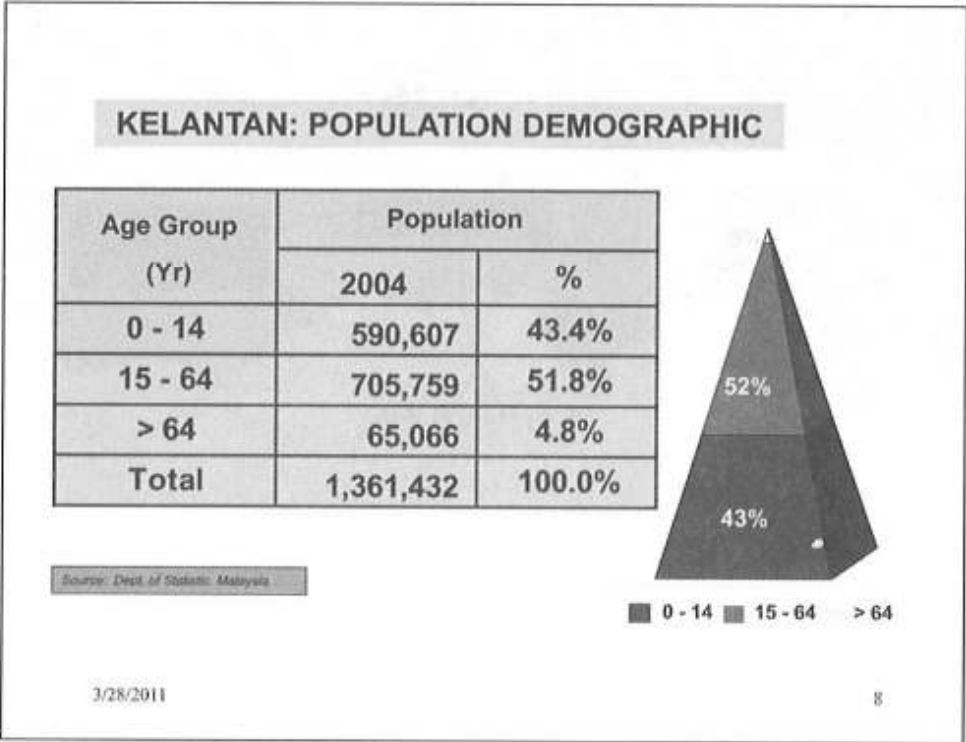
5

ANNEXURE 15



ANNEXURE 15

POPULATION OF KELANTAN BY DISTRICT		
DISTRICT	POPULATION	%
Kota Bharu	452,100	30.6
Pasir Mas	187,000	12.6
Tumpat	152,000	10.3
Bachok	124,000	8.4
Tanah Merah	117,900	8.0
Pasir Puteh	118,500	8.0
Kuala Krai	106,900	7.2
Gua Musang	89,200	6.0
Machang	89,500	6.0
Jeli	42,000	2.8
TOTAL	1,479,700	100

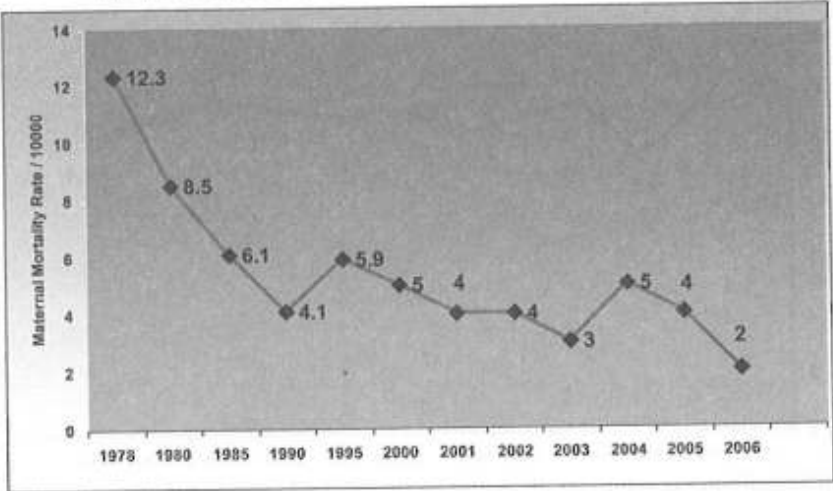


HEALTH STATUS

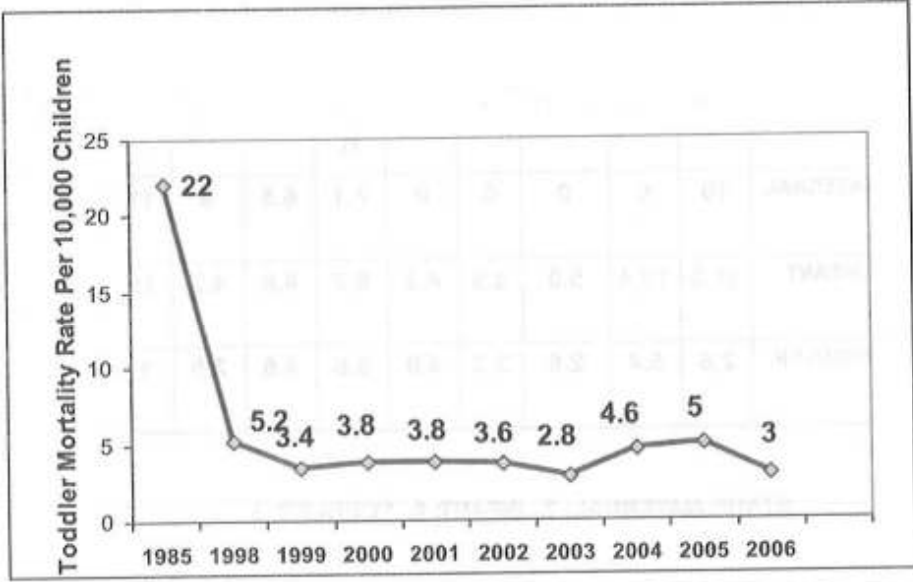
ANNEXURE 15

MORTALITY AND MORBIDITY
IN KELANTAN

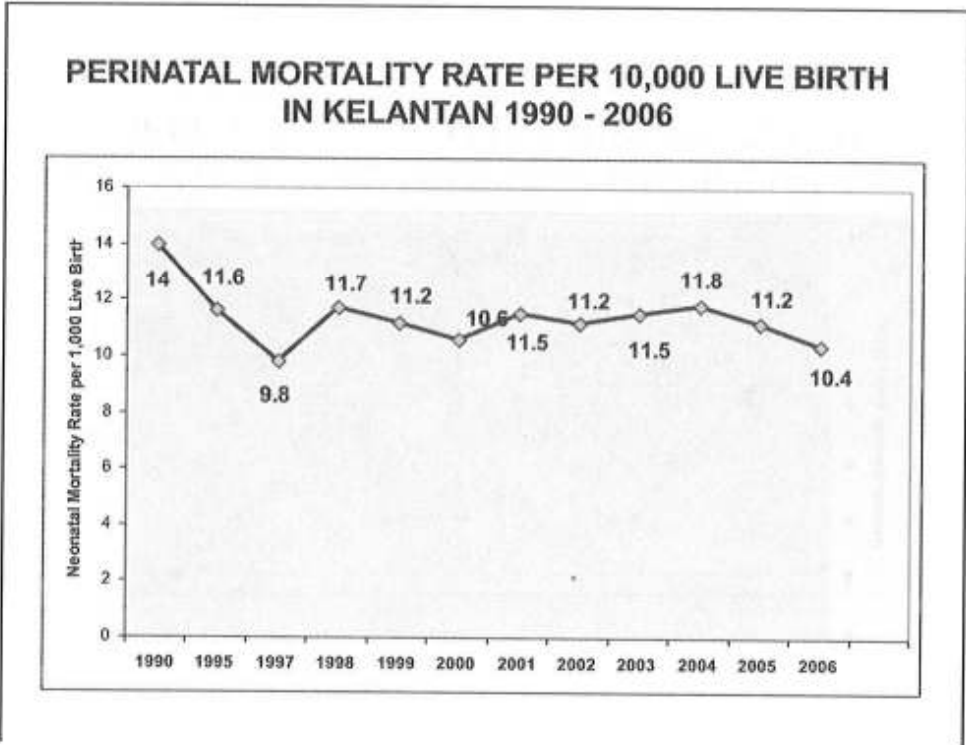
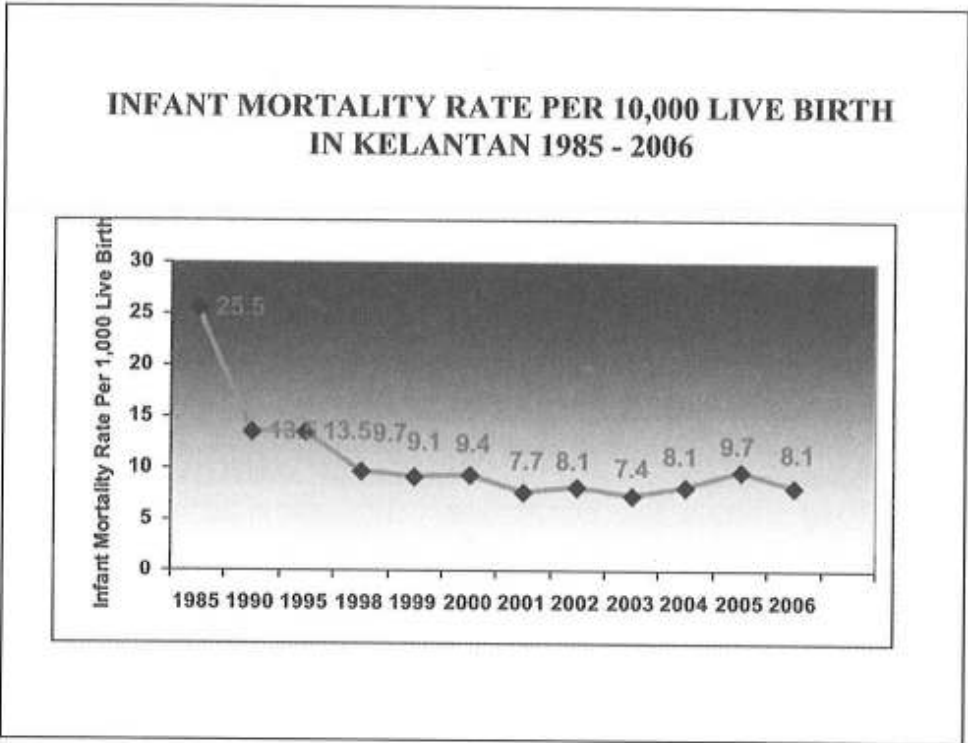
MATERNAL MORTALITY RATE PER 10,000
LIVE BIRTH IN KELANTAN 1978 - 2006



TODDLER MORTALITY RATE PER 10,000 CHILDREN
IN KELANTAN 1985 - 2006



ANNEXURE 15

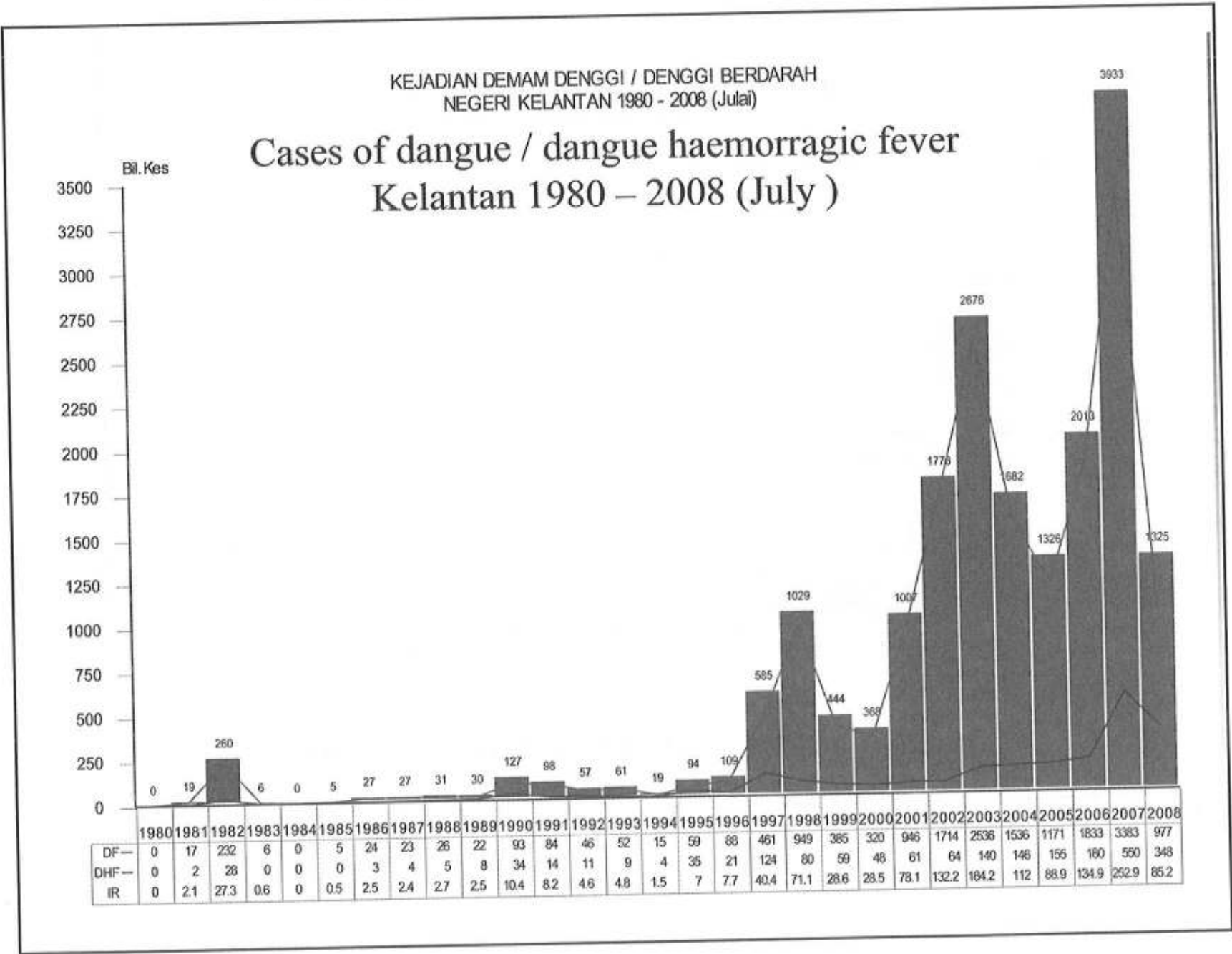
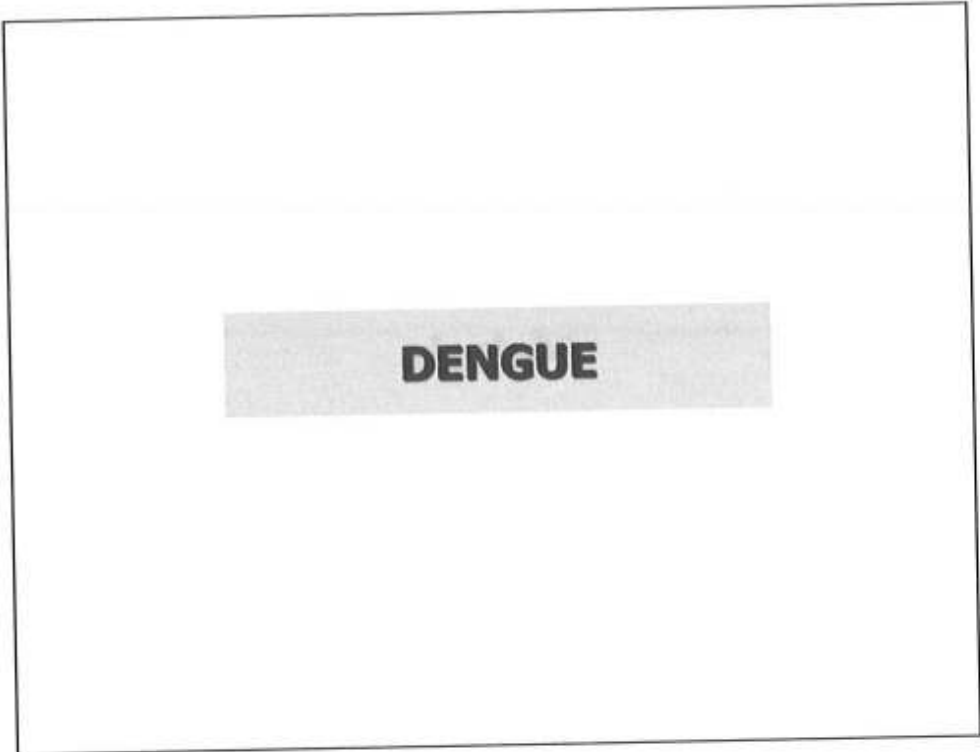


MORTALITY RATE BY DISTRICT 2006

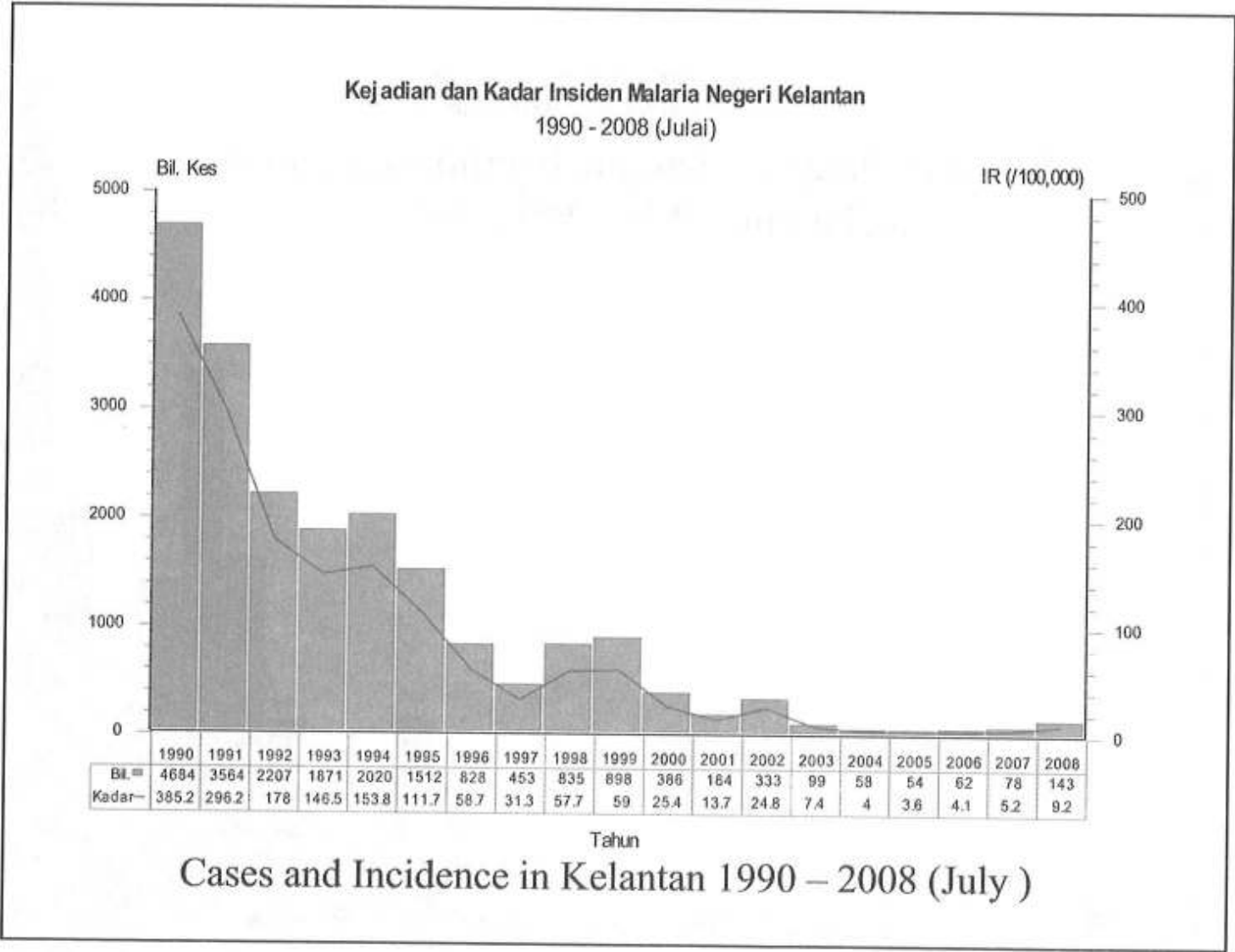
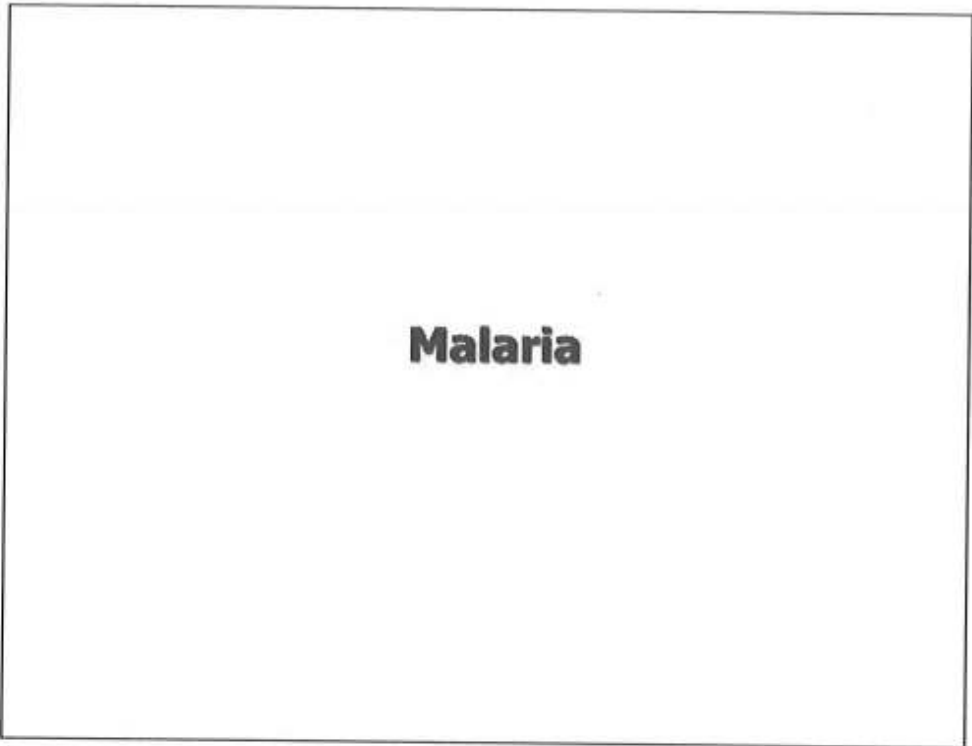
MORTALITY	GM	KK	MCG	TM	PP	BC K	PM	JL	TPT	KB
MATERNAL	10	0	0	0	0	7.1	6.5	0	11.8	5.7
INFANT	11.5	10.4	5.0	3.9	4.3	6.7	9.6	4.7	11.5	5.9
TODDLER	2.6	5.4	2.6	3.3	4.0	5.6	4.6	2.5	1.6	1.0

STATE: MATERNAL: 2, INFANT: 8, TODDLER: 3

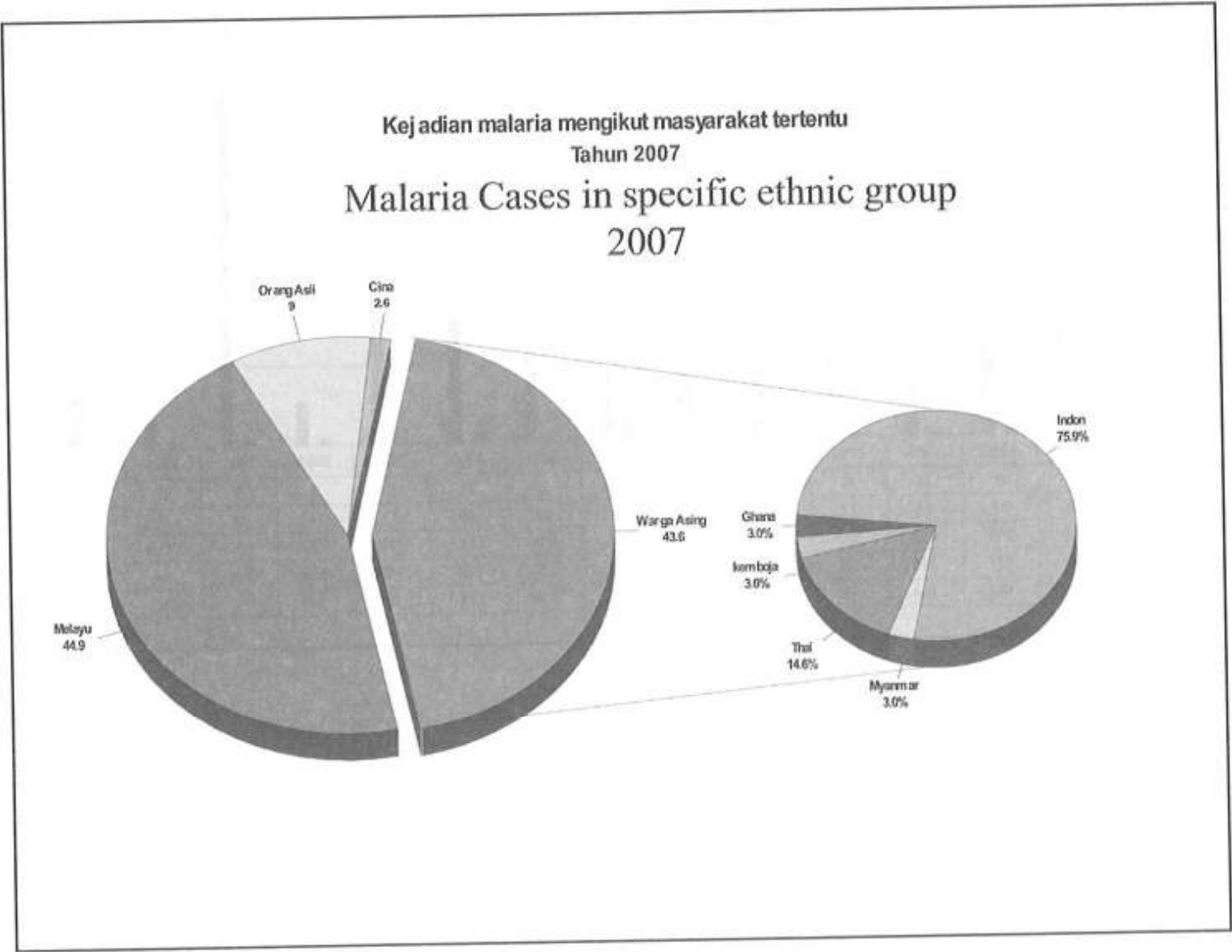
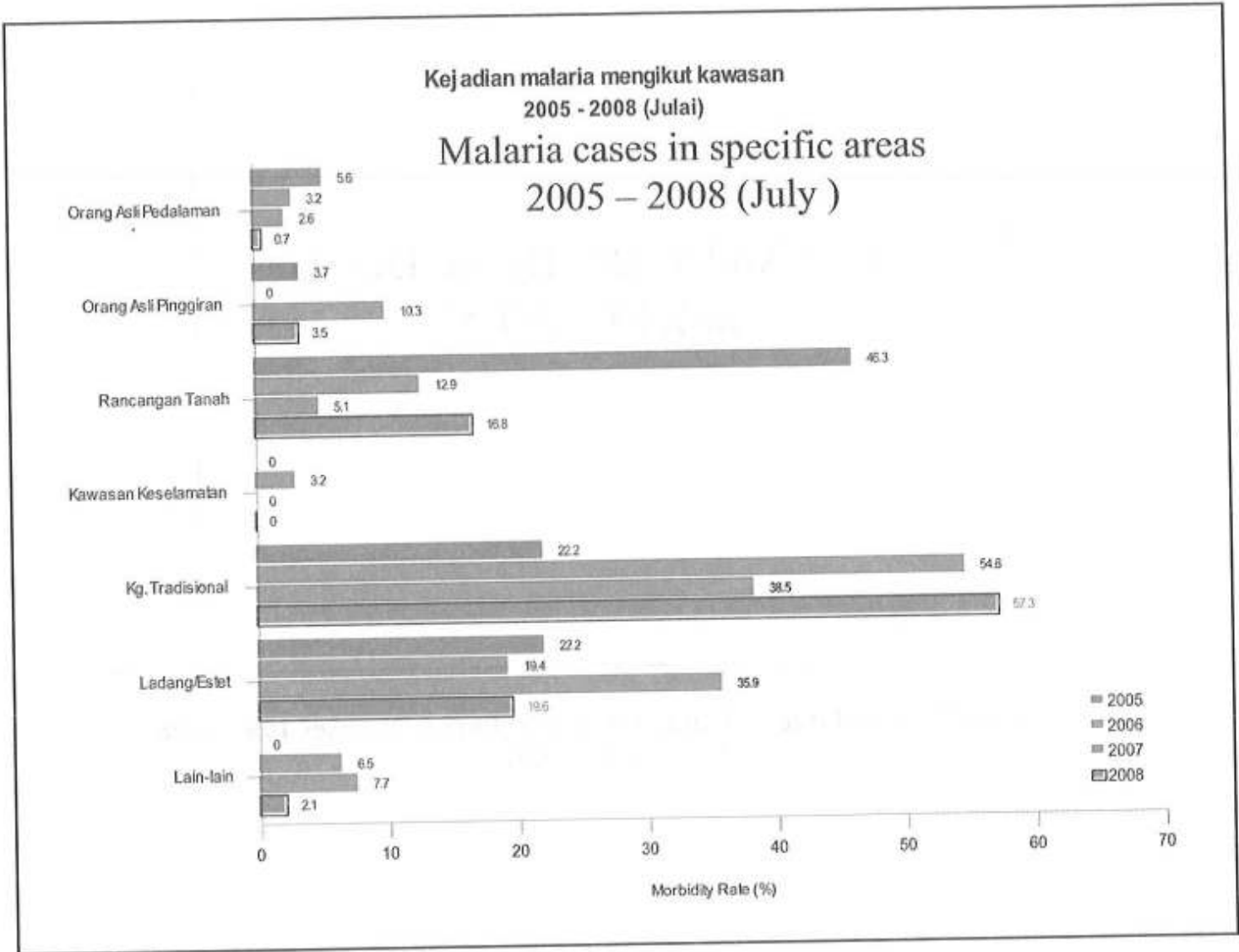
ANNEXURE 15



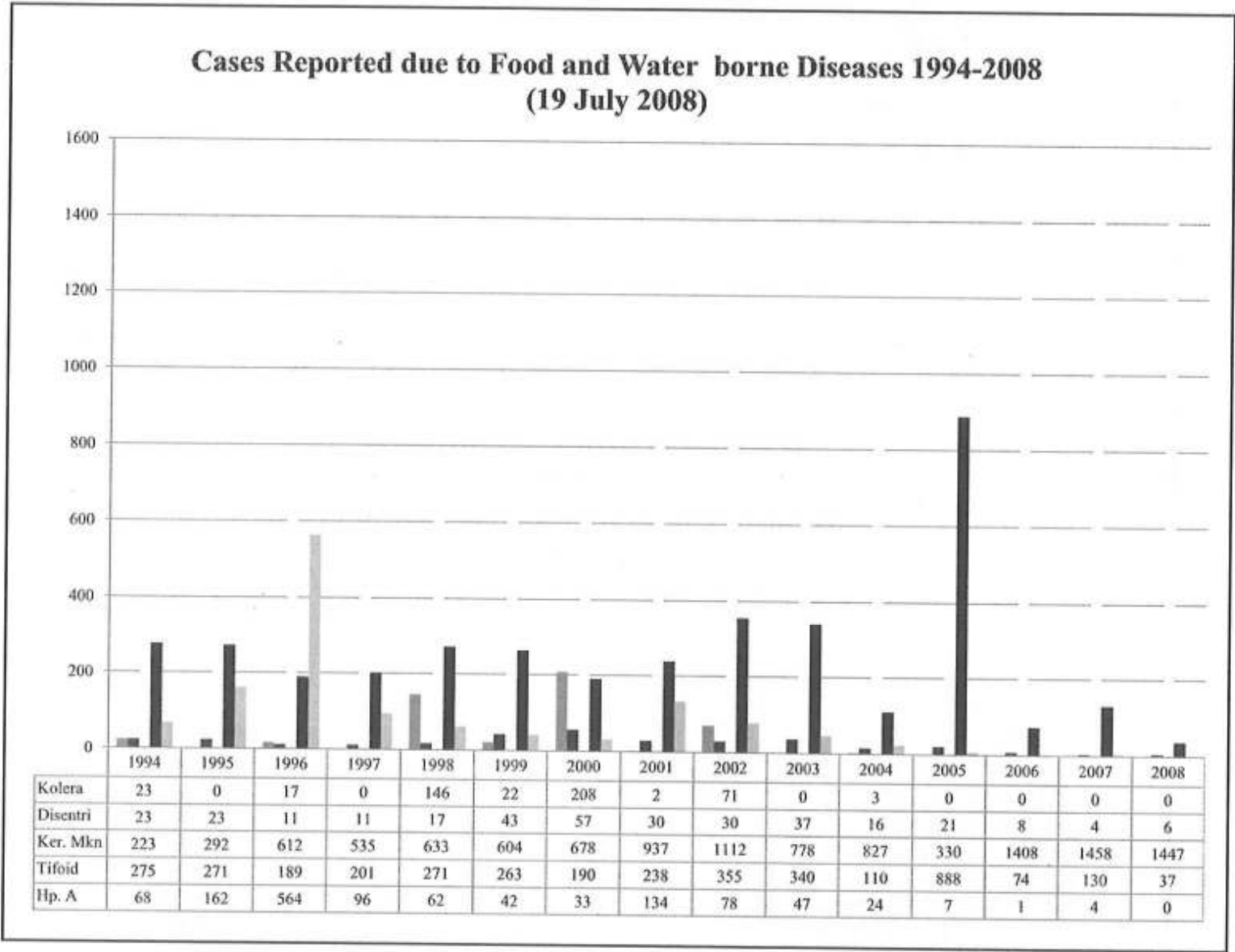
ANNEXURE 15



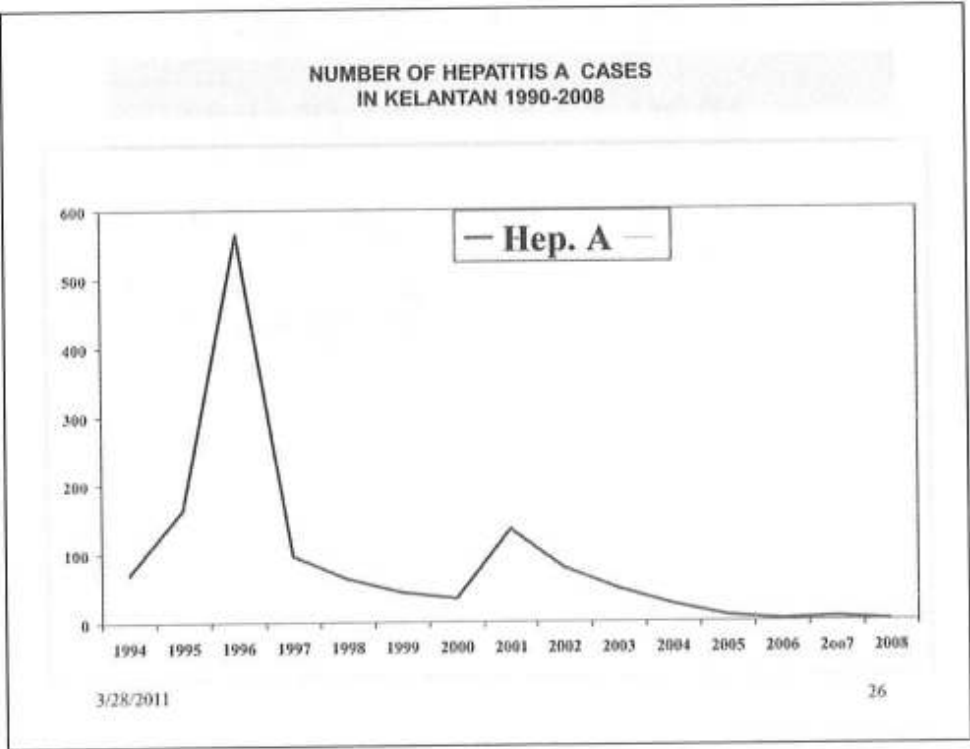
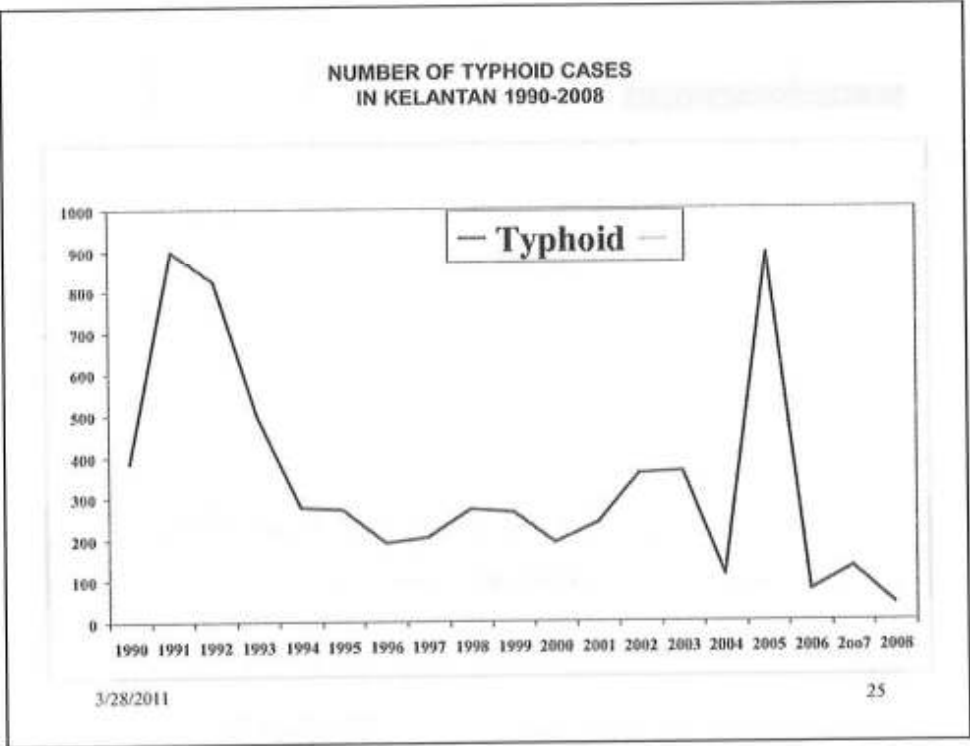
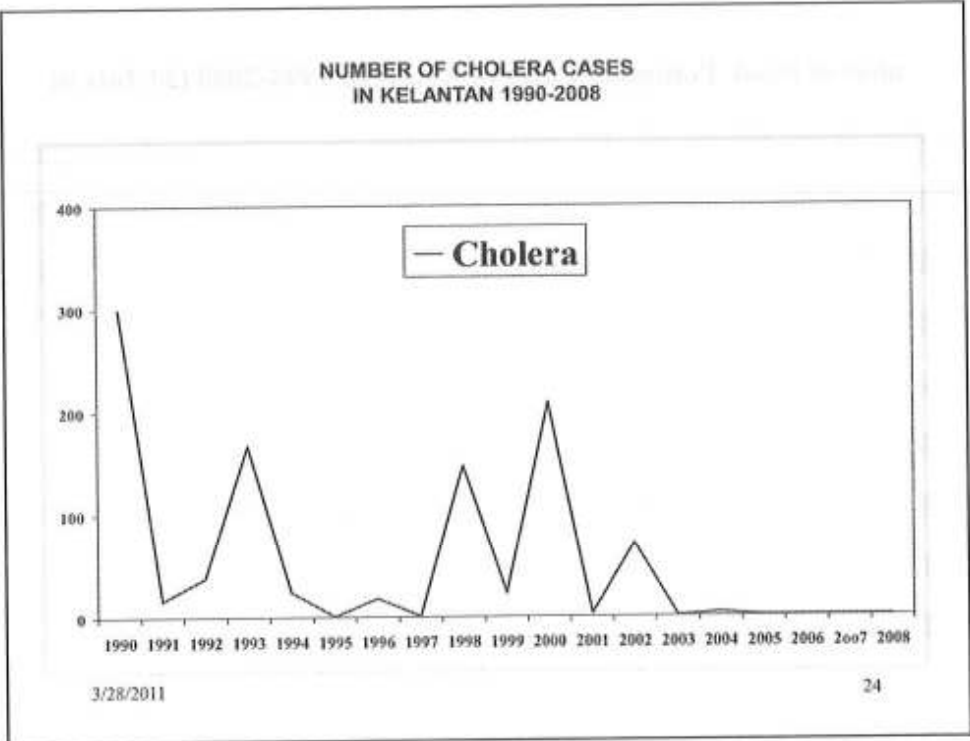
ANNEXURE 15

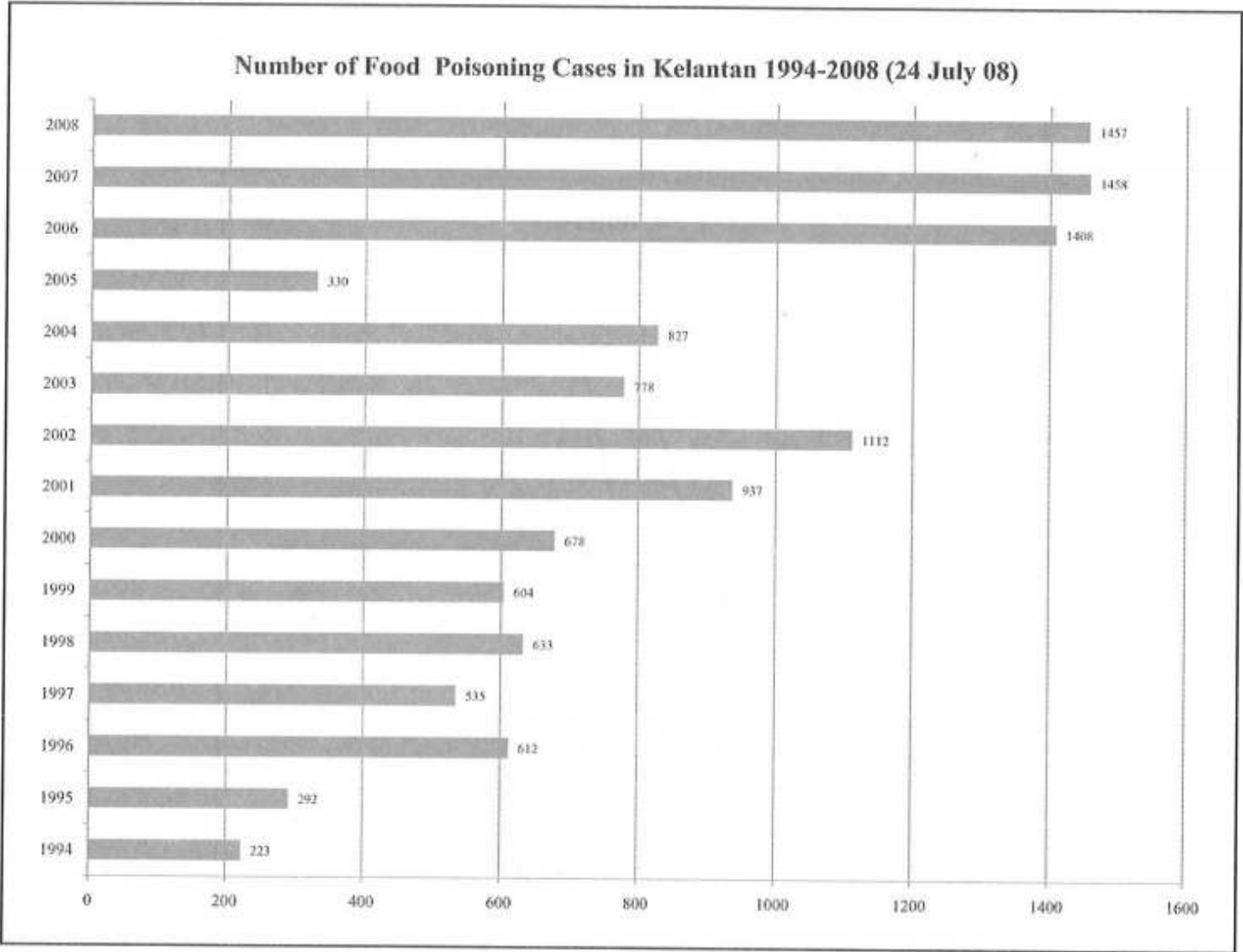


Food And Water Borne Diseases
in KELANTAN



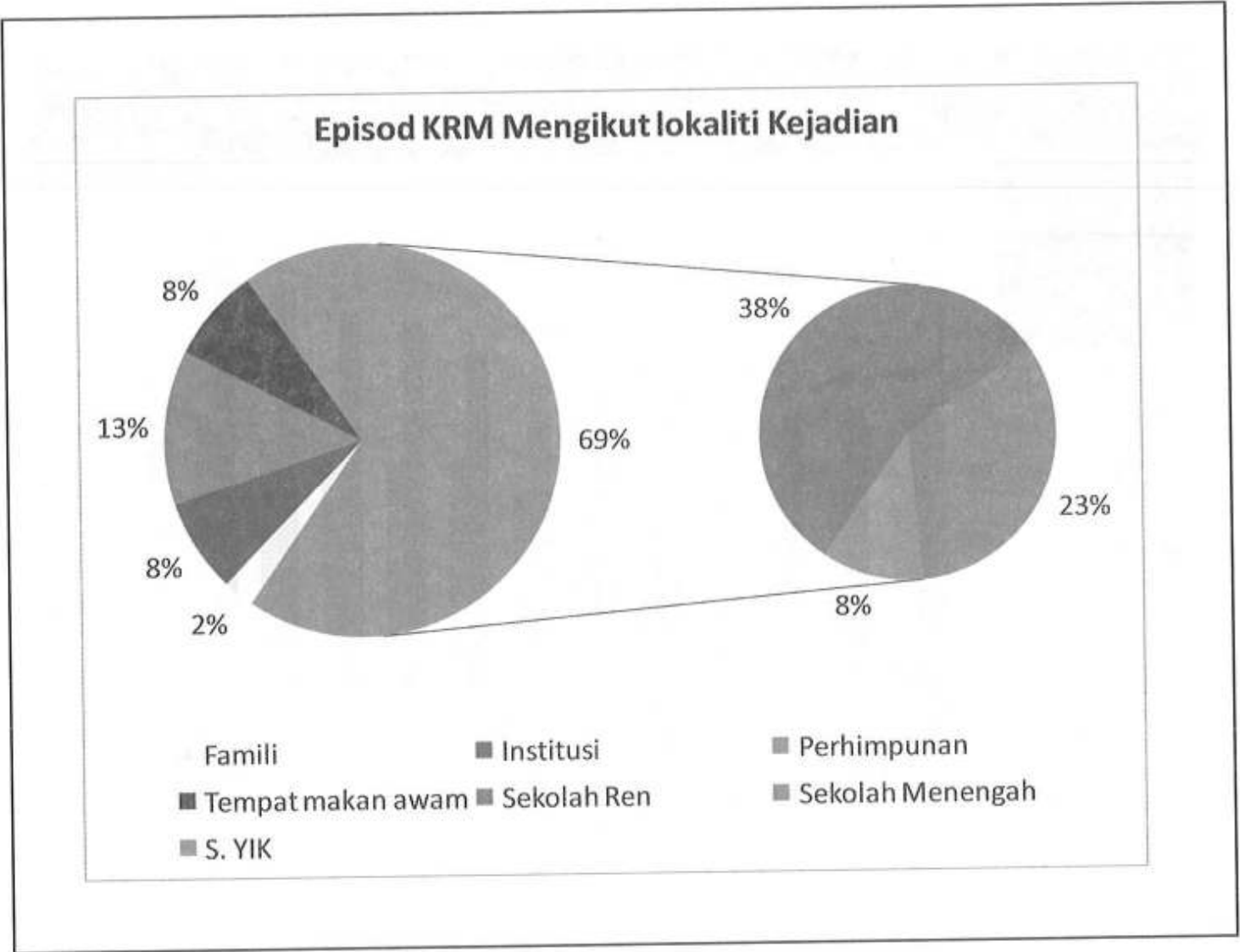
ANNEXURE 15





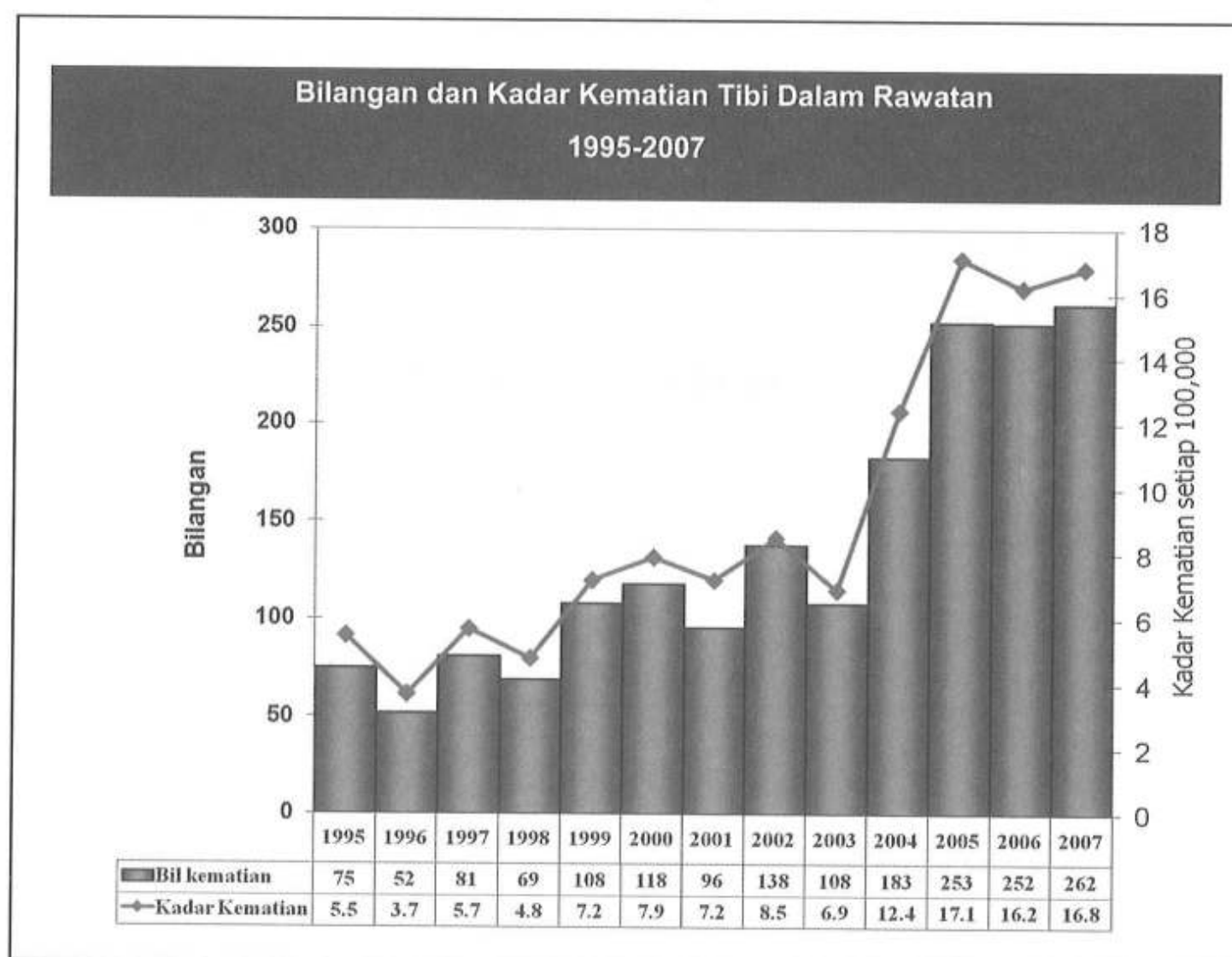
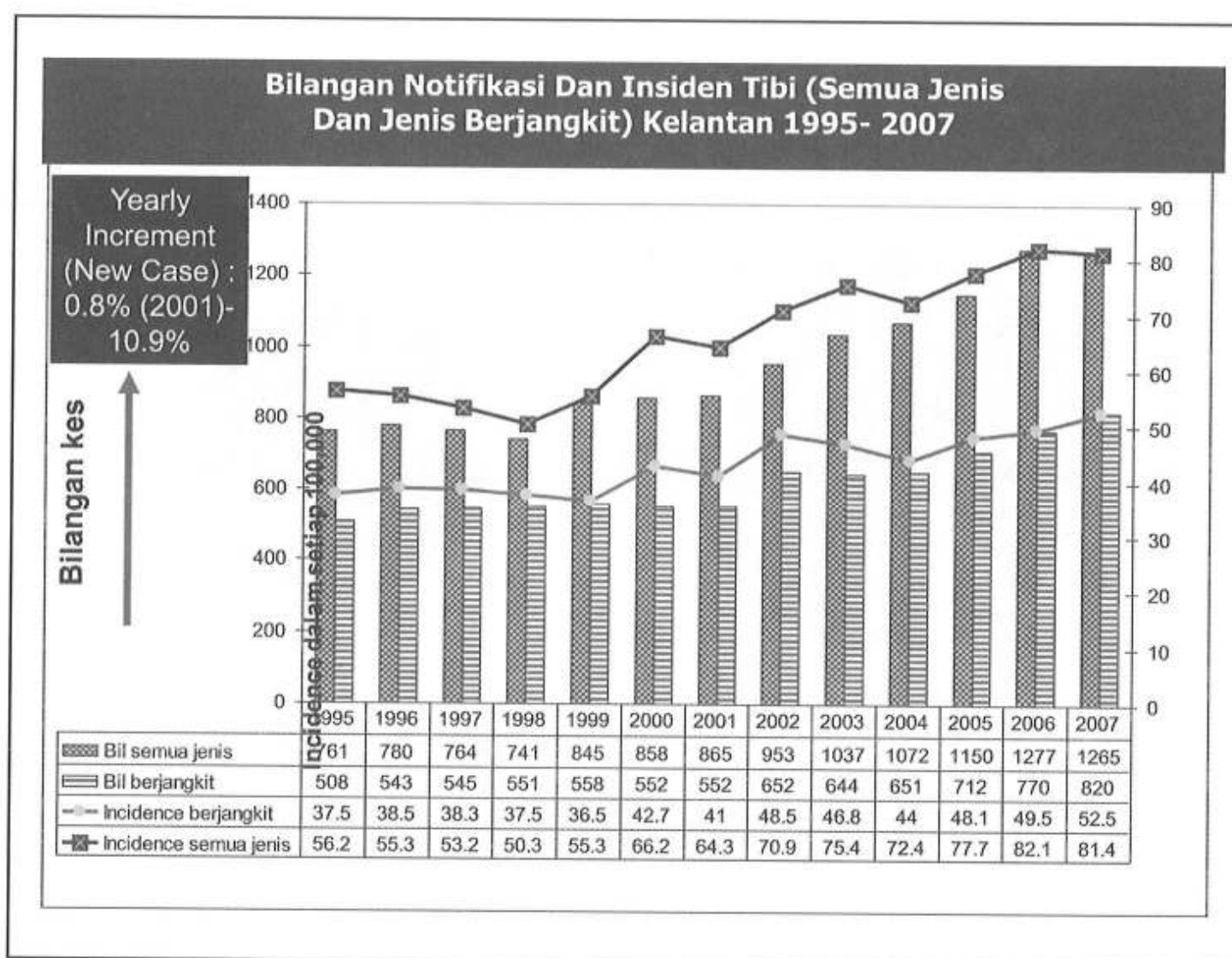
Cases of Food Poisoning during 2005 - 2008, In KELANTAN.	
Year	Number of cases
2005	11 (330)
2006	29 (1408)
2007	35 (1458)
2008	39 (1457)

ANNEXURE 15



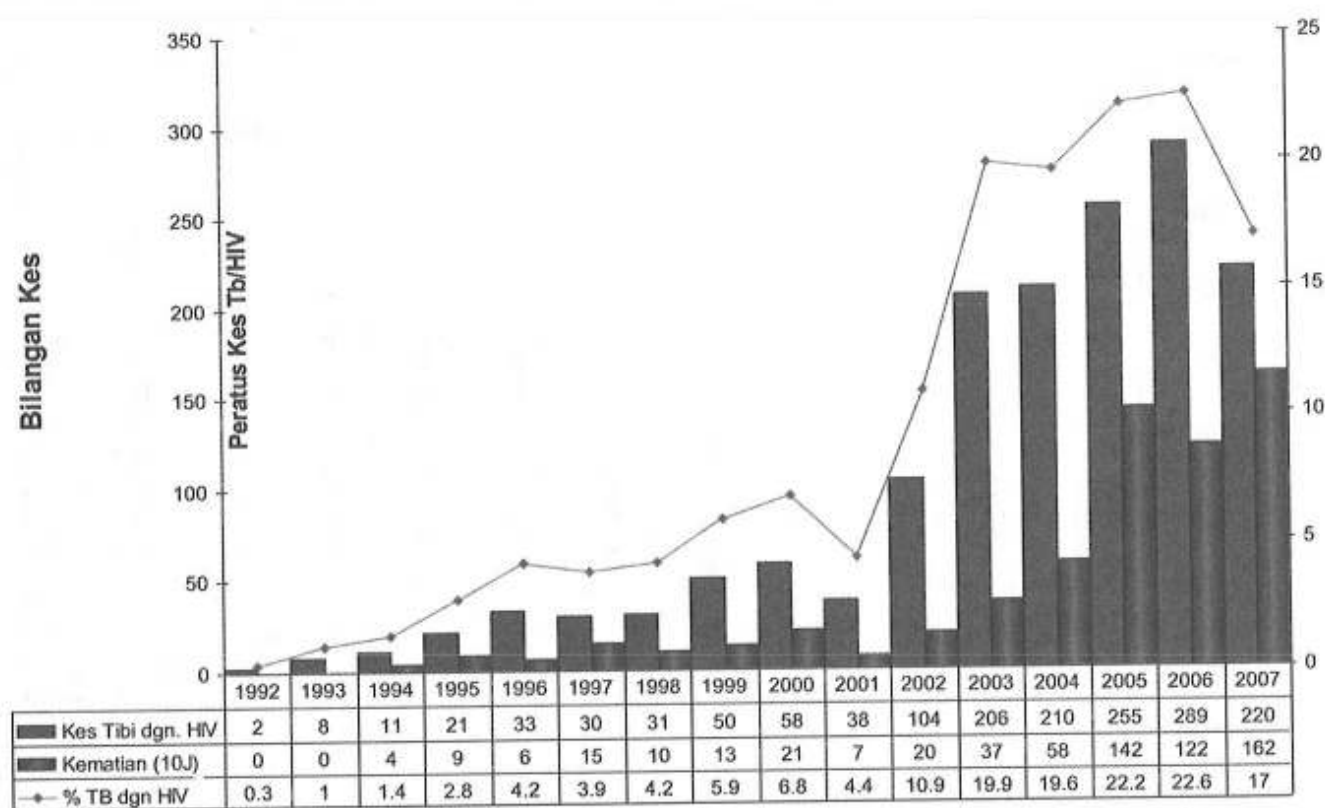
Tuberculosis (TB) In Kelantan

ANNEXURE 15



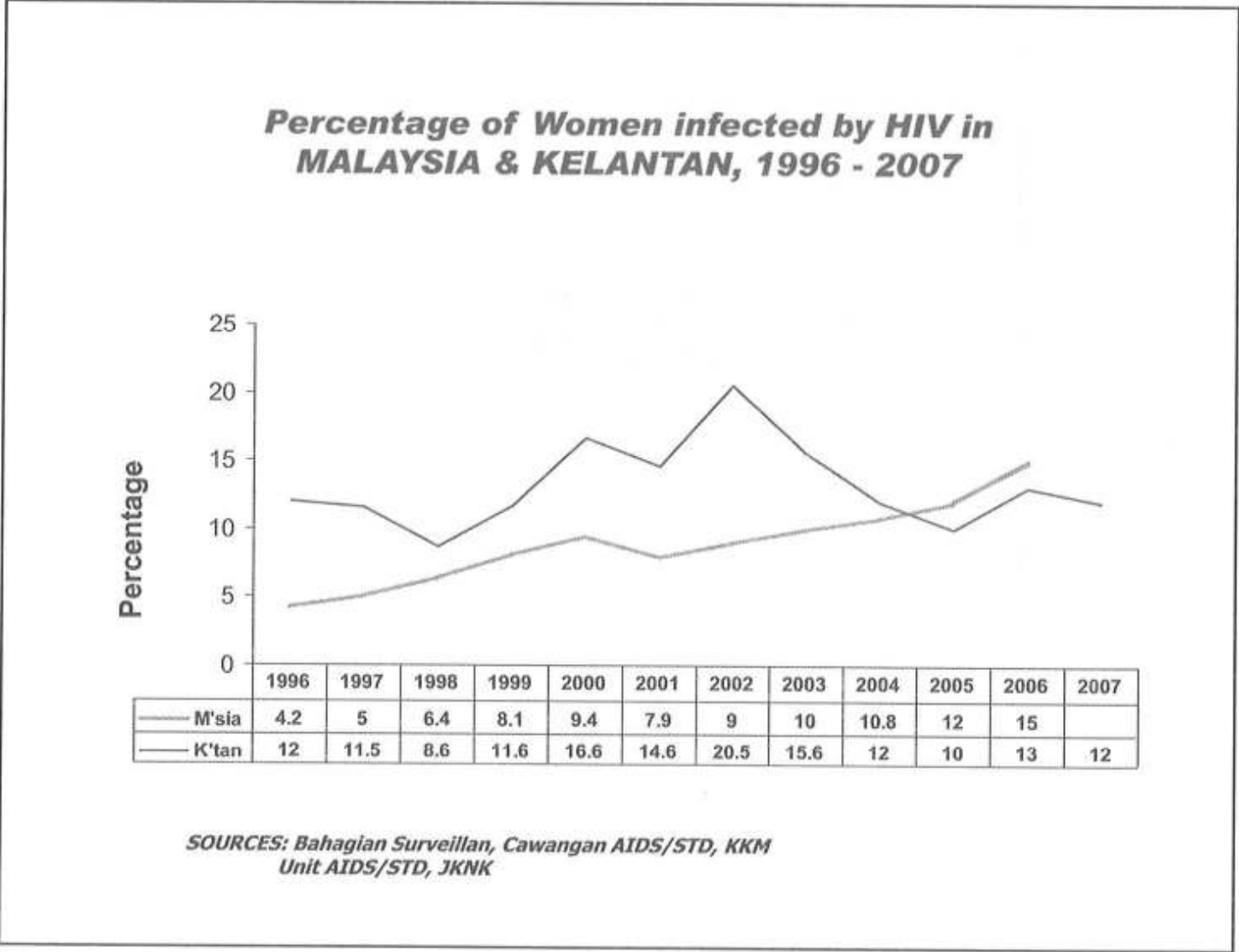
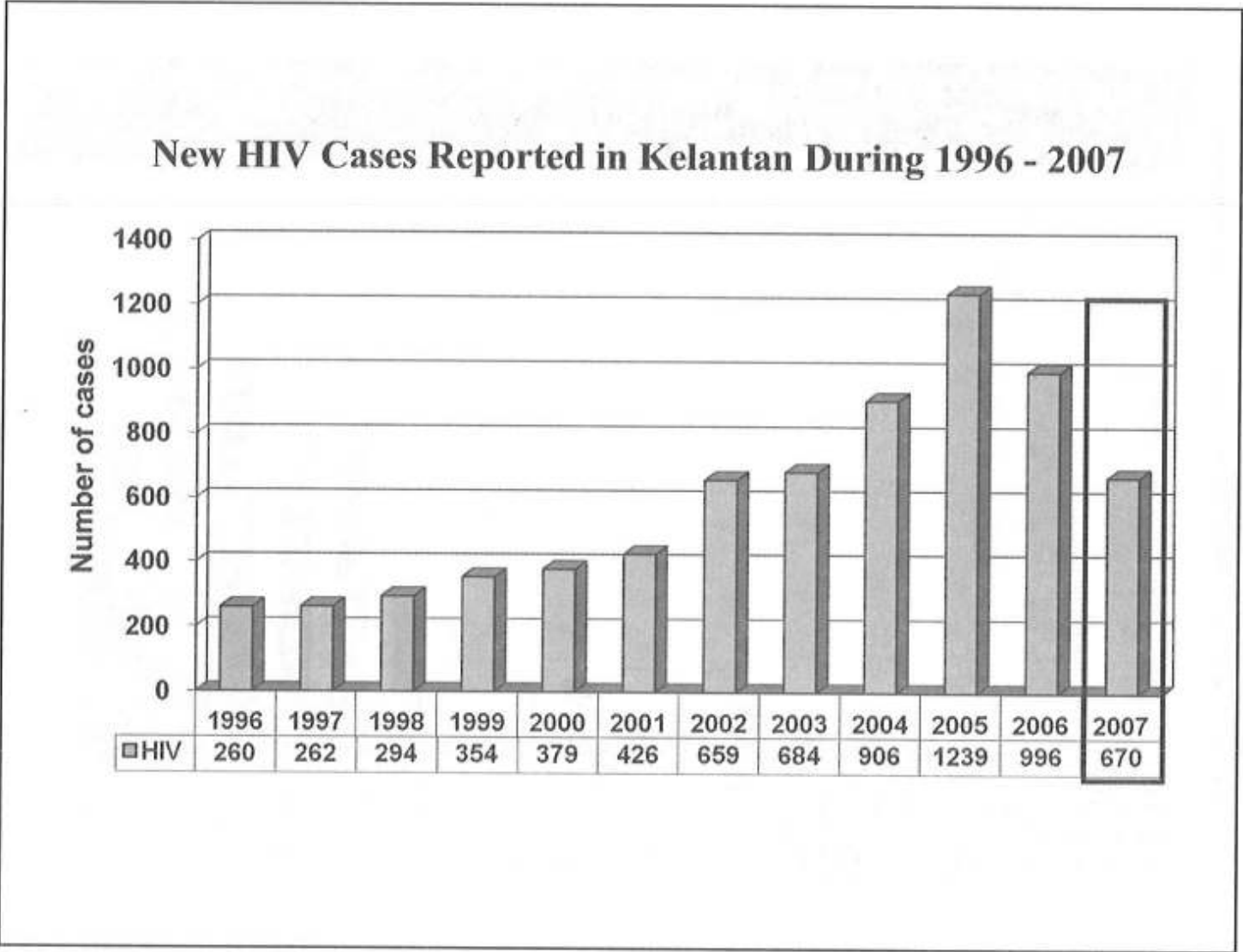
ANNEXURE 15

Bilangan Kes Tibi Baru dengan HIV Dan Kematian Kes Tibi Dengan HIV Kelantan, 1992-2007



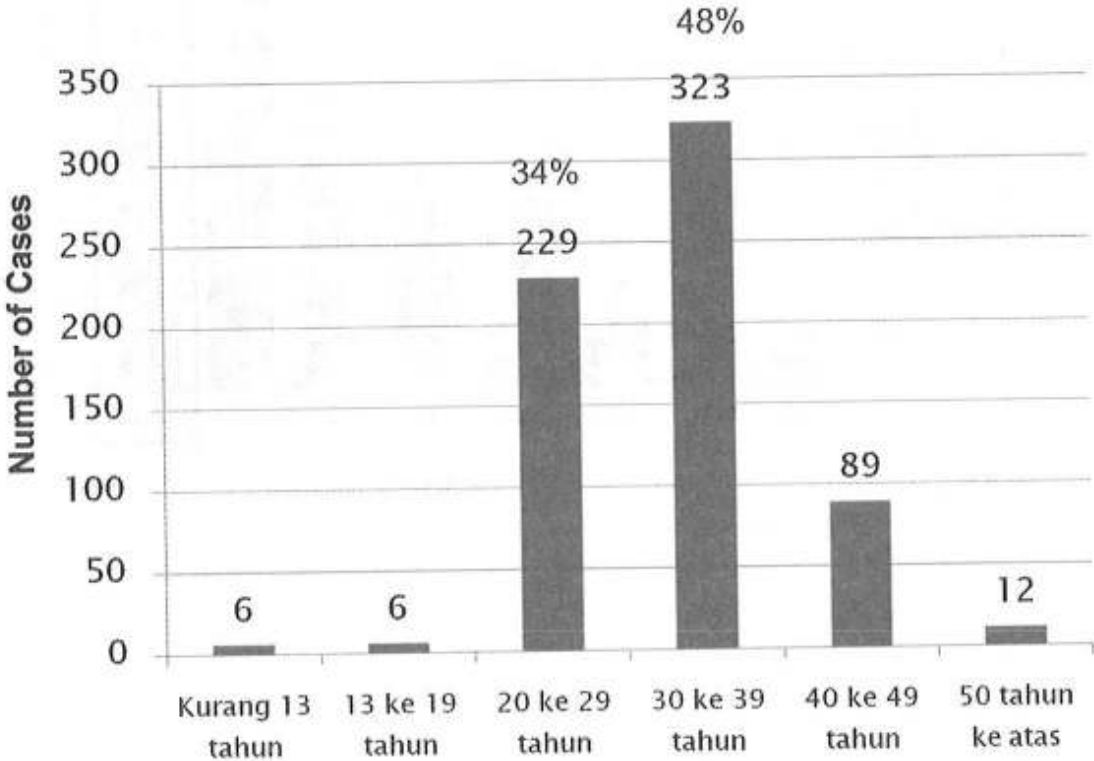
HIV/AIDS
KELANTAN

ANNEXURE 15

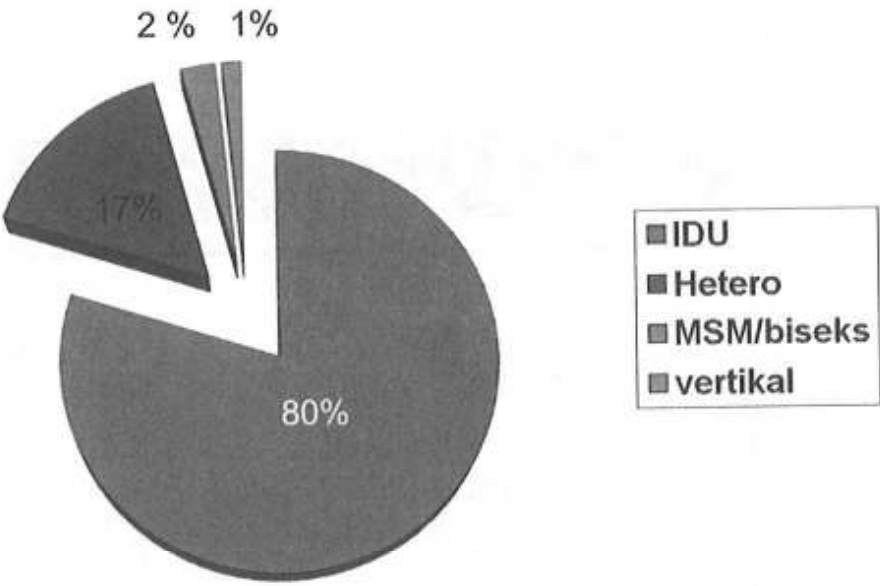


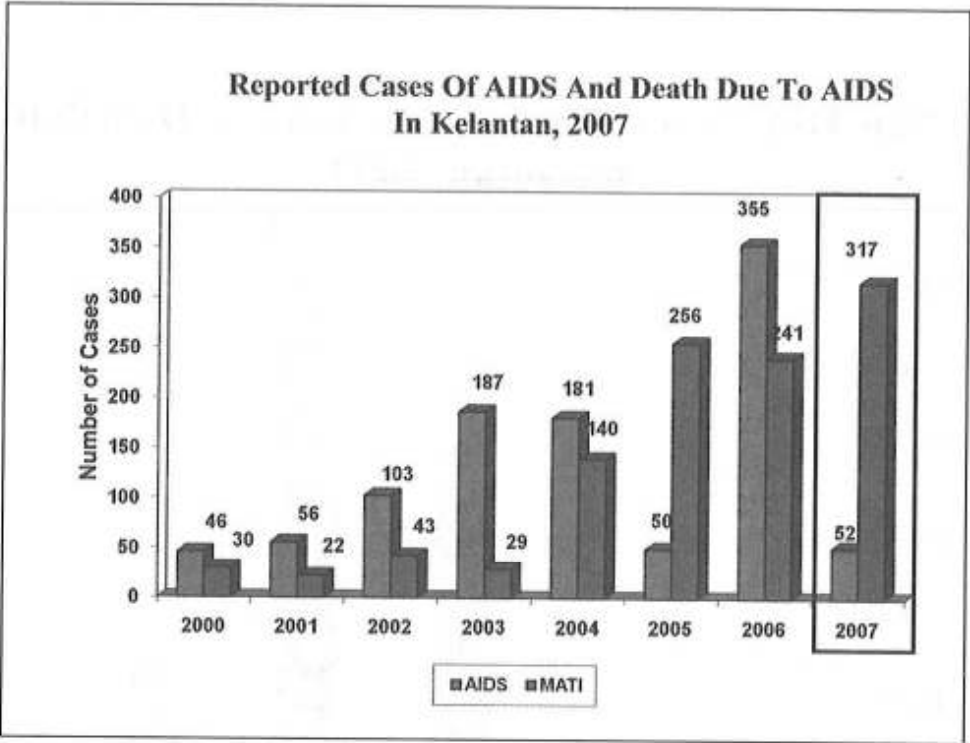
ANNEXURE 15

New HIV Cases And The Age Groups Distributions in Kelantan, 2007

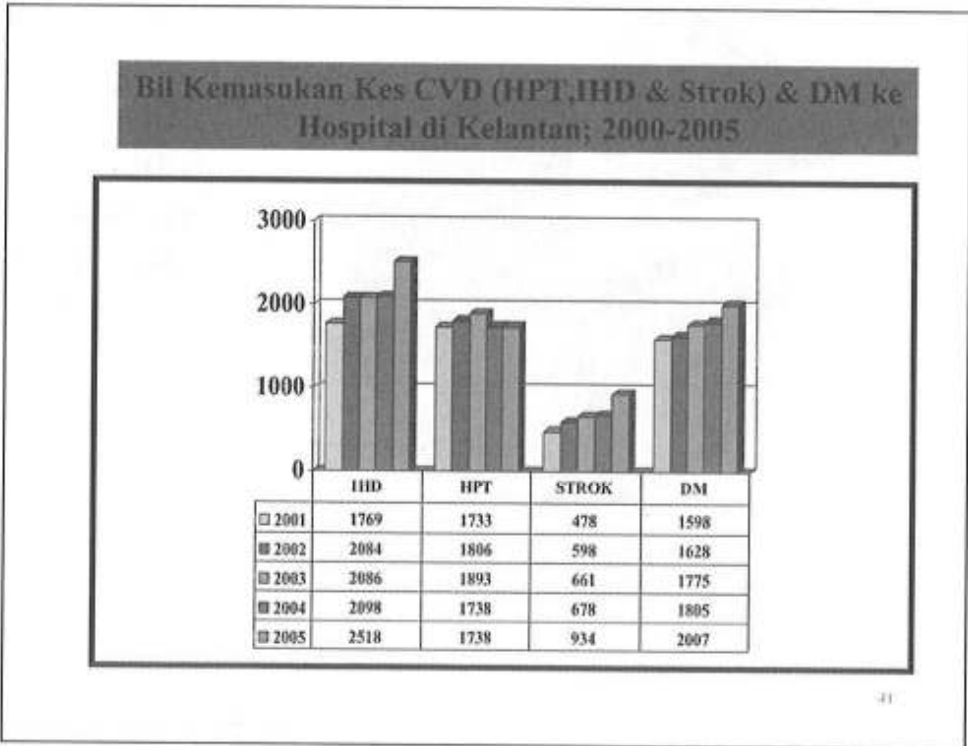


Rajah 5: Peratus Kes HIV Baru Mengikut Faktor Risiko Di Kelantan Bagi Tahun 2007

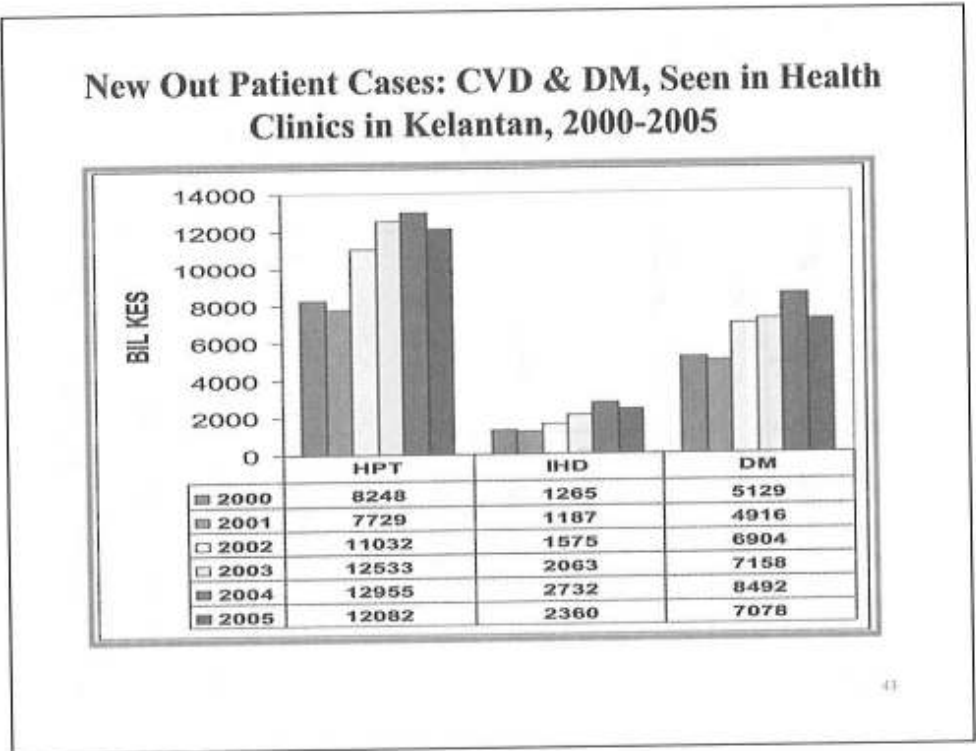
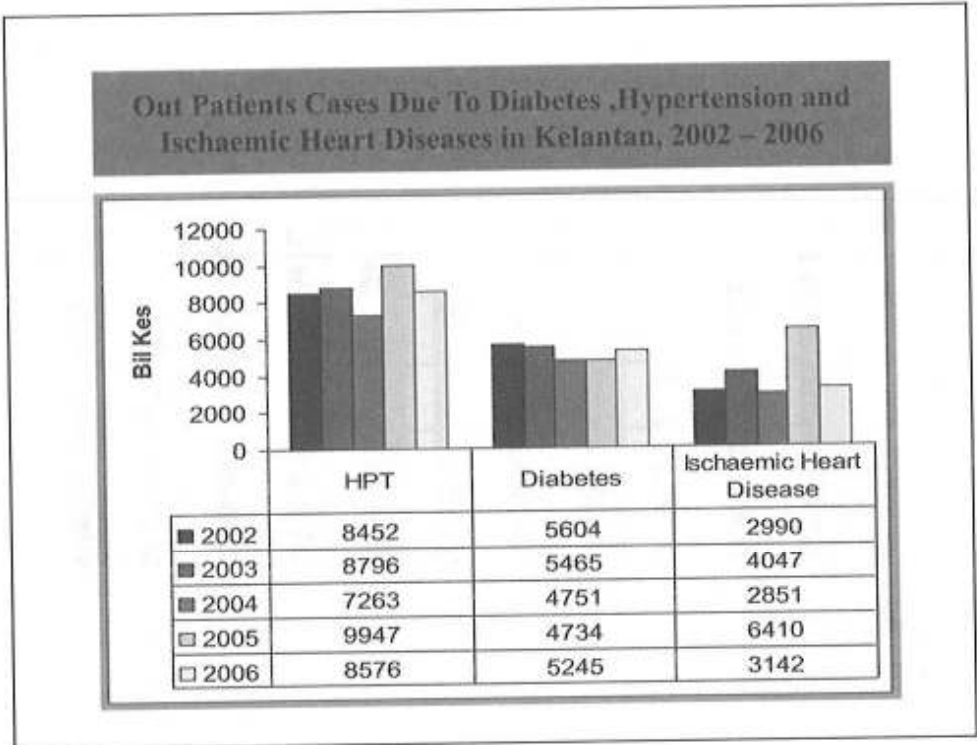




CHRONIC DISEASES

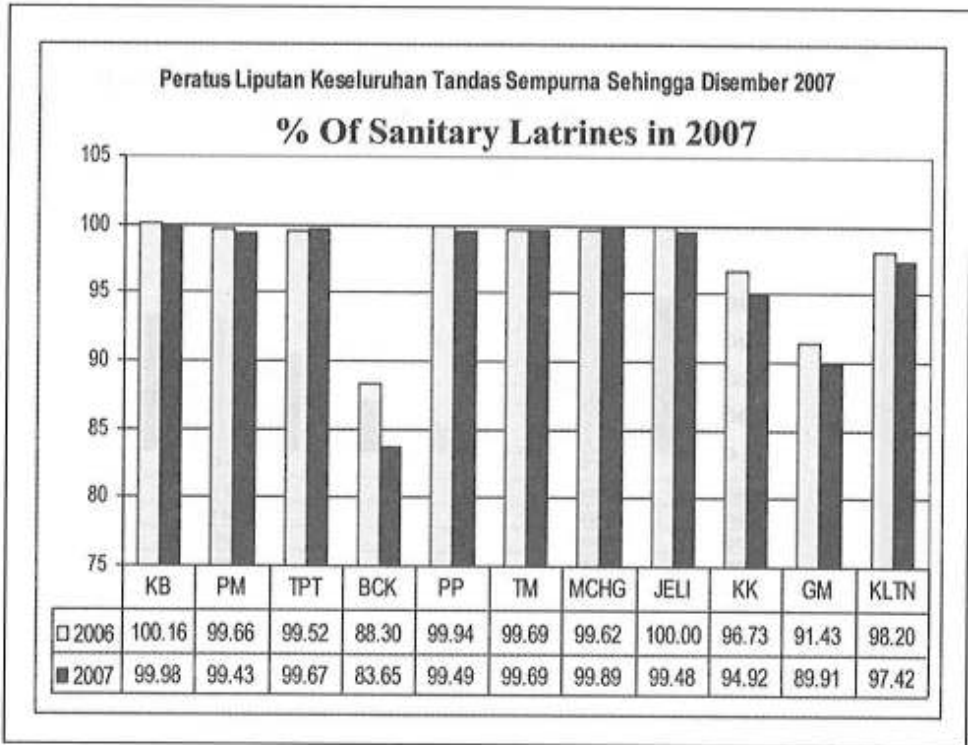
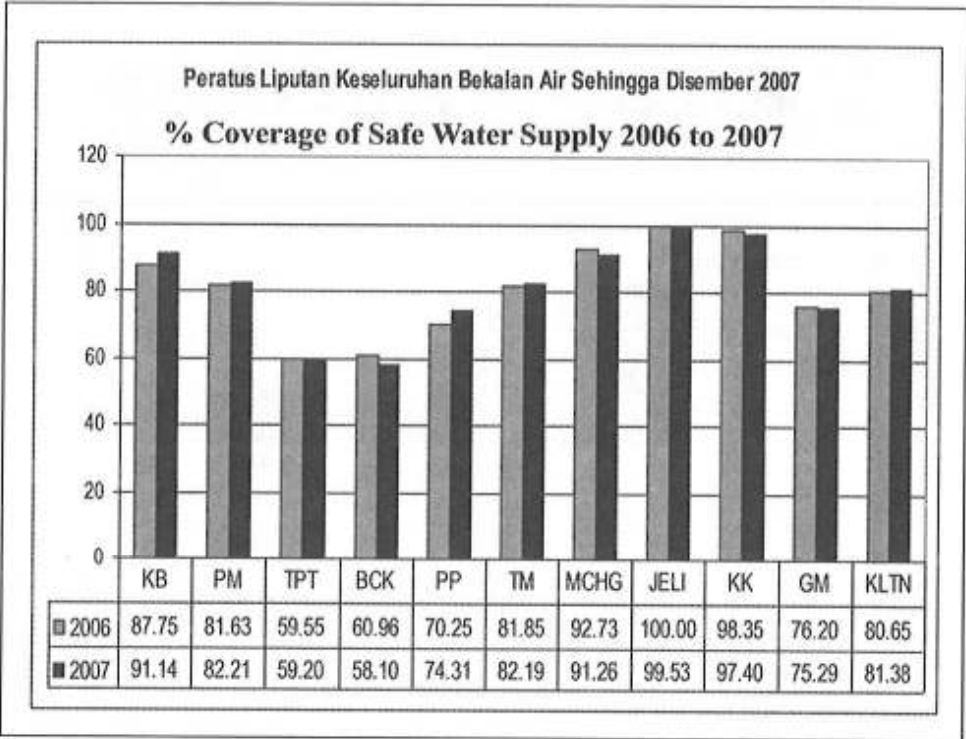


ANNEXURE 15



WATER SUPPLY AND LATRINE

ANNEXURE 15



OPPORTUNITIES

ANNEXURE 15

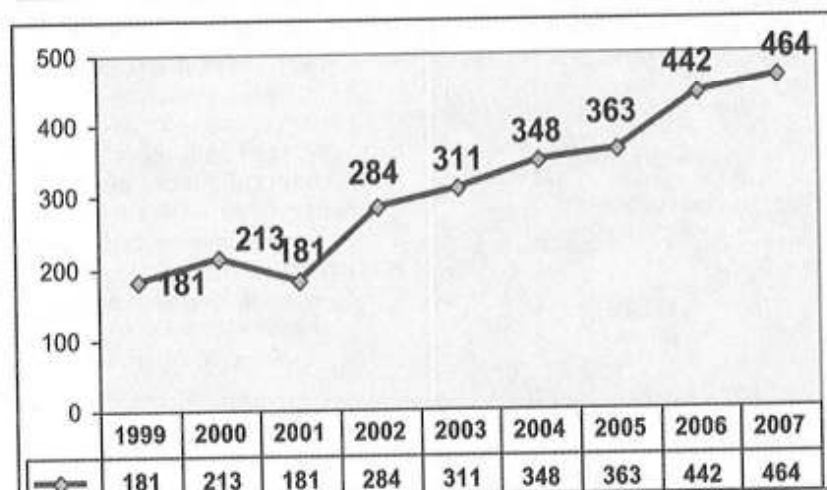
HUMAN RESOURCE HEALTH DEPARTMENT KELANTAN 2004-2006

POST	2004	2005	2006
HIGHEST POST	3	2	2
PROFESIONAL GROUP	592	607	654
SUPPORT 1	4214	4222	4605
SUPPORT 2	2891	2949	2794
TOTAL	7700	7780	8055

3/28/2011

48

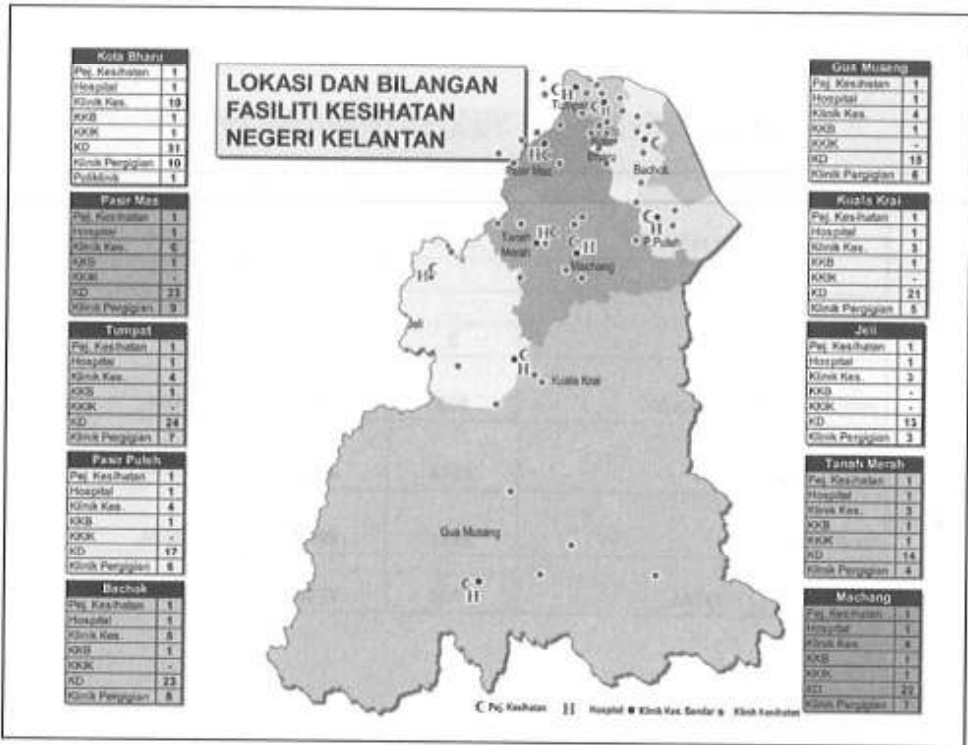
Operating Expenditure(million) For Kelantan Health Department



HEALTH FACILITIES IN KELANTAN 2007

FASILITY	Hospital	District Health Office	Health Clinic	Comm. Clinic	Dental Clinic	Private Clinic
DISTRICT						
Kota Bharu	2	1	12	31	37	134
Tumpat	1	1	5	24	14	12
Pasir Mas	1	1	7	23	18	15
Pasir Puteh	1	1	6	17	16	11
Bachok	0	1	6	23	14	15
Machang	1	1	6	22	14	8
Kuala Krai	1	1	4	21	9	6
Tanah Merah	1	1	5	14	10	12
Gua Musang	1	1	5	15	8	9
Jeli	1	1	3	13	7	3
KELANTAN	10	10	59	203	147	225

ANNEXURE 15



HOSPITAL WITH SPECIALIST

HOSPITAL RAJA PEREMPUAN ZAINAB II	HOSPITAL RAJA PEREMPUAN ZAINAB II
INTERNAL MEDICINE	FORENSIC MEDICINE(2007)
SURGERY	REHABILITATION(2007)
O & G	CARDIOLOGY(2007)
PEADIATRIC	PEADIATRIC SURGERY(2006)
ORTHOPEDIC	ORTHOPEADIC SPINE(2006)
ANAESTHESIOLOGY	ORTHOPAEDIC ONCOLOGY(2006)
RADIOLOGY	INFECTIOUS (DISEASE ADULT)(2002)
PSYCHIATRY	INFECTIOUS (DISEASE PEAD)(2002)
ORI	INFECTIOUS (DISEASE PATOLOGY)(2002)
OPHTHAMOLOGY	PLASTIK SURGERY(2005)
DERMATOLOGY	BREAST ENDOCRINE(2007)
NEFROLOGI	CYTOPATOLOGY(2005)
TRAUMA AND EMERGENCY CARE	
ORAL SURGERY AND MAXILFACIAL	
UROLOGY(1995)	
GESTROHEPATOLOGY(1998)	
NEONATOLOGY(1997)	

HOSP. UNIVERSITI SAINS MALAYSIA

HOSPITALS WITH SPECIALISTS

HOSPITAL KUALA KRAI	HOSPITAL TANAH MERAH
INTERNAL MEDICINE	INTERNAL MEDICINE
SURGERY	SURGERY
O & G	O & G
PEADIATRIC	PEADIATRIC
ORTHOPEDIC	ORTHOPEDIC
ANAESTHESIOLOGY	ANAESTHESIOLOGY
RADIOLOGY	
PSYCHIATRY	
OPHTHAMOLOGY	
NEFROLOGI	

ANNEXURE 15

**Upgrading Of Services in
Hospital**

- Upgrading of HRPZ II
- Additional Hospital – Hospital Jeli 2004
- Additional Specialise & Subspecialise Services in Hospital
- 2 District Hospital with specialist services – HKK(1998), HTM(2006)
- Hemodialysis services in all hospital in Kelantan(9 KKM + 1 HUSM hospital)
- Upgraded Medical Equipment – Mammography, CT Scan(2 – Hosp + 1 HKK - 2008)
- Tomography , MRI and Bone Densetometer
- Echocardiogram

**Upgrading Of Services In Rural
Areas**

- Family medicine specialists – 14 KK(All districts)
- Ultrasound – 46 KK + X-ray unit in 11 KK, Fundus Camera – 10 KK.
- Laboratory equipment – Chemistry analyser, heamatology analyser, HbA1c machine one / district
- Health services for special groups - Adolescent, Elderly, Children with special needs,
- Rehabilitation – Psychosocial for mental patients, Elderly and Children with special needs.

**New Progress For HIV/AIDS Program
2008**

- Needle Syringe Exchange Program
- ARV treatment by Family Medical Specialist
- Methadone replacement Therapy
- ‘National AIDS Registry’ (NAR)

CHALLENGES

CHALLENGES

1. Morbidity and mortality rate is still higher compared to national level

- Perinatal (10.4 / 1000 live birth)
- Infant (8.2 / 1000 live birth)
- Toddler (3 / 10,000 live birth)

CHALLENGES

2. Incidence of communicable disease is high

- Food and water borne (food poisoning, typhoid)
- Dengue fever
- HIV / AIDS
- Tuberculosis

ANNEXURE 15

CHALLENGES

3. Prevalence of non-communicable diseases (life- style related) increasing

- Diabetes mellitus
- Hypertension
- Mental problems
- Cancer

CHALLENGES

4. Infrastructure :

- Low coverage of treated water supply
- Inadequate solid waste disposal system
- Inadequate basic facilities in public areas
- Mashrooming of unlicensed food stalls

OTHERS

- PUBLIC ISSUE : High expectation ,too dependent on government aid, poor attitude toward health, poor hygiene practices, indiscriminate dumping,
- Increasing drug addicts - Hiv
- Illegal foreign workers- Hiv, malaria
- Increasing health cost
- Maldistribution of resources

3/28/2011

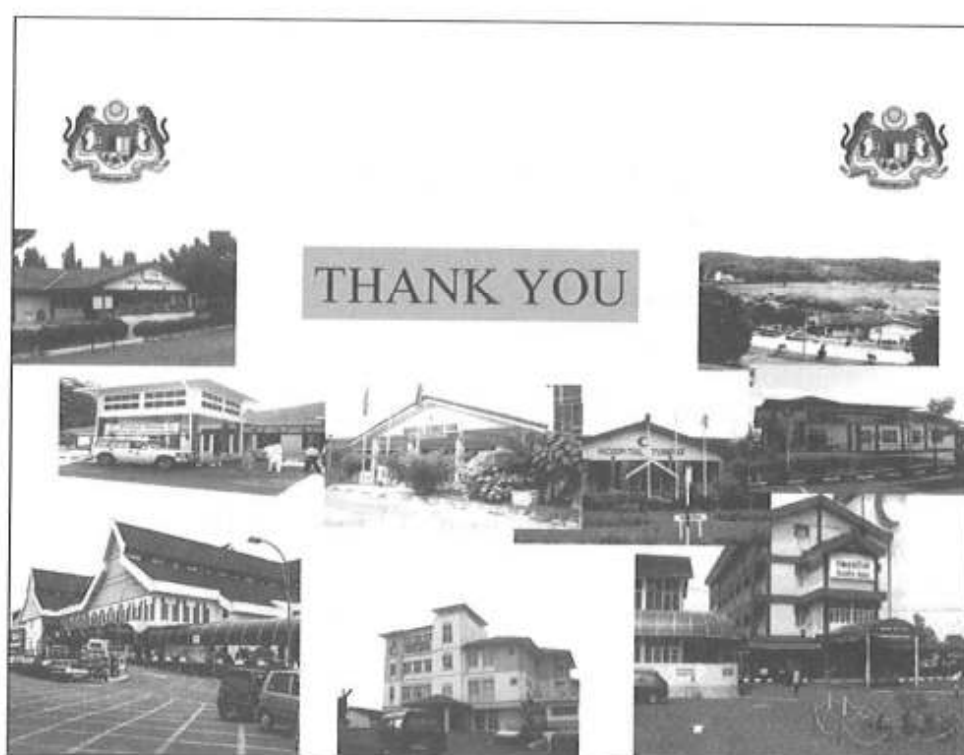
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CONCLUSION

Generally the health status of the population has improved over the years although it is lower than the national average. Inadequate basic facilities and community participation delay reduction of communicable and life – style related diseases.

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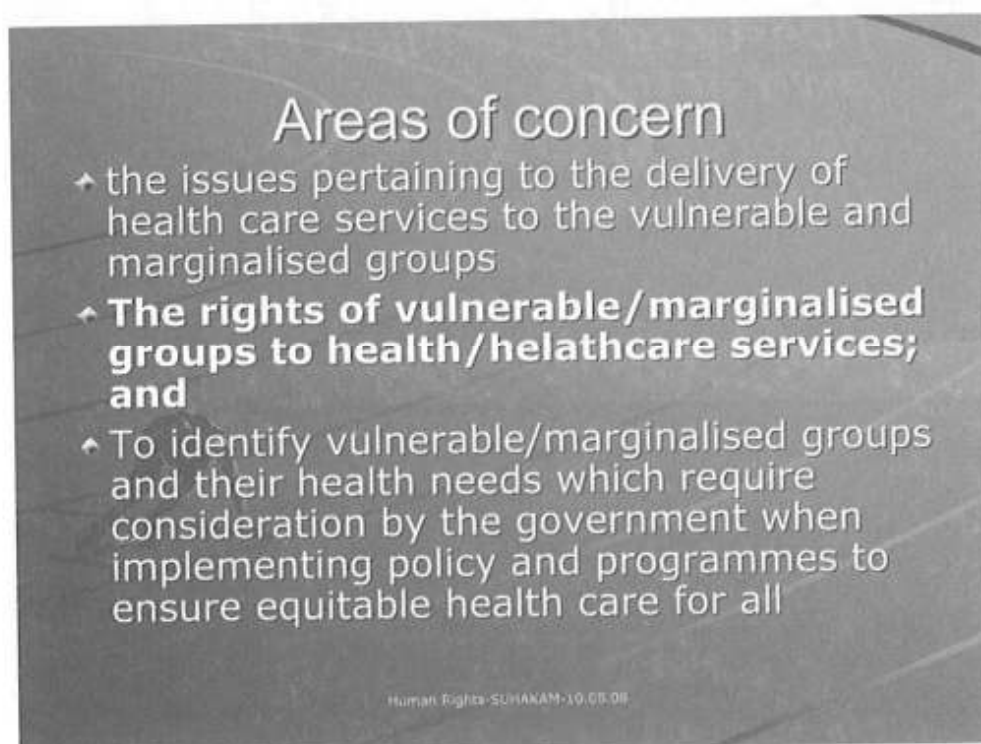
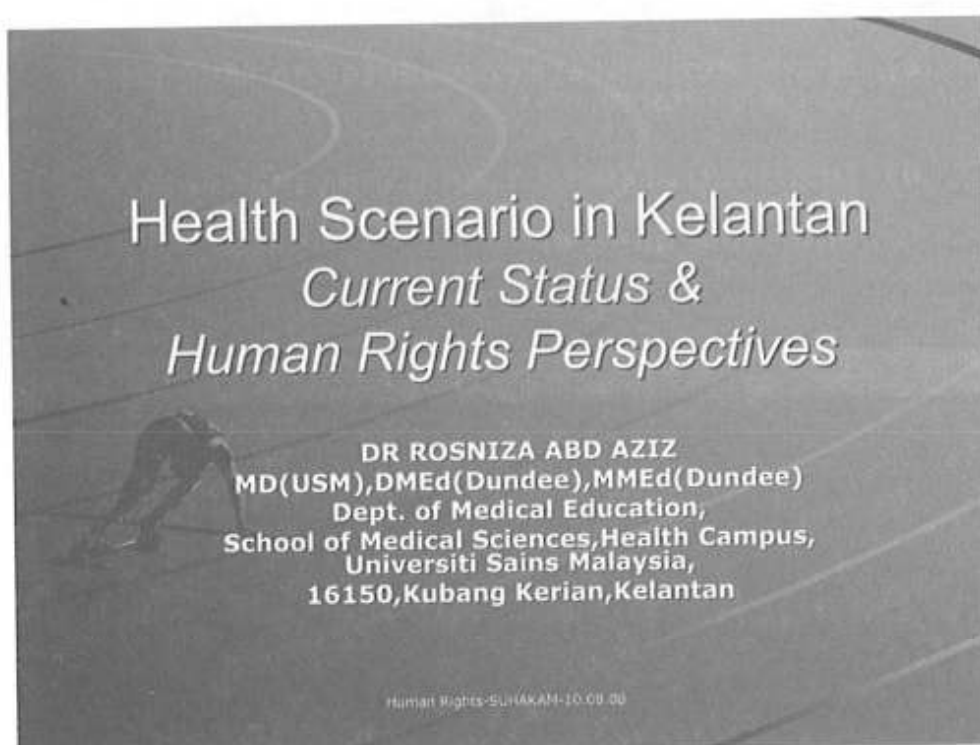


ANNEXURE 16

HEALTH SCENARIO IN KELANTAN - CURRENT STATUS AND HUMAN RIGHTS PERSPECTIVE

BY DR. ROSNIZA ABD AZIZ

DEPARTMENT OF MEDICAL EDUCATION, UNIVERSITI SAINS MALAYSIA, KELANTAN



ANNEXURE 16

Principles of Bioethics

- a) Autonomy: patients' right to make informed decisions About their health care.**
- b) Beneficence: refers to the physician's responsibility to benefit the patient.**
- c) Nonmaleficence: represents the injunction to do no harm.**
- d) Distributive justice: demands that limited healthcare resource be distributed in an equitable manner**

Human Rights-SUHAKAM-10.06.09

PRINCIPLES OF AUTONOMY

Beauchamp & Childress (1994)

.....affirms that individuals are to be permitted personal liberty to determine their own actions according to plans they themselves have chosen.

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HISTORY OF AUTONOMY

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ANNEXURE 16

Why Autonomy

- The WHO (1978) 'People have a right and a duty to participate individually and collectively in the planning of their healthcare'
- Biley (1992), 'essential that patients' are career are involved in decision making.
- Active patient participation & increase outcome.
- Giving patient the full range of choices and withholding their own recommendation are safeguards against law suits.

But

- Studies – patient prefer that the physician have most of the control over decision

Human Rights-SUHAKAM-10.08.08

Western Principle of Autonomy

- Individual - oriented principle.
- Independence from family, physician, cultural group.
- Social framework of decision making ↓ in significance
- Strullet et al-70% physician preferred truth telling in cancer Dx (35 years ago, 82% concealed)
- Eisemen et al 1999, 93% desired an advance directives in Boston, 92.3% in Canada
- Patient Self Determination Act-Enhance and preserve patient autonomy.

Human Rights-SUHAKAM-10.08.08

East Asian Principle of Autonomy

- Family centered autonomy.
- Harmonies dependence between family members.
- Strong familialist feature.
- Physicians don't offer the information to the patient directly
- Value loyalty to the extended family
- Encourage individual to sub ordinate personal wishes to the overall goals of the family and traditional community (Hui 1988, Triandis 1989)

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Western vs East Asian Autonomy

- Other countries have not experienced this recent paradigm shift, and physician-patient relationship is consequently quite different (*Pelligrino 1992, Gridon 1990, Thomson et al 1993, Glick 1997*)
- *Ruhnke et al (Oct 2000)* different attitude of American and Japanese to information disclosure and decision making
- *Strull et al (1993)* majority of African American and European American believed about patient autonomy as compared to Korean American and African American

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Current Status & Human Rights Perspectives

Related

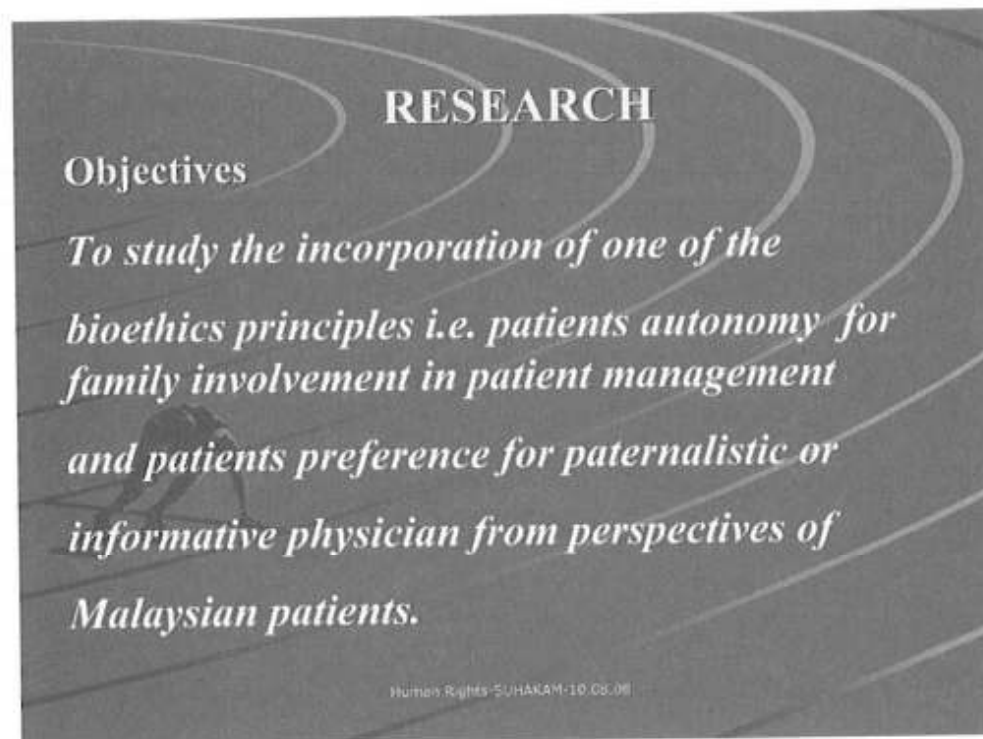
RESEARCH.....

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Principles of Patient Autonomy from Malaysian Perspectives

AA Rosniza MD
AMH Zabidi-Hussin FRCPCH
J Rogayah MHPEd

ANNEXURE 16

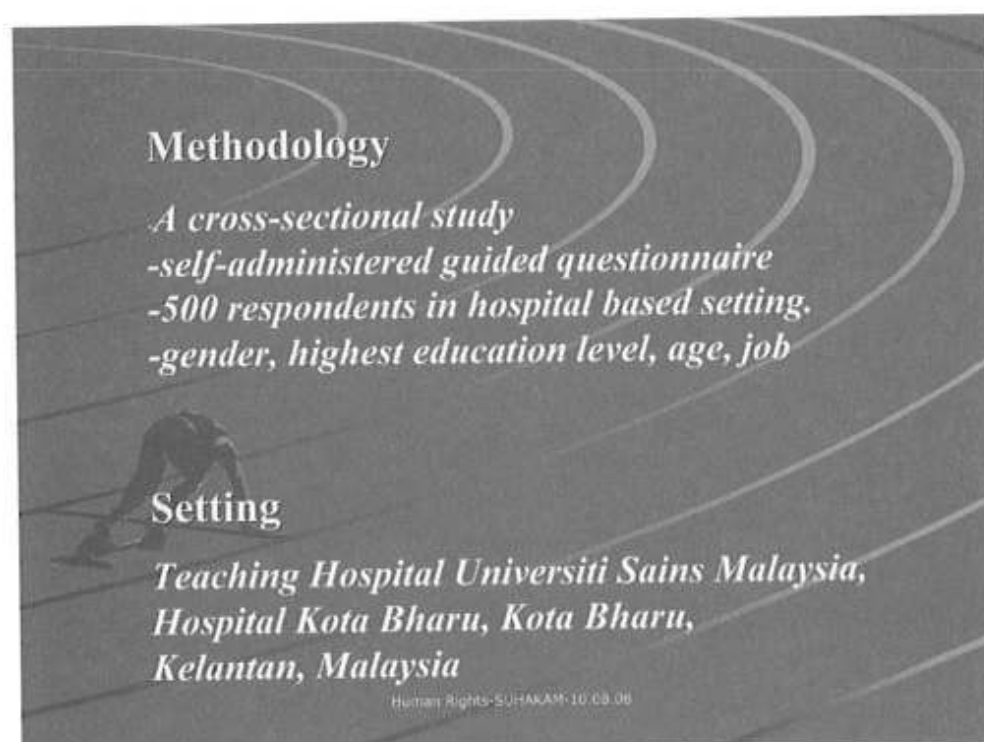


RESEARCH

Objectives

To study the incorporation of one of the bioethics principles i.e. patients autonomy for family involvement in patient management and patients preference for paternalistic or informative physician from perspectives of Malaysian patients.

Human Rights-SUHAKAM-10.08.08



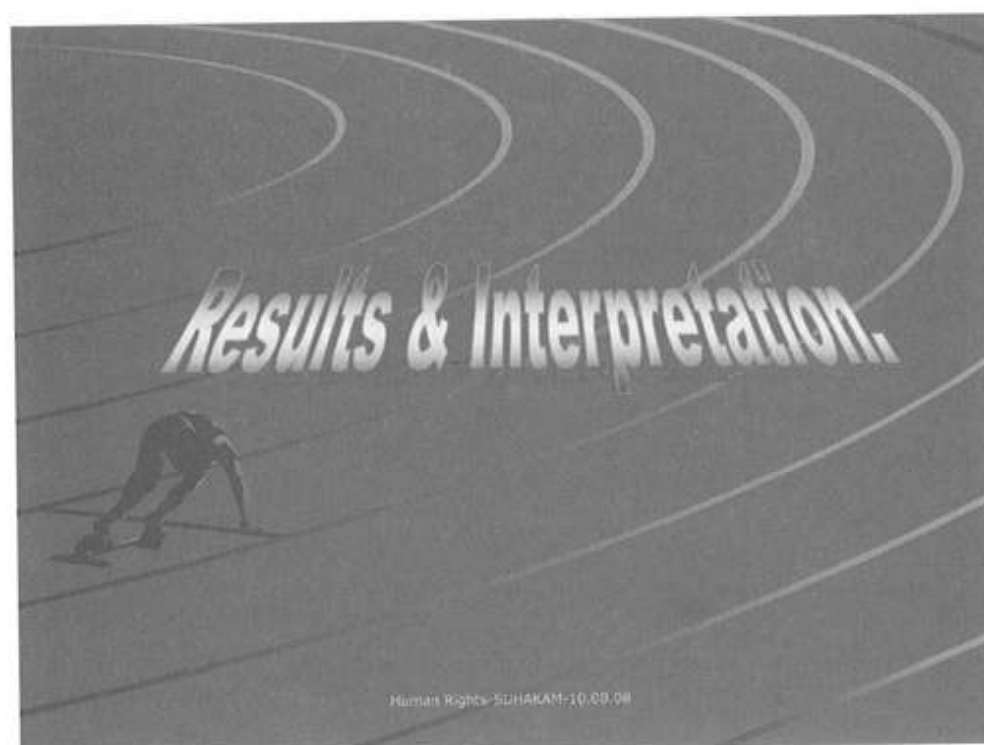
Methodology

*A cross-sectional study
-self-administered guided questionnaire
-500 respondents in hospital based setting.
-gender, highest education level, age, job*

Setting

*Teaching Hospital Universiti Sains Malaysia,
Hospital Kota Bharu, Kota Bharu,
Kelantan, Malaysia*

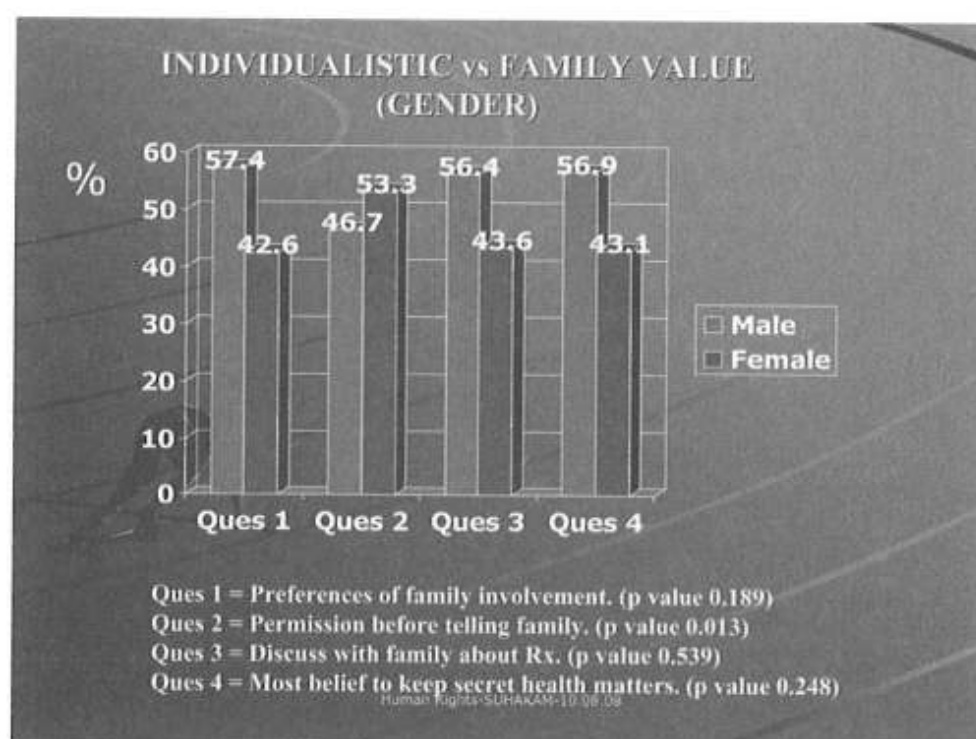
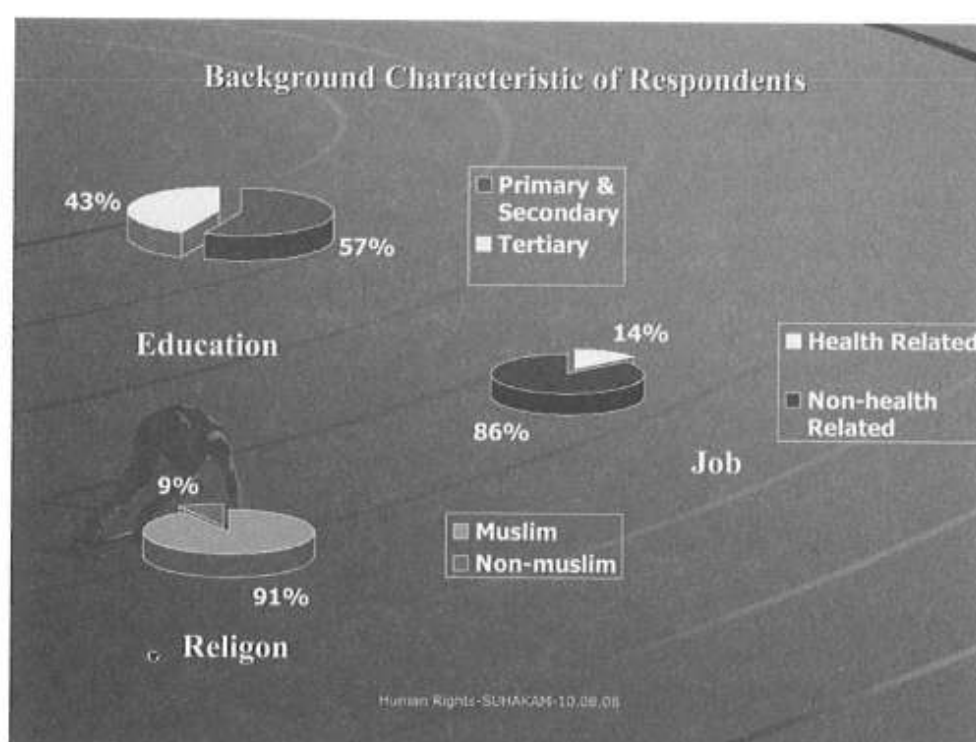
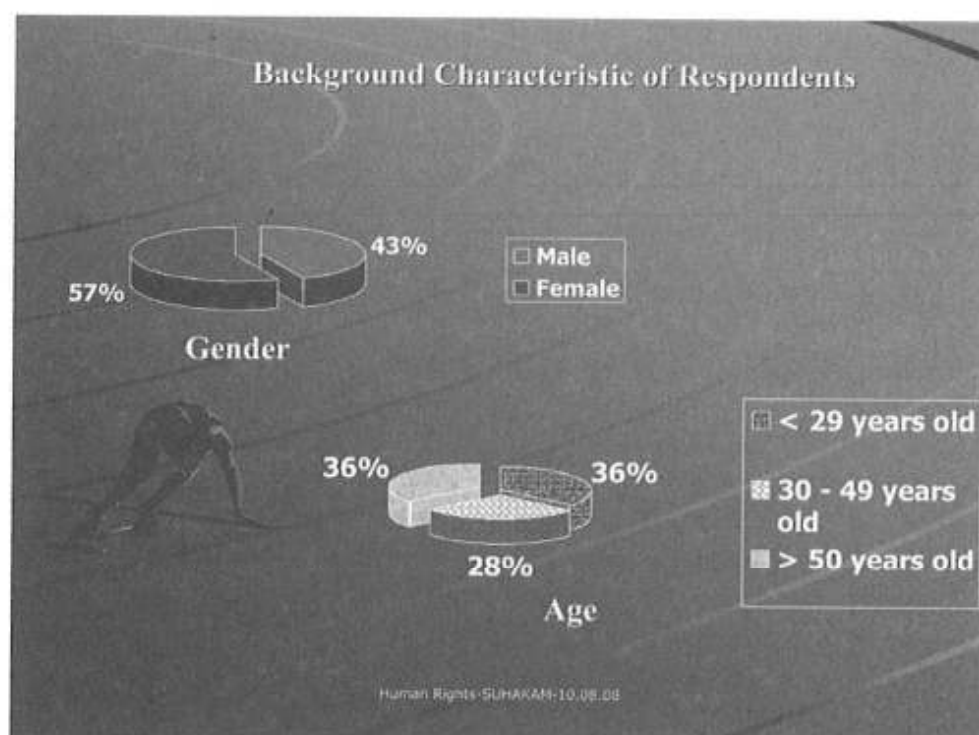
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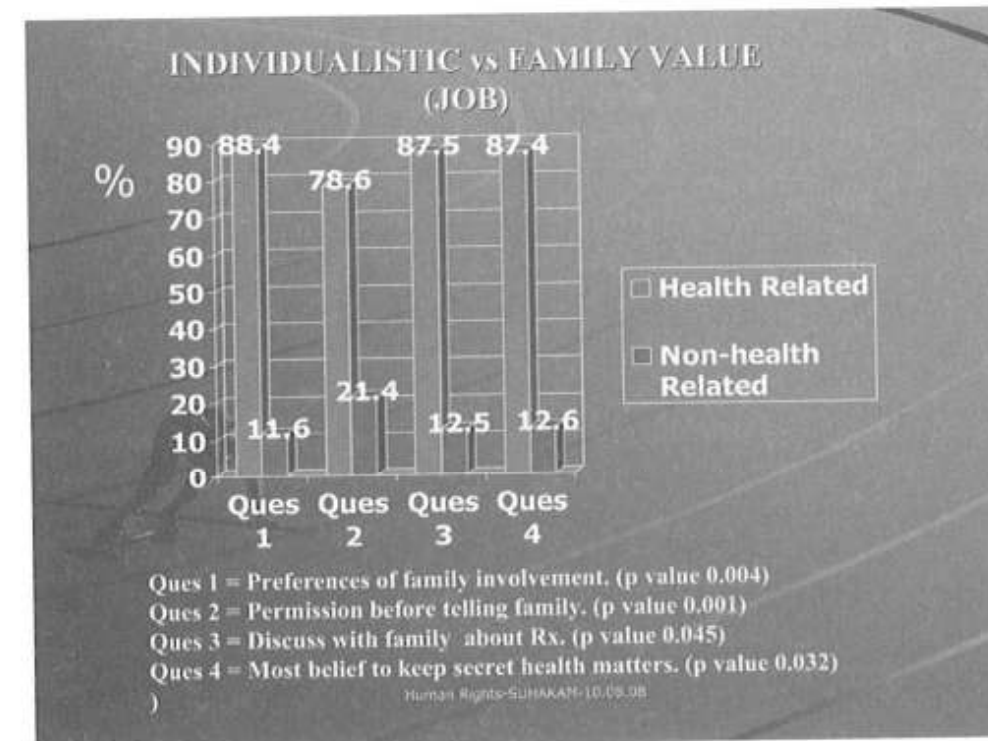
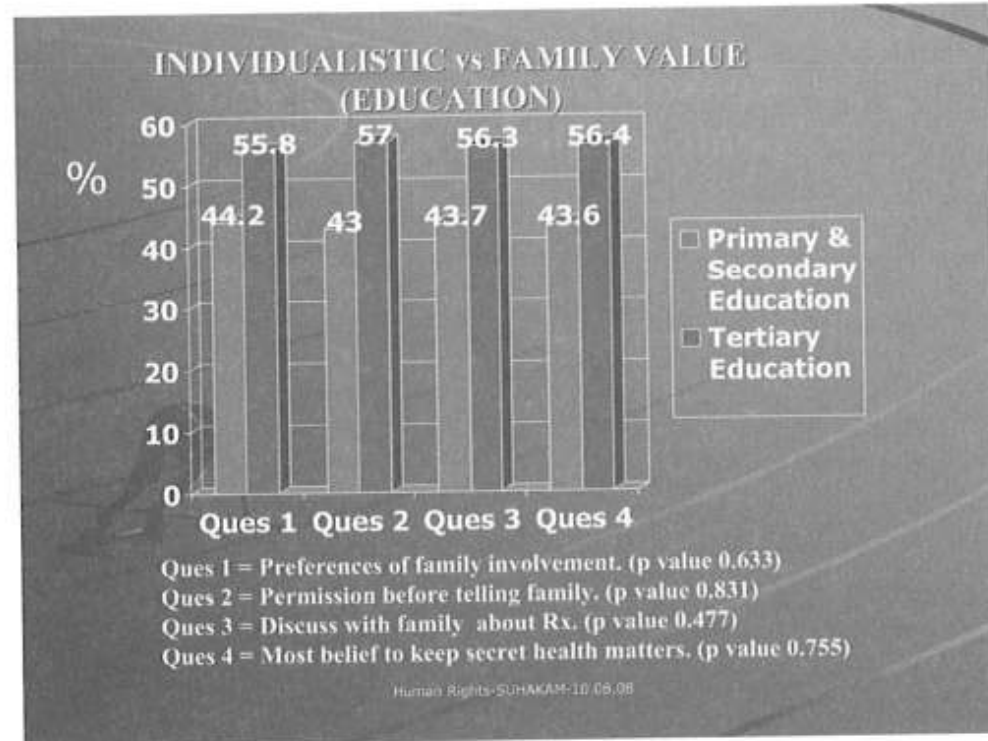
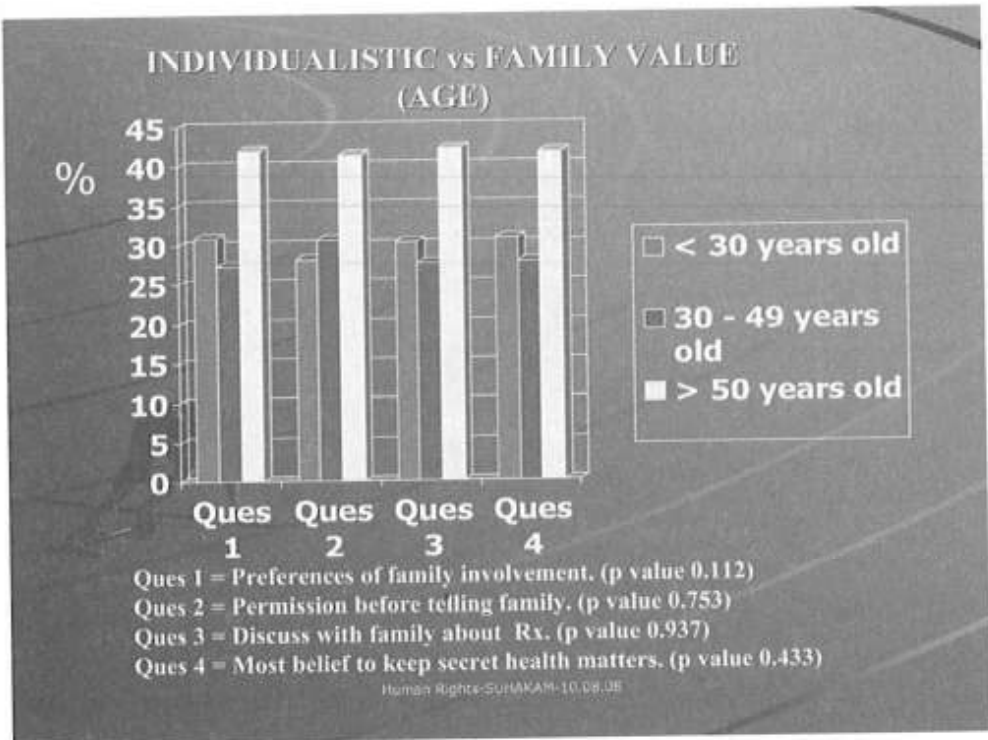
Results & Interpretation

Human Rights-SUHAKAM-10.09.08

ANNEXURE 16



ANNEXURE 16



ANNEXURE 16

Reasons for preferences of family involvement in one's own health

Reason	Percentage
They take care of me	33%
Need moral support	20%
We always share problems	65%

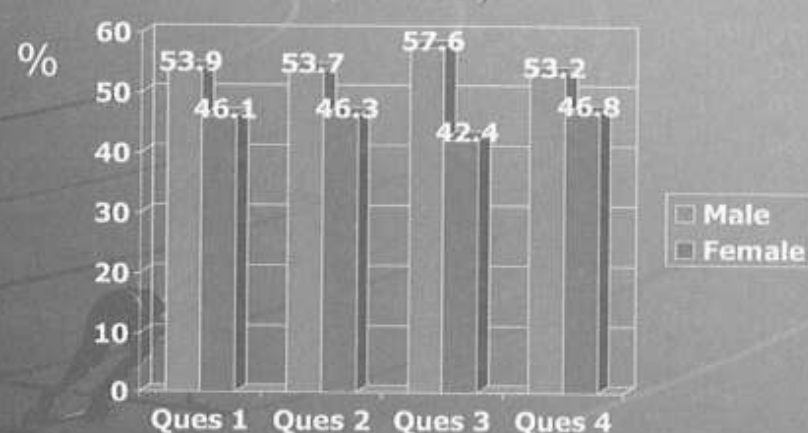
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Reasons to ask permission before telling the family.

Reason	Percentage
Don't want them to feel bad	71%
Certain diseases are confidential	24%
Bad family	5%

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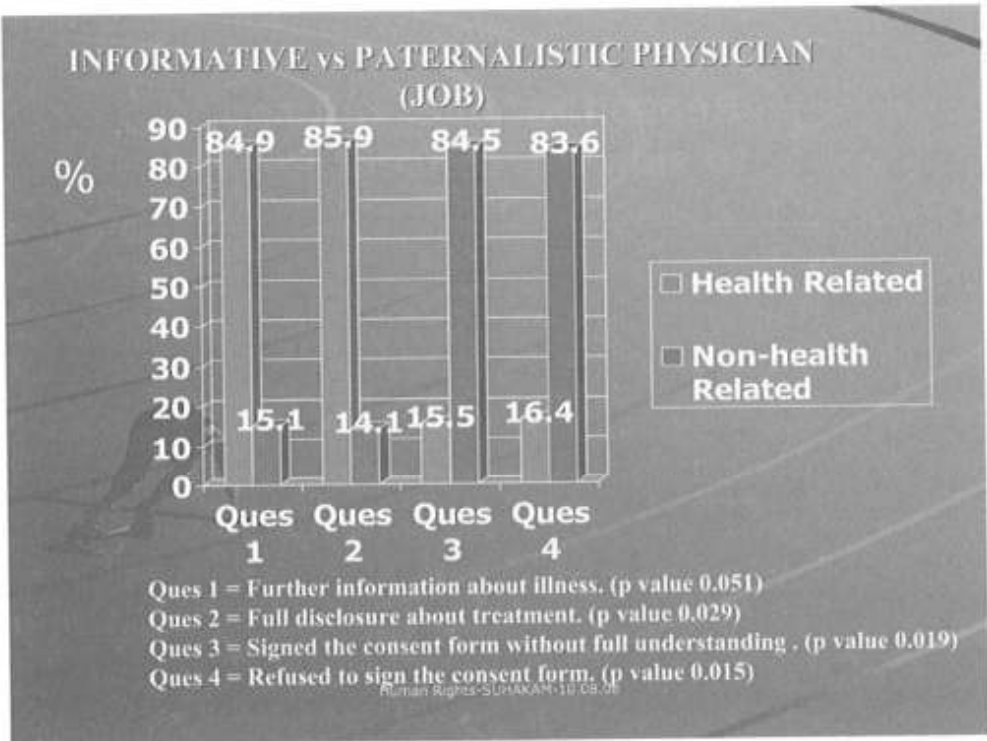
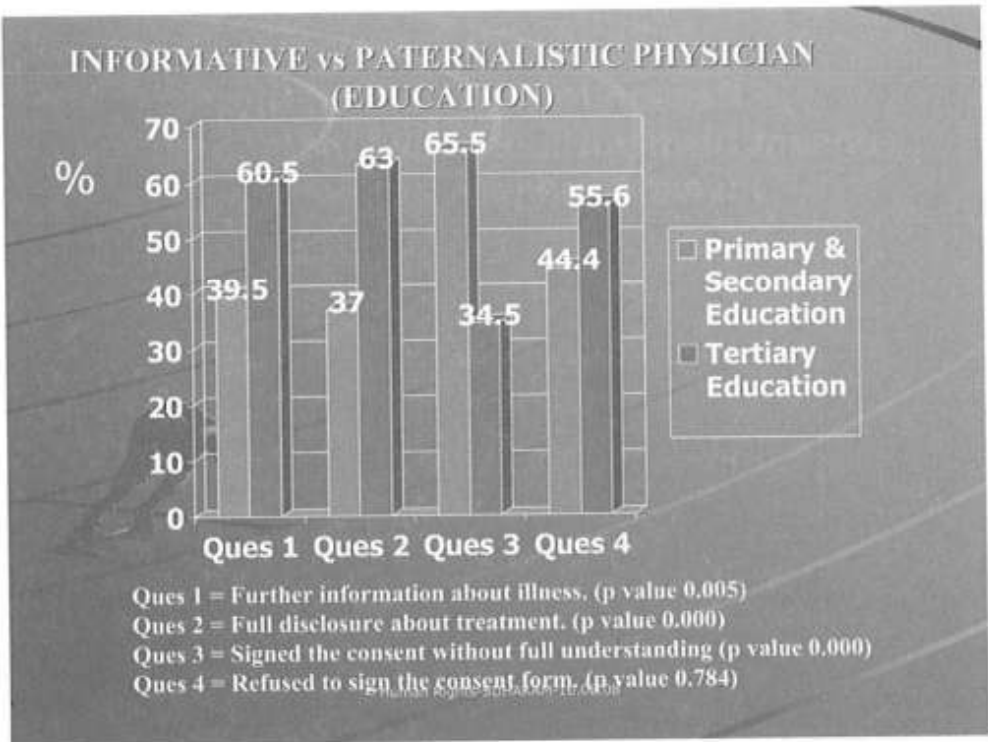
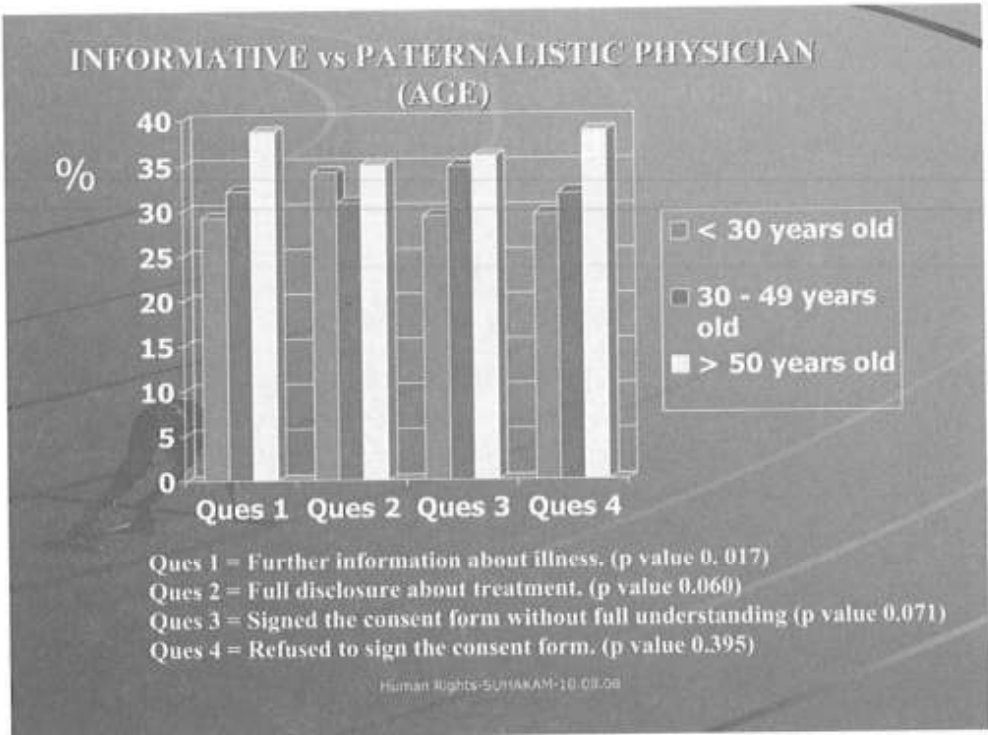
INFORMATIVE vs PATERNALISTIC PHYSICIAN (GENDER)



Ques 1 = Further information about illness. (p value 0.063)
 Ques 2 = Full disclosure about treatment. (p value 0.114)
 Ques 3 = Signed the consent without full understanding. (p value 0.385)
 Ques 4 = Refused to sign the consent form. (p value 0.197)

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ANNEXURE 16



ANNEXURE 16

Reasons for full disclosure about illness	
Reason	Percentage
For informed decision-making	15%
Just want to know	70%
To discuss with family	15%

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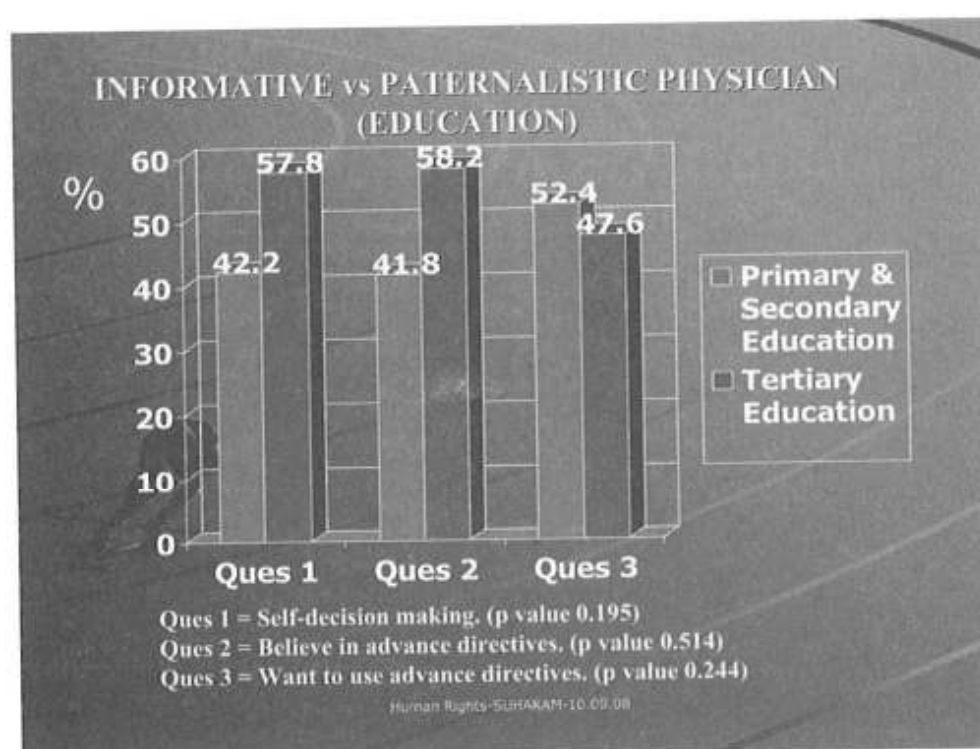
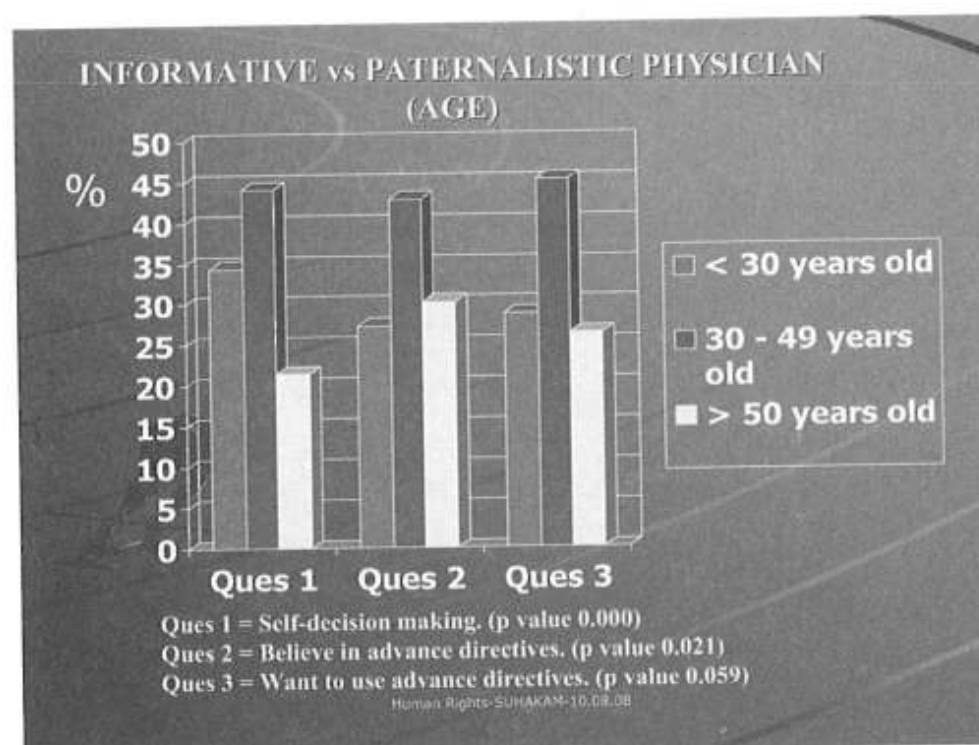
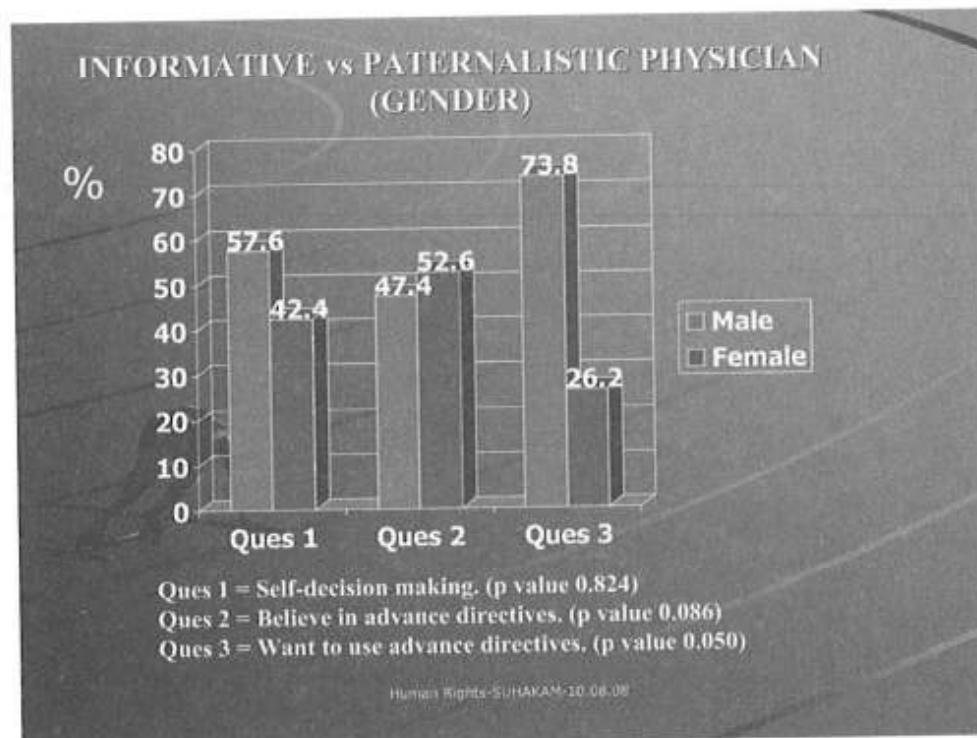
Reason for ever signed the consent form without fully understood the investigation/treatment plan	
Reason	Percentage
Doctors know better	60%
Family asked to sign	35%
Don't want to be responsible later	5%

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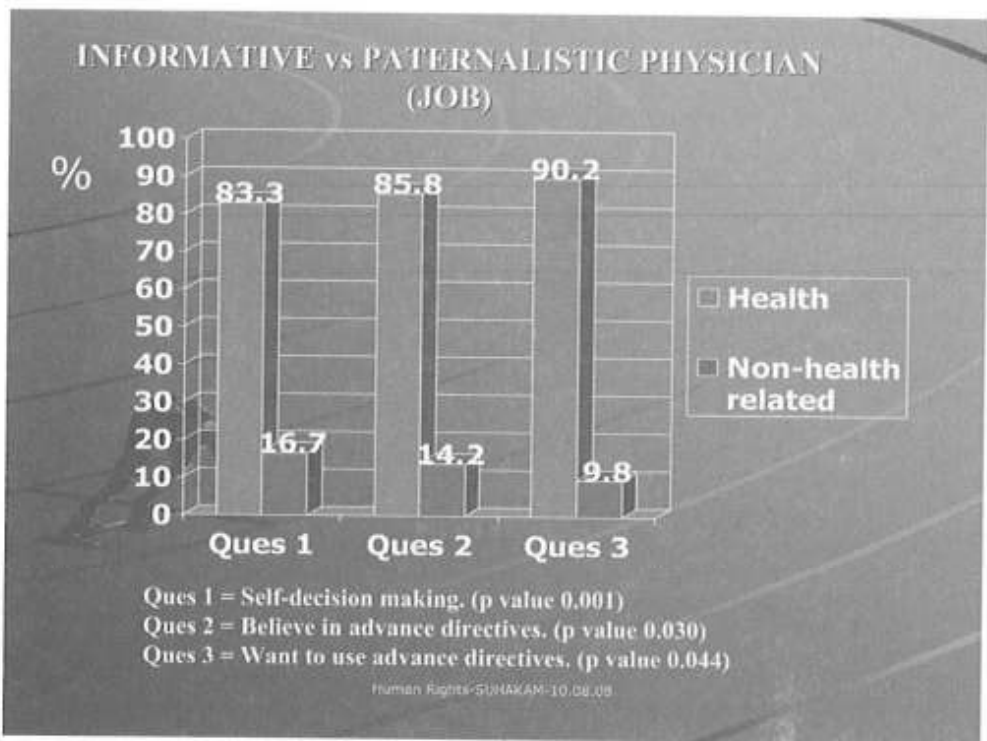
Reason for ever refused to sign the consent form	
Reason	Percentage
Family asked not to sign	40%
Afraid of the operation	12%
Want to seek alternative medicine	48%

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ANNEXURE 16



ANNEXURE 16



Reason for deciding the treatment or an operation by self

Reason	Percentage
Know better about self	20%
Want to be responsible	7%
Satisfied with physician' explanation	73%

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MULTIVARIATE ANALYSIS (GENDER, EDUCATION, AGE, JOB)

Hypothesis: Male with higher education level, age less than 40 didn't prefer family in health care matters.

	p value	odd ratio (C.I)
a) Tell the relatives.		
- Health related job:	0.006	3.777 (1.4478-7.8572)
b) Permission		
- Male:	0.0475	0.6381 (0.4091-0.9951)
- health related job:	0.3826	0.3826 (0.2091-0.7001)

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ANNEXURE 16

Hypothesis: Male with higher education level, age less than for 40 health related job are more concern about their.

	p value	odd ratio (C.I)
a. Fully disclosure		
- Male	: 0.0572	0.6500 (0.4215 - 1.0023)
- 2 ^o education	: 0.007	0.4752 (1.3713 - 3.2299)
b. Signed consent form		
- Male	: 0.0017	1.9971
- 2 ^o education	: 0.0472	2.1146
c. Self Decision-making		
- Male	: 0.000	0.2566 (1.1610 - 0.4087)
- Age (< 40)	: 0.001	0.4093 (0.2618 - 0.6399)
d. Belief in advance directive		
- Male	: 0.017	0.5240 (0.3156 - 0.8703)
- 2 ^o education	: 0.0294	0.5130 (0.2798 - 4.2968)
- Age (< 40)	: 0.081	2.2899 (1.2204 - 4.2968)

Human Rights-SUHAKAM-10.08.08

Conclusion

1. Female, older age group, less well educated are predictors of a preferences for the passive role in the doctor-patient relationship.
2. Patients didn't want an active role but neither they want to be entirely passive in the doctor-patient relationship
3. Impossible to predict individuals patient preferences for participation in medical decision making

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Informed Consent

- ◆ Definition
- ◆ "An informed consent is an **autonomous authorization by individuals** of a medical intervention or of involvement in research."

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The Requirement of Consent

PATIENT AUTONOMY

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."

Cardozo J in *Schloendorff v Society of New York Hospital* (1914) 105 NE 92.

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Different Types of Consent

Tacit Consent

Implicit or Implied Consent

Presumed Consent

Informed Consent

Meaning and Elements of Informed Consent

- ▲ Preconditions:
 1. Competence
 2. Voluntariness
- ▲ Informational elements:
 3. Disclosure of information
 4. Recommendation of a care plan
 5. Understanding of 3 & 4 by the patient
- ▲ Consent Elements:
 6. Decision by patient
 7. Authorization by the patient to proceed.

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ANNEXURE 16

Clinical Aspects of Informed Consent

- ♦ Informed consent is an ethical doctrine that rests on the principle of respect for persons and their **right to self determination**.
- ♦ Informed consent is a legal doctrine that is enforceable by law and as such as certain minimum standards that must be met.
- ♦ Standards include professional practice, reasonable person, subjective standard.

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The importance of informed consent

- ♦ Does the patient possess capacity to make a decision about his/her proposed care plan?
- ♦ Is the patient fully informed in terms of what a reasonable person should know?
- ♦ Is the decision voluntary? fit with goals?
- ♦ Does the patient understand that an experimental protocol may further scientific knowledge, yet unlikely to benefit him/her?

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Why is Consent Necessary

- ♦ Good Clinical Practice - willing patient better outcome

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Informed Consent in Research

- ▶ The burden of adequately informed consent is greater in research (therapeutic and non-therapeutic) than in therapeutic studies
 - Benefit to researcher
- ▶ The burden is greatest for non-therapeutic research
 - No benefit to patient

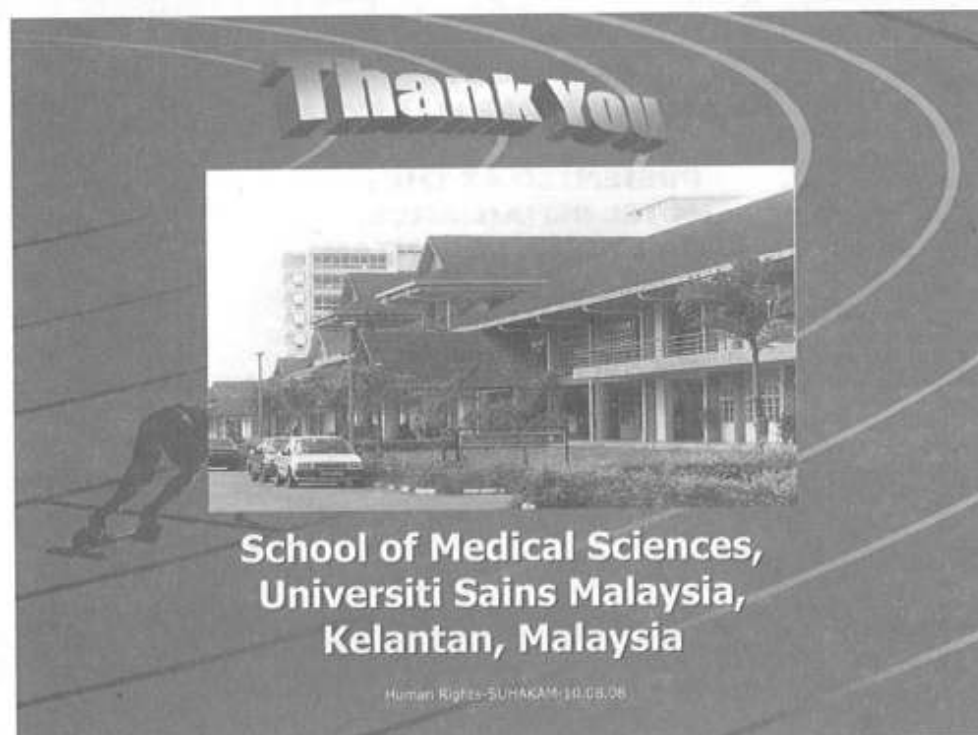
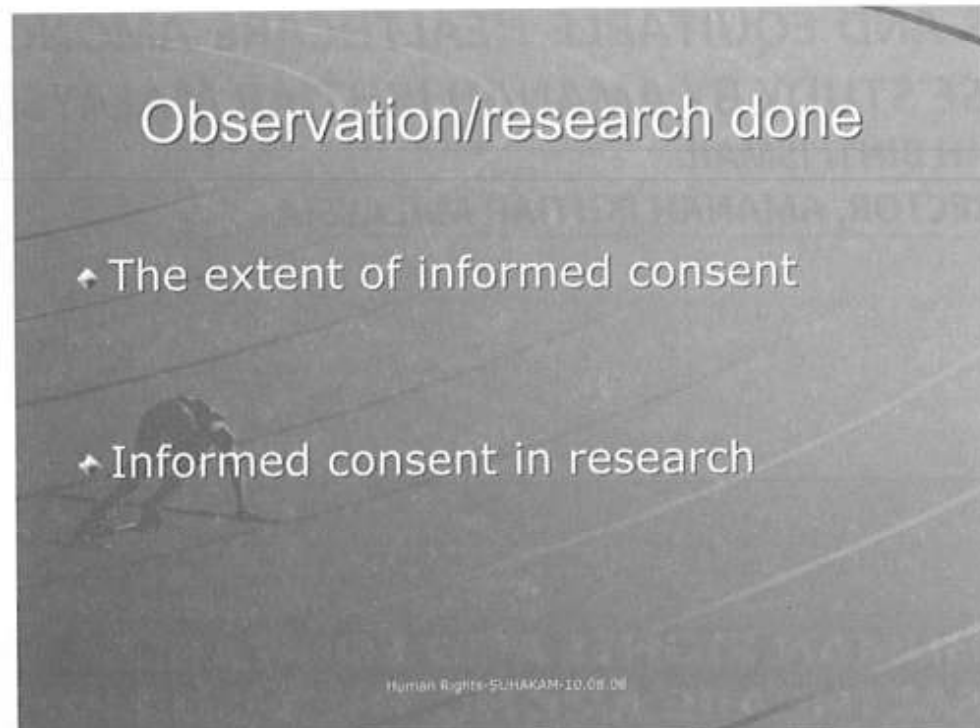
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Informed Consent: Problems and Uncertainties

Cultural Diversity and Autonomy

- ▶ *Informed consent is based on the principle of autonomy.*
- ▶ *Individual versus collective decision-making.*
- ▶ *Disclosure as central to the expression of autonomy and informed consent.*

ANNEXURE 16



**HUMAN RIGHTS AND EQUITABLE HEALTHCARE AMONG THE POOR IN
KELANTAN - CASE STUDY BY AMANAH IKHTIAR MALAYSIA**

BY HAJJAH ZABIDAH BINTI ISMAIL

MANAGING DIRECTOR, AMANAH IKHTIAR MALAYSIA

**HUMAN RIGHTS AND EQUITABLE
HEALTHCARE AMONG THE POOR IN
KELANTAN**

**CASE STUDY:
AMANAH IKHTIAR MALAYSIA**

**PRESENTED AT THE :
HOTEL RENAISSANCE,
KOTA BHARU, KELANTAN**

DATED : 10 AUGUST, 2008

PART ONE

BACKGROUND

ANNEXURE 17

AMANAH IKHTIAR MALAYSIA



- **Established on 17th September 1987 as a Registered Private Trust and regulated by the Instrument of Trust of Amanah Ikhtiar Malaysia.**
- **Registered under the Trustee (Incorporation) Act 1952 Revised 1981. Received Certificate of Incorporation on 20th October 1988.**
- **Governed by the Board of Trustees, comprising Senior Government Officers and experienced individuals in related fields.**



OBJECTIVE

Reducing poverty among very poor households in Malaysia by extending benevolent loans for the purpose of financing additional income generating activities. (Instrument of Trust of AIM, 1987)

VISION

To be a blessed and dynamic international Micro Finance Institution in alleviating poverty and improving society's prosperity.

DEFINITION OF POVERTY

“POVERTY” means a state of living in which a household has a total per-capita monthly household income of less than that defined from time to time by the government as required for a minimal level of living in the Malaysian context, and/ or in which some or all the basic human needs such as for health, education and housing are not satisfactorily met (Instrument of Trust of Amanah Ikhtiar Malaysia, 1987)

POVERTY LINE 1987-2005

YEAR	AIM POVERTY LINE INCOME (RM)	GOVERNMENT POVERTY LINE INCOME (GPLI) (RM)		
		PENINSULAR MALAYSIA	SABAH	SARAWAK
	MONTHLY	MONTHLY	MONTHLY	MONTHLY
1987	250 (2/3 GPLI)	350	533	429
1988-1990	250 (2/3 GPLI)	350	533	429
1991-1992	250 (2/3 GPLI)	350	533	429
1992-1994	270 (2/3 GPLI)	405	582	495
1995-1997	285 (2/3 GPLI)	425	601	516
1998-2002	340 (2/3 GPLI)	510	685	584
2003	620	529	690	600
2004-2005	529	529	690	600

POVERTY LINE BY STATE (PLI) (2006)

STATE	HOUSE- HOLDS SIZE	PLI POOR PER CAPITA (RM)	PLI POOR PER CAPITA (RM)
Johor	4.7	656	142
Kedah	4.7	676	144
Kelantan	5.4	672	126
Melaka	4.5	666	149
N Sembilan	4.2	612	147
Pahang	4.4	633	144
P Pinang	4.6	679	150
Perak	4.3	597	140
Perlis	4.2	589	142
Selangor	4.7	688	148
Terengganu	5.2	762	147
Sabah	5.4	897	170
Sarawak	4.7	753	164
WP Labuan	5.4	909	171
Semenanjung	4.7	657	142
Malaysia	4.8	698	148

ANNEXURE 17

Phases of Expansion

Pilot Phase (1986-1988)	Projek Ikhtiar – An Action Research Project by USM to test Grameen Approach in Malaysia – 2 ½ years in Northwest Selangor Area Financed by the State of Selangor, Asia Pacific Development Center, Malaysian Islamic Economic Foundation (VPEIM)
Phase 1 (1988-1995)	Expansion of AIM in Peninsular Malaysia Financed by Loan Fund – VPEIM, Banks, Credit Guarantee Corporation Administrative Cost – Grant from State and Federal Government/ Administrative Charge
Phase 2 (1996 – now)	Expansion of AIM in Sabah and Sarawak Financed by Loan Fund – Soft Loan From Federal Government Administrative Cost- Administrative Charge

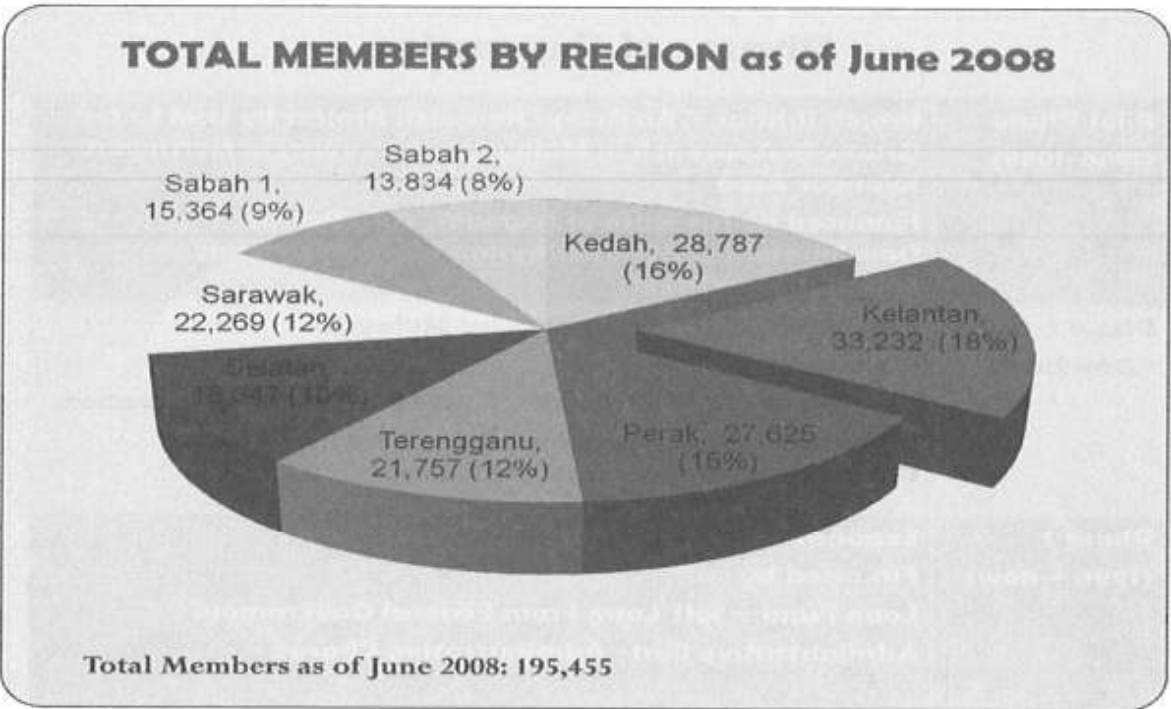
MALAYSIA



Persistence of Poverty in Malaysia vs AIM Outreach

	2004			Dec 2007		
	Total	Urban	Rural	Total	Urban	Rural
% Of Poverty	5.7	2.5	11.9	na	na	na
% of Poor Households	311,300	91,600	219,700	na	na	na
% of Hardcore Poor Households	1.2	0.4	2.9	na	na	na
No of Hardcore Poor Households	67,300	14,100	53,200	na	na	na
Total Households	5,459,400	3,605,900	1,853,500	na	na	na
AIM Total Outreach		192,032 (62% of poor hsholds)			257,000 (82% of poor hsholds)	
AIM Total Existing Members		131,892			178,352	

ANNEXURE 17



AIM'S MICROFINANCE PROGRAM	
Target Group	
Poor Women	
Products	Approaches
☐ Economic Loan	☐ Group Support/ Pressure
☐ Educational Loan	☐ Human Capital Development
☐ Multipurpose Loan	☐ Social Development
☐ Compulsory Saving	
☐ Welfare and Well Being Fund	

WELFARE AND WELL BEING FUND	
SOURCES	BENEFITS
MEMBERS COLLECTION RM 1/ MONTH	DONATION DURING DEATH
1% CONTRIBUTION FROM ECONOMIC LOAN	CHRONIC ILLNESS & HOSPITALIZATION
CONTRIBUTION FROM AIM	FIRE & NATURAL DISASTER
DONATION	DONATION TO PILGRIM (MECCA)

ANNEXURE 17

**SPECIFIC TARGET GROUP:
POOR WOMEN FROM ALL RACES**

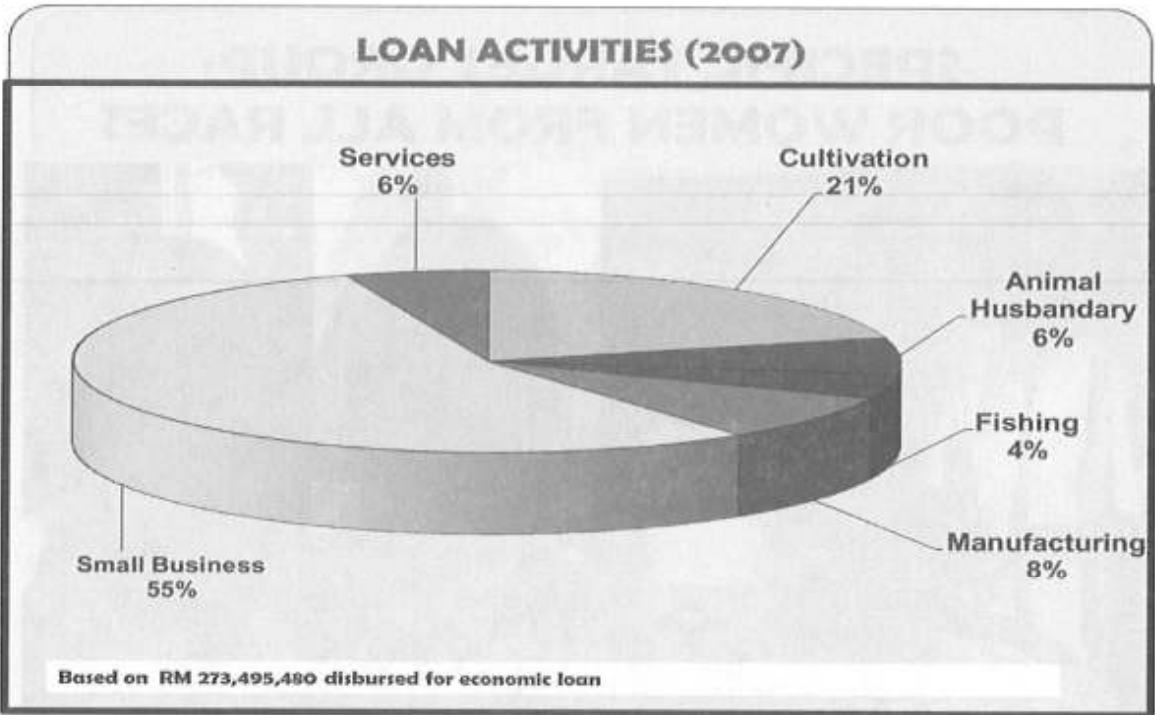


**SPECIFIC TARGET GROUP:
POOR WOMEN**

- Poor households with family income of less than the Government Poverty Line Income are eligible to become AIM's members and are entitled for services offered.
- No longer poor members are also entitled for AIM's services. This is to prevent members from falling back to poverty.
- Benefits from the program, for example increase in income will contribute to the well-being of family members.

ACHIEVEMENT AS OF JUNE 2008

Total Members	191,455
Total Disbursement (RM)	2,609,835,243
No of Branches	69
No of States	13
Group Savings (RM)	113,063,558
Welfare Fund – Collection (RM)	9,348,077.41
Claims	4,853,202.60
Portfolio At Risk (%)	2.94
Repayment Rate (%)	98.3

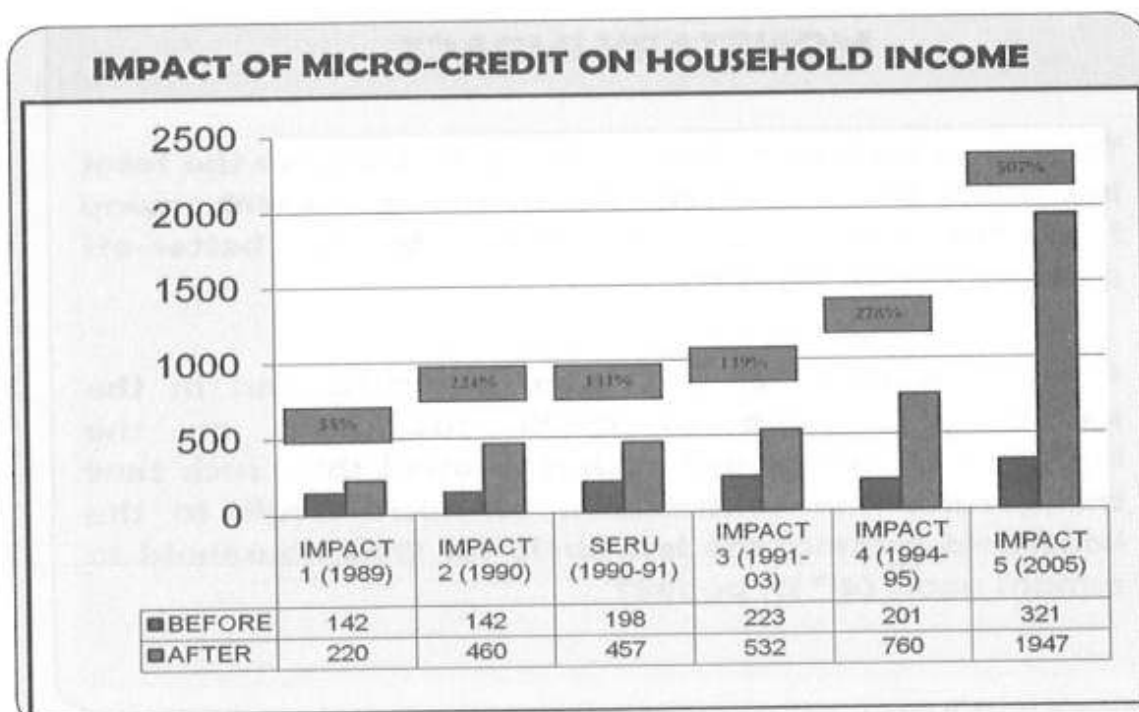


PREVIOUS AIM IMPACT ASSESSMENT STUDIES			
No	Name of Studies	Duration	Researchers
1	The First Internal Impact Assessment Study	1988	CPR-USM
2	The Second Internal Impact Assessment Study	April – July 1990	AIM Research Unit
3	The SERU Impact Assessment Study	1990	Social and Economic Research Unit of the Prime Minister's Department
4	The Third Internal Impact Assessment Study	1991 – 1993	AIM Research Unit
5	1994-1995 External Impact Assessment Study	1994 – 1995	CPR-USM

STATUS OF IKHTIAR'S MICRO-CREDIT PROGRAM AT VARIOUS IMPACT STUDIES (IS)						
1	Impact Studies	1 ST IS	2 ND IS	SERU IS	3 RD IS	4 TH IS
2	Year	1988	1990	1990	1991	1994
3	Researchers	Internal	Internal	External	Internal	External
4	Time Horizon	Cross Section	Cross Section	Cross Section	Longitudinal	Longitudinal
5	Duration of Data Collection				12 months	6 months
6	Sample Size	178	200	587	265	348
7	Population Size/ Total Members	448	909	3,220	9,401	25,470
8	HH Income/ Assets Survey	✓	✓	✓	✓	✓
9	Structured Questionnaire	✓	✓	✓	✓	✓
10	Daily Flow Income - Expenditure				✓	✓
11	Excessive use of Secondary Data					✓

ANNEXURE 17

MAJOR FINDINGS (1988-1995)		
No	Major Findings	Impact Studies
1	Borrowers' Income increase	All Impact Studies
2	Impact on female members/ female headed family are better than male members/ male head family	Impact Study 1, Impact Study 2 and Impact Study 4
3	Through rigorous means test, leakage to the non poor is very small	SERU Impact Study and Impact Study 4
4	Income increase among the borrowers are higher than those of control group eligible but non-participating poor	Impact Study 2 (570 vs 134), Impact Study 4 (627 vs 229)
5	Significant percentage of borrowers are moving out of poverty	Impact Study 2 (49%), SERU (63%), Impact Study 4 (57.5%)
6	Non-monetary impact – quality of housing, children education and nutrition, positive values among participants	SERU, Impact Study 4
7	Significant Cost Effectiveness in Poverty Reduction	SERU, Impact Study 4



MICROCREDIT, GENDER & POVERTY REDUCTION

- Overall 78% of the loan amount due before end of the pilot project was repaid in full and on time. It was below 97-98% cumulative repayment rate achieved by Grameen Bank. 78% repayment rate was also below the 90% target set for the pilot project. But among the women borrowers of Projek Ikhtiar the repayment rate had been 95%. Therefore, AIM considered women borrowers as the saviors of Projek Ikhtiar. (1st IS, 1988)
- Not only micro-credit an important element in poverty reduction, the effectiveness is greater in women headed households. (4th IS, pg 163)

IMPACT OF MICROCREDIT ON POVERTY REDUCTION

- Micro-credit is responsible for some major reduction of poverty particularly among “formerly very poor Active Borrowers”. Access to microcredit have enabled almost 57% of the Active Borrowers to get out of poverty by capitalizing on their income-generating survival skills while only 11% are still entrenched at the very poor poverty level. (4th Impact Study, pg 161)
- On the other hand, the general development in rural Malaysia enables the poor namely, the Non-Participating, the Non-borrowing Members and Dropouts to earn some income which is still insufficient for substantial poverty reduction. (4th Impact Study, pg 161)

MONETARY IMPACT

- The percentage contribution of micro-credit to the total household income increases with the movement away from the lowest economic status to the better-off position. (4th IS, pg 197)
- There is a trend of increasing diversification in the sources of income as credit capitalizes on the household's income generating survival skills such that the greater the contribution of micro-credit to the household income, the less likely for that household to remain poor. (4th IS, pg 198)

NON-MONETARY IMPACT

- The fact that most Active Borrowers manage to increase and generate a variety of non-monetary benefits over time compared to Non-participating Poor is another important dimension of the role of micro-credit in fulfilling basic human need through self-reliant. (4th IS, pg 318)

ANNEXURE 17

NON-MONETARY IMPACT

- Access to piped water, electricity and toilet facilities, improvement to physical housing conditions such as strengthening the house, improvement to wall and roof, accessibility to land and generation of a variety of savings, improved means of transportation are examples of non-monetary benefits that the poor can enjoy with a little help from micro-credit and the social development program associated with poverty reduction. (4th IS, pg 318)

FINDINGS FROM IMPACT STUDY 4:
SPECIAL FEATURE – CATEGORIZING ACTIVE BORROWERS
CONCLUDING REMARKS

Access to micro-credit, continuous utilization of it, managed by the borrowers themselves as fund managers and the ability to get substantially bigger amount of loan as high-jumpers were responsible for a significant number of formerly very poor and poor households to get out of poverty. This is then the experience of Active Borrowers. The absence of this important financial product was responsible for a greater number of the non-participating poor remaining very poor over the same period of time. (4th Impact Study, pg xv)

PART TWO

PERFORMANCE AND IMPACT OF
AIM PROGRAM IN KELANTAN
(IN RELATION TO HUMAN RIGHTS AND EQUITABLE
HEALTHCARE AMONGST THE POOR IN KELANTAN)

CONTENTS

- Persistence of Poverty in Kelantan vs AIM Outreach
- ACHIEVEMENT OF AIM AS OF JUNE 2008
- ACHIEVEMENT OF AIM IN KELANTAN AS OF JUNE 2008
- FINDINGS FROM AIM IMPACT STUDY 5
 - INCOME SURVEY
 - EXPENDITURE PATTERN (IN RELATION TO FULFILLMENT OF BASIC NEEDS/ HUMAN RIGHTS)
- THE SAHABAT WELFARE & WELL BEING FUND (HEALTH CARE RELATED PRODUCT OF AIM)
- WOMEN EMPOWERMENT

Persistence of Poverty in Kelantan vs AIM Outreach

	2004			Dec 2007		
	Total	Urban	Rural	Total	Urban	Rural
% Of Poverty	10.6	8.3	11.8	na	na	na
No of Poor Households	30,002	8,037	21,965	na	na	na
% of Hardcore Poor Households	1.3	0.8	1.5	na	na	na
No of Hardcore Poor Households	3,550	804	2,746	na	na	na
AIM Total Existing Members	25,250 (84%)			33,197 (111%)		

AIM’S ACHIEVEMENT AS OF JUNE 2008

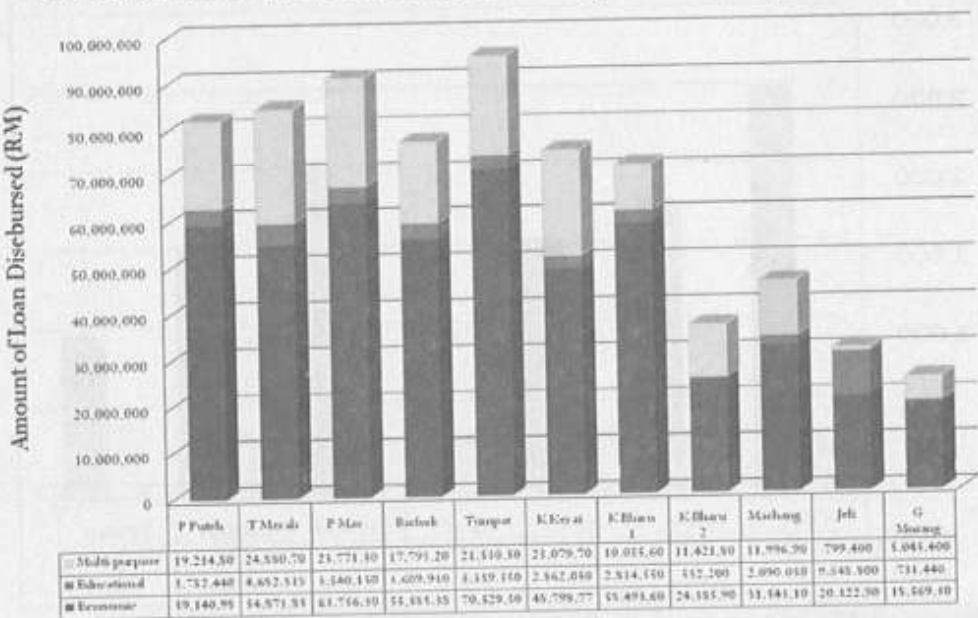
Particulars	Kelantan	AIM	%
Total Members	34,836	191,455	18
Total Disbursement (RM)	713,440,838	2,609,835,243	27
No of Branches	11	69	16
Welfare & Well Being Fund – Claims (RM)	1,170,711.00	6,599,079.00	18
Portfolio At Risk (%)	1.43	2.94	-
Repayment Rate (%)	98.73	97.30	-

ANNEXURE 17

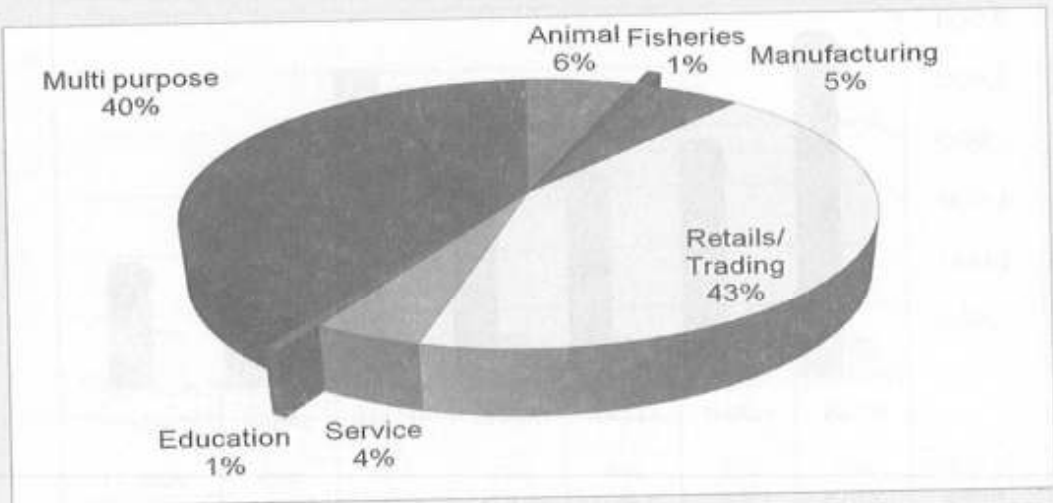
Total Members and Cumulative Loan Disbursement (June 2008)

Branch	No of Members	Amount of Loan Disbursed (RM)			
		Economic	Educational	Multi-purpose	Total
P Puteh	3,481	59,140,980	3,782,440	19,234,800	82,158,220
T Merah	3,085	54,871,850	4,682,818	24,880,700	84,435,368
P Mas	3,859	63,756,300	3,540,150	23,771,500	91,067,950
Bachok	3,591	55,585,380	3,609,910	17,793,200	76,988,490
Tumpat	3,925	70,529,500	3,339,350	21,530,500	95,399,350
K Keral	2,976	48,798,770	2,862,050	23,079,700	74,740,520
K Bharu 1	3,030	58,493,600	2,814,550	10,055,600	71,363,750
K Bharu 2	2,908	24,385,900	532,200	11,421,800	36,339,900
Machang	2,995	31,543,100	2,090,050	11,996,900	45,630,050
Jeli	2,656	20,322,900	9,848,800	799,400	30,971,100
G Musang	2,330	18,569,300	731,440	5,045,400	24,346,140
Kelantan	34,836	505,997,580	28,784,358	178,658,900	713,440,838

Cumulative Loan Disbursement (June 2008) - Kelantan



LOAN ACTIVITIES (2008) - KELANTAN



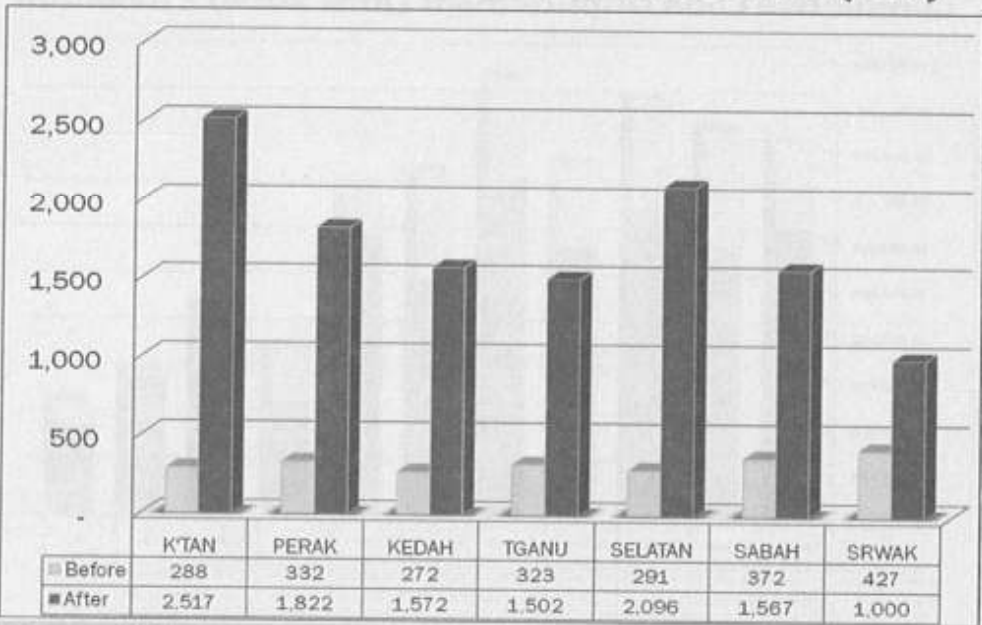
Based on RM 56,344,140 disbursed from Jan till May 2008

AIM IMPACT STUDY 5 (2004/05) – INCOME SURVEY

REGION	ALL RESPONDENTS			ACTIVE BORROWERS		
	Before	After	% Change	Before	After	% Change
K'TAN	288	2,517	774	266	2,815	958
PERAK	332	1,822	449	345	1,930	459
KEDAH	272	1,572	478	286	1,695	493
TGANU	323	1,502	365	342	1,574	360
SELATAN	291	2,096	620	300	2,580	760
SABAH	372	1,567	321	369	1,569	325
SRWAK	427	1,000	134	428	1,000	134
TOTAL	310	1,816	486	324	1,948	501

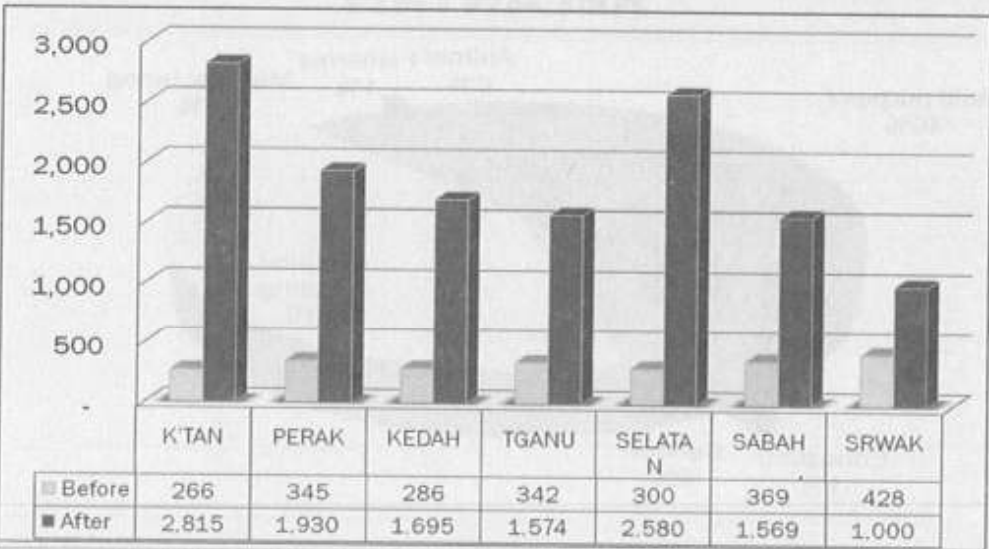
No of Respondents – 1,779: Active Borrowers – 1,497, Drop-outs – 102, Non-Borrowing Members – 30, Default Borrowers – 43, Non-Members – 75, Fishermen Scheme Members – 32

RESPONDENTS' MONTHLY INCOME (RM)



Source: AIM's Impact Study 5, 2004-2005, based on 1,779 samples

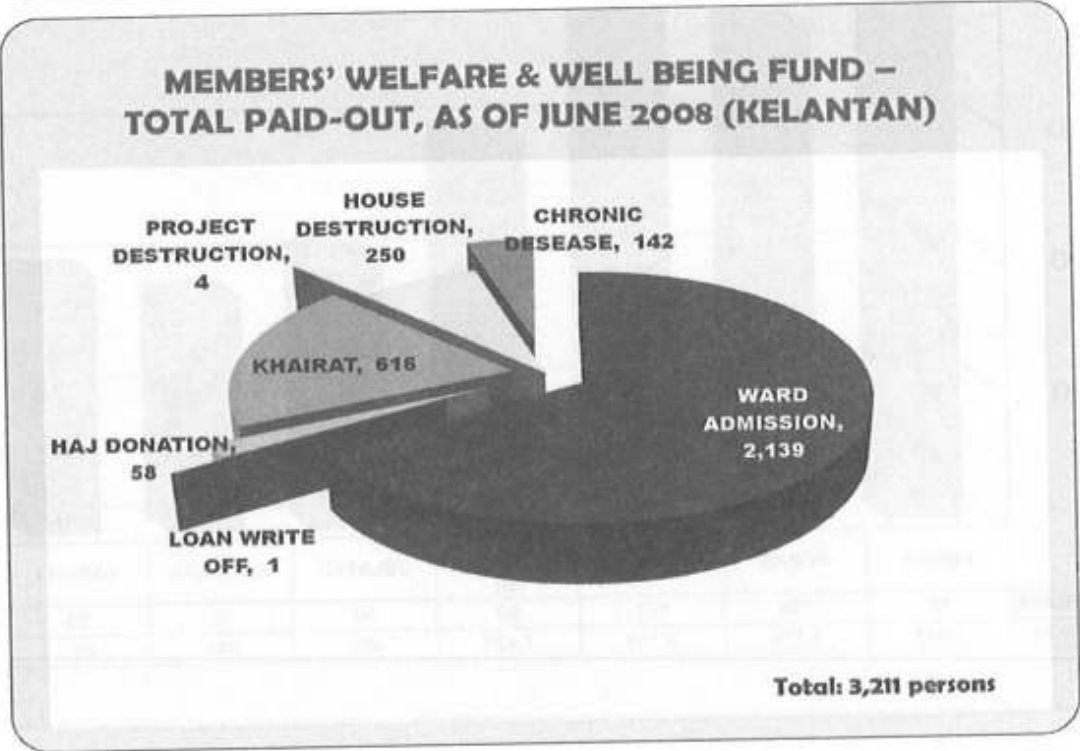
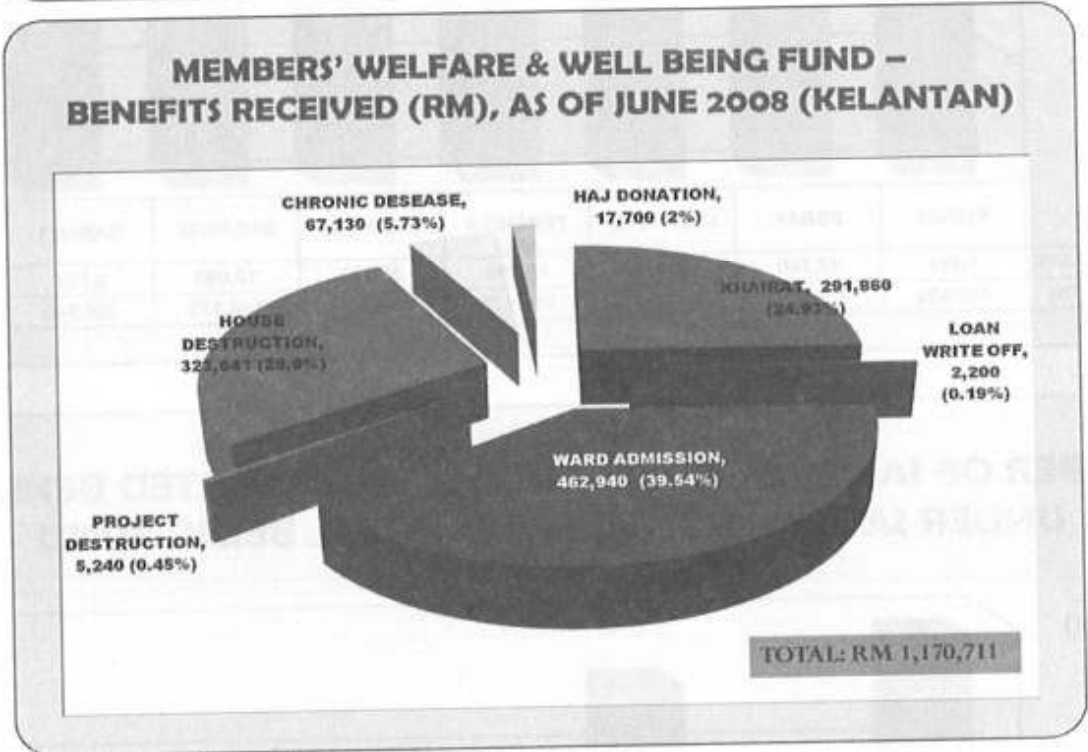
ACTIVE BORROWERS' MONTHLY INCOME



Source: AIM's Impact Study 5, 2004-2005, based on 1,497 samples

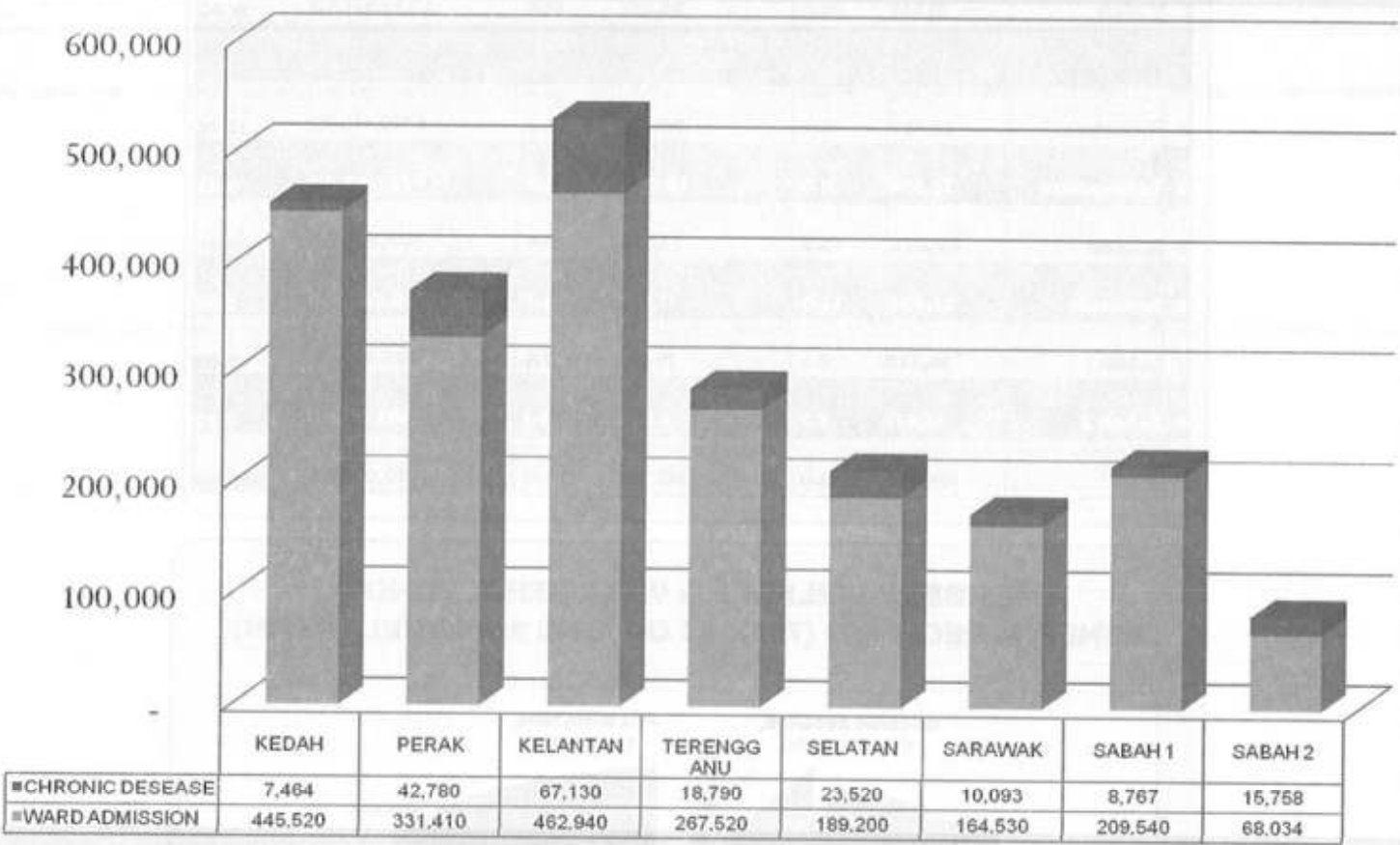
ANNEXURE 17

Members Welfare and Well Being Fund – Performance As Of June 2008 (AIM)							
Region	Total Members	% of total	Total Members Contribute to the Fund	% of total	Amount of Benefits Received (RM)	% of total	
1 Kedah	31,147	16.3	26,231	17.8	1,207,531.40	18.30	
2 Perlis	28,274	14.8	22,333	15.2	977,704.50	14.75	
3 Kelantan	34,836	18.2	29,231	19.9	1,170,711.00	17.74	
4 Terengganu	22,554	11.8	19,026	12.9	622,089.40	9.43	
5 Selatan	20,820	10.9	14,169	9.6	828,926.80	12.56	
6 Sarawak	22,926	12.0	17,167	11.7	520,064.00	7.88	
7 Sabah 1	16,227	8.5	11,021	7.5	793,910.40	12.03	
8 Sabah 2	14,671	7.7	7,567	5.1	483,141.00	7.32	
AIM	191,455	100.0	147,197	100.0	6,599,078.60	100.00	

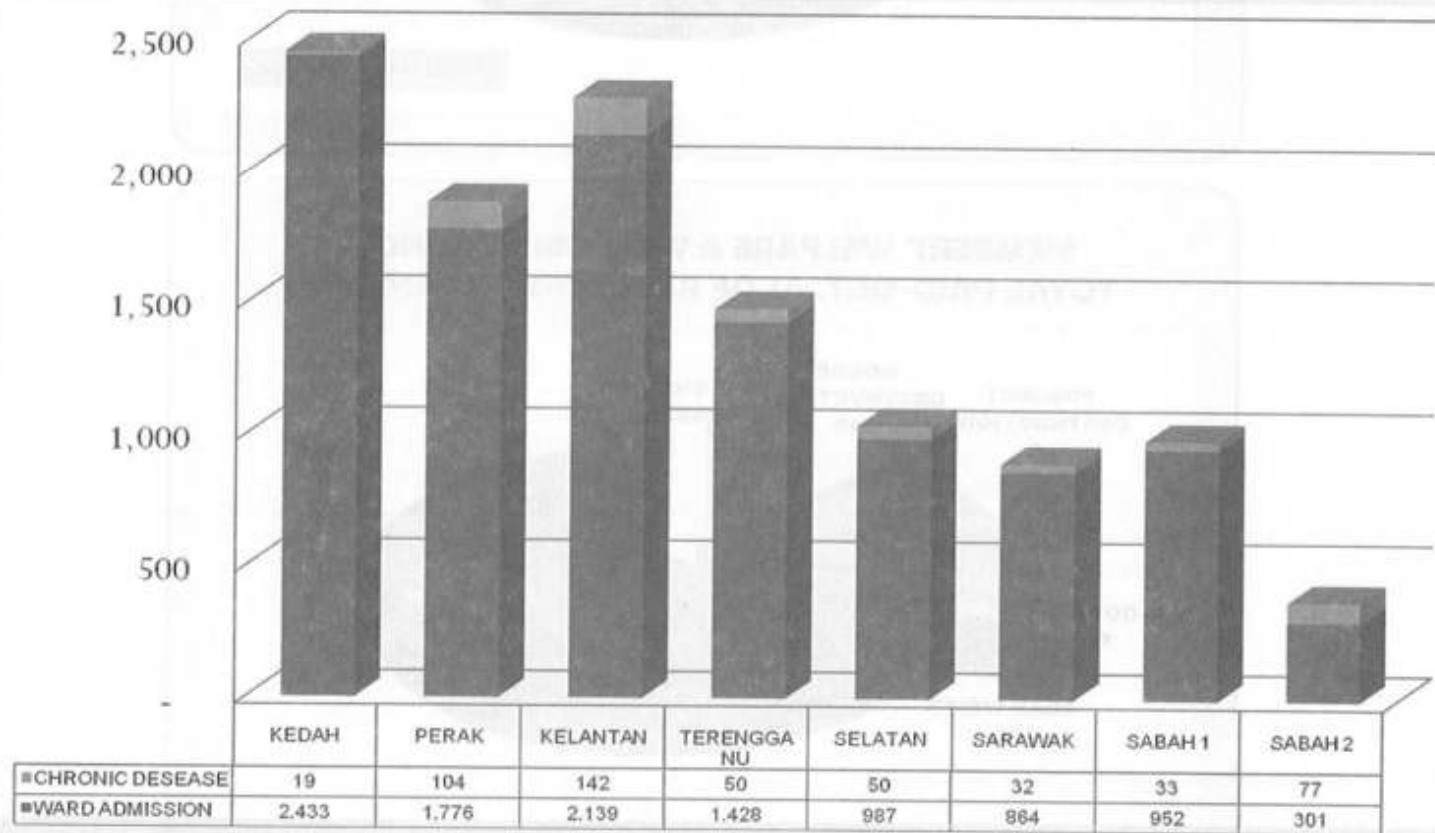


ANNEXURE 17

AMOUNT (RM) PAID FOR HEALTH RELATED BENEFITS UNDER THE SAHABAT'S WELFARE & WELL BEING FUND



NUMBER OF SAHABAT RECEIVING HEALTH RELATED BENEFITS UNDER SAHABAT'S WELFARE & WELL BEING FUND

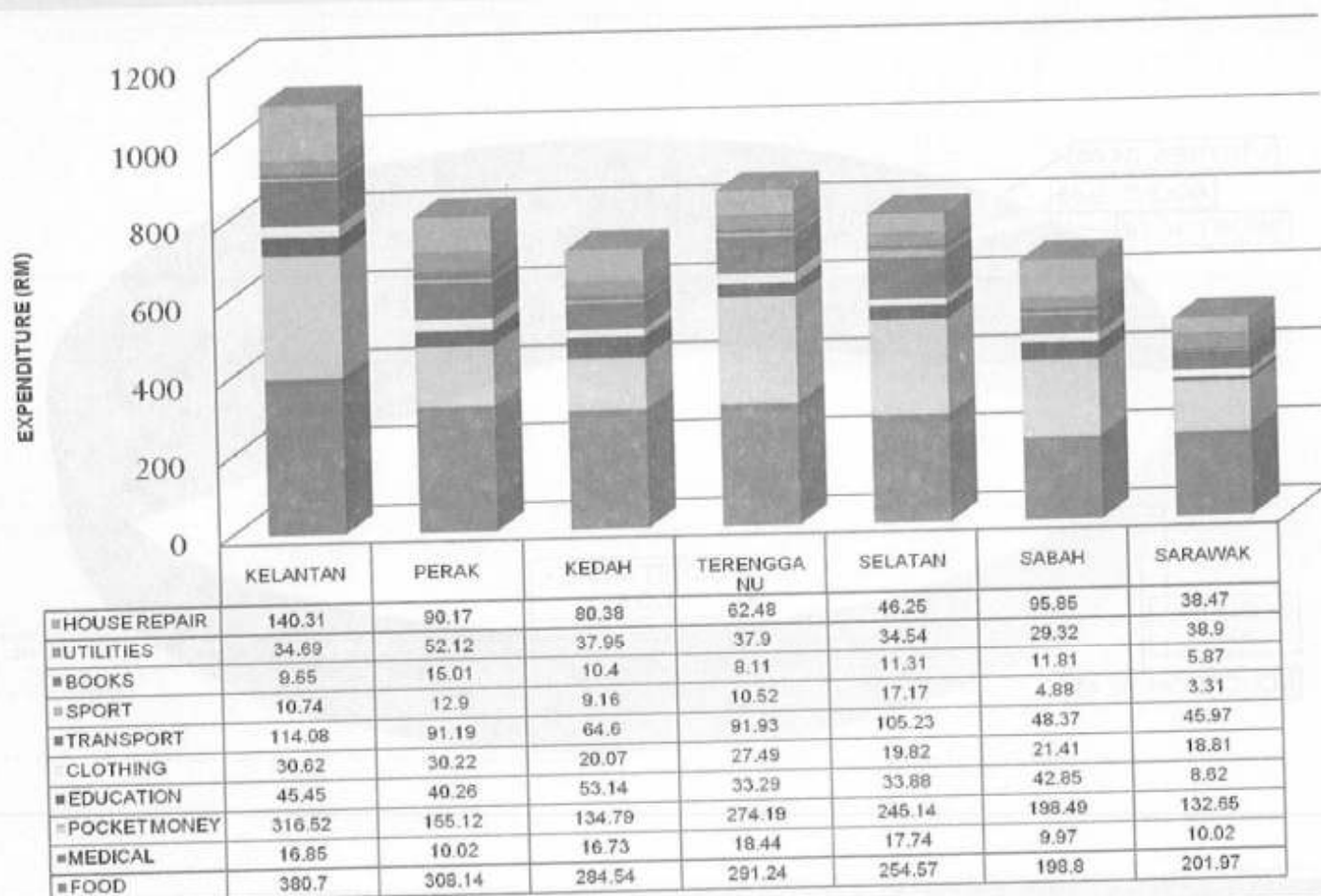


ANNEXURE 17

AIM'S IMPACT STUDY 5- MONTHLY EXPENDITURE PATTERN (RM)

REGION	FOOD	MEDI-CAL	POCKET MONEY	EDUCATION	CLOTHING	TRANSPORT	SPORT	BOOKS	UTILITIES	HOUSE REPAIR	TOTAL EXPENDITURE
KELANTAN	380.70	16.85	316.52	45.45	30.62	114.08	10.74	9.65	34.69	140.31	1,099.61
PERAK	308.14	10.02	155.12	40.26	30.22	91.19	12.90	15.01	52.12	90.17	805.15
KEDAH	284.54	16.73	134.79	53.14	20.07	64.6	9.16	10.40	37.95	80.38	711.76
TERENGGANU	291.24	18.44	274.19	33.29	27.49	91.93	10.52	8.11	37.9	62.48	855.59
SELATAN	254.57	17.74	245.14	33.88	19.82	105.23	17.17	11.31	34.54	46.25	785.65
SABAH	198.8	9.97	198.49	42.85	21.41	48.37	4.88	11.81	29.32	95.85	661.75
SARAWAK	201.97	10.02	132.65	8.62	18.81	45.97	3.31	5.87	38.9	38.47	504.59

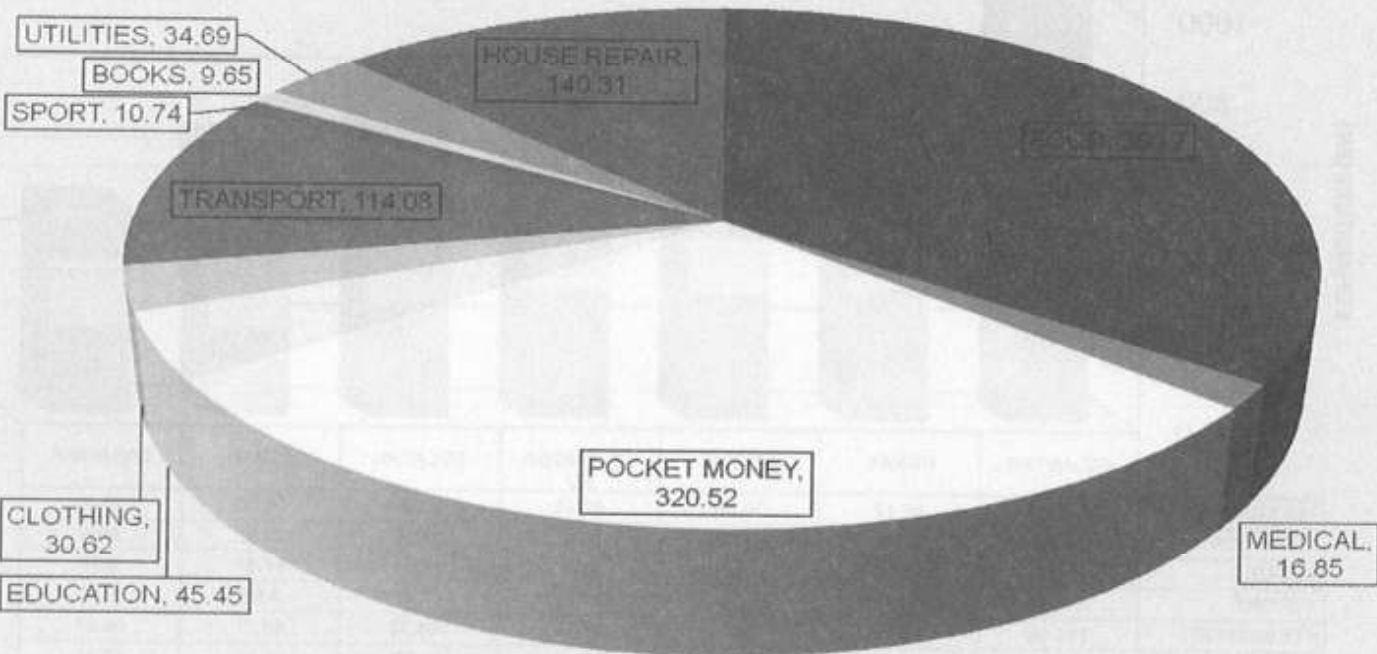
EXPENDITURE PATTERN AMONG RESPONDENTS



AVERAGE MONTHLY EXPENDITURE

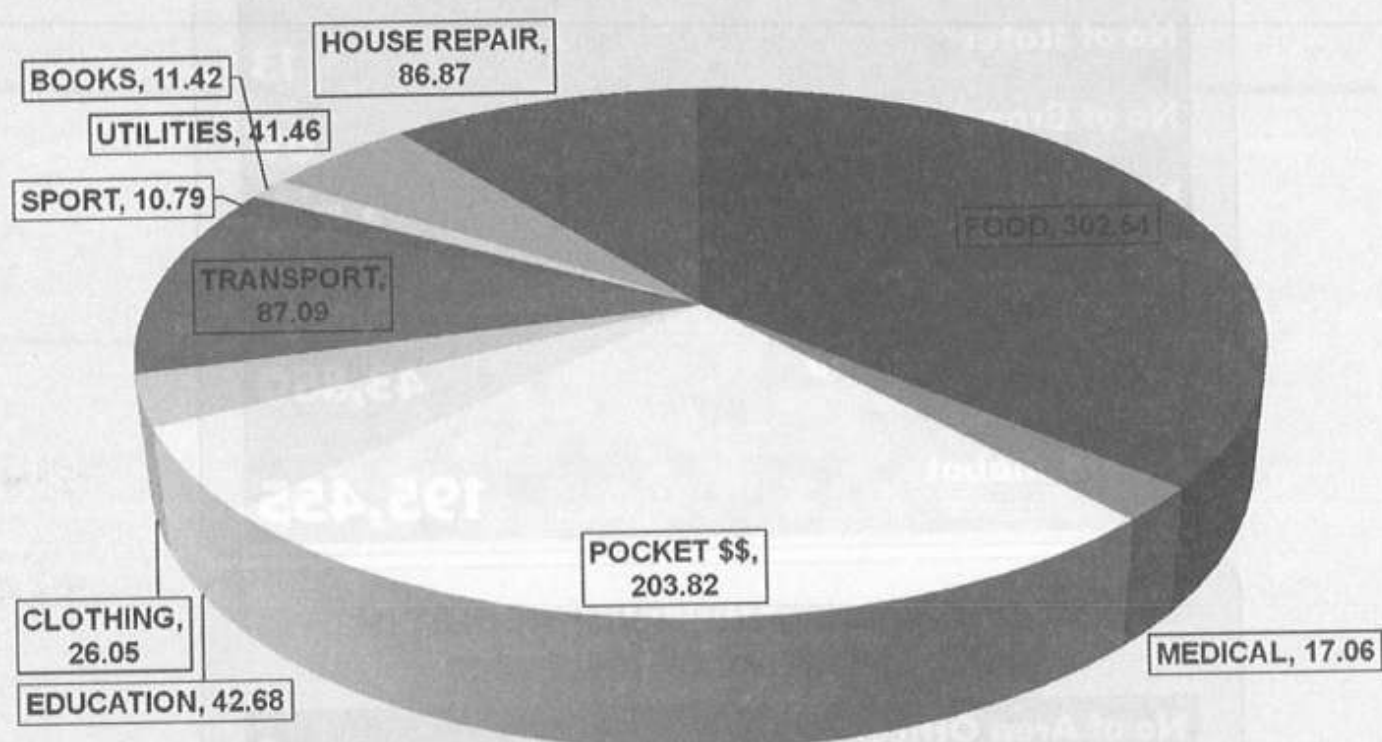
ITEM	AVERAGE MONTHLY EXPENDITURE (RM)			
	KELANTAN		ALL REGIONS	
	RM	%	RM	%
FOOD	380.7	34.62	302.54	36.46
MEDICAL	16.85	1.53	17.06	2.06
POCKET MONEY	316.52	28.78	203.82	24.56
EDUCATION	45.45	4.13	42.68	5.14
CLOTHING	30.62	2.78	26.05	3.14
TRANSPORT	114.08	10.37	87.09	10.50
SPORT	10.74	0.98	10.79	1.30
BOOKS	9.65	0.88	11.42	1.38
UTILITIES	34.69	3.15	41.46	5.00
HOUSE REPAIR	140.31	12.76	86.87	10.47
TOTAL EXPENDITURE	1,099.61	100.00	829.78	100.00

MONTHLY EXPENDITURE PATTERN (KELANTAN) (RM)

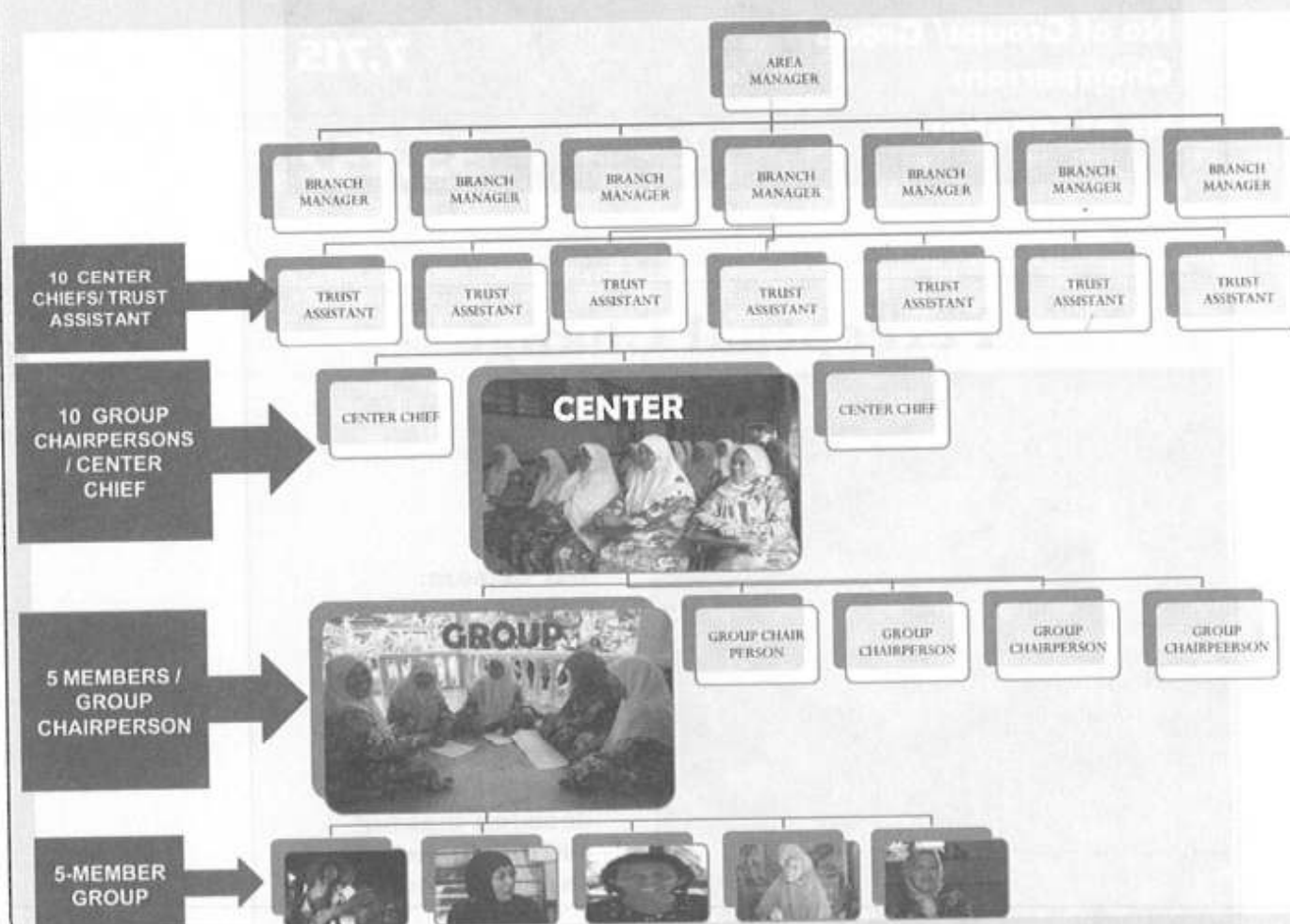


ANNEXURE 17

MONTHLY EXPENDITURE PATTERN (ALL REGIONS)



WOMEN EMPOWERMENT THROUGH DECENTRALIZED SUPERVISION MECHANISM



**AIM'S DECENTRALISED SUPERVISION
UNIT AS OF JUNE 2008**

No of Area Offices	8
No of States	13
No of Branches	69
No of Villages	3,745
No of Centers/ Center Chiefs	5,027
No of Groups/ Group Chairpersons	43,880
No of Sahabat	195,455

**DECENTRALISED SUPERVISION UNIT IN
KELANTAN AS OF JUNE 2008**

No of Area Offices	1
No of Branches	11
No of Villages	604
No of Centers/ Center Chiefs	882
No of Groups/ Group Chairpersons	7,715
No of Sahabat	33,232

Perceptual Change



Self Esteem:
Enhance perception
of own individuality,
interest and value

Decision-making:
Increase role in
decision making
within the household
and community

ANNEXURE 17

Perceptual Change



Weekly Center Meeting: To Build Visibility and respect: Increased recognition and respect for individual's value and contribution

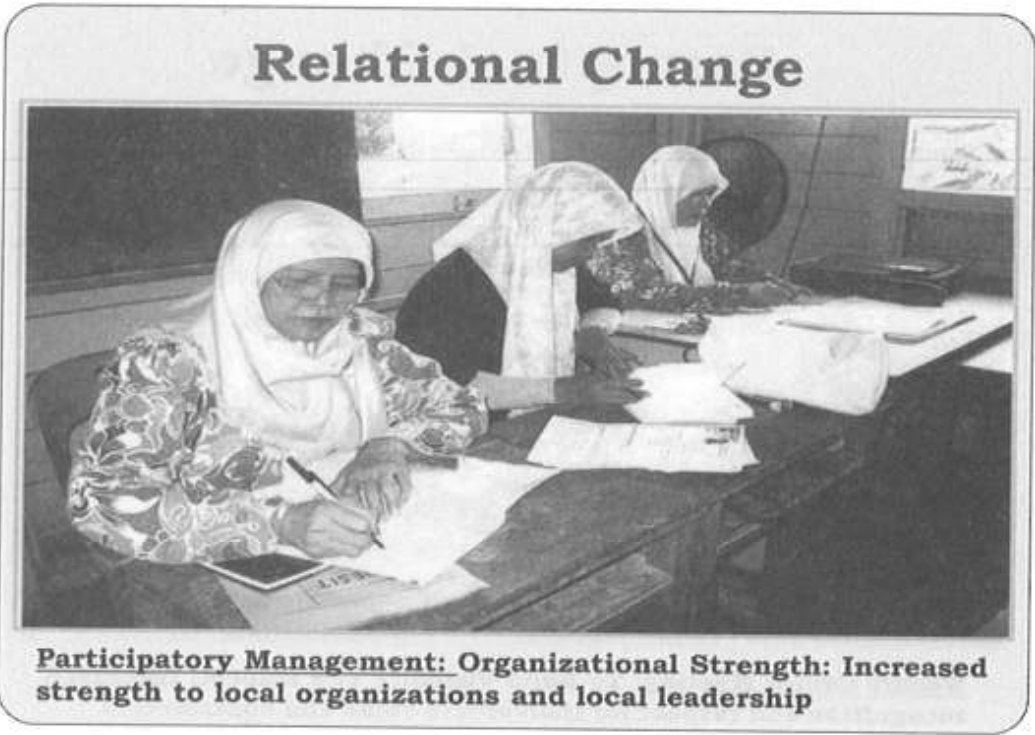
Relational Change

- | | |
|------|---|
| i. | Decision-making: Increase role in decision making within the household and community |
| ii. | Bargaining Power: Increase Bargaining Power |
| iii. | Participation: Increased participation in non-family groups, in local institutions, in local government, in political process |
| iv. | Self Reliance: Reduce dependence on intermediation by others for access to resources, markets, public institutions plus increased ability and ability to act independently |
| iv. | Organizational Strength: Increased strength to local organizations and local leadership |

Relational Change



Participatory Management (Group Meeting): Increased participation in non-family groups



**HAK ASASI MANUSIA DAN KESAKSAMAAN AKSES PERSEITARAN DAN
PENJAGAAN KESIHATAN DALAM KALANGAN OKU**

BY ASSOC. PROF. DR. TIUN LING TA

**SCHOOL OF SOCIAL SCIENCE, UNIVERSITI SAINS MALAYSIA / PRESIDENT, PERSATUAN
ORANG-ORANG CACAT ANGGOTA MALAYSIA (POCAM)**

Hak Asasi Manusia dan Kesaksamaan Akses
Persekitaran dan Penjagaan Kesihatan dalam
Kalangan OKU

Oleh
Prof. Madya Dr. Tiun Ling Ta
Presiden POCAM

Pengenalan

- Sebahagian drp masyarakat – warganegara yang sah – berhak menikmati semua kemudahan yang disediakan seperti warga lain.
- Takrifan – tidak seragam dan istilah OKU sendiri masih menjadi perdebatan

Statistik

- Jumlah terkini 220,250 orang di seluruh negara (Web. JKM). Kelantan – 17,239 orang. Hanya mereka yang berdaftar. Bagaimana mereka yang tidak berdaftar?
- Ketiadaan data – tiada perancangan yang jitu – perancangan hanya berasaskan keperluan – lebih kepada kebajikan dan tidak menyeluruh.

Isu dan Cabaran

- Anggap sebagai liabiliti –kebajikan harus dijaga
- Minda dunia ketiga
- Stereotype
- Masalah penguatkuasaan
- Masalah pergerakan

Isu Kesihatan

- Bukan sahaja di Kelantan – secara umum agak memuaskan tetapi masih banyak boleh diperbaiki.
- Usaha mempertingkatkan kesihatan melalui pencegahan, program pengesanan awal, program penjagaan kesihatan dan pemakanan – masalah kaitan dengan tahap kesedaran ibubapa
- Usaha cuba sembunyikan anak yang cacat

ANNEXURE 18

Sambungan...

- Pusat kesihatan menyediakan kemudahan pemulihan kepada kanak-kanak berkeperluan khas – sambutan tidak sepenuhnya
- Bagaimana dengan golongan OKU dewasa?
- Masih terdapat mereka yang tidak mendapat kemudahan kesihatan.

Sambungan...

- halangan persekitaran dan pengangkutan – Sistem pengangkutan yang ada tidak mesra
- Kemudahan pesakit luar percuma bukan di kesemua hospital kerajaan – hospital latihan tidak menyediakan kemudahan
- Kesan – rawatan secara tradisi dan mendapat ubat-ubatan di kedai-kedai runcit
- Hospital memberi rawatan dan ubat-ubat percuma tetapi yang amat diperlukan adalah bekalan untuk meneruskan kehidupan

Sambungan...

- Peralatan sokongan & tenaga mahir berkaitan dengan kecacatan amat berkurangan (physiotherapist, occupational therapist, audiologist dan kaunselor terlatih)
- (Sun. Jun. 2. 2008) cadangan Menteri Kesihatan untuk merujuk pesakit keronik kepada hospital swasta, OKU akan menjadi mangsa dan bertentangan dengan dikerasi BMF

Cadangan

- Penjagaan kesihatan untuk semua tanpa mengira jenis kecacatan – OKU juga diberi akses kepada rawatan pakar
- Wujudkan hospital pemulihan bagi yang mengalami kecederaan spina dan memerlukan jangka rawatan yang lama
- Telemedicine berupaya dicapai oleh golongan OKU
- Tenaga terlatih ditambah memandangkan jumlah kemalangan/OKU yang semakin meningkat
- Ahli perubatan harus dilatih tentang keperluan asas golongan OKU
- Peruntukan dimasukkan dalam akta

Kesimpulan

- Kesihatan merupakan aspek penting dalam kehidupan golongan OKU. Perancangan yang holistik amat diperlukan bagi membolehkan golongan ini sama-sama melibatkan diri dalam pembangunan negara
- Minda OKU sendiri harus beralih daripada keistemewaan kepada hak.

Terima Kasih

- Semua komen dan soalan dihargai
- Prof. Madya Dr. Tiun
lttiun@usm.my
HP: 0134302096



BY DR. SAIHAH BT. ABDULLAH

DR. SAIHAH BT. ABDULLAH
DIRECTOR, HEALTH AND MEDICINE, DEPARTMENT OF ORANG ASLI AFFAIRS (JHEOA)

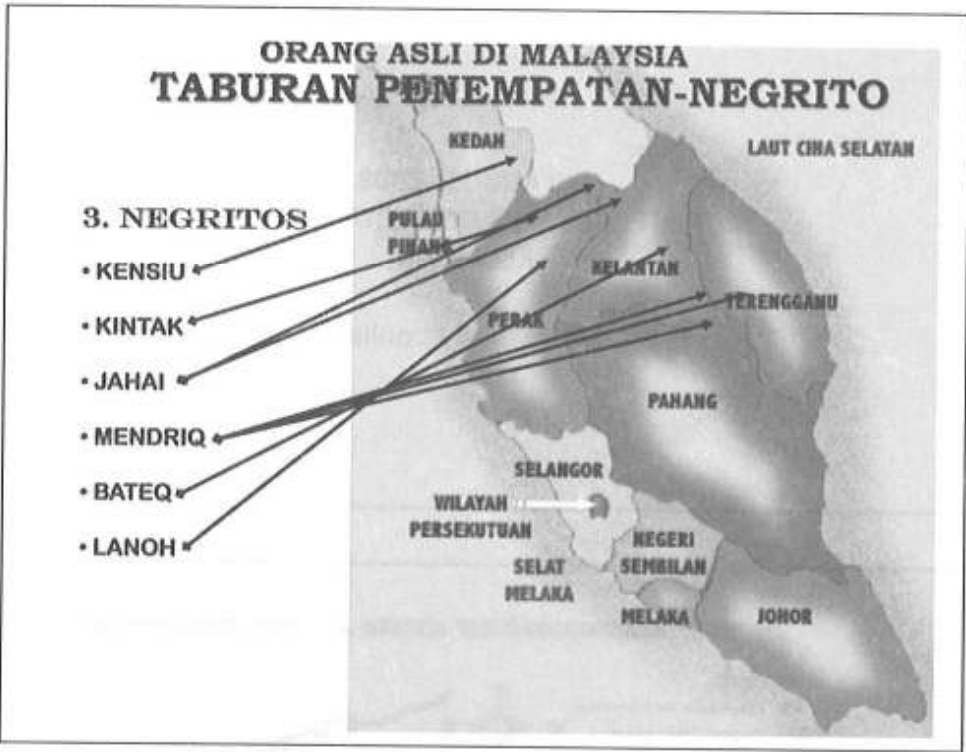
10 AUGUST 2008
HOTEL RENAISSANCE, KOTA BHARU,
KELANTAN

Dr. Saiah bt Abdullah



ANNEXURE 19

SUKU KAUM & JUMLAH PENDUDUK ORANG ASLI KELANTAN.			
1) Temiar	-	Gua Musang (Kecuali K.Lah, Lebir & Aring)	
2) Bateq.	-	Lebir/ Aring.	
3) Jahai.	-	Sg. Rual, Jeli.	
4) Mendriq.	-	Kuala Lah & Sg. Tako, Gua Musang.	
POS BROOKE #	1,914	POS SG. TAKO	13
POS HENDROP	638	POS BIHAI #	818
POS LEBIR	454	POS TOHOI #	466
POS SIMPOR	559	POS SG. RUAL	516
POS HAU	647		
RPS BALAR #	564	JUMLAH:	11,022
POS BELATIM	378		
POS KUALA WOK	154		
RPS PASIK #	708		
POS BLAU	392		
POS KUALA LAH	167		
POS GOB	424		
POS PULAT #	190		
RPS KUALA BETIS #	2,020		



TABURAN LOKASI PENEMPATAN	
➤Pekan /bandar	- 00%
➤Pinggir/kampung	- 18%
➤Pedalaman	- 82%
➤Kampung Orang Asli	- 143 kampung.
➤Penghulu	- 52 orang.

ANNEXURE 19

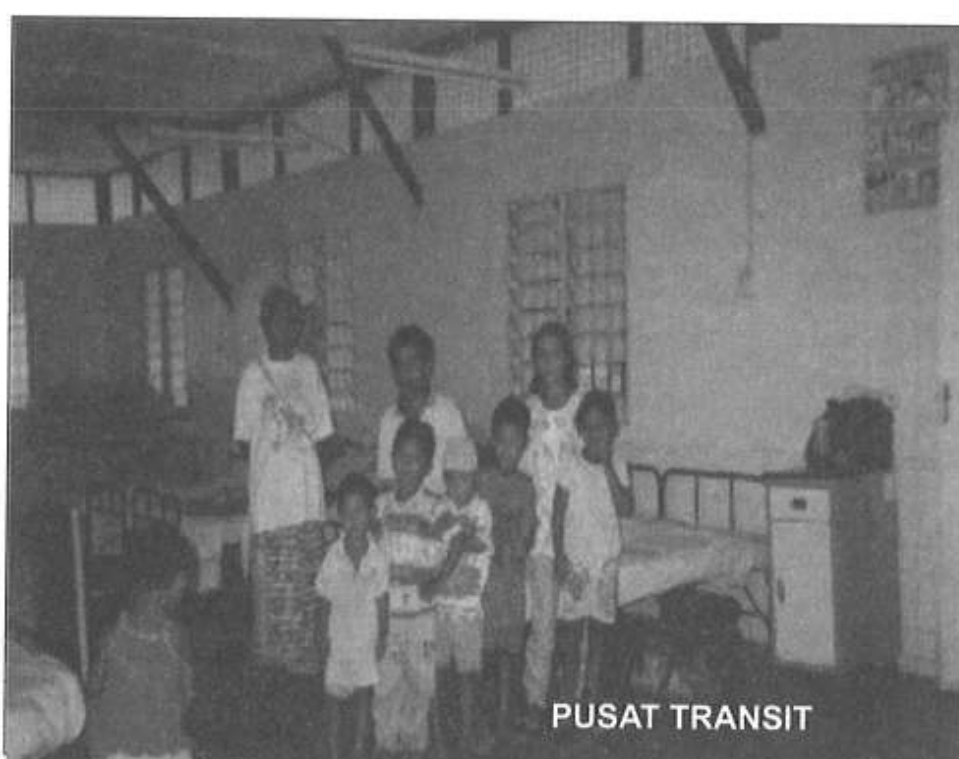
SENARAI PERMIS-PERMIS KESIHATAN JHEOA YANG TELAH DIBINA SEHINGGA TAHUN 2007					
Bil	Tahun Laksana	Jenis Projek	Lokasi	Kos (RM)	Catatan
1.	1990	Klinik	K. Betis	50,000.00	JHEOA – Projek RPS.
2.	1994	Klinik	Brook	35,000.00	S/W kepada KESEDAR.
3.	1994	Klinik	Hendrop	35,000.00	S/W kepada KESEDAR
4.	1994	Klinik	Tohoi	35,000.00	S/W kepada KESEDAR
5.	1994	Klinik	Batar	35,000.00	S/W kepada KESEDAR – (RPS)
6.	1995	B/R	Menrod	15,000.00	S/W kepada KESEDAR
7.	1995 – 2000	Transit	Jeli	509,747.79	Mula 1995 dan siap sepenuhnya 2000. Kos termasuk kerja-kerja Tambahan, sebuah rumah K/tangan, dwn mkn, wakaf&peralatan Bina B/R baru
8.	1996	Klinik	Bihai	30,000.00	Projek RPS.
9.	1996	B/R	Pulat	15,000.00	
	2002	B/R	Pulat	30,000.00	
10.	1996	Peralatan	Di atas	5,000.00	
11.	1997	Klinik	Lebir	30,000.00	
12.	1997	RKT	Hendrop	15,000.00	
13.	1997	RKT	Tohoi	15,000.00	
14.	1998	Klinik	Blau	30,000.00	
15.	1998	Klinik	Pasik	30,000.00	
16.	1998	RKT	Lebir	14,000.00	
17.	1998	RKT	Bihai	16,000.00	
18.	1998	Pej. Transit	K. Betis	28,000.00	Transit K. Betis mula beroperasi pada tahun ini. Projek dipindah ke Kg. Tapai,Hau
19.	1999	B/R	Tuel	20,000.00	
20.	1999	B/R	Simpur	20,000.00	
21.	1999	B/R	Aring	20,000.00	
22.	1999	Klinik	Gob	12,000.00	
23.	1999	Peralatan	Di atas	8,000.00	

Sambungan..					
Bil	Tahun Laksana	Jenis Projek	Lokasi	Kos (RM)	Catatan
24	2000	B/R	Redip	20,000.00	Membaiki Dewan Makan/ Dapur dan kerja-kerja kawasan Transit.(Kerja- kerja tambahan Transit).
25	2000	B/R	Sayap	20,000.00	
26	2000	B/R	Berua	20,000.00	
27	2000	B/R	Pergam	20,000.00	
28	2000	Peralatan	Di Atas	8,000.00	
29	2000	RKT	Aring	16,000.00	
30	2000	Baiki	Betis	16,595.00	
31	2001	B/R	Belatim	25,000.00	
32	2001	B/R	Ladoi	25,000.00	
33	2001	B/R	K.Lah	25,000.00	
34	2001	B/R	Kg.Tapai	17,000.00	
35	2001	Peralatan	32,33,34	6,000.00	
36	2001	RKT	Jeli	25,000.00	

Sambungan...					
Bil.	Tahun Laksana	Jenis Projek	Lokasi	Kos (RM)	Catatan
37	2002	Klinik	K. Betis	25,000.00	Baiki.
38	2002	BR	Tendrik	25,000.00	Bina baru.
39	2002	BR	Bering	25,000.00	Bina baru. 11
40	2002	BR	Galang	25,000.00	Bina baru.
41	2002	RKT	Jeli	35,000.00	Bina baru.
42	2002	Peralatan	35,39,40,41,42	15,000.00	Bina baru.
43	2003	BR	Encheng	30,000.00	
44	2003	BR	Jeli	35,000.00	
45	2004	RKT	Tiada	tiada	
		Tiada			Tiada
46	2005		Tiada	tiada	Tiada
		Tiada			Tiada.
47	2006		Tiada	Tiada	Bina baru.
48	2007	Tiada	Pos Blau	60,000.00	
		BR			
49	2008		Pasik & Aring 5	60,000.00 & 60,000.00.	Bina baru kedua-dua lokasi.
		BR			

**KEMUDAHAN PERKHIDMATAN
KESIHATAN MASYARAKAT
ORANG ASLI**

- 1. HOSPITAL ORANG ASLI - GOMBAK**
- 2. KLINIK KELUARGA - RPS BETAU & RPS KUALA BETIS**
- 3. 11 PUSAT-PUSAT TRANSIT**
- 4. 5 POS-POS PERUBATAN/20 LANDING ZONE**
- 5. 112 BALAI-BALAI RAWATAN**



ANNEXURE 19



Aktiviti Kesihatan

- Hospital Gombak
 - ▶ Bahagian Kesihatan Awam
 1. Unit Pesakit Luar
 2. Unit Kesihatan Ibu Dan Anak
 3. Unit Kawalan Tibi
 4. Unit Kawalan Kusta
 5. Unit Kawalan Malaria
 6. Unit Kesihatan Pergigian
 7. Unit Pendidikan Kesihatan
 8. Unit Kesihatan Bergerak.



ANNEXURE 19



GENERAL HEALTH SERVICE AT OA VILLAGE



Site Visit utilising the Military Helicopter

Perkhidmatan Doktor Udara

1950an – 1990an – Perkhidmatan Helikopter ehsan dari TUDM.

2003 – Sekarang - Perkhidmatan helikopter swasta dimulakan (RM900000/tahun).



Perkhidmatan Doktor Udara dengan bantuan TUDM.



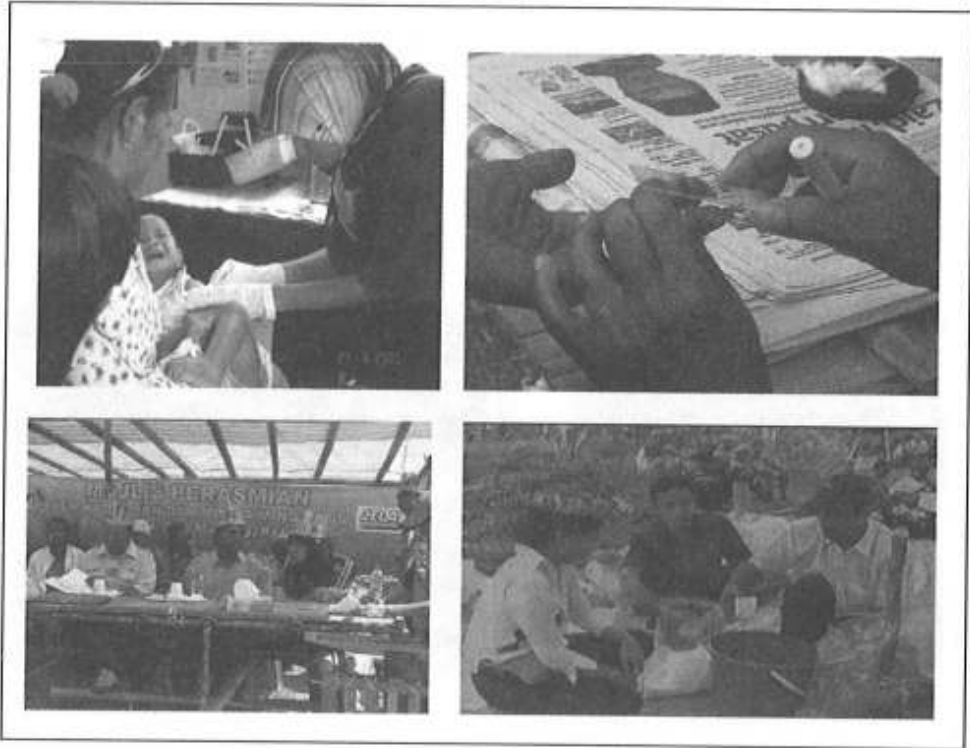
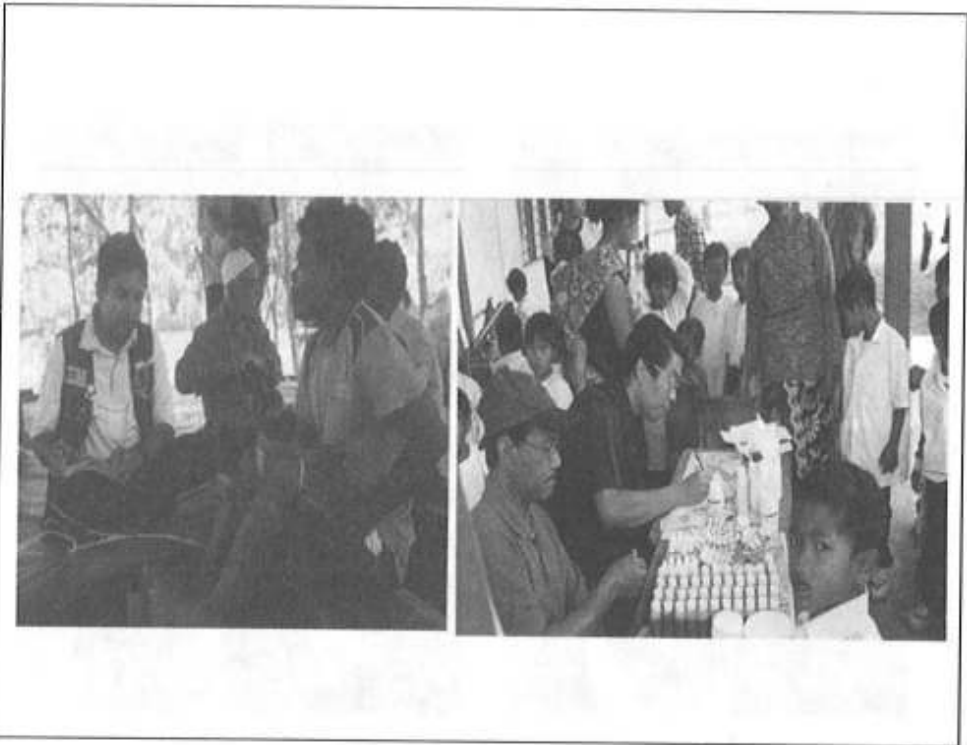
Helikopter mendarat di Pos Gawin, Gua Musang.

ANNEXURE 19



6. Unit Farmasi

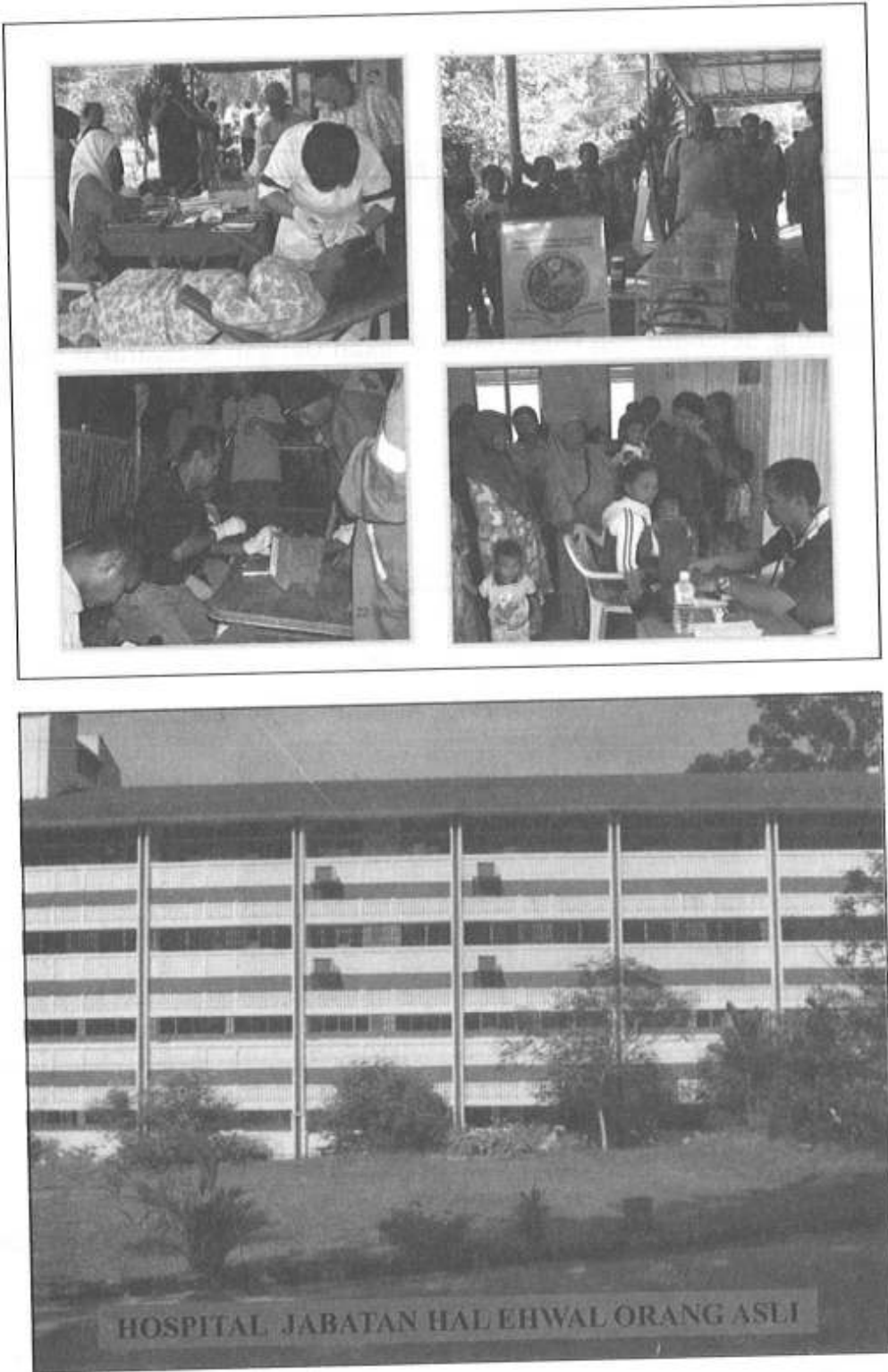




AKTIVITI – AKTIVITI DALAM PROGRAM KESIHATAN

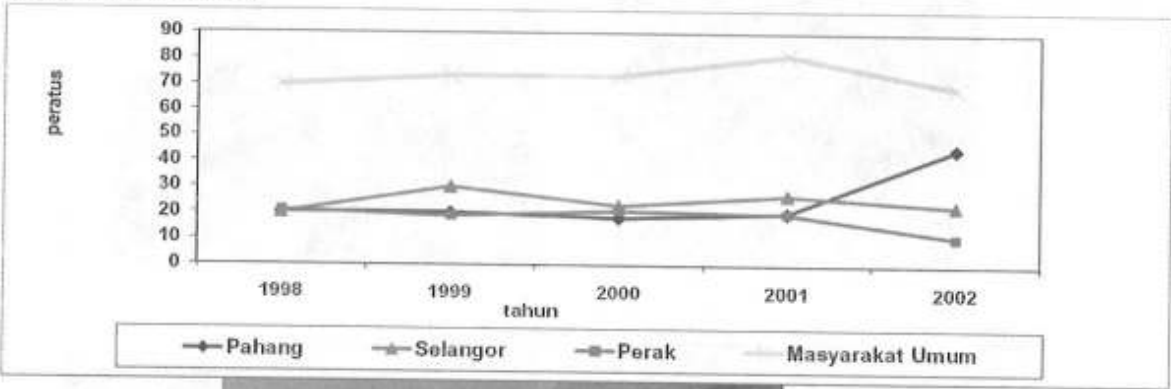


ANNEXURE 19



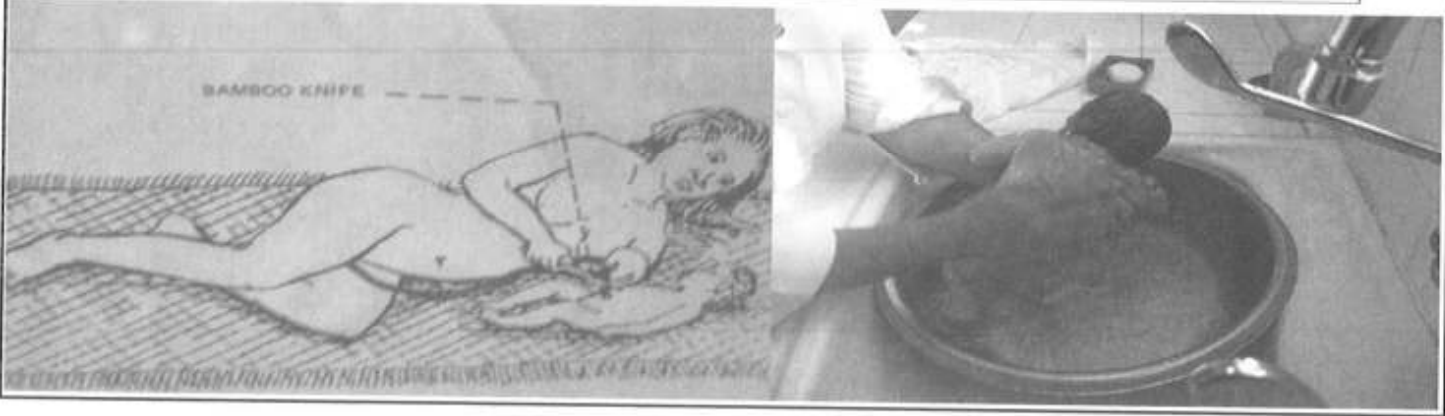
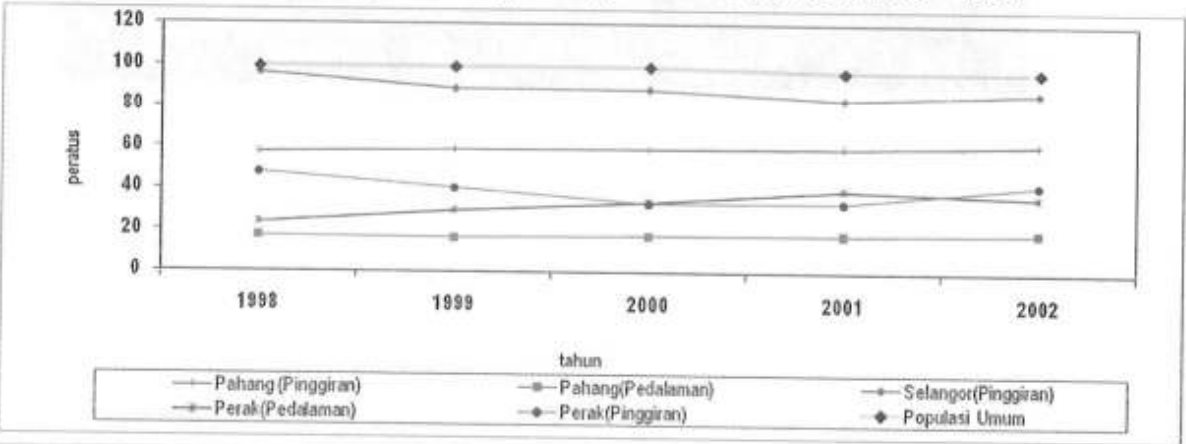
Penjagaan Ibu Mengandung

- Peratus Kehadiran Kes-Kes Baru Ibu-ibu Mengandung Dari Suku Kaum Orang Asli Di Negeri Pahang, Selangor dan Perak Dibandingkan Dengan Masyarakat Umum Dari Tahun 1998-2002.



Kelahiran Selamat

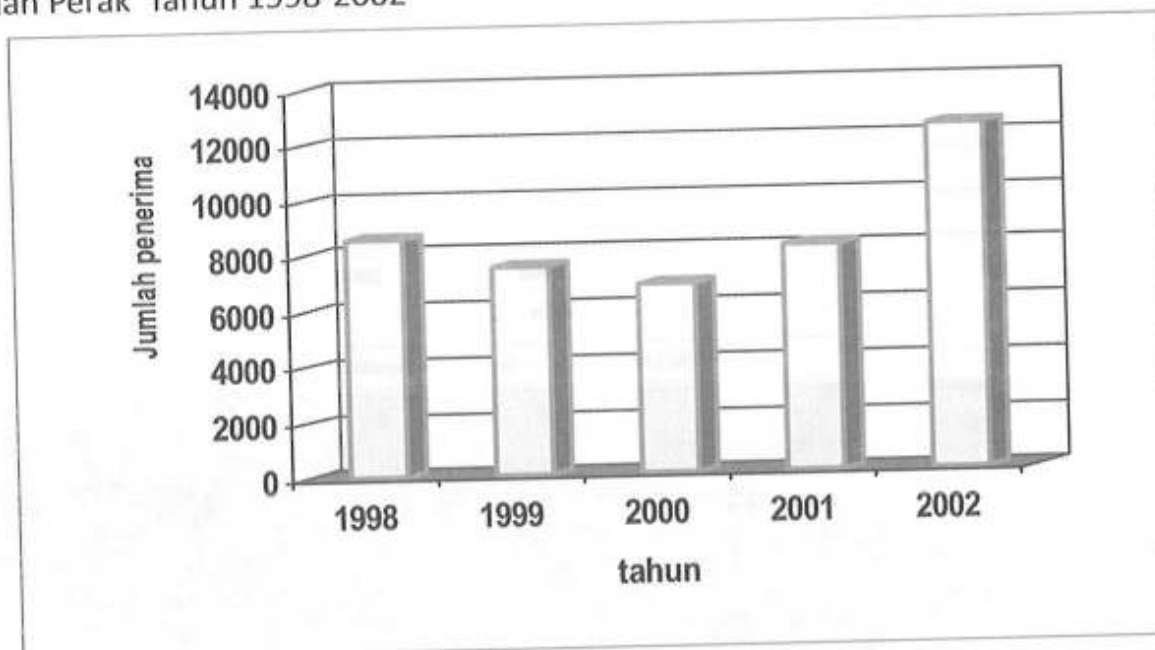
Peratus Kelahiran Selamat Di Kalangan Wanita Orang Asli Di Pedalaman Dan Pinggiran Di Negeri Pahang, Selangor and Perak tahun 1998 – 2002



ANNEXURE 19

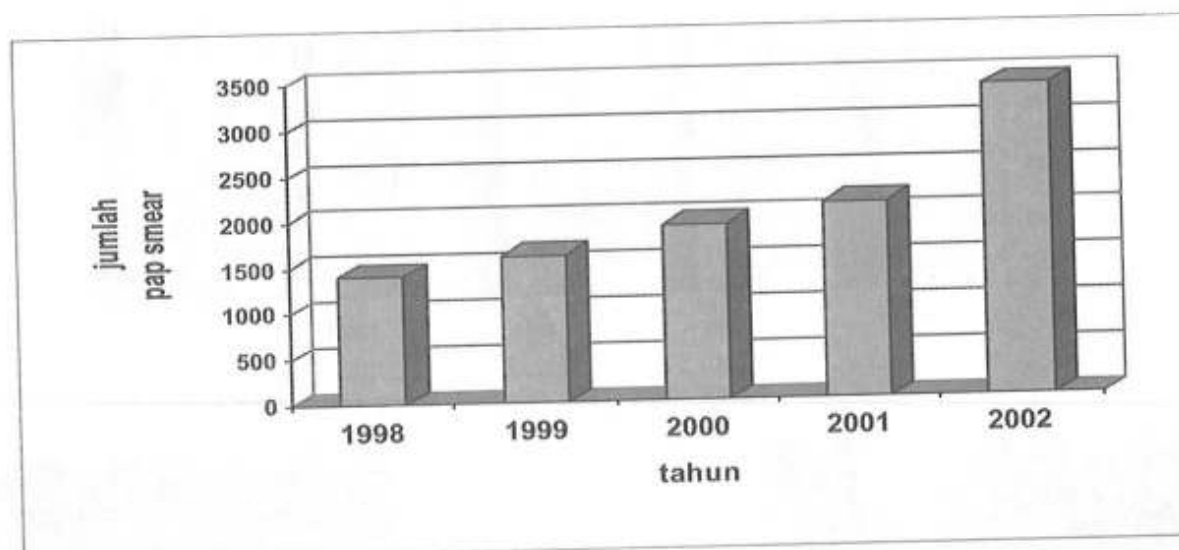
Perkhidmatan Perancang Keluarga

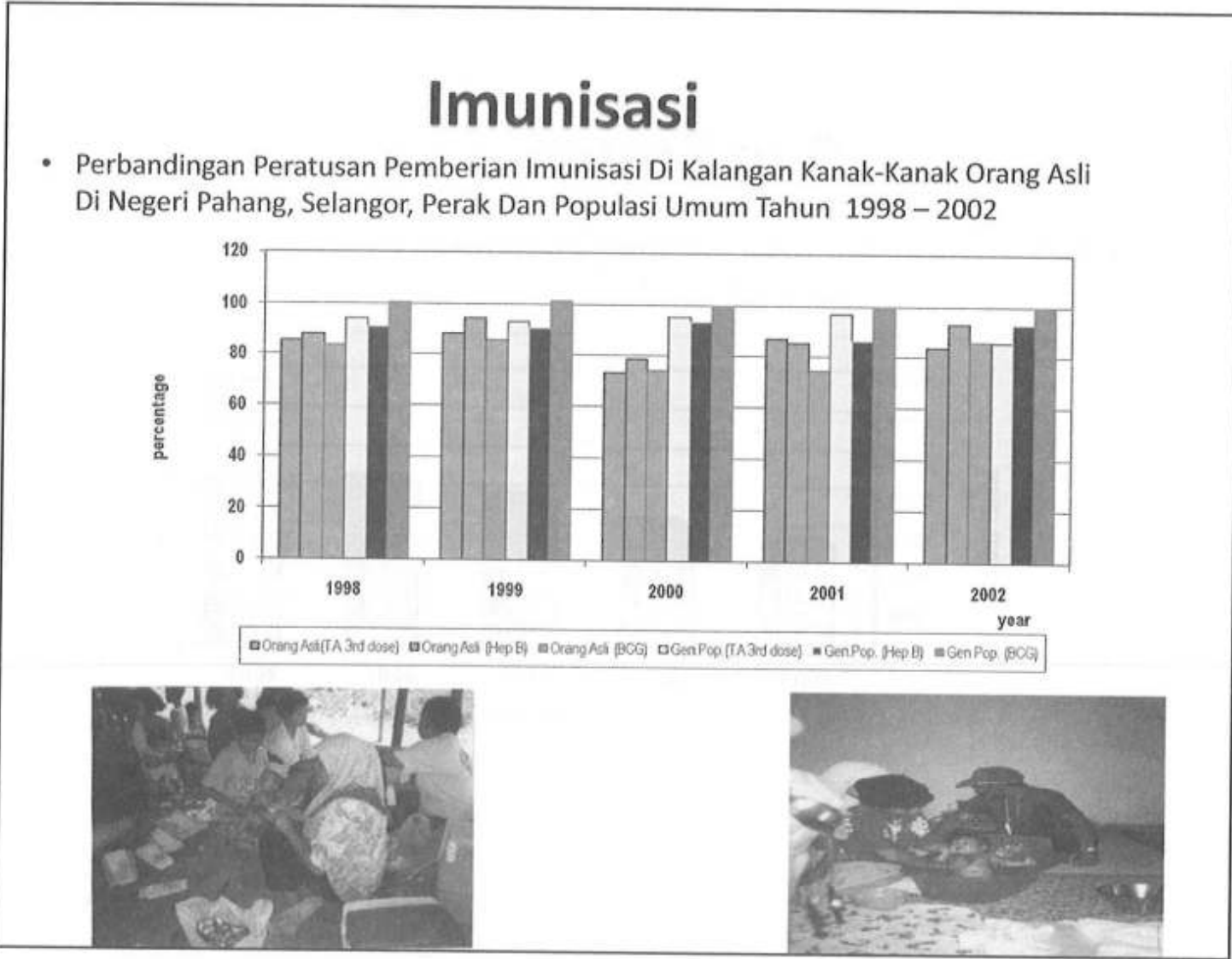
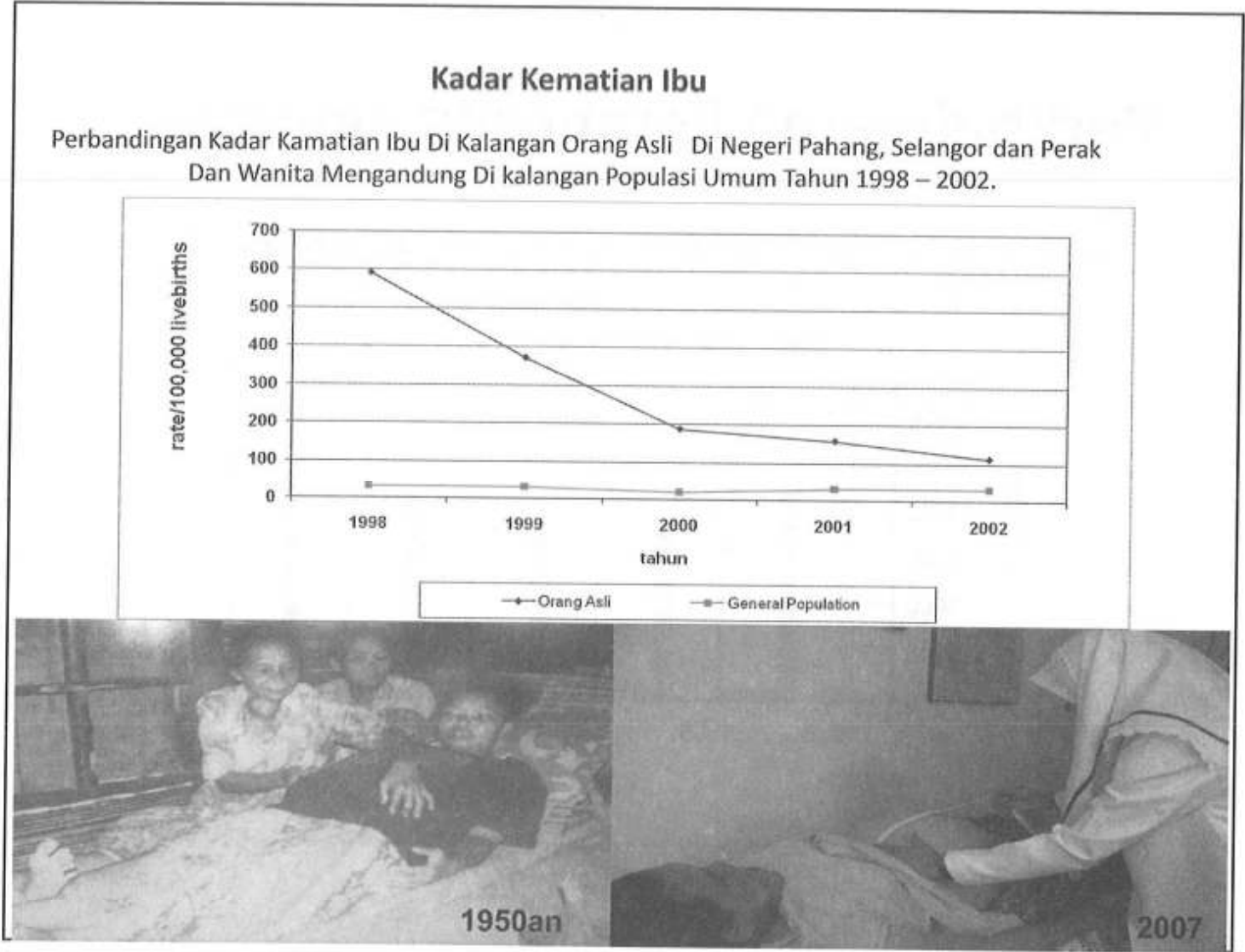
- Jumlah Bilangan Penerima Kaedah Perancang Keluarga Di Negeri Pahang, Selangor dan Perak Tahun 1998-2002



Pap Smear

Jumlah Pap Smears Yang Dibuat Ke Atas Wanita-Wanita Orang Asli Di Pahang, Selangor dan Perak, 1998-2002

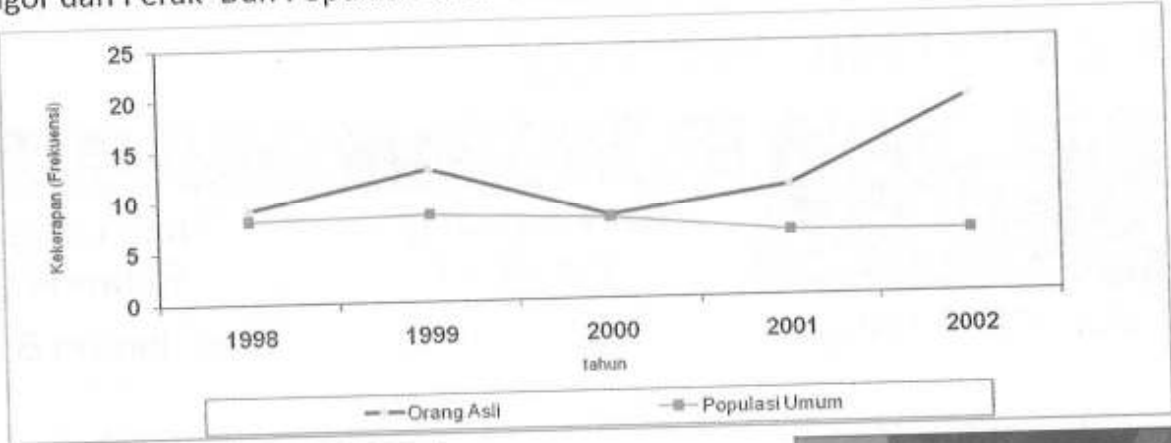




ANNEXURE 19

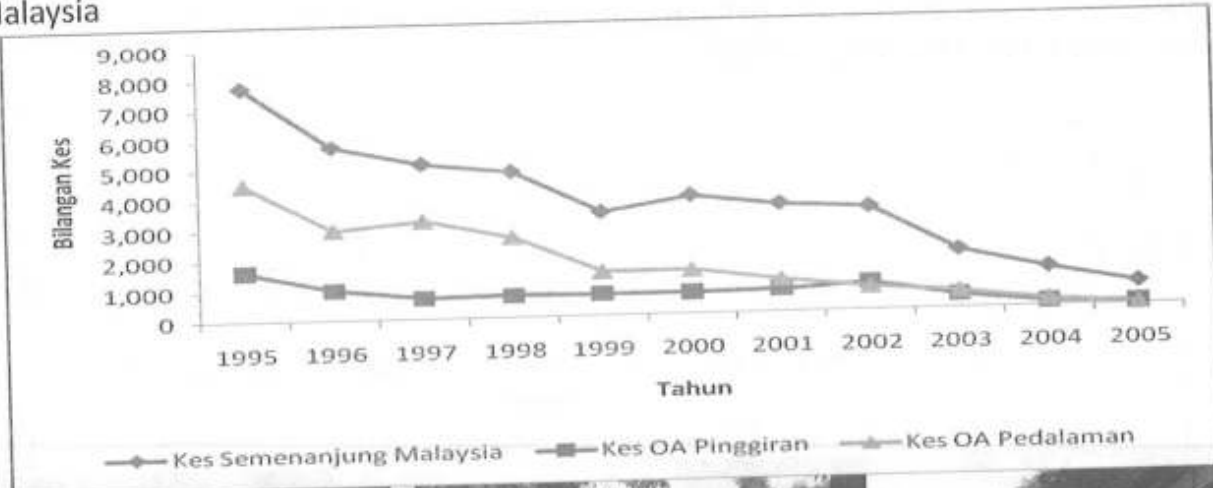
Kematian Bayi

- Perbandingan Kadar Kematian Bayi Di Kalangan Orang Asli di negeri Pahang, Selangor dan Perak Dan Populasi Umum 1998 - 2002



Malaria

- Bilangan Kes Malaria Dari Tahun 1995 Hingga 2005 Orang Asli Dan Semenanjung Malaysia



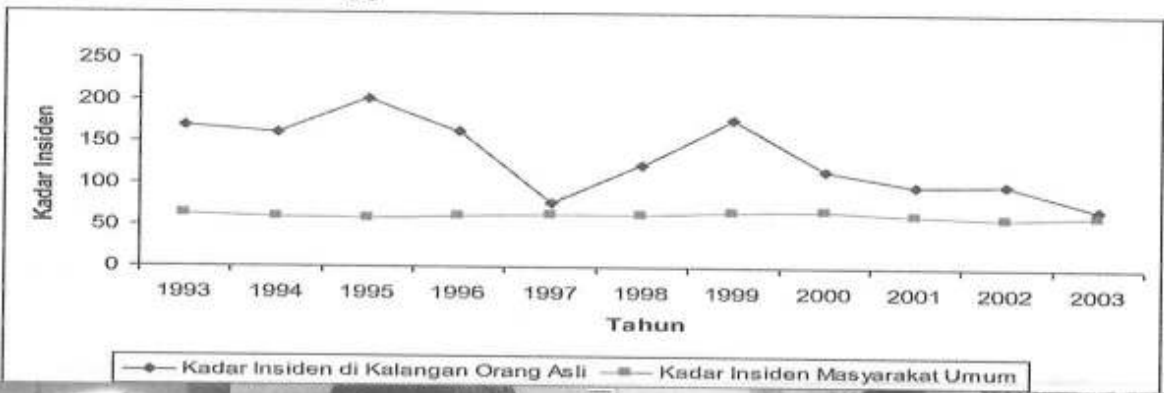
Kesihatan Pergigian

- Prevalen karies dan min DMFX pelajar sekolah di 2 lokasi yang berlainan.

	Pelajar Orang Asli	
	Gua Musang, Kelantan	Kuala Langat, Selangor
Cara Perhubungan	Pacuan 4 Roda	Kenderaan Biasa
% Kejadian Karies Gigi Kekal	10.62	25.39
Min DMFX 12 Tahun	0.23	0.46

Tuberculosis

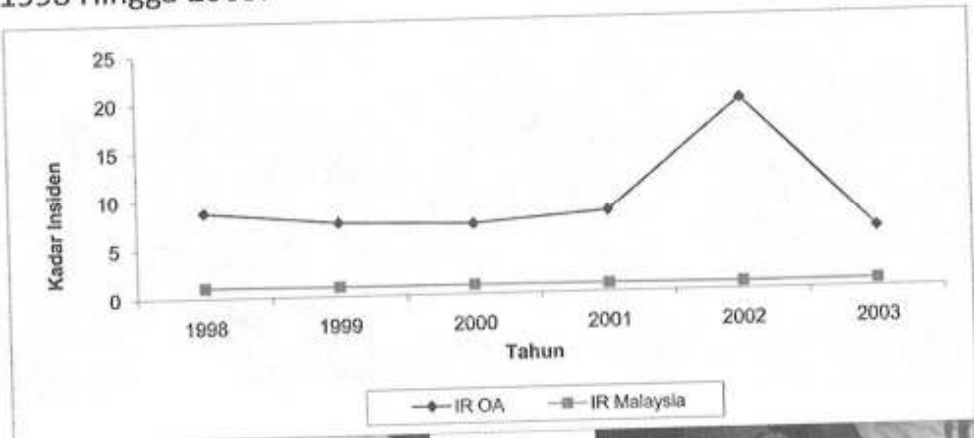
- Perbandingan Kadar Insiden Tibi Di Kalangan Orang Asli Dengan Masyarakat Umum Dari Tahun 1993 Hingga 2003



ANNEXURE 19

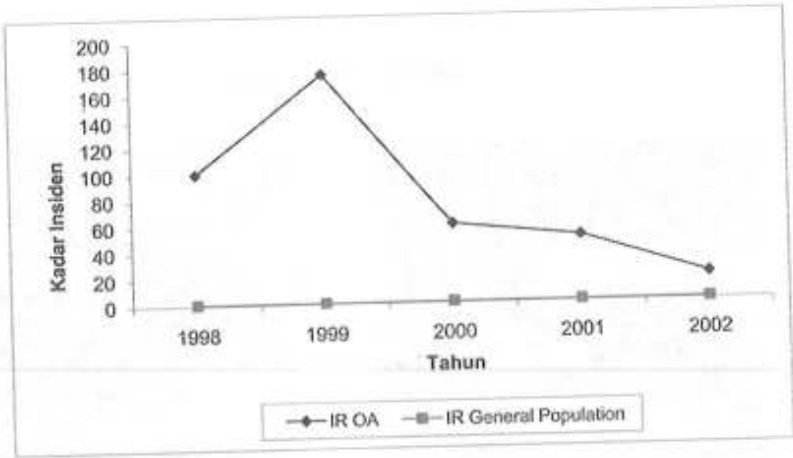
Kusta

- Perbandingan Kadar Insiden Kusta Di Kalangan Orang Asli Dan Masyarakat Umum Dari Tahun 1998 Hingga 2003.



Filariasis

- Kadar Insiden Di Kalangan Orang Asli Dengan Masyarakat Umum 1998 Hingga 2002.



ANNEXURE 19



ANNEXURE 19



Cabaran



1. PUSAT TRANSIT GUA MUSANG.

- Antara cadangan ialah membina Pusat Transit Gua Musang yang baru dengan kos yang dahulunya berjumlah RM2 juta dan sekarang ini kosnya telah dinaikkan menjadi RM4 juta.
- Ianya akan mula dibina pada bulan September 2008.

2. KLINIK DESA POS HENDROP.

- Antara cadangan ialah membina Klinik Desa Pos Hendrop dengan kos sebanyak RM1.5 juta.
- Ianya akan mula dibina pada bulan Ogos 2008.

3. BALAI RAWATAN RPS PASIK.

- Ianya mula akan dibina pada bulan Ogos 2008 dengan kos sebanyak RM60,000.00.

4. BALAI RAWATAN POS ARING 5.

- Ianya mula akan dibina pada bulan Ogos 2008 dengan kos sebanyak RM60,000.00.

CADANGAN

**Kementerian kesihatan membina
klinik di pos pendalaman
perkampungan orang asli yang telah
mempunyai sekolah kementerian
pendidikan**

ANNEXURE 19

- **ISU DAN MASALAH.**
- **1. Kenderaan baru dan kenderaan tambahan sangat diperlukan untuk menangani segala kesulitan yang sering dihadapi oleh kakitangan kesihatan.**
- **2. Dapatkan kakitangan yang terlatih untuk mengendalikan Pusat Transit dan Balai Rawatan samada melatih orang-orang asli sendiri menjadi pekerja-pekerja kesihatan.**
- **3. Perlu mengadakan kerjasama yang lebih erat dengan Kementerian Kesihatan untuk menangani masalah pendaerahan kesihatan.**

1. Introduction

2. Methodology

The study was conducted using a combination of qualitative and quantitative methods. Data was collected through interviews, surveys, and archival research. The analysis was performed using statistical software and thematic analysis. The results are presented in the following sections.

ISBN 978-983-2523-70-3



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