MALAYSIA's

RACISM AND THE RIGHT TO HEALTH

Questionnaires from the Special Rapporteur (SR) on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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Question no.1: What are the main ongoing manifestations of racism, and related form of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly?

Malaysia is a multi-ethnic country and is unique with its diversity in races, religions and cultures where everyone respects each other's culture and religion and we live in harmony and racial tolerance. There is no issue of racism or racial intolerance prevalent in regards to the right to health.

The Malaysian government places much emphasis and is concerned with the performance of the health care system, whose primary purpose is to improve health of the nation. This stems from the understanding that health represents the human capital, which is the central thrust to sustainable economic growth and development of the country. Hence, it has always been Malaysia and Ministry of Health (MOH)'s focus in ensuring equity and to increase accessibility to the public, especially the marginalised, those with specials needs, rural and remote areas in particularly East Coast and East Malaysia. However, providing equitable healthcare access for all, regardless of their citizenship and social status remains a challenge, particularly within the framework of a resource-limited healthcare system. Since Malaysia's First Malaysia Plan (1966-1970), healthcare has always been one of the focus areas given emphasis for development as per population health needs.

Malaysia's healthcare system is divided into two highly developed sectors 'a government-led and funded public sector, and a booming private sector that is consumer/market driven has grown substantially in the last quarter of a century. Public healthcare is paid by Malaysian citizens through the general taxation of income. As a result, patients only need to pay nominal fees in this heavily-subsidised public sector. However, the nominal fees in this public system are only applicable for Malaysian nationals, and the government does not have a reciprocal healthcare policy with any other country.

That being said, the fundamental principle of Malaysian health care system is that accessibility to health care is based on needs and not 'Ability To Pay' (ATP), especially in regards to the public health sector. MOH also adopts a "no wrong door" policy whereby all patients who go to MOH health facilities for treatment should receive proper treatment, regardless of age, race, gender, race, socio-economic status, occupation or other factors. This is also in line with the core of the MOH client charter and the country's commitment towards Universal Health Coverage. Thus, there is no issue of racism, or discrimation on the grounds of race, colour, descent, caste, national or ethnic origin, migration status, age, sex, gender identity/ expression/ sexual orientation, disability or health status, on the enjoyment of the right to health. However,

if a health facility is unable to provide proper treatment to such patient, due to capacity and or resource constraints, the patient may be referred or "redirected" to another health facility that can provide the necessary treatment. This is to ensure that every patient receives the best treatment, at the right time, at the appropriate facility (“right patient, right treatment, right time, right place”).

Question 2: Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic orgin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regards maybe also be reflected.

There is no disparities between citizens, non- citizens or other groups in the provision of and access to health services. Regardless of status, all those who seek treatment in public health facilites will be treated according to their medical/ clinical needs at the time of presentation.

However, medical treatment rates in public hospital for non-citizens will differ from that of Malaysians as per the Fees (Medical) (Amendment) Order 2014. Foreigners holding permanent resident status, those married to locals and children with one local parent and is under 12 will be exempted from this amendment.

While the rate of medical treatment fee to United Nations High Commissioner for Refugees (UNHCR) cardholders who are legally registered with UNHCR is 50% of the fee rate for foreigners found in the Fees (Medical) (Cost of Services) Order 2014 (*Perintah Fi (Perubatan)(Kos Perkhidmatan) 2014*). The charge rate of 50% of the treatment charge rate for foreigners is only applicable for Class 3. While the deposit rate charged is 50% of the deposit rate of foreigners as stated in the Fees (Medical) (Cost of Services) Order 2014 (*Perintah Fi (Perubatan)(Kos Perkhidmatan) 2014*).

But, although treatment charges may differ for non-citizens, MOH does not turn away patients who cannot afford to pay in particularly in regards to acute care and communicable diseases.

The MOH Health Informatics Centre does not collect outpatient attendance data or inpatient admissions for Illegal Immigrants/undocumented immigrants, refugees and asylum seeker with UNHCR Card specifically. The data collected are classified as citizen and non-citizen patients only.

Question 3: Under the right of health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising of minorities, asylum seekers and migrants including undocumented migrants, to preventive, curative and palliative services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health - related services provided by third parties. Please explain how the above point is implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.

Malaysia hosts some 181,000 refugees and asylum-seekers. 85% are from Myanmar, including some 103,000 Rohingyas. The remaining are from 50 other countries, including Pakistan, Yemen, Syria, and Somalia. 67% of refugees and asylum-seekers are men, while 33% are women. 45,650 are children below the age of 18. They live in cities and towns across the peninsular, with sizeable populations in Klang Valley, Johor, and Penang (UNHCR 2022).

Malaysia is considered a major destination country for migrant workers, with official estimates quoting the number of foreign workers in Malaysia to be as high as 3 million, but the actual total number of foreign workers is postulated to be around 5.5 million (World Bank Group 2020). The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population (UNHCR Malaysia, n.d.c). However, Malaysia is not one of the signatories to the 1951 Convention Relating to the Status of Refugees and its associated 1967 protocol. But MOH has been working closely with UNHCR in regards to access and provision of healthcare to refugees. Undocumented migrants, refugees and asylum seekers requiring medical treatment at MOH hospitals; whether in the Emergency & Trauma Department, Specialist Clinics or as inpatient; will be treated based on their clinical needs. Although they may be subjected to a different treatment rates as non-citizens, however, MOH does not turn away patients who cannot afford to pay in particularly in regards to acute care and communicable diseases.

At present, there are limited healthcare financing options for refugees, asylum-seekers and migrant workers in Malaysia. In 2017, the UNHCR in collaboration with RHB Bank launched the Refugee Medical Insurance (REMEDI) for refugees, but only 12.2% of UNHCR cardholders were enrolled (UNHCR Malaysia, n.d.c). The low rate of enrolment and a high rate of payouts have incurred significant losses to the partnering bank, leading to the cessation of the insurance policy scheme from 16 June 2018 (Asia Pacific Refugee Rights Network 2018). To date, refugees registered with the UNHCR are accorded a 50% discount off the foreigner's rate at Malaysian government healthcare facilities. On the other hand, the Hospitalisation and Surgical Scheme for Foreign Workers (SPIKPA) was introduced as a mandatory healthcare financing system for all documented migrant workers. Through the implementation SPIKPA, foreign worker who are admitted to MOH hospitals need not pay any deposit or submit a letter of guarantee from the insurance company. Foreign workers only need to present a valid passport for the confirmation process in the hospital register counter.

While refugees and migrant workers are able to seek medical attention in public or private healthcare facilities, equitable access to such services are often hindered by a variety of factors including the cost of treatment, language barriers and the restriction of mobility in the public due to a fear of discrimination or persecution (UNHCR Malaysia, n.d.c)

Question 4: What has been the impact of colonialism and the imposition of allopathic medicine on the availability of indigenous and traditional health

knowledge systems, medicine and practices, and on the right to health more broadly in your country? Are health services available in your country that give due consideration and acknowledgement of, or respectfullly incorporate indigenous/ traditional health knowledge systems and practices, preventive care, healing practices and medicines? Please share examples of good practices.

Traditional and Complementary Medicine (T&CM) in Malaysia has been contributing to the better health of Malaysians for decades. Due to the unique multi-ethnic and sociocultural background of the Malaysian population, T&CM services in Malaysia are also highly diversified to suit the needs of all. Being pivotal to achieving sustainable healthcare services, the Malaysian Government recognises T&CM as an integral part of the national healthcare system and steadily introduced targeted legislation and various measures to secure the quality, safety, and effectiveness of T&CM.

Traditional and Complementary Medicine Division (T&CM Division) under the Ministry of Health Malaysia is the authority to regulate the practice and practitioners of T&CM in Malaysia. There are 6 T&CM Branch Offices established and in charge of T&CM relevant affairs at the State level.

The initiatives taken by the T&CM Division are aimed at ensuring the safety and quality of T&CM practices for the well-being of all citizens; this includes the enforcement of the T&CM Act and Regulations, standardization and accreditation of T&CM training and education, provision of T&CM services in public health care facilities, promotion of the safe use of T&CM, and enhanced collaboration in T&CM research and development.

The T&CM Division cooperates with strategic partners like China, India, and neighbouring ASEAN countries for mutual benefits in the field of T&CM from the aspects of practice, medicinal materials and products, training and education, and research and development. The T&CM Division is also designated as a WHO Collaborating Centre for Traditional, Complementary and Integrative Medicine, to support WHO in education and capacity-building activities, provide technical assistance to Member states, and collaborate with WHO on regulation and policy associated with T&CM practice.

There are 7 recognized practice areas of T&CM in Malaysia, which reflect the strong ethnocultural relationship, i.e., traditional Malay medicine, traditional Chinese Medicine, traditional Indian medicine, homeopathy, chiropractic, osteopathy, and Islamic medical practice. While the private sector remains the mainstay of T&CM services in Malaysia, there is a total of 15 MOH hospitals in Malaysia which provide selected T&CM services, including traditional massage, shirodhara, external basti therapy, varmam therapy, acupuncture, and herbal therapy. In addition, T&CM services (such as acupuncture and traditional massage) have been incorporated as one of the principal pillars of the national Pain-Free programme.

Traditional postnatal care services are provided with participation of all states in Malaysia, involving 121 primary healthcare facilities. This represents the government's initiatives to expand the role of T&CM at the primary healthcare level in Malaysia and is in line with the WHO's conviction that traditional medicine can contribute to strengthening primary health care.

T&CM services, similar to any medical services, have faced several issues and challenges in healthcare service delivery. Selected issues and challenges have been highlighted in the list below:

- **Highly diverse**
  Due to the multi-ethnic and multi-cultural background, T&CM in Malaysia is highly diverse and complex. This imposes great challenges to formulate appropriate policy and regulations that suit all types of T&CM available in Malaysia.

- **Inadequate access to T&CM services:**
  In larger states and states with high rural populations with only one public hospital providing selected T&CM services and the indications for the treatment are limited (e.g. herbal therapy as an adjunct treatment for cancer, shirodhara provided as a complementary treatment for insomnia, anxiety and stress).

  Furthermore, T&CM health care delivery is skewed towards primary health care with only minimal participation at secondary and tertiary levels. To date, there are only two private T&CM Centres with inpatient services in Malaysia.

  These may be due to the undefined role or positioning of T&CM at various levels of health care and the inadequate study of the potential contribution of T&CM towards better health outcomes.

- **Absence of regulatory and monitoring system for T&CM premises**
  The T&CM service in Malaysia is mainly private driven. However, the appropriate regulatory and monitoring system for T&CM premises has yet to be implemented, which is important to ensure the patients received safe and high-quality care.

- **Low acceptance of T&CM amongst healthcare professionals**
  There is resistance from medical and other healthcare providers to referral for T&CM services. In the long-present gap between western and traditional medicine, many medical providers from the western medical field are still not convinced that their patients may benefit from T&CM services due to low levels of knowledge and awareness of T&CM.

- **Lack of sufficient evidence/ relevant data to facilitate policy formulation and policy support**

The vast field of T&CM is dynamic and ever changing while research gaps are aplenty. Enhancing research capacities in the field of T&CM would inadvertently provide evidence to make an informed decision about T&CM practices.

- **Limited expertise and resources**
  While T&CM services have progressed and developed tremendously globally, limited T&CM expertise, in both public and private sectors and inadequate funding remains a vital factor for the future of T&CM in Malaysia.

The Ministry has always been aware of the importance of T&CM in Malaysia from the healthcare, economic and socio-cultural perspectives.

The enforcement of T&CM Act and Regulations serve as an important catalyst to professionalize the T&CM industry and ensure safe and quality T&CM services. Registration of T&CM practitioners under the recognized practice areas commenced March 2021 with grace period given until February 2024.

Together with the stakeholders from the T&CM industry, the Ministry addressed the relevant challenges and established the National T&CM Blueprint 2018-2027, which offers guidance and coordination to build a strong foundation of T&CM practices.

Question 7 : Please share good practices and examples of public health interventions resulting in adequate acess (inside and outside health sector), support knowledge production or implementation of programs that successfully address inequalities in particular the impact of racism and related racial discrimination, as well as other factors such as poverty, or discrimination based on sex, gender indentity, expression, sexual orientation, disability and migration status.

Malaysia's Five Year Plan, is an outline of its policies and strategies for development. It spanned for a period of five (5) years covering development agenda, where priority areas are outlined, goals are set, and a pathway towards achieving them is outlined.
In all Malaysia's 5-year Plan since 1966, healthcare accessibility to all has always been one of the main key areas given emphasis to improve equity, especially to marginalised groups, those with special needs, in remote/ rural areas. Several challenges we faced in our efforts in increasing accessibility are the sustainability of the healthcare system due to finite resources, increasing healthcare cost, dual disease burden and the increasing expectation and needs- which most healthcare system are also facing. Moreover, due to the Malaysia's geographical features and landscapes especially in the East Coast and East Malaysia such as mountainous regions, beaches, and tropical rainforests, geographic accessibility remains an issue which MOH's continual efforts are being made to increase accessibility to healthcare to marginalised, indigenous groups in remote and rural areas in these states. Several initiatives implemented includes the deployment of mobile healthcare teams, flying doctor services, mobile dental/ cataract clinics, telemedicine, virtual clinics and domiciliary healthcare service in community setting. MOH has also implemented the

Hospital Cluster concept nationwide since 2016 where MOH hospitals within the same geographical location work together as 1 unit (cluster), sharing common resources such as assets, amenities and personnel. It is a hospital merger exercise to establish an integrated network of specialist and non-specialist hospitals. The resource sharing, services realignment, and better care coordination from this integration have been shown to improve operational efficiency and quality of care. This arrangement enables the provision of specialist service/ care in district hospitals, increasing accessibility to specialist care and brings care closer to home. To date, a total of 42 Clusters have been established involving 140 MOH hospitals. MOH has also implemented the Global Surgery Initiative nationwide, where identified basic/ essential surgery services can be conducted in district hospitals and patients need not travel to a specialist hospital located far from the patient's home. The Government is also improving accessibility to quality care by building more clinics and hospitals in underserved areas in both urban and rural. The development of new facilities will take into account the functionality, cost-effectiveness and health needs of local population. Focus is also on the upgrading of existing healthcare facilities and assets to ensure continuity and reliability of service delivery. Ageing healthcare facilities and assets such as staff quarters, equipment and ambulances will be replaced in phases. Selected non-specialist district hospitals will be upgraded to become specialist hospitals.

Malaysia has a robust health system with universal health coverage, in which the public healthcare service is funded by general taxation and health services are heavily subsidized for its citizens and residents. Malaysian citizens pay a nominal fee of RM for a general outpatient consultation and RM 5 for specialist-level medical care at a specialist outpatient consultation. The Malaysian government subsidises about 98 per cent of the treatment cost for citizens at public health facilities. For patients who are less able to pay medical bills, namely those who belong to the B40 group (bottom 40% of the income scale), there is already a mechanism in place for applying for exemption or reduction by outpatient and third-class patients to ensure they get the necessary health services, such as government subsidy, application through the Social Welfare Department and mySalam; which is a free takaful income assistance scheme provided by the government to provide social health protection to help the poor and needy overcome financial difficulties in the unexpected event of a critical illness. The government also provides medical aid to those in need, like the Medical Relief Fund which was established in 2005 to assist the needy patient to make partial or full payment for treatment cost or purchase rehabilitation equipment or medicines. Subsidies are also given for hemodialysis treatment and erythropoietin injections in haemodialysis centres managed by non-governmental organisations (NGOs) that are registered with the Ministry of Health. *Peduli Sihat* scheme for the B40 group (Peka B40) is another scheme that that provides free medical screenings for low-income people in participating private clinics, in the government’s bid to tackle non-communicable diseases. The above is some of the examples of initiatives by Malaysia to address the issue of accessibility of healthcare to the poor.

MOH is preparing for the implementation of Private Aged Healthcare Facilities and Services Act 2018, that will ensure care recipients in private aged care centres receive better holistic care including personal care and nursing care.

Question 8 : Please share good examples and practices that enable accountability in public and private sector that enable access to justice and redress to victims of racism and discrimination on the grounds such as colour, descent, national or ethnic origin or migrant or refugee status in the provision of health care and as it intersects with factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status eg HIV, Albinism etc and the rural and urban divide.

To achieve safe and competent healthcare services in the country, the Malaysian Medical Council (MMC) was established through an Act of Parliament passed on 27 September 1971 and gazetted on 30 September 1971. The MMC has disciplinary jurisdiction over all doctors who registered pursuant to section 29A (1) of the Medical Act 1971. Patients can lodge complaint against any registered medical practitioner to MMC. All complaints and information received by the MMC will be investigated to confirm that a doctor has committed the offense as complained of. As a guide, MMC has issued several Ethical Codes to address this issue. If a medical practitioner violates any of the Ethical Codes provided by the MMC, then according to Section 30 of the Medical Act 1971, the MMC has the power to impose fines as well as remove names from the list of registered doctors.

The Code of Malaysian Conduct 2019 outlines those medical practitioners should provide best treatment practices by providing professional, efficient and considerate treatment when treating patients.

Good Medical Practice 2019 is a guideline provided to clarify the professional code that governs the form and manner of medical practice internationally. This Code was adopted by the MMC on 18 June 2019 and is based on the principles of moral responsibility, ethics and professional attitude that can be trusted by the medical profession and society. Good Medical Practice 2019 states that the relationship between a doctor and his patient is a professional relationship and it is the responsibility of the doctor to provide the best treatment for the patient's health.

Code of Ethics and Conduct Ministry of Health Malaysia (MOH) The MOH Code of Ethics and Conduct is a set of values and morals as well as guidelines that are in line with the MOH's corporate culture and public service rules. This code covers work ethic and professional ethics that must be adhered to by all MOH staff as well as a guide and control for MOH staff to perform their duties and responsibilities properly. The MOH Code of Ethics and Code of Conduct outlines that every MOH staff must give the best service to all its patients without discrimination of race, ethnicity and religion.

Therefore, every MOH staff should provide quality health care services to every customer. If MOH staff violate any of the standards set out in this code, they will be subject to disciplinary action under the Public Officers (Conduct and Discipline) Regulations 1993.

Nursing staff is also bound to similar set of guidelines, rules and regulations as the medical practitioners. Every registered nurse has a moral obligation to abide by the principles provided in the 1998 Code of Professional Conduct for Nurses. The first code states nurses should respect patients and not judge them. Therefore, every nurse should treat and give the best possible treatment to every patient regardless of their origin, health condition, religion and social status. Pursuant to Section 32 of the Nurses Act 1950 (Act 14), the Malaysian Board of Nurses has disciplinary jurisdiction to impose punishment on registered nurses if found guilty of misconduct or indecency while performing their duties by canceling the registration of names from the registration list, suspending names from registration for such period as the Board deems fit.

The Public Complaints Management System (SisPAA KKM) MOH is an online channel to manage feedback such as complaints, appreciation, inquiries and suggestions from the public regarding KKM services.

Question 11: Please share good practices and examples of reparations for racial discrimination related to the right of health violations and abuses.

Please refer input for question 7