HEALTHCARE EQUITY AND ACCESS TO CARE FOR MALAYSIAN CHILDREN

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Introduction

Malaysia has made significant progress in the development and improvement of child healthcare. According to 2022 statistics, children account for 28% of Malaysia’s total population of 32.65 million people (equal to 9.19 million children) [1]. The infant mortality rate in 2023 in Malaysia is 5.152 deaths per 1000 live births, with a decline of 2.81% from 2022, and the rate of under-5 children mortality was reported as 7.4 deaths per 1000 live births in 2021 [2].

Child health equity is defined as providing every child with a fair and equal opportunity to be as healthy as possible [3]. One of the major determinants of child health equity is the social determinants of where children are conceived, born, live, develop, and grow. To achieve child health equity, access to effective healthcare is essential. Child Health 2021-2030, a national framework for enhancing child survival and promoting young children’s growth and development, was introduced by the Malaysian Ministry of Health in 2021. The aim is to ensure the implementation of health in all policies, to empower families and communities to provide a supportive environment for child development and to ensure access to comprehensive and quality healthcare services [4]. It is hoped that with concerted efforts from the various stakeholders, barriers to healthcare equity can be ameliorated.

Gaps and Challenges

The recent COVID-19 pandemic has opened Pandora’s box, revealing the fragility of our healthcare system. Despite the improvement in children’s healthcare deliveries, there are still pockets of inequalities affecting vulnerable cohorts of children. A study of children with disabilities in Penang revealed that they faced inaccessibility to dental services (49.6% needed, 59.9% unmet), dietary advice (30.9% needed, 63.3% unmet), speech therapy (56.9% needed, 56.8% unmet), psychology services (25.5% needed, 63.3% unmet), and communication aids (33.0% needed, 79.2% unmet), with logistical issues and caregivers not knowing where to get services cited as the main reasons [5].

Certain diseases affecting children are labelled as orphan diseases as there are no recognised stakeholders available or may being neglected by the authorities. For example, healthcare practitioners treating primary immunodeficiency diseases (PID) are not included in Malaysia’s National Specialist Register, leading to it being an orphan disease. Orphan diseases have been known to be susceptible to being forgotten and the equity access to healthcare may be impairead. A study on the life experiences of caregivers for children with primary immunodeficiencies reported PID healthcare support struggles with four sub-themes (PID health system, treatment, diagnosis and financial issues) as one of the five main issues affecting their lives [6].

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Figure 1. The five themes of issues identified from the thematic analysis of the caregivers’ perspective on the living experiences of patients with primary immunodeficiency diseases [6].

Services for children in Malaysia
Child health services have been carefully developed since the 1970s [4]. All children attend child health clinics for growth, developmental and health assessment. Those with high-risk conditions will be referred for evaluation. Child Health Record Book is a form of recording and documenting relevant information and history within the government or private health circles to facilitate continuity of care. Newborn screening program (G6PD, congenital hypothyroidism and neonatal hearing), childhood immunization and preparation of guidelines for perinatal care manual, neonatal jaundice, monitoring preventable and non-preventable deaths of infant mortality have been implemented ever since.

Mental health issues in children showed an increasing trend from a prevalence of 13.0% (1996) to 20.0% in 2011 [4]. The National Health and Morbidity Survey 2017 (NHMS 2017) reported that the prevalence of depression, anxiety, and stress was 18.3%, 39.7%, and 9.6%, respectively [7]. Socially and economically disadvantaged groups were most vulnerable to mental health problems. In the Malaysian context, more than half of parents and caregivers believed that corporal punishment is needed for child education. The negative experiences early in life have been shown to cause adverse childhood experiences, leading to poor learning, behaviour, and mental well-being. Positive parenting and engagement are needed to allow a better environment for nurturing their physical and psychological growth.

There are also issues related to children’s admission to adult wards due to inadequate infrastructure, especially in the adolescent age group. Services for children in general are not on par with adult services, with a lack of financial investment despite knowing that approximately 30% of the population are children [8]. There are also barriers to refugees, stateless and migrant children accessing healthcare due to fear of being deported, poverty, work mobility, language, and the lack of respect and treatment received from health staff.

Progress and potential solution
Access to care is a crucial feature in the delivery of health services. The aim is to provide adequate, fair and equitable access to healthcare services to the population at large. Access refers to the potential and actual entry of an individual or population group into the healthcare delivery system. Having access denotes the theoretical utilization of a service having appropriate systems that allow service utilisation. It also alludes to the actual procedure of admission into the processes of utilising the service. Financial factors may encourage or discourage patients’ use of services, leading to defaulting follow-up. The Malaysian healthcare system has a minimum payment with charges on specific services, equipment, or specialized tests [9]. Children outside the school age also are not officially covered by a specific ministry. There is a call for the whole population to be insured. However, there are financial implications, and insurance companies do not provide full coverage for all diseases. Government policies must come parallel to the needs and rights of children. This includes revamping the policy to accept children and adolescents for appropriate child-friendly health facilities and trained personnel. Fundamental child rights need to be fulfilled, which covers routine, primary health care and immunisation to all children in Malaysia, regardless of their status [8].

The healthcare system must also focus on alleviating marginalised communities. Mapping communities with high child mortality rates and focusing on sufficient resources are essential to tackle the health disparity in the community. Health funding from government agencies is needed to end child poverty, malnutrition, and child hunger. The funding also should cover children with disability and rare diseases [9]. Other areas that require attention include better school health programmes and better access for institutionalised children, with the contribution of all
agencies with similar goals to achieve humane access for children in Malaysia.

Conclusion
'Social Determinants of Health', including those related to poverty, marginalized populations, and disability, determine health access and equity for children in Malaysia. All stakeholders must not look at disease-specific issues but look at the bigger picture to ensure a holistic approach to enabling communities to care and work for themselves. Government sectors must realize that major illnesses are frequently linked to socioeconomic maldevelopment and inadequate first disease approach care by the Ministry of Health. More significant change can be made by revolutionizing the healthcare system with a more child-friendly focus.

References