MEDICAL PLURALISM IN POLICY AND PRACTICE

The case of Malaysia

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Introduction and research background

Various forms of medical practice such as Chinese herbal medicine, Ayurveda, acupuncture, homeopathy, Islamic medical practice, and so on, were brought to Malaysia by the migration of different ethnic groups such as Indians, Muslims, Chinese, and Europeans. Hindu and Buddhist Indian merchants and religious travellers arrived in Malaysia as early as the seventh century and most likely brought Indian medical traditions, Ayurveda in particular (Singh 2009: 49). Islam was first introduced in Malaysia during the twelfth century by Muslim Indian traders and firmly established during the fifteenth century by Arab, Chinese, and Muslim Indian traders, although the Arabs had maintained a trading colony in Malacca port since the eighth century (Ahmed 2001: 1). They also introduced various forms of Islamic herbs, spiritual healing, and massage. Although Chinese medicine was brought to and practised in Malaysia since the early years of Chinese migration across the Southeast Asian region it began to take root formally in the Malaysian soil only during the eighteenth century (Kim 2017). Europeans were the latest migrants to Malaysia, bringing Western medicine; by the middle of the nineteenth century, Western medicine became the mainstream medical service in Malaysia. Today Malaysia idealizes itself as an example of religious, medical, and ethnic pluralism as portrayed by the Malaysian tourism board as ‘Truly Asia.’

This chapter is divided into three sections: the first section gives a historical and general overview on medical pluralism in Malaysia. This primarily includes Western medicine, Chinese medicine, and Ayurveda, which are the three largest systems of medicine practised in Malaysia. This section also discusses the theoretical debates about medical pluralism and analyzes their connection to ethno-religious political diversity. The next section discusses health policies and priorities related to traditional and complementary medicine. Although traditional medicine, including Ayurveda, Chinese herbal medicine, acupuncture, and so on, was practised in Malaysia for centuries, they were only incorporated into public healthcare facilities after the foundation of the Traditional and Complementary Medicine Division under the Ministry of Health in February 2004. The ways that Malaysian health policies and practices regarding medical pluralism are linked to the rise of global capitalism is also explored in this section. The challenges facing medical pluralism and traditional and complementary medicine in particular, are explored in the final section of this chapter.
Medical pluralism in policy and practice

This chapter focuses on medical pluralism in urban areas where both Western and traditional medicines are recognized by the government. Although signs of informal medical practices exist in rural areas and may also be defined as medical pluralism, this chapter is unable to address these examples due a lack of primary data. Further, this chapter is a combination of empirical data collected through fieldwork in three major locations in Malaysia—Penang Island, Selangor State, and Kuala Lumpur—plus secondary sources. Face-to-face interviews were conducted for primary data among traditional and complementary medical practitioners, patients, and health centre managers using an open ended questionnaire. Some hospitals and health centres were also visited as part of empirical data collection. Government policy papers, web pages of relevant departments, and published sources were used as secondary data. Empirical data was collected from February 2018—July 2019 and a total of four trips were made to Malaysia, of two to three weeks each, for this research project.

Medical pluralism: Malaysia’s theoretical debate

Medical pluralism has been defined by medical anthropologists and sociologists from various angles: ‘experiential,’ ‘political,’ and ‘theoretical.’ Experiential aspects are empiricist and functional, explaining various treatment needs and choices among different traditions and cultures of the globe (Hörbst et al. 2017: 7). Under an empiricist perspective, medical pluralism is a phenomenon where a variety of complex and overlapping medical traditions coexist within a chosen context, some of which are systematically organized whereas others are scattered individual practices. In complex modern societies, three types of medical practices are found based upon their geographic and cultural settings: local medical systems, regional medical systems, and the cosmopolitan medical system (Dunn 1976; Baer et al. 1997: 9; Islam 2005: 2). Local medical systems are considered indigenous or folk system treatments practised in small-scale, horticultural, or pastoral societies, or peasant communities under a modern state. Regional medical systems are generally more organized and professionalized and some of them are practised through family apprenticeship, such as Ayurveda in India. Cosmopolitan medicine refers to the global medical system or what is commonly known today as Western medicine or modern biomedicine (Ibid.). Arthur Kleinman (1978: 422) used different terminology but made similar classification of overlapping and interconnected health sectors that exist in a complex society: the popular sector, the folk sector, and the professional sector. The popular sector includes therapeutic options such as self-treatment or medication, advice or treatment given by relatives, friends, and so forth, home remedies, and consultation with other lay persons who have special experience of particular disorders. Generally, the popular sector of medicine does not require any payment for medical or healing advice. The folk sector is more professionalized compared to the popular sector and exists in most of the non-industrialized societies where certain individuals or families ‘specialize in forms of healing that are either sacred or secular, or a mixture of two’ (Kleinman 1978: 422). Although practitioners in the folk sector are not part of the centralized governmental healthcare system in some countries, they still require payment for healing advice (Ibid.). The professional sector comprises the organized, legally sanctioned healing professions, such as Western biomedicine, which has become the mainstream healthcare system all over the world (Kleinman 1978: 422).

The political perspective of medical pluralism is connected to the idea of the nation-state and nation building and came from an inspiration of nationalist revival. Many nation-states initiated a national culture-building project after dismantling colonial rule and the presence of indigenous medical system and traditions became a part of that project. There is clear ambiguity and paradox under the nationalist claims of medical practices in most of these countries.
India is a good example, where the rise of nationalist sentiment emerged during the first half of the twentieth century as part of anticolonial resistance. Indigenous medical practice such as Ayurveda came to symbolize intangible Indian cultural heritage and was tied to Indian nationhood by mainstream political leaders. Since Western medicine in India was introduced by the colonial administration as a colonizing process, Ayurveda was pushed forward by Indian nationalist leaders as a substitute to oppose colonial medicine (Arnold 1993: 8; Islam 2017: 15). However, there were several ambiguities found under nationalistic claims of indigenous medicine during the post-colonial era. First, Western medical science and technology was increasingly utilized in the regulation and standardization of Ayurveda. Western style educational institutions for Ayurvedic education were founded all over the country and they adopted integrated education curricula that combined Ayurveda with Western medicine. The graduates from these institutions were detached from the traditional apprenticeship mode of education and did not hesitate to practise Western medicine under their integrated degree. Secondly, several nation-states emerged within the Indian subcontinent after decolonization, each having a potential claim to various forms of indigenous medical practices in the region such as Ayurveda, Unani, and so forth, as their national cultural heritage (Islam 2017: 16). Since the Malay Peninsula had also been under British colonial rule from the nineteenth to mid-twentieth century, it contains similar features of medical pluralism. Western medical education has been used as a benchmark for standardizing the education and training of traditional and complementary medicine in the country after decolonization. As a meeting point of several of the oldest civilizations, including Chinese, Indian, Islamic, and European, different medical heritages coexist in Malaysia, such as Chinese herbal medicine, Ayurveda, acupuncture, Islamic medical practices, and Western medicine. The country also has multicultural and multilingual characters because of its ethnic composition. Medical, religious, and ethnic pluralism coexisted in Malaysia with less tension after decolonization because of the single nation-building initiative of the political leadership. Malaysia became ‘Malaya,’ independent from the British colonial rule in the year 1957 and became Malaysia on 16 September 1963. The national independence and ‘constitution were grounded upon the political bargaining process among ethnic groups,’ primarily the Malay, Chinese, and Indians (Saad 2012: 115). Political sensitivities and ethnic tensions were remarkably reduced during the first tenure of Prime Minister Dr. Mahathir Mohamad in the 1980s and’90s because of the liberalization of language and education, and the promotion of national unity, popularly known as Bangsa Malaysia or the united Malaysian nation. The ‘One Malaysia’ slogan of former Prime Minister Najib Razak also helped to improve inter-ethnic and inter-religious relations and demolished walls of segregation between various ethnic groups in the country (Ibid.). Medical pluralism in Malaysia is thus deeply rooted in ethnic and religious segregation and political connotation. Almost all of the large political parties in the country have a direct or indirect ethnic and religious affiliation. The majority of ethnic Malays are Muslim, the overwhelming majority of ethnic Chinese are Buddhist and ethnic Indians are generally Hindu (Rooij 2015: 233). About 61.7 per cent of the Malaysian population are Bhumiputra—a word that literally means ‘son of the land,’ combining ethnic Malays and indigenous peoples. Chinese are the second largest ethnic group, accounting for about 20.8 per cent of the total population, followed by 6.2 per cent ethnic Indians. There are also 10.4 per cent non-citizens residing in Malaysia. Muslims are the largest religious group in Malaysia counting about 61.3 per cent of the total population and the vast majority of them are ethnic Malays. Buddhism is the second largest religion at about 19.8 per cent of the total population, the vast majority of them being ethnic Chinese. The number of followers of Christianity is 9.2 per cent of the population followed by 6.3 per cent Hindus, the majority of whom are ethnic Indian. There are also Confucianism, Taoism, and
other traditional Chinese religions existing in Malaysia and their followers count about 1.3 per cent of the total population (CIA World Factbook 2018). The presence of a variety of medical traditions within the same community is a common feature all around the country. Western medicine was introduced on the Malay Peninsula by the European traders from the sixteenth century onwards, when various European powers such as the Portuguese, Dutch, French, and British competed for control over Southeast Asia. Christian missionaries were also active in promoting Western medical care as part of their religious mission. Today, Malaysia has adopted the Western medical system as a mode of mainstream medical care. Citizens from all ethnic and religious backgrounds generally head to hospitals and practitioners offer Western medical care. However, traditional medical care is generally offered by individual ethnic groups and the majority of their patients choose their particular form of traditional medicine based on their ethnic identity. For example, the Chinese population generally chooses Chinese medicine as well as Western medicine although Western medicine is their priority. There is also evidence of receiving cross-ethnic medical care such as Malay people going to Chinese medical care or Chinese undergoing Ayurvedic care, although the number of these users is small.1

Apart from Western medical practice, the 2017 Acceptance of traditional and complementary medicine in Malaysia recognized seven practice areas: traditional Malay medicine, traditional Chinese medicine, traditional Indian medicine, homeopathy, chiropractic, osteopathy, and Islamic medical practice (MoHM 2017a). Among them, traditional Chinese medicine and traditional Indian medicine are the two largest and are therefore the two on which this chapter focuses.

**Ethnic pluralism to medical segregation**

Medical pluralism in Malaysia is interconnected with ethnic diversity and religious pluralism, which also cause the diversity and segregation within the medical practices in the country. Because of its strategic and geo-political position, travellers, missionaries, traders, religion pilgrimages, and colonizers from various ethnic backgrounds landed on the Malaysian territory over the centuries and introduced their belief systems, social customs, material cultures, etc. (Guan 2012: 3). All of these contributed to the ethnic and religious diversity of Malaysian society. As one of the earliest immigrants, Indian cultural influence in Malaya reached its peak in the seventh century with the rise of the powerful Hindu maritime kingdom of Sri Vijaya and lasted until the arrival of the Muslim merchants in the thirteenth century (Colley 1978: 78). The influence of Indian medicine in Malaya society became deeply embedded during that time and was further boosted by new arrivals of Indians as indentured workers, auxiliaries, and traders during British colonial rule (Singh 2009: 49).

Chinese and Muslim immigration took place in the fourteen century and onward. Although large number of Chinese migrants began to arrive in Malaysia from the beginning of the nineteenth century, it was in 1878 when Chinese medicine practitioners were first acknowledged in Malaysia (Kim 2017). With the boom of immigrants from mainland China, the first voluntary traditional Chinese medicine clinic was opened in Selangor State, named Pei Shan Tang, and in Kuala Lumpur at the beginning of twentieth century, now known as TUNG-Tshin Hospital (Bao 2012). In 1955, the Federation of Chinese Physicians and Medicine Dealers Associations of Malaysia established the Malaysian Chinese Medicine College (Gao and Zhang 2011). It took several decades after decolonization to set up formal framework for practising traditional and complementary medicine in Malaysia and it was only in 2016 that Malaysia regulated the practice of Chinese medicine on a national level. According to the statistical data obtained from the Division of Traditional and Complementary Medicine (T& CM) of the Ministry of Health,
as of 2015, a total of 13,846 local T&CM practitioners was registered with the e-PENGAMAL (a free, voluntary registration system set up by the Ministry of Health for Traditional and Complementary Medicine practitioners) system since 2008, 8408 of whom are practitioners of Chinese medicine (MoHM 2015). As of 2017, there are seven institutions/universities offering a Bachelor of Traditional Chinese Medicine and two more institutions are offering a diploma programme in traditional Chinese medicine (MoHM 2017b). Chinese medicine received momentum again in Malaysia in recent years with the rapid rise of tourists flocking to the peninsula from mainland China and purchasing various Chinese medicine products and services. Large Chinese property developers are also eyeing the Chinese medicine industry in Malaysia. Country Garden Pacific Holdings announced its establishment of a Chinese medicine hub in their billion dollar ‘Forest city’ project in Iskandar, Johor state, with the collaboration of Foshan Chinese Medicine Hospital in Guangdong province of China (Malaysia aims to become the largest Chinese medicine hub in Southeast Asia; Jaipragas 2017).

Before introducing Western medicine peoples from Malay territory were largely dependent on various forms of holistic medicine such as traditional Indian, Chinese, and Malay health practices (Colley 1978: 77–85). However, Western medicine became a state system of medical care for the Malay people after the establishment of British Malaya (1826–1957) as a crown colony. The colonial administration treated local Malay medical practices including Ayurveda, Chinese herbal medicine, acupuncture, etc., as superstitious modes of treatment while Western medicine was said to be grounded in evidence-based science. Some of these aforementioned healing modalities existed exclusively as a family practice.

Some practitioners from China or India immigrated to the Malay Peninsula with their medical knowledge and skill. They started medical practices and transferred this skill to their children as a family secret to continue in their family practice. These families exclusively controlled not only these medical practices but also related business and activities such as the import and export of herbal drugs, medicinal cultivation, offering charitable practice under religious missionaries, and so forth. The education and training of young students were usually followed by an apprenticeship programme or in informal night schools. Practitioners usually relied on herbal prescriptions, health food and drink, and some non-invasive modalities such as acupuncture, cupping, *tuina*, Ayurvedic *sirodhara*, bone setting, and so on. Although the British colonial administration was sceptical about these, it tolerated such practices for economic reasons. For example, Chinese medicine contributed to the care of the ethnic Chinese community without causing any financial burden on the colonial government to provide Western clinical care (Ling 1991). Because of the presence of uneven and unequal access to healthcare facilities, the majority of ethnic Chinese on Malay Peninsula had little choice but to rely on Chinese medicine.

The penetration of Western medicine on the Malay territory and other parts of colonial Asia was part of a larger process of colonization (Arnold 1993). Western medical practitioners, a majority of whom were European, gained the trust and acceptance of the native people through ‘implementing systems of first aid, such as ambulances and nursing stations’ while ‘simultaneously infiltrating’ Malay territory (Falconer 2015: 46). By the early twentieth century, Western medicine had established itself as the state medicine system in British Malaya and became mainstream for medical care in public health facilities.

Although a variety of medical practices coexist in contemporary Malaysia, there is a serious imbalance between Western and complementary medical facilities and utilization. According to Ministry of Health statistics, there are a total of 50,087 Western medicine doctors available in Malaysia as of 31 December 2016, whereas the number of traditional and complementary medicine practitioners registered was 17,973 on the same date. There were also a total of 7,186
registered dentists and 10,508 pharmacists trained under the Western system on the same date. An additional 130,549 registered nurses were available in Malaysia, including community and dental nurses, representing almost 50 per cent of the human resources in healthcare (MoHM 2017a: 8–9).

Even within the traditional and complementary medical systems, there is disparity in the number of available practitioners, where traditional Chinese medicine practitioners accounted for more than 60 per cent of the total T&CM practitioners in Malaysia. Although Malays and indigenous people contributed 61.7 per cent of Malaysia’s total population, there are only 2,401 traditional Malay practitioners available in the country, or about 17 per cent of the total T&CM practitioners in 2015. The number of registered traditional Indian medicine practitioners in Malaysia is only fifty-eight, or about 0.4 per cent of T&CM practitioners (MoHM 2015). The aforementioned statistics have economic and political significance. Ethnic Chinese are economically dominant in Malaysia and control a large share of the private sector. According to the data from Malaysia’s Statistics Department, ethnic Chinese mean household incomes are higher than Malay and Indian households among high, middle, and low income groups. Since traditional and complementary medicine modalities mostly exist and are controlled by the private sector, Chinese are the largest service providers and recipients who can afford to make out-of-pocket payments.2

Malaysian policy and actions towards medical pluralism

Although medical pluralism existed for hundreds of years in Malaysia, it was only in the beginning of the twenty-first century that the Malaysian government recognized and took initiative to promote complementary form of medicine, including a national policy on traditional and complementary medicine in 2001. As already mentioned, in 2004, the government of Malaysia founded the Traditional and Complementary Medicine Division under the Ministry of Health Malaysia to regulate and promote traditional forms of medical practices apart from mainstream Western medicine. The government also formulated the T&CM act 2016 as a regulatory framework in compliance with the World Health Organization’s (WHO) regional strategy for traditional medicine in the Western Pacific (2011–2020), which stipulates five strategic objectives: to include traditional medicine in national health systems; to promote safe and effective use of traditional medicine; to increase access to safe and effective traditional medicine; to promote protection and sustainable use of traditional medical resources; and to strengthen cooperation in generating and sharing traditional knowledge and skills (MoHM 2015: 4).

National policy on traditional/complementary medicine (2001)

The national policy on traditional/complementary medicine was formally adopted by the Ministry of Health Malaysia in August 2002. The policy statement highlighted two major issues:

The traditional & complementary medicine (T&CM) system shall be an important component of the healthcare system. It will co-exist with modern medicine and contribute towards enhancing the health and quality of life of all Malaysians.

The government will facilitate the development of T&CM in the country and ensure the quality, safe practices and products of T&CM. It will support the identification of its health, economic and social benefits.

(MoHM 2002: 3)
The policy adopted the definition of traditional medicine and complementary medicine from the WHO, where traditional medicine has been defined as:

the sum total of knowledge, skills and practices on holistic healthcare, which is recognized and accepted by the community for its role in the maintenance of health and the treatment of diseases. Traditional medicine is based on the theory, beliefs and experience that are indigenous to the different cultures, and that is developed and handed down from generation to generation.’

(WHO 1999; MoHM 2002: 3)

Complementary medicine refers to ‘a wide range of health interventions originating from different cultures across thousands of years of history’ (SODH 1996; MoHM 2002: 3). The vision of the policy is to integrate traditional and complementary medicine ‘into the Malaysian healthcare system to achieve a holistic approach towards enhancing health and the quality of life’ (MoHM 2002: 5). The mission of the policy is to ‘ensure the quality and safe use of traditional & complementary medicine practices and products in order to attain the optimum potential in healthcare delivery’ (Ibid.).

**The traditional and complementary medicine act (2016)**

The traditional and complementary medicine act of 2016, published in the *Gazette* on 10 March 2016, comprises a total of eleven parts and sixty-three sections. It is also called ACT 775 and provides for the establishment of the traditional and complementary medicine council to regulate the T&CM services in Malaysia and to provide for matters connected therewith (PoM 2017: 8). Regulating the practice and practitioners of T&CM and ensuring the quality of service and patient safety is the point of the act, although the date of its enforcement has still to be determined by the Ministry of Health. The act defines the practice of T&CM as ‘a form of health-related practice designed to prevent, treat or manage ailments or illness or preserve the mental & physical wellbeing of an individual & includes such practices as traditional Malay medicine, traditional Chinese medicine, traditional Indian medicine, homeopathy, Islamic medical practice, and complementary therapies’ (MoHM 2015: 16).

Although the aforementioned policy and acts are applicable to all practice areas in T&CM there is clear ethnic segregation within the practice. The practitioners from various practice areas are registered under different practitioner bodies and divided along ethnic lines. Practice of T&CM in Malaysia has been self-regulated mode until now. The Ministry of Health has appointed eight T&CM practitioner bodies representing different types of T&CM modalities available in Malaysia and registered, ensuring the regulation of practice. The major role for these bodies is to look after the formal and professional sector of traditional and complementary practice in Malaysia, such as the educational and training background of practitioners, the authenticity of diplomas, and so forth. Informal practice areas such as religious and spiritual healing, prescription divinity, and so on, are beyond the scope of these regulatory bodies. T&CM practitioners are also highly encouraged to register with the appropriate practitioner body: the Federation of Chinese Physicians and Medicine Dealers Association of Malaysia (FCPMDAM), the Federation of Chinese Physicians & Acupuncturists Association of Malaysia (FCPAAM), the Malaysian Chinese Medical Association (MCMA), the Majlis Perubatan Homeopathy Malaysia (MPHM), the Federation of Complementary & Natural Medical Association of Malaysia (FCNMAM), the Pertubuhan of Traditional Indian Medicine (PEPTIM), Persatuan Kebajikan dan Pengubatan Islam Darussyifa,
and Gabungan Pertubuhan Pengamal Perubatan Traditional Melayu Malaysia (GAPERA) (MoHM 2015: 20).

**Medical pluralism in policy and practice**

After the endorsement of the T&CM act by the Malaysian parliament, various organizations from the public and private sector paid more attention to areas including education and training facilities for Malaysian citizens, registration of T&CM practitioners, and the provision of T&CM services through the public and private healthcare system. However, all these initiatives came as part of the rise of global capitalism and made T&CM a middle-class private phenomenon in contemporary Malaysia.

**Example 1: education and training facilities for T&CM**

The education and training facilities on T&CM in present day Malaysia, post-secondary education and training in particular, is controlled by the private sector. There is no public institution which offers an accredited graduate or postgraduate programme on any T&CM practice area. Private universities usually charge high tuition fees ranging from RM 20,000–30,000 (per annum) (1 USD = RM 4.10 app.) and only students coming from a middle or upper middle-class background can afford to pay for such education. For example, Xiamen University Malaysia charges an annual fee of RM 23,000 for their Bachelor of Medicine in Traditional Chinese Medicine programme in the 2018–19 academic year. Other universities such as INTI International University charge an annual fee of RM 28,454. The programme duration ranges from four to five years for a bachelor degree and two to two and a half years for a diploma (MoHM 2015). However, post-secondary education and training for Western medicine is in a better position compared to T&CM practice areas, where a total of thirty-three institutions currently offer programmes such as a Bachelor of Medicine and a Bachelor of Surgery (MBBS), a Doctor of Medicine (MD), etc. and one third of them are public institutions (Ibid.).

**Example 2: health service delivery**

Although the Malaysian government took the initiative to promote medical pluralism, the delivery of health services is still dominated by Western medical care. A large share of the national health budget goes to the promotion and maintenance of Western medical facilities. The existing healthcare facilities are also heavily dependent on Western medical services. There are a total 143 licensed government hospitals (excluding dental clinics) under the Ministry of Health, with 41,389 hospital beds offering Western medical care. There are also 2,875 health clinics, 343 One Malaysia clinics, and nine non-Ministry of Health hospitals totalling another 3,913 hospital beds for Western medical care. On top of this, there are 183 private licensed hospitals (excluding maternity homes, nursing homes, hospice, ambulatory care centres, blood banks, dialysis centres, community mental health centres, and combined facilities) in the country with 12,963 hospital beds and 7146 privately registered medical clinics (excluding dental clinics). On the other hand, only fourteen government hospitals and two clinics offer T&CM services (MoHM 2016: 12–14).

Huge disparities could also be found the area of health service utilization. According to the Ministry of Health statistics, the number of Western medical care services utilized at government hospitals were 20,260,479 in 2015, whereas the number of T&CM care services utilized in government hospitals were only 69,133 in the same year (MoHM 2016: 1–2). There is
variation within T&CM service use in the public healthcare system, where the plurality of T&CM service recipients received acupuncture treatment (nearly forty-eight per cent), followed by traditional massage (nearly 29 per cent) (MoHM 2016: 44). This demonstrates the leading position of acupuncture among T&CM practice areas in Malaysia.

Challenges to Malaysian medical pluralism: accessibility of quality herbs and medicinal preparations

Both the traditional Chinese and Indian medicine practitioners interviewed mentioned that the accessibility of quality herbs and medicinal preparations causes major setbacks for the promotion and development of their medical practice in Malaysia. The country has very few manufacturing units for traditional and complementary medicine. The country also does not have adequate herbal cultivation fields for growing quality herbs. Traditional Chinese and Indian medicine rely heavily on imported herbs and medicinal preparations from China and India. Importing herbs and medicinal preparation from overseas is a complex and time-consuming procedure in Malaysia given the fact that they have to go through regulations and controls. Since Chinese and Indian crude herbs and preparations have a limited time of potency, many are expired when they arrive in Malaysia. Although Chinese herbal medicine is more popular in China compared to acupuncture, in Malaysia, the majority of patients focus on acupuncture. Similarly, while Ayurvedic preparations are more popular in India, Ayurvedic massage therapy is used by most clients in Malaysia. Also, ‘Malaysia is a Muslim majority country and some of the Chinese and Ayurvedic herbal preparations are considered not as halal by the Muslim community, keeping them away from using Chinese herbal medicine or Ayurvedic preparation.’

Challenges to Malaysian medical pluralism: foreign practitioners

The presence of non-registered foreign Chinese medicine practitioners causes a negative reputation for this type of medicine in Malaysia. Although the number of registered foreign practitioners in different T&CM practice areas is not very large, there is an additional range of non-registered practitioners practising under the table as seasonal service providers. Malaysian patients, ‘particularly those suffering from chronic diseases have a mind-set that if a Chinese medicine practitioner comes from mainland China or Taiwan he might have miraculous power. They prefer to visit those practitioners coming from China or Taiwan rather than local practitioners.’ Some of these practitioners are acupuncturists or herbal practitioners and visit Malaysia on a tourist visa on a short-term basis. The Malaysian government has set up certain requirements for one to register as a foreign practitioner of medicine, which includes: possession of basic qualifications relevant to the area of practice; adequate working experience (five years or above for bachelor degree holders and three years or above for a diploma and lesser qualification); ability to use technology; twenty-seven years of age or older for degree holders and twenty-three years or more for diploma and lesser degree holders; registration of the recruiting company with the company commission of Malaysia and licensing by the relevant local authority; and previous advertisement to recruit locals before hiring foreign practitioners. Because of the aforementioned requirements, there are only 203 foreign registered medical practitioners for practising T&CM across the country and nearly half of them are practitioners of traditional Chinese medicine (MoHM 2015).
Challenges to Malaysian medical pluralism: payment

The healthcare system in Malaysia comprises two tiers of services: a government-led and funded public sector which is heavily subsidized, where patients pay only nominal fees for access to both in-patient and out-patient services; a private sector where patients make out-of-pocket payments or private health insurance covers the cost. To date, Malaysia does not have a unified system of universal access to healthcare for every citizen although the public sector caters to the bulk of the population sixty-five per cent (Quek 2014: 1). However, very few public healthcare centres offer traditional and complementary medical care. Many Malaysian patients are not used to making out-of-pocket payments and prefer to explore public healthcare facilities. As stated before, T&CM services are mostly run by the private sector and therefore it is difficult for healthcare centres and individual practitioners to get enough patients who are willing to pay themselves. The fees charged by a qualified Chinese medicine practitioner vary from clinic to clinic and depend on the individual practitioner. For example, One Flower With Five Leaves Sdn Bhd clinic in Kuala Lumpur charges RM 180 for the diagnosis and treatment of a new patient, RM 80 for Acupoint therapy, RM 15 (per day) for Chinese herbal medicine, and so on. This amount is generally affordable for middle to higher income households in Malaysia.5

Lack of education facilities

Until now, there is no public institution in Malaysia that offered tertiary education and training on traditional and complementary medicine. Unlike training on Chinese medicine the training facilities for Ayurveda is worse while only few small institutions/centres offered certificate courses for few weeks to month duration. The government of India launched AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy) scholarship programme for the Malaysian students for training on various practice areas of Indian medicine through the High Commission of India in Malaysia. This scholarship provides for tuition fee, living allowance, contingent grant, and house rent allowance. The High Commission of India in Malaysia invites for the 2015–2016 for the courses on Bachelor of Ayurvedic Medicine & Surgery (BAMS), Bachelor of Siddha Medicine &Sciences (BSMS), Bachelor of Unani Medicine & Surgery (BUMS), and Bachelor of Homeopathy Medicine & Surgery (BHMS) under this scheme. All the aforementioned courses are for five-and-a-half years duration (High Commission of India in Malaysia 2018). Despite the Indian government’s effort, the response from Malaysian student body is not very optimistic. They prepare to study Western medicine in India rather than Indian System of Medicine or go to other Western countries for higher education. At the same time although there are some tertiary institutions in Malaysia those offer Chinese medicine courses a large number of Malaysian Chinese students prefer to study Chinese medicine in mainland China (XUM 2018).6

Conclusion

Medical pluralism in recent decades has become an increasingly popular phenomenon in multi-ethnic societies such as Malaysia. The Malaysian government is also instrumental in capitalizing on the benefit of various medical traditions through her state organs. However, there are obvious challenges in Malaysia for the further growth of T&CM practice areas. As noted, there is a discrepancy between the policy and the practice of medical pluralism in the
country. Western medicine dominates the public health system and accounts for a large share of the national health budget. T&CM practice areas remain part of private healthcare, which is only affordable to middle-class citizens who are willing to pay for themselves. Although the majority of Malaysians rely on public health facilities, the incorporation of T&CM practices in government-subsidized healthcare delivery is limited. All these trends and developments related to T&CM practice are subservient to the rise of global capitalism in Malaysia and accessible to an emerging middle class who are seeking alternative healthcare. The terms and conditions set up within the regulatory framework for T&CM practice are usually in place for the practice of Western medicine as well, but their application to T&CM remains a question and needs to be explored further. Western medicine has a different history, theory, and methods than T&CM and standardizing T&CM according to the Western line may not necessarily produce effective outcomes. There are also informal health practices that still exist in rural areas and are not recognized by the government as T&CM.

T&CM is also divided along ethnic and religious lines. The Chinese are the second largest ethnic minority in the country and Chinese medical education is available in the overwhelming majority of the private universities offering graduate and diploma programmes on T&CM. The majority of T&CM service recipients in the public healthcare system are also Chinese.

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Notes

1 Patients/service recipient statistics from One Flower with Seven Leaves in August 2018 illustrates that 22.45 per cent of their service recipients were ethnic Malay, even though the clinic exclusively offers various modalities of Chinese medicine such as acupuncture, tuina, cupping, herbal prescription, and so on. Similarly, patients/service recipient statistics from the My Ayurveda Health Way of Life Clinic, which exclusively offers various Ayurvedic treatment and services, shows that 33.33 per cent of their August 2018 clients were ethnic Chinese and 5.55 per cent were ethnic Malay. These statistics were collected by the author during personal visit to those clinics.

2 Patients/service recipient statistics from the One Flower with Five Leaves clinic during the month of August 2018 illustrate that 77.55 per cent of their clients were ethnic Chinese and received exclusively Chinese medicine treatment and services. These statistics were collected by the author during personal visit to the clinic.

3 A point mentioned by a practitioner of Chinese medicine from Kuala Lumpur during an interview with the author.

4 A statement made by a practitioner of Chinese medicine from Malaysia’s Penang Island during an interview with the author.

5 The Malaysian Department of Statistics divides Malaysian household income into three categories based on the monthly mean of household incomes. T20 (the top 20 per cent) households had a monthly mean income of RM 16,088 in 2016 and shared 46.2 per cent of the national income. M40 (the middle,
40 per cent) households had a monthly income of RM 6,502 in 2016 and shared 37.4 per cent of the national income. B40 (the bottom 40 per cent) households had a monthly mean income of RM 2,848 in 2016 and had only 16.4 per cent of the national income (DoSM 2016).

The Traditional Chinese Medicine Program of Xiamen University, Malaysia’s (XUM) School of Medicine listed a total twenty-two faculty members on their webpage, a majority of whom are from mainland China. The author found during his personal visit to the above institution in 2018 that 93.75 per cent of their faculty members received graduate or postgraduate training in Chinese medicine from an institution located in mainland China.

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