

**WHAT YOU THINK**

As Malaysia turns 63, rural communities are still waiting for equal healthcare — Mohd Zaidi Md Zabri

Follow us on [Instagram](#), subscribe to our [Telegram](#) channel and [browser alerts](#) for the latest news you need to know.

Saturday, 12 Sep 2026 12:30 PM MYT

SEPT 12 — As Malaysians prepare to mark Malaysia Day on September 16, the wreckage at Long Lellang Airport offers a sobering starting point for reflection.

On September 8, a helicopter carrying a medical team from the Flying Doctor Service (FDS) crashed in Ulu Baram, Sarawak, killing all five people on board: the pilot, a medical officer, an assistant medical officer and two nurses.

The decision by the Health Ministry (KKM) to suspend all FDS operations in Sarawak pending a review of safety, governance and the service delivery model was necessary and appropriate. Health Minister Datuk Seri Dr Dzulkefly Ahmad has said the review will cover contracts, governance, operational safety, coverage requirements and the effectiveness of the existing model. In the interim, emergency evacuations will continue in cooperation with the Fire and Rescue Department, while discussions proceed with the Armed Forces over possible backup transport.

Necessary though that response is, it also exposes an uncomfortable reality: a single incident can reveal just how thin the safety net is on which rural Sarawak has depended for more than five decades. As of April 2026, the FDS served 97 localities across the interior regions of Kapit, Miri and Limbang. Most were visited only once a month, and some only once every two months, depending on operational capacity.

63 years of equal partnership?

As Malaysia marks 63 years since the formation of the federation, it is worth asking plainly whether equal partnership has translated into equal access to a doctor.

In Putrajaya, healthcare is often no more complicated than getting into a car and driving to the nearest hospital. In Ulu Baram, however, reaching the same care can depend on a chain of contingencies: whether a leased helicopter is airworthy, whether the weather

permits flying, and whether an operator has both an aircraft and crew available to make the journey.

That disparity reflects a policy reality that has remained largely unchanged for decades. In some of Malaysia's most remote communities, access to healthcare still depends on extraordinary measures rather than ordinary, resilient infrastructure.

Seen in that light, the FDS is both a lifeline and a reminder. It provides essential care to communities that might otherwise go without it, while also underscoring a problem that successive governments have never fully resolved.

A stopgap that became permanent

This is not an argument for assigning blame to any particular government. The FDS has persisted, and remained necessary, across successive administrations because the underlying challenge, geographic isolation without adequate road or scheduled air transport alternatives, has never been comprehensively addressed.

But the service's longevity is itself revealing. Introduced in Sarawak in 1973 to bridge a profound gap in rural healthcare, the FDS remains, 53 years later, a principal means by which many remote communities gain access to medical care.

A stopgap can be defended in the short term. It is harder to continue treating it as temporary after half a century. 63 years of federation should have been long enough to move rural healthcare beyond a service re-tendered every few years and towards resilient infrastructure planned in decades rather than contract cycles.

If that sounds demanding, it is worth remembering that Malaysia is hardly the first country to confront the challenge of delivering healthcare across vast and sparsely populated terrain. The question is not whether such access can be sustained, but how a country chooses to sustain it.

What Australia got right

Australia's Royal Flying Doctor Service, founded in 1928 and funded by the Australian government since the 1930s, offers an instructive model, not simply for the aircraft it operates, but for the institutional architecture that supports them.

For decades, agreements between the RFDS and the Australian government ran for only four years at a time. In 2022, that approach gave way to a decade-long strategic partnership worth close to A\$1 billion (about RM2.9 billion), covering the period from 2022–23 to 2031–32. In December 2024, Canberra reinforced that commitment by announcing an additional A\$74.8 million over three years and reaffirming its long-term partnership with the RFDS.

Crucially, the arrangement requires the RFDS to conduct a formal needs assessment every 3 years. This helps ensure that services are directed towards documented coverage

gaps rather than having their necessity repeatedly contested through short-term budget cycles.

The approach has supported one of the world's largest remote healthcare networks. The RFDS records more than 345,000 patient contacts annually through clinics, aeromedical transport and telehealth consultations.

More important than its scale, however, is what the model represents: remote healthcare is treated as a permanent national responsibility and supported through a long-term institutional framework.

The lesson for Malaysia is not the size of Australia's fleet or the scale of its budget. It is the policy discipline of planning beyond the next contract cycle.

Financing equity, not just flights

A significant first step would be to move the FDS beyond the uncertainty of short-term leasing arrangements and annual competition for funding. In their place should be a multiyear, ring-fenced funding framework tied to published assessments of community needs.

A 3-year review cycle, similar to the RFDS model, would help ensure that future allocations respond to documented coverage gaps rather than shifting budget priorities. It would also provide a clearer basis for evaluating whether existing routes, visit frequencies and transport arrangements remain adequate as communities and healthcare needs change.

Such a review should not be the responsibility of KKM alone. In remote communities where access to healthcare depends on aviation, health policy and transport policy are inseparable.

The Ministry of Transport, aviation regulators, the Sarawak government, emergency services and airport operators should all have a role in assessing capacity, identifying vulnerabilities and planning for future demand. Potential cooperation with state-linked aviation providers such as AirBorneo could also be examined as part of a broader review, rather than assumed in advance.

Just as importantly, redundancy should be treated as a deliberate feature of the system rather than an avoidable expense. Whether achieved through a second operator, supplementary transport arrangements, shared access to government assets or a dedicated contingency mechanism, resilience carries a cost. But so does dependence on a single point of failure.

None of these measures would eliminate the challenges of geography. Weather would still disrupt flights, remote settlements would remain difficult to reach, and aviation would continue to carry inherent risks. But better funding, coordination and

contingency planning would reduce the extent to which access to healthcare depends on a single aircraft, a single operator or the timing of the next procurement exercise.

For communities that continue to rely on the Flying Doctor Service, that would represent meaningful progress.

A promise still owed

Budgets, contracts and governance frameworks, however important, are ultimately means rather than ends. What matters is whether they enable people in remote communities to receive care when they need it.

These questions matter because they affect communities that rarely feature in national debates except in moments of crisis. The five lives lost at Long Lellang were given in service of a basic promise: that every Malaysian, regardless of where they live, deserves a fair chance of seeing a doctor.

As the country marks another Malaysia Day, that promise remains only partially fulfilled. Malaysia does not lack the fiscal capacity to do better, nor does it lack examples of what sustained commitment can achieve. What has been missing is the decision to treat rural healthcare access as permanent national infrastructure, planned and funded over decades rather than renewed contract by contract.

The true test of that commitment will not be another review, inquiry or statement of condolence. It will be whether a parent in a remote longhouse can seek care for a sick child with the same certainty as a parent in Putrajaya, without first wondering whether an aircraft is available, whether the weather will hold, or whether help can arrive at all.

** Dr Mohd Zaidi Md Zabri is an Assistant Professor at the IIUM Institute of Islamic Banking and Finance (IIBF), International Islamic University Malaysia.*

**** This is the personal opinion of the writer or publication and does not necessarily represent the views of *Malay Mail*.**

Copy

Related Articles

- **Conditions for Najib's house arrest to reflect govt's resolve to fight corruption and abuse of power — Hafiz Hassan**
- **Puteri Umno could be the voice of reason Umno needs, if it actually lives its 'politics of trust' — Rabi'ah Aminudin**

- **Foreign funding is not foreign control — Ivy Josiah**
- **If everything comes to our door, what will draw us outside? — Nur Aulia Rosni and Yong Adilah Shamsul Harumain**

YOU MAY ALSO LIKE