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The Malaysian health system in transition

The ambiguity of public and private

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ABOUT THE PROJECT

The Municipal Services Project (MSP) is a research project that explores alternatives to the privatization and commercialization of service provision in electricity, health, water and sanitation in Africa, Asia and Latin America. It is composed of academics, labour unions, non-governmental organizations, social movements and activists from around the globe who are committed to analyzing successful alternative service delivery models to understand the conditions required for their sustainability and reproducibility.

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EXECUTIVE SUMMARY

Since decolonization in 1957, Malaysian citizens have become accustomed to a de facto entitlement to publicly provided and highly subsidized health care. The country's primary healthcare system is one of the most accessible in the world. Remarkably, this was achieved with public sector health expenditures that seldom exceeded 2.5 per cent of gross domestic product (GDP). These modest expenditures however also impose limits on the level, timeliness and (perceived) quality of care that can be delivered, and furthermore translates into lower salaries for healthcare professionals than in the private sector, which sustains a continuing exodus of experienced staff from the public sector.

In recent years, Malaysian government agencies have acquired controlling stakes in major for-profit healthcare enterprises. The Johor state government, for instance, controls a large diversified healthcare conglomerate which includes the largest chain of private hospitals in the country. Meanwhile, the Malaysian federal government's sovereign wealth fund (Khazanah) controls the second largest listed private healthcare provider in the world. Government-linked companies¹ now account for more than 40 per cent of 'private' hospital beds in Malaysia.

This novel situation raises many intriguing questions: Is this a "nationalization" of private enterprises in human services, or an infusion of the ethos and logic of capital into the institutional dynamics of the state? How are conflicts of interests playing out, as the state juggles its multiple roles as funder and provider of public sector health care, as regulator of the healthcare system, and as prime investor in the for-profit health services industry? Is a targeted approach to publicly provided services (as opposed to a universalistic approach) an attempt to harmonize the state's competing priorities in public and private sector healthcare?

The alternative scenario of a more progressive taxation regime to improve universal access to quality care on the basis of need seems to be off the radar screen. Furthermore, there is little evidence thus far that the state is exercising its ownership prerogatives in commercial healthcare enterprises to pursue a balance of social versus pecuniary objectives (e.g. through cross-subsidies or playing a price-restraining role in the commercial healthcare sector), beyond cosmetic corporate social responsibility initiatives.

The conclusion that emerges is that public ownership (or control) of commercial healthcare enterprises in Malaysia may not work in favour of the equitable provision of health care on the basis of need. Much depends on the evolving character of the state and the constituencies and class interests it prioritizes.

Introduction

While health care is not inscribed in the Malaysian constitution as a human right, citizens have become accustomed to a de facto entitlement to publicly provided and highly subsidized health care as an important element of social policy since decolonization in 1957 (SUHAKAM 2003). In practical terms, this universalistic entitlement expands or shrinks depending on the level of funding allocated by the federal government, staffing levels and competencies in government health facilities, necessary equipment and treatment accessories, geographical access and co-payments required, among other factors. In 2011, government healthcare expenditures amounted to 2.32 per cent of GDP, while private spending added another 2.08 per cent (Ministry of Health 2013a). Overall, user fees for the government-provided services amount to 2-3 per cent of the Health Ministry's actual expenditures (Safurah et al 2013, 44), but these costs for households may not include occasional purchases of medicines and other treatment accessories not available in government health facilities (i.e. patients' co-payments).

Malaysian citizens may or may not avail themselves of this universalistic entitlement, but they all benefit from its second order effects insofar as the availability of subsidized, publicly provided health care acts as a fallback option – a restraining price bulwark – that helps to keep private healthcare charges more affordable.

Presently, employees and pensioners in the public sector enjoy practically free access to publicly provided health care as an employment benefit, with a tiered entitlement to inpatient ward class in accordance with their occupational grade within the civil service. For others, outpatient primary care in the urban areas entails a nominal payment of RM 1 (roughly US\$0.30) to cover consultations, necessary investigations, and medicines. In rural areas, there are no charges for government-provided primary care.

Patients who are referred to public specialist clinics are charged RM 5 for each outpatient visit after the first free referral visit,² and they are also charged for the necessary investigations. Inpatient care at government facilities is also highly subsidized on a graduated scale. In 2008, government health facilities accounted for 74 per cent of hospital admissions and 38 per cent of outpatient visits (Ministry of Health 2010a).

To address geographical barriers to access, the Health Ministry's Rural Health Service began in 1953 and has expanded rapidly to provide extensive primary care coverage. As of 1993, 93 per cent of the population of Peninsular Malaysia lived within five kilometers of a permanent primary care facility. In the more sparsely populated states of Sabah and Sarawak however, the coverage was 76 per cent and 61 per cent respectively – although these figures would be higher if flying doctor squads and mobile health teams were included (WHO 2006).

Overall, this geographical coverage for primary health care is quite impressive, reportedly the second best in the world after Cuba. Indeed, Malaysia was notable in achieving much of Alma Ata's Primary Health Care goals via an institutionalized formal healthcare delivery system with minimal resort to health auxiliaries and community health workers, as generally envisaged for resource-constrained settings. In addition to vaccination, pre- and post-natal care, maternal and child health programs, primary medical care with referral backup, health education and promotion, and vector control of communicable diseases, the Rural Health Service also addressed social and environmental determinants of health such as potable water supply, sanitary latrines, environmental hygiene, village midwifery practices, and nutrition.

An underfunded public healthcare sector

This extensive coverage and universalistic entitlement to publicly provided health care has benefited large segments of the Malaysian population. But the modest expenditures on these services also impose limits on the level, timeliness and (perceived) quality of care that can be delivered, and furthermore translates into modest salaries for healthcare professionals in the public sector.

At the present time, the public healthcare sector receives a yearly infusion of young inexperienced medical graduates who are required to serve a four-year mandatory national service. Some stay on out of preference for public service, while others do so for the postgraduate training opportunities, but after the completion of their specialty training, there is a steady attrition of senior experienced staff over the duration of their contractual obligations. In the period 2005–2008, for instance, 1,427 doctors left the government service, equivalent to an annual attrition rate of three per cent of staff over and above those retiring (Ministry of Health 2010a).

This perennial exodus of senior experienced staff from the public sector gives rise to a lopsided distribution of specialists, one third of whom currently practise in the private sector (Ismail Merican 2013), attending to a quarter of total hospital beds (Ministry of Health 2013a). The outflow of public sector doctors, nurses, specialists and technicians sets off a vicious circle, as understaffing translates into heavier workloads for those who remain, thereby further reinforcing pressures to leave the public sector. Meanwhile, the unrelenting promotion of medical tourism adds to the lure of private practice, which increasingly services a clientele that is regional in scope (Chee 2010). Many health professionals decide to migrate too. Dr Fong Chan Onn, a former minister of human resources, has observed that more than half of the medical specialists at Singapore's premier Mount Elizabeth Hospital for instance were Malaysian émigrés (The Star 2010a). With the continuing outflow of experienced personnel, patients in the public sector can expect little relief from the long queues and service of harried and stressed-out staff.

Corporatizing public health care

In 1999, the Malaysian government announced plans to corporatize its hospitals and other health-care facilities, in part to try and stem the outflow of health professionals, and in part due to this growing trend elsewhere in the world (Salmon 1985). The corporatized institutions would continue to be publicly owned but vested with more operational and financial autonomy outside the purview of civil service rules. This was intended to allow for more flexibility in salary scales, patient fees, procurements, and timely response to shifts in market demand and client preferences. Coming in the wake of the outsourcing of hospital support services and pharmaceutical supplies, however, it aggravated public anxieties about a future privatization of clinical and hospital services. This quickly became a contentious issue in the run up to general elections in November of that year, and the blueprint was quietly shelved.

Eight years passed before the issue re-emerged on a pilot scale in the form of opportunities for limited private practice in government hospitals. Effective August 1, 2007, Putrajaya Hospital and Selayang Hospital, two of the newer public hospitals with advanced treatment facilities for liver-related illnesses, hand surgery, breast cancer, and endocrine diseases, began to offer to “full-paying patients” preferential access to consultation and treatment by specialists of their choice, in an ‘executive’ or ‘first-class’ facility – to be charged accordingly.

In justifying this departure from a previous practice based largely on priority of medical need, Health Minister Dr Chua Soi Lek stated at the time: “we are losing [hundreds of] specialist doctors every year, who resign to join the private hospitals... We hope this approach will enable the hospitals to allocate some additional incentives for the specialist doctors [to remain in the public sector]...” (The Star 2007).

The introduction of the full-paying patient scheme followed an earlier proposal in 2004 to establish full-fledged private wings in selected government hospitals. Government-employed doctors at the time had declared their support (MMA-SCHOMOS n.d.):

[T]he setting up of these private commercial wings would not only supplement the income of specialists but would also generate income for supporting staff as well as for hospitals to further improve services. As more specialists would consider staying back in government service, the quality of care would improve. Private patients too would be able to enjoy better quality of health care at lower cost compared to the private sector at present. With such a set-up, health tourism would emerge as a natural consequence, thus setting up a cycle of generating more income for the government and boosting further improvement of health services. It is our [SCHOMOS] sincere hope that these private commercial wings would be fully owned by the government so as to ensure a maximum win-win situation for the government, health providers as well as health care receivers.

The Coalition against the Privatization of Health Services (Gabungan Membantah Penswastan Perkhidmatan Kesihatan or CAPHS), formed in 2005 and uniting some 70 NGOs, was less sanguine about these prospects, and has consistently opposed proposals for private wings in public facilities on the grounds that (CAPHS 2007):

- only 30 per cent of specialists are employed in the government sector, but they serve 70 per cent of hospital admissions throughout Malaysia
- in addition to their clinical and ward duties, specialists have teaching, training and mentoring responsibilities toward their junior colleagues in the public hospitals
- the full-paying patient scheme would unavoidably get disproportionate attention, and priority and would further compromise the quality of services received by regular patients

Interestingly, the Association of Private Hospitals of Malaysia was also opposed to the private wings proposal that would create price competition from a subsidized and publicly owned service. Ridzwan Abu Bakar, then president of the association, demanded a level-playing field in which “all players must be exposed to the same subsidies and business risks.” In place of full-fledged private wings, he said the association would encourage limited private practice by specialists in government hospitals (The Star 2004).

Equally interesting was the stance of the health insurance industry, whose wariness and ambivalence vis-à-vis private healthcare providers was well captured in an interview with Dr Nirmala Menon, senior vice-president of ING Insurance Berhad in 2004 (cited in Chan 2010a, 452):

What we would like to see in the public sector is improvement in the [health-care] services, shortening of queues... [Our customers] purchase insurance so that they can get out of going to public hospitals... We would like people to go to public hospitals because it costs less for us, but once you buy an insurance, you almost never go to a public hospital. You always go to a private hospital. It's a perception that Malaysians have that private equals better... In fact, we even have policies where we ask for less information if they go into a public hospital, we pay faster and we even have policies where we give them some money on [a] daily basis [for] hospital allowance if they get into the public hospitals but that doesn't really matter.

Health insurers thus appear to have an ambivalent attitude toward healthcare providers (and the state). Deteriorating public hospitals reinforce people's felt need for private health insurance, but health insurers also complain endlessly about moral hazards and price gouging by private providers (Annual Health Dialogue 2001), so much so that they provide monetary incentives to access

public hospitals when in need of care. Going by their rhetoric, they want low-cost, no frills, “medically necessary,” evidence-based care, which sounds engagingly like the original progressive vision of managed care (Kuttner 1998). Under certain circumstances, the insurance companies might even be supportive of subsidized, publicly provided health care with moderate user charges or co-payments.

It would be a stretch to say that the insurance (and managed care³) industry was instrumental in the push for private wings and private patients in government hospitals, but this was clearly an option they favoured given their testy relationships with fee-for-service healthcare providers in the private sector, which they invariably suspected of price-gouging, padding of bills, and unnecessary investigations and procedures.

The state as entrepreneur

The Malaysian state has an unusual characteristic born of its recent history. In 1970, in the wake of post-election ethnic rioting and a brief period of emergency rule, a New Economic Policy (NEP) was promulgated with the twin goals of reducing poverty and inter-ethnic disparities, most notably between the predominantly Malay indigenous (*bumiputra*) community and a sizeable ethnic Chinese minority. One of the indicative targets of the NEP was to increase the *bumiputra* ownership of incorporated share capital from 2.4 per cent in 1970 to 30 per cent by 1990. Given the small size of the Malay business and shareholding class at the time, this ambitious task of restructuring share ownership inevitably fell to the state. *Bumiputra* trust agencies were duly created to acquire and manage massive holdings of corporate equities from which were spawned unit trust funds that could reach a broader base of eligible *bumiputra* beneficiaries.

In parallel with these initiatives were efforts to foster the emergence of a *bumiputra* commercial and industrial community (a Malay bourgeois elite) that could take on leading roles in a diverse range of government-acquired or government-spawned commercial enterprises. Within two decades, Malaysian government trust agencies and government-linked companies had acquired sizeable if not controlling stakes in the commanding heights of the national economy (e.g. finance and banking, agribusiness, oil and gas, heavy industry, media and broadcasting, infrastructure and construction, power generation and distribution, telecommunications, transportation). In this manner, the Malaysian state, going beyond its more traditional *welfarist* and *developmentalist* roles, took on the character of an entrepreneurial state as well.

In the health services sector, the Johor state government’s venture into private hospitals, via its corporate arm the Johor Corporation, has grown into the largest chain of private hospitals in Malaysia, KPJ Healthcare Berhad (26 hospitals in the country, and two in Indonesia) (Chan 2010a). A publicly listed healthcare conglomerate, KPJ has a diversified portfolio of services that

also includes hospital management, hospital development and commissioning, basic and post-basic training for nurses and allied health professionals, laboratory and pathology services, central procurement and retailing of pharmaceutical products, healthcare informatics, and laundry and sterilization services.

Meanwhile, the Malaysian federal government's strategic investment fund Khazanah Nasional Berhad has emerged as the controlling shareholder of the second largest listed private health-care provider in the world. In 2006, Khazanah intervened to forestall a corporate takeover of Pantai Holdings by the Singapore-listed Parkway group (Khazanah Nasional Berhad 2006). Pantai Holdings, another Malaysian healthcare conglomerate which operated the second largest hospital chain with nine private facilities in Malaysia, was also a major beneficiary of lucrative outsourcing concessions for hospital support services for the health ministry's facilities, and foreign worker medical registration. Over the next five years, Khazanah's healthcare subsidiary (IHH Healthcare Ltd) consolidated its control of both Pantai and Parkway (Khazanah Nasional Berhad 2010), eventually acquiring as well Turkey's largest private hospital group Acibadem on the way to a joint listing on the Kuala Lumpur and Singapore stock exchanges in what was reported as the third largest IPO (Initial Public Offering) in the world in 2012 (IHH 2012; Reuters 2012).

Domestically, these developments mean that the Malaysian government, in concert with government-linked companies at both federal and state levels, effectively own or operate three parallel systems of healthcare providers in Malaysia: the regular Health Ministry facilities; corporatized hospitals (National Heart Institute and the university teaching hospitals of Universiti Malaya, Universiti Kebangsaan Malaysia and Universiti Sains Malaysia); and commercial hospital chains that account for more than 40 per cent of private hospital beds.

The ambiguity of public and private

This ownership storyline raises a number of intriguing questions. Are the KPJ and Parkway-Pantai hospitals public or private? Is this a progressive "nationalization" of private enterprises in essential human services, or an infusion of the ethos and logic of capital into the institutional dynamics of the state? Clearly, this fusion of state and capital is rife with conflicts of interest, as the state wears multiple hats and attempts to reconcile sometimes divergent priorities in the public and private healthcare sectors. As Khazanah comes under pressure, for instance, to secure commensurate returns from its costly acquisition of Parkway (The Star 2010b), will the public sector suffer from neglect? Will the poaching of public sector staff by the private sector continue unabated, or will it be subject to some restrictions? What safeguards will be put in place for impartial regulation, given the potential for regulatory conflicts of interests in the healthcare sector?

The case of the National Heart Institute

An illustrative example of divergent priorities and public/private ambiguities in the healthcare system was the attempted acquisition of the National Heart Institute (Institut Jantung Negara, IJN) by a government-linked company in 2008. Previously in 1992, the IJN had been hived off from the Kuala Lumpur Hospital and corporatized as a government-owned referral heart centre. One of the missions of this 430-bed corporatized hospital was to provide high quality services in cardiovascular and thoracic medicine at reasonable cost. Civil servants and government pensioners would continue to receive treatment for heart ailments at IJN at government expense (as an employment health benefit) and low-income patients would be eligible for fee waivers or discounts.

For Malaysian citizens who were not civil servants, patient charges at the corporatized IJN increased – though not quite to the level of the private hospitals – and IJN staff were paid salaries markedly above the corresponding Ministry of Health scales. The IJN continued to be subsidized by public funds, although not to the extent of 90-95 per cent as was commonly the case for Ministry of Health facilities. The intention was that IJN should also act as a ‘price bulwark’, that is, a more affordable fall-back option which could help restrain escalating charges at private hospitals such as the Subang Jaya Medical Center (SJMC).

In December 2008, Sime Darby Ltd, the controlling stakeholder of SJMC, and one of the largest government-linked companies in Malaysia (with diversified interests in property development, motor vehicles, industrial equipment, energy and utilities, etc), submitted a proposal to the Ministry of Finance to acquire a 51 per cent stake in IJN. The federal cabinet initially responded positively. In explaining the cabinet’s stance, Finance Minister Najib Abdul Razak alluded to demands from IJN’s medical staff for higher pay, and the likelihood they would leave IJN if their demands were not met. This prompted a statement signed by 33 of IJN’s 35 medical consultants rebutting this argument and distancing themselves from the privatization initiative (The Star 2008a):

[O]ver the last 7 years of operation, out of a total of 35 consultants, only 7 have left IJN. Therefore, our consultants’ annual attrition rate is only 3 percent and we have responded over time to promote our home grown talents to fill the voids accordingly. Currently, 75 percent of IJN consultants have been in their posts for more than 10 years... Whilst we have yet to get a clear picture of the proposed privatization by Sime Darby, we would like to reiterate our commitment to serve IJN in its current form and want to stress that the proposed privatization of IJN must not be seen as a response to our demands for better pay. The medical personnel of IJN are not at all involved, directly or otherwise, in the negotiations for the said privatization.

Meanwhile, an investigative report in *The Star* (2008b) noted substantial fee differentials for comparable procedures at the public IJN and Sime Darby’s SJMC, with prices 50 to 100 per cent higher

at the private hospital. Evidently, Sime Darby, by acquiring IJN, hoped to establish a commanding presence in a lucrative medical specialty, and at the same time absorb and neutralize a lower priced competitor. In the ensuing public furore over this attempted takeover the proposal was quietly shelved by the cabinet.

Targeting policies

Policies of targeting (as opposed to universalism) are another illustration of the public/private tension in the Malaysian health care system (Chan 2006). With the devolution of social services to private enterprise, entrepreneurs in search of investment prospects are primarily interested in the “market-capable” segments of society.

As government-linked entities built up their stakes in the commercial healthcare sector in Malaysia, a succession of health ministers have argued that Malaysians who could afford it should avail themselves of private healthcare services (suitably encouraged thus with income tax rebates). This would allow the government to target its limited healthcare resources on the ‘really deserving poorer citizens’. Senior health ministry officials have likewise noted that (Safurah et al 2013, 90):

[A]n argument in favour of a two-tier system is that while the private sector concentrates on illness management among better-off urban people (thus reducing government outlays on this group), this frees the public sector to provide health care for the poor. The opting out by the ‘better off’ from public health services, thus, could improve the capacity of the public health system to extend increased access to poor people.

This intuitively appealing logic ignores the consequential poaching of staff from the public sector, which exacerbates the already burdensome workload of its remaining staff, thus feeding into a vicious downward spiral. Identifying and tracking the “targeted eligibles” (means testing, etc.) would furthermore entail administrative and transactional costs that are unnecessary with a policy of universal entitlements. Most importantly, a policy of selective targeting would detach a politically vocal, well-connected and influential middle class from any remaining interest in public sector health care, hastening the arrival of a rump, underfunded, decrepit public sector for the marginalized poorer classes (Mkandawire 2005).

Indeed, government expenditures on health care, amounting to 2.3 per cent of GDP in 2011 are far from extravagant. Whether this is tantamount to an implicit policy of benign neglect of the public sector – to encourage a migration of the “market-capable” to the private sector – is debatable. While health expenditures in the private sector have increased more than four-fold between 1997 and 2009 (Ministry of Health 2011), there has been a parallel increase in government health expenditures⁴ so that the private sector share has remained steady at about 45 per cent of total health expenditures (see Table 1).

TABLE 1:
Total health expenditure by source of financing by public and private sectors, 1997-2011

Year	Public		Private		Total (MYR million)
	MYR million	%	MYR million	%	
1997	4,317	52.72	3,872	47.28	8,188
1998	4,753	53.46	4,138	46.54	8,891
1999	5,243	53.82	4,498	46.18	9,741
2000	6,235	53.43	5,434	46.57	11,670
2001	7,297	56.48	5,623	43.52	12,920
2002	7,827	55.50	6,276	44.50	14,103
2003	10,258	57.68	7,526	42.32	17,784
2004	10,354	54.40	8,677	45.60	19,031
2005	9,499	49.29	9,775	50.71	19,274
2006	12,384	53.01	10,979	46.99	23,363
2007	13,557	52.36	12,337	47.64	25,894
2008	15,460	53.55	13,410	46.45	28,870
2009	17,716	56.65	13,555	43.35	31,271
2010	19,331	54.68	16,024	45.32	35,355
2011	19,797	52.27	18,075	47.73	37,871

Source: Ministry of Health 2013b.

In any case, an alternative scenario that would rely on more progressive taxation regimes to improve universal access to quality care on the basis of need, which dispenses with much of the administrative and transactional costs of managing a proposed national health insurance scheme, is notably absent from the options under consideration.

Regulatory environment

The practice of senior civil servants retiring into organizations previously under their regulatory purview (or suppliers in government procurements) poses a further challenge. The retired officials are expected to help their new employers secure government contracts, circumvent regulatory oversight, and generally benefit from preferential treatment by bureaucracy. Senior civil servants approaching their retirement may also look forward to a reward for discretionary favours bestowed upon their prospective future employers. Either way, such post-retirement placements encourage corruption and undermine an impartial regulatory role for the government. To cope with this, the penal code in France, for instance, imposes a three-year wait before a retiring official can accept a potentially compromising position in the private sector.

In Malaysia, a regulatory official faces the additional complication that a regulated entity may be a government-linked company with influential connections. This would not be unusual, given that government-linked companies in 2005 accounted for approximately a third of the market capitalization of the Kuala Lumpur stock exchange, coupled with the interpenetrating intimacy of 'political business' in Malaysia, which is well documented (Gomez 2002). In the securities industry, the Institute of International Finance observed in a report on Malaysia that "despite its operational independence, the Securities Commission (SC) is perceived as being influenced by the MoF [Ministry of Finance] by a cross-section of market participants and is considered to be a weak regulator" (2006).

The healthcare sector by comparison is relatively less regulated. The Medical Act (1971), which created and empowered the Malaysian Medical Council (MMC) to register medical practitioners who hold recognized medical degrees, also designates the director general of health as the chairman of the MMC. Because the current regulations do not bar retiring senior government officials from taking up positions in organizations over which they once exercised regulatory authority, two retired director generals of health have gone on to be presidents of private medical universities in Malaysia. Other retiring senior officials have taken up leading executive positions at agencies monitoring the performance of concessionaires that have been awarded outsourcing contracts for hospital support services.

Conclusion

In this paper I have described in some detail the Malaysian state's ventures into for-profit health care by governmental entities at both federal and state (provincial) levels. The salient points that emerge are as follows:

- The state is juggling multiple hats: (i) funder and provider of public sector healthcare; (ii) regulator; and (iii) key investor in for-profit health care, along with the inherent conflicts of interest.
- Public sector health care is underfunded and is plagued by a shortage and continuing outflow of senior experienced staff, thus affecting the quality of its care and its ability to restrain the escalation of charges in the private sector.
- Whether there is a de facto policy of benign neglect of the public sector is unclear, but a succession of health ministers have argued that those who can afford it should avail themselves of private health care, so that the government can conserve its modest resources for the 'truly deserving poor'. This seductive logic is encouraging a two-tiered healthcare system, deluxe priority care for the rich, and a rump, underfunded public sector for the rest.

- The alternative scenario, a more progressive taxation regime to improve universal access to quality care on the basis of need, seems to be off the radar screen (hobbled in part by public skepticism over the unaccountable stewardship of public financial resources).
- The potential for regulatory conflicts of interest has not been addressed.
- There is little evidence that the state is exercising its ownership prerogatives in commercial healthcare enterprises to pursue a balance of social versus pecuniary objectives (e.g. through cross-subsidies or a price-restraining role in the manner envisaged for the IJN) beyond cosmetic corporate social responsibility initiatives.

The conclusion that emerges from this investigation is that public ownership (or control) of commercial healthcare enterprises in Malaysia may not work in favour of the equitable provision of health care on the basis of need. Indeed, it may undermine it. Malaysian politics is in flux and much depends on the evolving character of the state and the constituencies and class interests it prioritizes. In the new environment created by the watershed 2008 election – where opposing political coalitions in Malaysia approach electoral parity, and a rotation of governing parties is conceivable, if not likely (Chan 2010b) – there are signs of a stepped-up pace of privatization and divestment of publicly owned corporate assets to well-connected private individuals and entities (Prime Minister's Dept 2012; The Edge Financial Daily 2012). This may have been a consideration in the aborted privatization of the National Heart Institute, shortly after the 2008 election. If this trend of divestment continues, we may see a publicly owned commercial healthcare sector increasingly taken over by private interests.

Endnotes

1 Government-linked companies are defined as companies that have a primary commercial objective and in which the Malaysian government has a direct controlling stake, not just percentage ownership. Controlling stake refers to the government's ability to appoint members to the Board of Director, senior management, to make major decisions (e.g. contract awards, strategy, restructuring and financing, acquisitions and divestments, etc.), either directly or through government-linked investment companies (Khazanah 2014).

2 Unless the patient is referred from the private sector in which case the consultation charge is RM 30 for the initial visit.

3 "Managed care" is a phrase referring to health services for a beneficiary population that are monitored (and sometimes approved) by an intermediary party which contracts with the ultimate payer (e.g. employer) who transfers the responsibility of employee health benefits to the intermediary in return for a financial settlement paid to the intermediary. There are a number of managed care organizations in Malaysia, including a Pantai subsidiary.

4 A notable drop in public sector health expenditure in 2005, reflecting an austerity budget to reduce the federal deficit from 4.5 per cent GDP to 3.7, was reversed in the subsequent years. Increased public sector health expenditures from the mid-1990s also reflect the increased outlays for outsourced pharmaceutical and medical supplies (1994) and hospital support services (1996).

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