

ECONOMICS WORKING PAPER

What Lies Ahead for Malaysian Healthcare?

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Abstract

Healthcare in Malaysia has been characterised by a strong public sector presence where government hospitals and clinics acted as a primary source of care. The healthcare system has also been lauded as a model for other developing countries to follow as it has succeeded in improving the health status of Malaysians over time. With the rising costs of healthcare over the last three decades, the government is now facing increasing pressures to restructure its healthcare system. Social healthcare insurance, corporatisation, and privatisation have been increasingly seen as possible measures to supplement the current healthcare system dominated by the public sector. In Malaysia, the involvement of government-linked companies in the private healthcare sector has, however, raised conflict-of-interest issues. Political economy factors will continue to play out; the private sector will continue to play an increasingly important role in the provision of healthcare while a long-awaited social healthcare insurance plan takes shape. Ultimately, clear rules of governance, regulations, and transparency have to be put in place to ensure that standards are maintained, conflict-of-interest issues are checked, and that healthcare continues to remain accessible.

Keywords: Social Protection; Public Healthcare; Private Healthcare; Malaysia

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1. Introduction¹

Universal coverage and quality healthcare are very important components of social protection. One of the main challenges in Malaysia is a continuation of the provision of healthcare that is accessible to all communities and income groups, especially when Malaysia's population is still growing although increasingly ageing over time (with higher demands expected with greater longevity), rising per capita incomes, changing disease patterns, and when the cost of providing healthcare is rising.

Universal coverage focuses on the “public good” elements of healthcare. Since decolonisation, Malaysians have been accustomed to an easily accessible and highly subsidised healthcare system due to the spread of government health centres and clinics.

The increase in demand for health services over the years has reportedly placed strains on the public healthcare system. In turn, Malaysian policymakers see privatisation, corporatisation, and social healthcare insurance as possible solutions to ease the crunch in healthcare provision. In rhetoric, privatisation has been hailed to improve efficiency (and reduce costs) but, in reality, privatisation led by political elites with links to the government has resulted in a less optimal outcome manifested by higher costs. This paper examines how the healthcare system has evolved over time and how cost considerations together with government and quasi-government players in the private sector have driven this change. The healthcare system in Malaysia has come to a turning point where certain issues need to be resolved before developments can effectively forge ahead.

Section 2 provides a brief comparison of the key healthcare indicators of six Southeast Asian countries. Section 3 discusses the economic and social demography of Malaysia and how this would place increasing pressures on the healthcare system in the years to come (demand side). Section 4 measures Malaysia's healthcare performance against the World Health Organization (WHO) framework. Section 5 discusses Malaysia's public healthcare system and the challenges it is facing presently. Section 6 compares public healthcare to its private counterpart in terms of the number of establishments and staffing. An increase in the prevalence of non-communicable diseases (diabetes, hypertension, and obesity) is likely to place additional

¹ I wish to thank Francis E. Hutchinson for comments on an earlier version of this paper and Evelyn Ooi for editing the piece. Any errors remaining are my own.

demand pressures on the Malaysian healthcare system in the future (demand side). This is discussed in Section 7. Section 8 examines the privatisation process (supply side) in detail covering the background, resistance to privatisation, regulatory slack, corporatisation, privatisation of non-medical services, privatisation of health services in public hospitals and the national health insurance scheme. Section 9 concludes.

2. Healthcare in Malaysia: A Regional Comparison

Malaysia's health indicators compare well to countries like Singapore, Indonesia, the Philippines, Thailand and Vietnam. Among the six countries, Malaysia has the second highest life expectancy (74.3 years), and its healthcare spending as a percentage of GDP of 4.4 per cent is only lower than the Philippines (4.6 per cent) and Vietnam (7.2 per cent). The ratio of doctors per 1000 people (1:1,000) is only lower than that of Singapore (1.6:1,000) and the Philippines (1.2:1,000). Public expenditure on health is the second highest (US\$ 471 per head) out of the six countries. General government expenditure on health as a percentage to total health expenditure in Malaysia is also the second highest among the six countries (55.5 per cent).

Table 1: Healthcare: Key Indicators 2013: Selected Southeast Asian Countries*

	Malaysia	Indonesia	Philippines	Singapore	Thailand	Vietnam
Life Expectancy, Average (Years)	74.3	71.9	72.2	84.1	74.1	72.7
Life Expectancy, Male (Years)	71.5	69.3	69.3	81.7	71.7	70.2
Life Expectancy, Female (Years)	77.2	74.6	75.3	86.6	76.6	75.4
Healthcare Spending (% of GDP)	4.4	2.8	4.6	3.9	3.3	7.2
Healthcare Spending (US\$ per Head)	471	98	119	2,114	200	138
Doctors (Per 1000 People)	1.0	0.3	1.2	1.6	0.3	0.6
Nursing and midwifery Personnel (Per 1,000 People) (2006-2013)	3.2	1.3	n.a.	6.4	2	1.1
Pharmaceutical Personnel (Per 1000 People) (2006-2013)	0.4	0.1	0.9	0.4	0.1	0.3

General Government Expenditure on Health as % of the Total Expenditure on Health (2010)**	55.5	36.1	36.1	31.4	75.0	37.1
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*Estimates by Economist Intelligence Unit. Industry Reports. Healthcare. Various Countries. 2013 and 2014.

** The sum of outlays by government entities to purchase healthcare services and goods. It comprises the outlays on health by all levels of government, social security agencies, and direct expenditure by parastatals and public forms. Besides domestic funds, it also includes external resources (mainly grants passing through the government or loans channelled through the national budget. Source: The Economist Intelligence Unit,² and *World Health Statistics 2013*.³

3. Economic and Social Demography of Malaysia

Malaysia is a multi-racial country with a total population of about 30.49 million.⁴ The population is made up of three major ethnic groups: Malays, Chinese and Indians. *Bumiputeras*, which includes the Malays and the indigenous people, make up about 67.8 per cent of the total population, the ethnic Chinese about 24 per cent, ethnic Indians about 7.2 per cent, while the rest make up about 1 per cent of the total population.⁵

Malaysia's GDP per head (US\$ at PPP) stood at US\$ 17,685 in 2013. Its infant mortality rate is one of the lowest in the world; in 2013, this stood at 16.3 per 1,000 live births.⁶ Between 1970 and 2008, life expectancy increased for women from 65.6 to 76.4 and for men from 61.6

² The Economist Intelligence Unit, Industry Report, *Healthcare: Indonesia*. London, United Kingdom: The Economist Intelligence Unit, November 2013; The Economist Intelligence Unit, Industry Report, *Healthcare: Malaysia*. London, United Kingdom: The Economist Intelligence Unit, December 2013; The Economist Intelligence Unit, Industry Report, *Healthcare: Philippines*. London, United Kingdom: The Economist Intelligence Unit, October 2013; The Economist Intelligence Unit, Industry Report, *Healthcare: Singapore*. London, United Kingdom: The Economist Intelligence Unit, January 2014; The Economist Intelligence Unit, Industry Report, *Healthcare: Malaysia*. London, United Kingdom: The Economist Intelligence Unit, December 2013; The Economist Intelligence Unit, Industry Report, *Healthcare: Thailand*. London, United Kingdom: The Economist Intelligence Unit, November 2013; The Economist Intelligence Unit, Industry Report, *Healthcare: Vietnam*. London, United Kingdom: The Economist Intelligence Unit, December 2013.

³ World Health Organization, *World Health Statistics 2013*. Geneva, Switzerland: The World Health Organization, 2013.

⁴ Figure obtained from Malaysia, Department of Statistics, *Population Projections, Malaysia 2010-2040, November 2012*. Kuala Lumpur: Department of Statistics, Malaysia, 2012, p. 7. Accessed 10 April 2013.

⁵ Calculated from *ibid.*.

⁶ The Economist Intelligence Unit, Industry Report, *Healthcare: Malaysia*. London, United Kingdom: The Economist Intelligence Unit, December 2013. See Table 1.

to 71.6 years.⁷ In 2013, this stands at 71.5 for men and 77.2 for women. For high-income countries in general, the life expectancy was 83 years for women and 77 years for men.⁸

Malaysia's population is ageing and its annual birth rates have been decreasing although its population is still increasing. This is expected to exert extra pressure on its healthcare resources because Malaysians will be living longer. By 2040, it is projected that Malaysia's proportion of population 65 years old and above will rise to 11.4 per cent of the total population (Table 2). Even by 2020, this is expected to hover around 7 per cent of the population (2.21 million out of 32.44 million). From 2010 to 2040, the old age dependency ratio is expected to more than double from 7.4 to 16.6. In the meantime, the proportion of the young age dependency ratio would fall from 40.4 in 2010 to 28.3 in 2040.⁹

Table 2: Population Projection by Age Group, Malaysia, 2010-2040

Year	0-14 (‘000)	%	15-64 (‘000)	%	65+ (‘000)	%	Median Age
2010	7,822.1	27.4	19,341.4	67.6	1,425.1	5.0	26.3
2015	7,733.4	25.4	20,971.9	68.8	1,779.9	5.8	28.2
2020	7,780.7	24.0	22,445.9	69.2	2,214.6	6.8	29.9
2025	8,009.5	23.4	23,533.4	68.6	2,751.3	8.0	31.5
2030	8,087.9	22.5	24,542.0	68.2	3,335.7	9.3	33.0
2035	7,893.4	21.1	25,606.1	68.5	3,889.9	10.4	34.5
2040	7,537.2	19.6	26,615.6	69.0	4,405.1	11.4	36.0

Source: Malaysia, Department of Statistics, *Population Projections, Malaysia 2010-2040, Summary of Findings, November 2012*. Kuala Lumpur: Department of Statistics, Malaysia. http://www.statistics.gov.my/portal/images/stories/files/LatestReleases/population/Ringkasan_Penemuan-Summary_Findings_2010-2040.pdf. Accessed 10 April 2014.

4. The World Health Organization Benchmark

Chua and Cheah (2012) used the World Health Organization (WHO) Health Financing Strategy for the Asian Pacific Region (2010-2015) as a baseline framework to appraise the Malaysian

⁷ Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, *et. al.*, “Malaysia Health System Review”, *Health Systems in Transition* 3, no.1 (2013), p. 7.

⁸ *Ibid.*, p. 8.

⁹ Malaysia, Department of Statistics, *Population Projections, Malaysia 2010-2040, Summary of Findings, November 2012*. Kuala Lumpur: Department of Statistics, Malaysia, 2012. http://www.statistics.gov.my/portal/images/stories/files/LatestReleases/population/Ringkasan_Penemuan-Summary_Findings_2010-2040.pdf. Accessed 10 April 2014.

healthcare system. In the WHO framework, four target health indicators are deemed important.¹⁰

- i. Total health expenditure should be at least 4 to 5 per cent of GDP;
- ii. Out-of-pocket expenses should not exceed 30 to 40 per cent of total health expenditure;
- iii. Over 90 per cent of the population is covered by prepayment and risk pooling schemes;
- iv. Close to 100 per cent coverage of vulnerable populations with social assistance and safety-net programmes.

With respect to all the above indicators, Malaysia has fared credibly well with total health expenditure close to 5 per cent of its GDP (4.75 per cent), out-of-pocket expenses below 40 per cent of total health expenditure (out-of-pocket expenditure accounted for 30.7 per cent of total health expenditure in 2008),¹¹ providing a comprehensive social safety net for vulnerable populations, and a taxed-based financing system that fundamentally posed as a national risk-pooled scheme for the population.¹²

5. Malaysia's Public Health System: Issues and Challenges

A three-tier primary healthcare model existed from 1956 to 1970. Since 1970, the three-tier system was replaced by a two-tier system (Table 3). This was to increase the number of such establishments, albeit smaller entities, to increase the spread and outreach of the Malaysian healthcare system. The 1167 community and health clinics in 1970 increased to 2234 community and health clinics in 1980.¹³

¹⁰ Chua Hong Teck and Cheah Julius Chee Ho, "Financing Universal Coverage in Malaysia: A Case Study", *BMC Public Health* 12 (Suppl 1): S2, (2012), pp. 2 to 3. <http://www.biomedcentral.com/content/pdf/1471-2458-12-S1-S7.pdf>. Accessed 26 September 2012.

¹¹ The latest figure available is for 2012, where private out-of-pocket expenditure accounted for 36.88 percent of the total health expenditure. See Malaysia National Health Accounts, *Health Expenditure Report: 1997-2012*. Malaysia National Health Accounts Unit, Planning Division, Ministry of Health, 2014, p. 16.

¹² Chua and Cheah, *op. cit.*, p. 4.

¹³ Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, *et. al.*, *op. cit.*, p. 17.

Table 3: Structure of Government Primary Healthcare

Structure	Level of Service	Staff	Services
Three-tier System [1956-70]	Main Health Centre [1:50000]	Doctor, Dentist	Priority Patient Care, Dental Care
	Health Subcentre [1:10000]	Medical Assistants and Staff Nurses	Outpatient Screening, Maternal and Child Health (MCH) Care
	Midwife Clinics [1:2000]	Midwife	Home Delivery and Home Visits
Two-tier System [1970-Present]	Health Clinic [1:20.000]	Doctor, Dentist, Pharmacist, Assistant Medical Officer, Public Health Nurses, Assistant Pharmacy Officer	Outpatient Services, Dental Care, MCH Care, Health Promotion, Family Planning
	Community Clinic [1:4000]	Community Nurse, Midwife	MCH Care, Home Care, Family Planning

Source: Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, *et. al.*, Malaysia Health System Review, *Health Systems in Transition* 3, no. 1, (2013), p. 17.

The government share on health expenditure is above half (about 55 per cent) of total health expenditure. Hospitals and specialist care were for the most part provided by the government, even after the 1980s when there was a drive towards privatisation.¹⁴

Private health insurance is voluntary. Premiums are charged based on an individual's health status, the type of health insurance, and the level of coverage. Welfare and health benefits may be offered to their employees by private companies who typically negotiate packages with Managed Care Organizations (MCOs) and private insurance companies cover.¹⁵ Public healthcare services are funded through taxation and allocated by the Ministry of Finance to the Ministry of Health (MOH). Public sector employees and their families have free access to medical services provided by the public sector.

The MOH has played a tripartite role as funder, provider, and regulator. Public healthcare is heavily subsidised with very low user fee (unrevised since 1982) with revenue collection

¹⁴ Chee Heng Leng and Por Heong Hong, "1 Care' and the Politics of Healthcare in Malaysia" in Meredith Weiss, editor, *Routledge Handbook of Contemporary Malaysia*. London and New York: Routledge, 2015, p. 313.

¹⁵ Chua Hong Teck and Cheah Julius Chee Ho, *op. cit*, p. 2.

estimated to be around 2 per cent against its spending (Chua and Cheah, 2012). Patients are charged RM 1 for A&E treatment or visits to the government health clinics. For specialist clinics, patients are charged RM 5 inclusive of consultation, investigation, and treatment.¹⁶

As Chua and Cheah note:

The public sector health-care services (MOH) can be considered as a national health service with its tax-based financing and heavy subsidies. In 2010, there were about 2.3 million admissions in public hospitals which accounted for about 73.2 % of the total number of admissions. Public health facilities registered about 19.2 million outpatient attendances or 87 % of the total attendances, and only a nominal sum of RM1 (approximately USD 0.30) is charged which is inclusive of medication The maximum amount that can be billed to a patient in a third class ward is RM500 (USD156) inclusive of all procedures, medication, diagnostic services and ward charges. Exemptions are also provided to those who cannot afford to pay the fees.¹⁷

Ward charges, for example, start from RM 10 for a bed in a first class ward for a government employee. A non-civil servant would be charged RM 80 for a similar bed, whereas a foreigner would be charged RM 160.¹⁸

Given that political issues in Malaysia are at times racialised, Chan (2013) points out an oddity from Malaysian healthcare as it "... is one notable sector in the country which was founded upon and approximates to the universalistic ideal of equal access on the basis of need, without regards to race or socioeconomic status (ability to pay)...".¹⁹

Public healthcare in Malaysia is also largely paid for by the better-off but used mostly by the less well-off.²⁰ As a result, public spending on healthcare has in effect redistributed welfare from the rich to the poor. A study by the HPRA and IHSR reported that the poorest in Malaysia contribute about RM 5.8 per month towards funding healthcare while the rich contribute almost

¹⁶ *Ibid.*

¹⁷ *Ibid.*, p. 4.

¹⁸ Chan Chee Khoo, "Healthcare Policy in Malaysia: Universalism, Targeting and Privatisation" in Edmund Terence Gomez and Johan Saravanamuttu, editors, *The New Economic Policy in Malaysia: Affirmative Action, Ethnic Inequalities and Social Justice*. Singapore: National University of Singapore Press, and Singapore: Institute of Southeast Asian Studies, 2013, p. 154.

¹⁹ *Ibid.*, p. 152.

²⁰ Health Policy Research (HPRA) and Institute for Health Systems Research (IHSR), *Malaysia Health Care Demand Analysis: Inequalities in Healthcare Demand & Simulation of Trends and Impact of Potential Changes in Healthcare Spending*. Malaysia: Institute for Health Systems Research, Ministry of Health (MOH), Malaysia, 2013, p. 100.

28 times as much. The government also spends about RM 34 per month on healthcare on the poorest 10 percent of the households and RM 22 per head on the richest decile.²¹

The public health system has not kept pace with population growth, especially in urban areas. As Safurah, *et.al.* (2013) points out:

Government clinics are under strain from growing public demand and insufficient supply; for example, a shortage of clinics in densely populated areas, such as the Klang Valley, means that people are facing long waiting times. The population ratio for MOH clinics of 1:33,600 has not met the target of 1:20,000. The lack of health professionals, particularly doctors, is a major problem, with over half of the Ministry of Health positions unfilled in 2008 and an average of about only one doctor for each of the 802 government health clinics.²²

In recent years, rightly or wrongly, the public health system has been perceived to be for the poor, and private healthcare for the rich. Private hospitals are better equipped with more advanced medical equipment. 75 out of the 105 magnetic resonance imaging (MRI) machines, 91 out of 143 computerised tomography (CT) scan machines were in private hospitals compared to the public sector.²³ There has also been an outflow of professionals from the public to the private sector.²⁴ Another key concern has been that out-of-pocket expenses has averaged 34 per cent of the total health expenditure (THE) from 2005 to 2010.²⁵ This out-of-pocket expenditure is seen as a regressive method of financing and a social safety net needs to be in place to protect the poor and to ensure accessibility.

6. Public Healthcare versus Private Healthcare

In terms of health facilities, public hospitals beds outnumber private hospitals (Table 4). Nevertheless, the rate of growth of private hospitals took place rapidly in the last two decades when it increased from 50 private hospitals and institutions in 1980 to 224 in 2000.²⁶ In terms

²¹ *Ibid.*, pp. 100-101.

²² Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, *et. al.*, *op. cit.*, p. 87.

²³ Ng Chiu Wan, Noran Naqiah Mohd Hairi, Ng Chirk Jenn, Adeba Kamarulzamam, "Universal Health Coverage in Malaysia: Issues and Challenges", In National Population Conference on the Inter-Relationship between Population Dynamics and Development, 26 June 2014, Palm Garden Hotel, IOI Resort, Putrajaya (Unpublished), p. 4.

²⁴ Safurah Jafaar, *op. cit.*, p. 86.

²⁵ *Ibid.*.

²⁶ Chee Heng Leng and Simon Barraclough, "The Growth of Corporate Health Care in Malaysia", in *Health Care in Malaysia: The Dynamics of Provision, Financing and Access*. Edited by Chee Heng Leng and Simon Barraclough, London and New York: Routledge, 2007, p. 23.

of doctors and nurses to beds, the ratio of doctors to beds in the public hospital is 0.7:1 compared to 0.82:1 in private hospitals in 2012. For nurses to beds, the ratio is 1.4:1 in public hospitals compared to 2.11:1 in private hospitals in the same year. Both ratios attest to more favourable staffing levels in the private sector (Table 4).

Table 4: Healthcare Establishments, 2013: Government and Private Sector (as at 31 December 2013)

	Public	Private
Hospitals	141 [#] 8 ^{##}	214
Number of Beds	39,728 [#] 3,709 ^{##}	14,033
Dental Clinics	52	1,686
Mobile Dental Clinics*	27	--
Health Clinics*	1,039	--
Community Clinics*	1,821	--
Flying Doctor Services*	8	--
1Malaysia Clinics*	254	--
1Malaysia Mobile Clinics (Bus)*	5	--
1Malaysia Mobile Clinics (Boat)*	3	--
Medical Clinics**	--	6,801

*Does not apply to the private sector **Does not apply to the public sector

#Ministry of Health ##Non Ministry of Health

Source: Ministry of Health Malaysia. *Health Facts 2014*. Health Informatics Centre, Planning Division, June 2014, pp. 4-7.

The Malaysian government launched the 1 Malaysia Clinics or Klinik 1 Malaysia in 2010. The total cumulative attendance to these clinics has been increasing over the years: from 1.32 million patients in 2010 to 1.98 million in 2011, and 2.72 million in 2012 and 4.42mil million in 2013.²⁷ Such facilities have been set up for the poorer urban population but considerations are now in place to establish these clinics in rural areas. About 20 per cent of the clinics with higher attendances are staffed by medical doctors, while the rest are staffed by assistant medical officers who can only treat a limited range of ailments.²⁸ The service is offered free to senior citizens while the rest pay RM 1 per visit.

²⁷ "Health Ministry Director-Deneral Datuk Dr Noor Hisham Abdullah Explains", *The Star Online*, 26 May 2014, <http://www.thestar.com.my/News/Community/2014/05/26/Health-Ministry-directorgeneral-Datuk-Dr-Noor-Hisham-Abdullah-explains/>. Accessed 8 October 2015.

²⁸ "With qualified nurses and medical assistants with at least five years of experience, the clinics are able to carry out minor surgeries, stitching, wound cleaning and dressing as well as treating illnesses like cough, flu, fever, diabetes and hypertension!". Information taken from <http://www.1malaysia.com.my/en/products/klinik-1malaysia-1malaysia-clinic>. Accessed 8 October 2015.

Table 5 shows that the ratio of medical personnel to population has been improving over time. For example, the number of doctors per population has improved from 1:1,105 to 1:758. However, for nurses, this has fallen from 1:512 to 1:541. The figure for nurses is far below the WHO recommended level of 1:200 for nurses.²⁹

Table 5: Health Professionals in the Public and Private Sector: Malaysia as at 31 December 2012 (2008, in brackets, for comparison)

	Public	Private	Total	Profession as a Ratio to Population
Doctors	27,474 (15,078)	11,240 (10,006)	38,718 (25,102)	1:758 (1:1,105)
Dentists	2,664 (1,692)	1,894 (1,673)	4,558 (3,365)	1:6,436 (1:7,618)
Pharmacists	5,908 (3,070)	3,744 (3,327)	9,652 (6,397)	1:3,039 (1:4,335)
Opticians	-	2,940 (2,514)	2,940 (2,514)	1:3039 (1:4,335)
Optometrists	10,902 (159)	944 (532)	11,846 (691)	1:2,477 (1:40,128)
Asst. Medical Officers	56,089 (8,310)	28,879 (768)	84,968 (9,078)	1:345 (1:3,054)
Nurses	56,089 (38,575)	28,879 (15,633)	84,968 (54,208)	1:541 (1:512)
Pharmacy Assistants*	4,068 (2,778)	482 n.a.	4,550 2,778	—
Asst. Environmental Health Officers	4,952 (2,566)	n.a.	4,952 (2,566)	—
Medical Lab Technologists	6,161 (4,039)	n.a.	6,161 (4,039)	—
Occupational Therapists	836 (426)	n.a.	836 (426)	—
Physiotherapists	1,041 (593)	n.a. n.a.	1,041 (593)	—
Radiographers	2,883 (1,518)	1,451 n.a.	4,334 (1,518)	—
Dental Nurses	2,684 (2,679)	- n.a.	2,684	—
Community Nurses	22,917 (18,143)	301 n.a.	23,218 (18,143)	—
Dental Technologists*	963 (722)	749 (704)	1,712 (1,476)	—
Dental Surgery Assistants	3,834 (2970)	44 n.a.	3,878 (2,970)	—

²⁹ Wan Horhayati Mohamed and Mahadzirah Mohamad, "Measuring the Quality of Nursing Work Life in Public Hospitals", 2nd International Conference on Management (2nd ICM 2012) Proceeding, 11th - 12th June 2012. Holiday Villa Beach Resort and Spa, Langkawi Kedah, Malaysia.

Traditional & Complementary Medicine Practitioners*	n.a.	n.a.	13,367	—
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Source: Ministry of Health Malaysia. *Health Facts 2013*. Health Informatics Centre, Planning Division, July 2013, p. 8. http://vlib.moh.gov.my/cms/documentstorage/com.tms.cms.document.Document_4336afb0-a02c4149-1b47cc20-40304b93/HEALTH_FACTS_2013.pdf. Accessed 25 February 2014; For 2008 figures: Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, et. al., “Malaysia Health System Review”, *Health Systems in Transition* 3, no.1 (2013), p. 53.

* Referred to as “Assistant Pharmacy Officers”, “Dental Technicians”, “Complementary Medicine Practitioners” in the statistical source in 2008.

The number of hospital beds for both public and private healthcare has, however, increased from 55,180 in 2010 to 58,530 in 2014. Of these, public hospital beds accounted for 75 per cent of total hospital beds in 2014. The ratio of doctors to population improved between 2010 and 2014, from a ratio of 1:859 to 1:581; for dentists, it was from 1:7,437 to 1: 5,112; for pharmacists it was 1:3,652 to 1:2,448 and for nurses it was 1:410 to 1:325.³⁰

Other improvements in the healthcare system would be partly measurable through a higher life expectancy over time and a reduction in infant mortality rates, and other quantitative measures.

7. Non-Communicable Diseases and Changing Patterns of Demand

There is evidence to suggest that non-communicable diseases are becoming a serious issue. This has been partly caused by rising affluence. The EIU reports that cases of hypertension have increased by 43 per cent, diabetes by 88 per cent and obesity by 250 per cent in 2012 compared to 2002.³¹ Earlier data from 1986 also show that diabetes and hypertension has been on the increase since 1986 when the first National Health Morbidity Surveys (NHMS) was conducted. From Table 6, the prevalence of hypertension increased from 14.4 per cent in 1986, 32.9 per cent in 1996 to 42.6 per cent of the adult population in 2006, although it fell to 32.7 per cent in 2011.

³⁰ *Eleventh Malaysia Plan 2016 – 2020: Anchoring Growth on People*. Malaysia: Economic Planning Unit, 21 May 2015.

³¹ The Economist Intelligence Unit, “How Sustainable is Malaysian Healthcare”, London: The Economist Intelligence Unit, 11 April 2014.

Table 6: Prevalence of Diabetes and Hypertension

Disease	NHMS I (1986) ≥35 years	NHMS II (1996) ≥30 years	NHMS III (2006) ≥18 years	NHMS III (2006) ≥30 years	NHMS IV (2011) ≥18
Diabetes Prevalence	6.3%	8.3%	11.6%	14.9%	15.2%
- Known Diabetes	4.5%	6.5%	7.0%	9.5%	7.2%
- New Diagnosed	1.8%	1.8%	4.5%	5.4%	8.0%
Hypertension Prevalence	14.4%	32.9%	—	42.6%	32.7%

Source: Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, et. al., Malaysia Health System Review, Health Systems in Transition, Vol 3, No.1, 2013, Geneva, Switzerland, World Health Organization 2013, p. 10; and National Health and Morbidity Survey 2011, Fact Sheet; <http://moh.gov.my>. Accessed 3 May 2014.

In terms of non-communicable diseases, about 35.2 per cent of the adult population were classified as inactive, 33.3 per cent of the adult population overweight, and 27.2 per cent of the population obese in 2011 (Table 6 below). This compares to 16.6 per cent and 4.4 per cent respective in 1996 when the second NHMS was conducted.

Table 7: Prevalence of Risk Factors for Noncommunicable Diseases

Risk Factor	NHMS II (1996) ≥18 years	NHMS III (2006) ≥18 years	NHMS IV (2011) ≥18 years
	Percentage of population (%)		
Smoking	24.8	21.5	25.0
Physically Inactive	88.4	43.7	35.2
Overweight (BMI ≥25 & <30kg/m ²)	16.6	29.1	33.3
Obesity (BMI ≥30kg/m ²)	4.4	14.0	27.2
High Blood Cholesterol	n/a	20.6	32.7
Current Drinker	23.0	24.1	12.8

Source: Safurah Jaafar, Kamaliah Mohd Noh, Khairiyah Abdul Muttalib, Nour Hanah Othman, Judith Healy, et. al., Malaysia Health System Review, Health Systems in Transition, Vol 3, No.1, 2013, Geneva, Switzerland, World Health Organization 2013, p. 11; and National Health and Morbidity Survey 2011, Fact Sheet; <http://moh.gov.my>. Accessed 3 May 2014.

The figures in Table 7 suggests that obesity and pre-obesity are both on the rise and that resources from hospitals would have to be increasingly allocated for treating ailments related to weight issues. Indeed, this may become a significant contributor to rising health costs in Malaysia, more than an ageing population.³²

8. Privatisation of Healthcare: Issues and Challenges

The argument for privatisation rests on the ability of free market forces to promote allocative efficiency (Chan, 2010). This would imply that important prerequisites like information asymmetry between the provider and consumer does not exist, there are many players in the market, and there must be safeguards and regulations in place to ensure that there is a level playing field for all providers and consumers in the market. There must also be “robust institutions ensuring that microeconomic policies are designed, executed and monitored in accordance with the principles of transparency and good governance.”³³ If these conditions cannot be met, then privatisation will not result in an efficient outcome. In Malaysia, the privatisation of health services was ostensibly “to improve economic efficiency in the health sector.”³⁴ The official rationale for the expansion of private healthcare also rested on the fact that “it will cater for those who can afford it, thereby freeing the public healthcare services for those who cannot afford to use private healthcare.”³⁵

Background to Privatisation

It was in the 1980s under the Mahathir administration that the government announced its push towards privatisation. In 1985, two committees were set up to examine the privatisation of medical and non-medical services.³⁶ In 1991, an unpublished internal MOH document revealed a highly cautious approach to privatisation.³⁷

³² Phua Kit Lai, “Rising Health Care Costs” in in Chee Heng Leng and Simon Barraclough, editors, *Health Care in Malaysia: the Dynamics of Provision, Financing and Access*. London and New York: Routledge Malaysian Studies Series, 2007, p. 66.

³³ Shankaran Nambiar, “Revisiting Privatisation in Malaysia: The Importance of Institutional Process”, *Asian Academy of Management Journal* 14, no. 2 (July 2009), p. 21.

³⁴ *Ibid.*, p. 28.

³⁵ Chee and Barraclough, *op. cit.*, p. 31.

³⁶ Simon Barraclough, “The Politics of Privatization in the Malaysian Health Care System”, *Contemporary Southeast Asia* 22, no. 2 (August 2000), p. 345.

³⁷ *Ibid.*, p. 345.

Privatisation was however slow to reach the health sector; it was after the early 1990s that the Government Medical Stores were identified as privatizable. In 1993, Dr Mahathir indicated that the government was no longer able to provide free or heavily subsidized treatments to all patients because of rising costs.³⁸ The Mid-Term Review of the Sixth Malaysia Plan published in 1993 indicated that the role of the MOH would shift from its traditional role of providing public healthcare “towards more policy-making and regulatory aspects as well as setting standards to ensure quality, affordability and appropriateness of care.”³⁹

Most of the policy directions and planning of the Malaysian public health sector have been “highly secretive”.⁴⁰ The Malaysian Medical Association (MMA) had expressed its deep concerns about the overall lack of transparency in the policy-making process and the absence of debate on health policy. Matters pertaining to privatisation have been kept from the public on the grounds that they came under the purview of the Official Secrets Act.⁴¹ This lack of transparency meant that those outside the government circle would also have no clear indication as to where health privatisation would be heading, suggesting that only “insiders” will benefit.

In an obvious attempt to legitimize the privatisation of hospital support services, then Health Minister Chua Jui Meng painted a miserable picture of the low standards in public hospitals in 1996 when he estimated that only 35 per cent of ISO standards were met by the public sector.⁴² However, as Barraclough points out: “[s]uch an admission by the Minister responsible for such services was candid indeed, and perhaps says more about the need to improve management in the civil service than any intrinsic inability of the public sector to meet expected standards.”⁴³

Resistance to Privatisation

The strong encouragement for the expansion of private hospitals was nevertheless met with resistance. For example, the move to privatize haemodialysis clinics announced in 1992, and

³⁸ *Ibid.*, p. 343.

³⁹ Cited in Rajah Rasiah, Nik Rosnah Wan Abdullah and Makmor Tumin, “Markets and healthcare Services in Malaysia”, *International Journal of Institutions and Economics* 3, no. 3 (October 2011), p. 477.

⁴⁰ Barraclough, *op. cit.*, p. 344.

⁴¹ *Ibid.*.

⁴² In clinical wastes, only 15 percent of ISO standards were met, in linen and laundry 35 percent, cleaning and engineering maintenance was 45 percent and bio-medical engineering met 60 percent of the standard. See Barraclough, *op. cit.*, p. 350.

⁴³ *Ibid.*, p. 346.

the absence of implementation even after two years, is indicative of the “resistance” associated with the privatisation of health services. The government offered to subsidize dialysis treatment for the poor in an effort to allay concerns about equity, as public facilities only charged RM 10 as opposed to private clinics which charged RM 150.⁴⁴ Eventually, the Malaysian government had to provide RM 25 million to charitable organizations in 1997 to establish these dialysis centres. This attempt at privatisation still meant that the government had to provide “substantial subsidies for the treatment of those unable to pay the full cost of their care”,⁴⁵ suggesting that privatisation would not be making healthcare more viable.

To encourage the use of private healthcare, the Malaysian Government also introduced a scheme in 1994 of allowing up to 10 per cent of an individuals’ provident fund (Employees Provident Fund or EPF) to be withdrawn for critical medical treatments and also to be used under a voluntary scheme to purchase private health insurance. The tax relief for approved pension funds and life insurance premiums was also increased by RM 2,000 to RM 7,000 to encourage savings for healthcare and health insurance coverage.⁴⁶ At the tabling of the Seventh Malaysia Plan (1996 – 2001), the government, Dr Mahathir reiterated that the “government could no longer afford to provide treatment for free or at a nominal charge.”⁴⁷

Regulatory Slack

The privatisation of health services has however been accompanied by policy inaction in terms of regulation:

Overall, state encouragement of private hospitals took the form of inaction, rather than action. Even as private hospitals proliferated, no effective measures were taken to control the rapid growth in their numbers, or even to modulate the distribution and consequences of this growth. Policy inaction was the most obvious in the realm of regulation. ... It was not until 1998 that comprehensive regulatory legislation was enacted and, even so, not until 2006 that this new legislation was implemented.⁴⁸

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ Chee and Barraclough, *op. cit.*, p. 21.

Strange as this may be, the involvement of the state and officials and their vested interests in the privatisation process may explain why regulations were either not strongly enforced or were inadequate or both for the private healthcare sector.

In terms of regulation, there are three acts: one concerned with standards and liability for medical equipment; another for service standards and minimum requirements for the operation of clinics and hospitals; and the third for planning permission and building regulation of hospitals as well as all other types of buildings.⁴⁹ Specifically, the acts were: the Atomic Energy Licensing Act 1984, the Private Hospital Act 1971 (Laws of Malaysia Act 43) and the new Private Healthcare Facilities and Services Act 1998, and the Local Government Act 1976 (Act 171).⁵⁰ Three main bodies regulated medical professionals: the Malaysian Medical Council (MMC), the MMA, and the government through the MOH.

The Local Government Act 1976 which relates to standard government planning and building regulation procedures, is not specific to health facilities alone, but is nevertheless applicable to such buildings. The Atomic Energy Licensing Act 1984 provides for the “control and licensing of radiation equipment and radioactive materials and for the establishment of standards, liability for nuclear damage and related matters.”⁵¹ This relates to X-ray equipment in hospitals. The Private Hospital Act, the existing act governing private hospitals, is still in force and provides for control through registration, licensing and inspection of existing private hospitals, nursing homes and maternity homes. The licence is issued or renewed every year and sets the basic service standards and minimum requirements for the operation of clinics and hospitals. However, the act and its associated regulations (the Private Hospitals Act 1973) do not provide adequate provisions to regulate private health facilities other than hospitals. Many services and facilities, including “medical and dental clinics, day surgeries, and screening and diagnosis services, were not covered under these Acts. Neither were ambulance services, clinical laboratories, haemodialysis centres and hospices.”⁵²

⁴⁹ Nik Rosnah Wan Abdullah, “The Private Health Sector and Public Policy Objectives: The Case of Malaysia”, FEA Working Paper No. 2004-3, Department of Administrative Studies and Politics, Faculty of Economics and Administration, University of Malaya, 2004, p. 5.

⁵⁰ Nik Rosnah Wan Abdullah, “Regulating Malaysia’s Private Health Care Sector” in Chee Heng Leng and Simon Barraclough, editors, *Health Care in Malaysia: the Dynamics of Provision, Financing and Access*. London and New York: Routledge Malaysian Studies Series, 2007, p. 42.

⁵¹ *Ibid.*, p. 42.

⁵² *Ibid.*.

In terms of implementing the acts, there was no directive or guidelines issued from the authorities or the MOH regarding the siting of private health facilities.⁵³ The only important consideration taken into account on the part of the private hospital itself was related to the viability of the business.⁵⁴ Considerations like the population to be served and the distance from the nearest health facility for the siting were not requested or taken into consideration.

Interviews with managers of six private hospitals also revealed that the health authorities did not require any information on the schedule of fees and charges when applying for a licence. The Private Healthcare Facilities and Services Act 1998 stated that a Minister could make regulations prescribing a fee schedule but the managers interviewed mentioned that they did not receive any information pertaining to this new act and hence only referred to the Act of 1973 which did not require information on fees and hospital charges.⁵⁵ This was in spite of the fact that the new Act was already in existence when the interviews were conducted. Also an interview with a key informant in the MOH studying private hospital charges revealed that the system did not promote price control.⁵⁶ The government's call for private hospitals to shoulder some social responsibilities was however well received by some private hospitals. They provided some form of social and community services (including public education), free medical services to special groups, medical screening, and accident and emergency services.⁵⁷

Inspecting officers also faced difficulties inspecting private facilities as individuals from the private hospitals have complained that the MOH has not provided them with the guidelines beforehand.⁵⁸ There was also not much official capacity to "assess technical information received from the private sector on the establishment of the hospitals."⁵⁹

On the issuing of licenses for the use of radiation and medical equipment for newly established health facilities, the evidence has indicated that licenses were issued "based on the reports and testing by the physicist engaged by the supplier."⁶⁰ This scenario allowed for lapses to take place. The Radiation Safety Unit from the regulator also only made random visits based on

⁵³ *Ibid.*, p. 43.

⁵⁴ *Ibid.*, p. 43. This study was based on a sample of six hospitals.

⁵⁵ Nik Rosnah Wan Abdullah, 2004, *op. cit.*, p. 7.

⁵⁶ *Ibid.*.

⁵⁷ Nik Rosnah Wan Abdullah, 2007, *op. cit.*, p. 43.

⁵⁸ Nik Rosnah Wan Abdullah, 2004, *op. cit.*, p. 10.

⁵⁹ *Ibid.*, p. 10.

⁶⁰ *Ibid.*, p. 10.

requests from the public for them to check particular premises, or when complaints were received from the public.

Between 1996 and 1999, less than 10 per cent of the premises visited complied fully with the acts and regulations.⁶¹ Only warnings were issued but because of a shortage in manpower, further visits could not be made as follow-up.⁶² Cases of hospitals employing unqualified personnel to operate x-ray machines and also providing examination of intravenous pyelogram (IVP) on patients were documented. Both were brought to a magistrate court and fined.⁶³ However, they were only fined small sums of RM 5,000 and RM 3,000 were imposed.⁶⁴ There was also the case of a private healthcare facility operating for one year without a licence, as its permit was temporarily suspended for non-compliance.⁶⁵ Under the Private Hospitals Act 1971, the penalty applicable for such cases was only RM 1,000; the MOH, however, does not have the authority to close such premises, its powers were to only regulate private hospitals.⁶⁶ Under the new Private Healthcare Act 1998, the penalty has been increased to RM 300,000.⁶⁷ This act was only enforced from 1 May 2006, about eight years after its introduction.⁶⁸

Notably, the Private Healthcare Facilities and Services Act 1998 (Act 568) and Regulations 2006 (PHFSA) were implemented after twenty years of private sector growth.⁶⁹ In addition, the powers of the MOH to carry out effective regulatory intervention were limited due to a lack of enforcement capacity and adequate information to regulate such entities.⁷⁰ Only a staff strength of 62 (13 doctors, 12 nursing staff, and 37 paramedic and support staff) was allocated to supervise 288 facilities throughout the country.⁷¹

Another anomaly in the regulatory process was the “practice of senior civil servants retiring into organizations under their regulatory purview (or suppliers in government procurements)

⁶¹ *Ibid.*, p. 11.

⁶² *Ibid.*, p. 11.

⁶³ *Ibid.*, p. 12.

⁶⁴ Nik Rosnah Wan Abdullah, 2007, *op. cit.*, p. 45.

⁶⁵ Nik Rosnah Wan Abdullah and Lee Kwee-Heng, “Impact of the Private Healthcare Facilities and Services Act 1998 (Act 586) & Regulations 2006 on the Medical Practice in Corporate Private Hospitals in Malaysia”, *OIDA International Journal of Sustainable Development* 2, no. 9, (2011), p. 101.

⁶⁶ *Ibid.*, pp. 39-40.

⁶⁷ *Ibid.*, p. 40.

⁶⁸ Chee and Barraclough, *op. cit.*, p. 34.

⁶⁹ Chee and Por, *op. cit.*, p. 319.

⁷⁰ Nik Rosnah Wan Abdullah and Lee Kwee-Heng, *op. cit.*, pp. 102 – 103.

⁷¹ *Ibid.*, p. 102.

[which] poses a further challenge.” These officials, in their new positions, are “expected to help their new employers secure government contracts, circumvent regulatory oversight, and generally benefit from preferential treatment by bureaucracy.”⁷²

Such placements encourage corruption and undermine an impartial regulatory role for the government. In Malaysia, a regulatory official faces additional complications, as the regulated entity may be a government-linked company (GLC) with influential connections. This would not be unexpected as GLCs accounted for nearly one-third of the market capitalization of the Kuala Lumpur Stock Exchange.⁷³

Corporatisation

The government also explored the feasibility of corporatising public hospitals in 1992. Hospitals under this scheme were incorporated as government-owned companies operating along commercial lines. Such hospitals were able to pay higher salaries to their staff.

The National Heart Institute or the *Institut Jantung Negara* (IJN) had been a corporatised entity (government-owned referral heart centre) from its inception in 1992. The IJN represented an attempt by the Malaysian government to adopt a different modality to regulation besides that of outright privatisation (Barraclough, 2000; Chan, 2010). According to Barraclough, Malaysian policy planners were influenced by the example of Singapore, where “corporatized hospitals, although government-owned, had autonomy in their financial and staff management and were encouraged to compete with one another and also with the private health sector.”⁷⁴ Corporatisation has been perceived as a first step towards privatisation but this did not eventually mean that all corporatised entities would become private. As the hospital would be commercially run, the government concede that operating costs could rise.⁷⁵

One of the explicit missions of the IJN was to provide “high quality services in cardiovascular and thoracic medicine to Malaysian citizens at medium cost.”⁷⁶ Civil servants and government

⁷² Chan, 2014, *op. cit.*, p. 11.

⁷³ *Ibid.*, p. 12.

⁷⁴ Barraclough, *op. cit.*, p. 346

⁷⁵ *Ibid.*, p. 347.

⁷⁶ Chan Chee Khoo, “Healthcare Policy in Malaysia: Universalism, Targeting and Privatisation” in Edmund Terence Gomez and Johan Saravanamuttu, editors, *The New Economic Policy in Malaysia: Affirmative Action, Ethnic Inequalities and Social Justice*. Singapore: National University of Singapore Press, and Singapore: Institute of Southeast Asian Studies, 2013, p. 153

pensioners would continue to receive treatment at government expense but for Malaysians who were not civil servants, patient charges at the corporatized IJN would increase but not rise to the level of private hospitals. This would allow the IJN to be a “fallback option and a price bulwark which would serve as a competitive price check against steep price increases in the private sector.”⁷⁷

Government health services, through corporatisation, therefore play an essential role in providing a “ceiling price” which consumers could use to compare with private services. If a private health service has been priced too exorbitantly, consumers would then have the choice to use the lower priced public or corporatised alternative. Corporatisation may have an impact on accessibility and equity “[i]f public hospitals can no longer rely on central treasury allocations, unprofitable facilities may have to be closed, thereby affecting geographical accessibility, unless profits generated from other facilities are centralized and ploughed back into non-profit making facilities for the sake of maintaining accessibility and equity.”⁷⁸

Privatisation Exercise of Non-Medical Services

Beginning in 1994, the government privatized the non-medical services segment of its medical functions and services. This included the divestiture of the MOH’s pharmaceutical store and services in 1994, the outsourcing of hospital support services in 1996 and the privatisation of the health examination of foreign workers in 1997 to FOMENA.⁷⁹

In terms of privatizing the government’s medical stores and laboratory, a fifteen-year renewable concession was awarded to Remedi Pharmaceuticals, a subsidiary of United Engineers Malaysia (UEM) in 1994. This included manufacturing, purchasing, storage and distribution activities previously handled by the government, which accounted for 8 per cent of the MOH budget. The performance of this entity was to be overseen by a committee headed by the Ministry of Finance and representatives of other ministries including the MOH. UEM was, however, largely involved in construction projects not healthcare; it was part of the conglomerate of Renong, “the investment arm of Fleet Holdings, a corporation which had been

⁷⁷ Chan Chee Koon, “Reinventing the Welfarist State? The Malaysian Health System in Transition”, *Journal of Contemporary Asia* 40, no. 3 (August 2010), p. 458.

⁷⁸ Chee Heng Leng, Current Health Care Financing Issues in Malaysia. Asia Research Institute Working Paper Series No. 18, Asia Research Institute, National University of Singapore, February 2004, p. 6.

⁷⁹ The health certification of foreign workers was privatized to Fomena. See Nambiar, *op. cit.*, p. 30.

used an investment vehicle by UMNO.”⁸⁰ Remedi Pharmaceuticals had no experience in the industry but had links to the government.

A study in 1997 subsequently showed that prices increased by 3.3 times after privatisation.⁸¹ That privatisation was supposed to lead to efficiency and cost reduction did not manifest itself in this instance as the costs of these services rose after the exercise. Remedi Pharmaceuticals has since been renamed Pharmaniaga and has been taken over by Khazanah Nasional Holdings, and acquired by Boustead Holdings Berhad in June 2010.⁸² The major shareholder of Boustead is the Lembaga Tabung Angkatan Tentera of the Malaysian Armed Forces.

The privatisation of hospital support services was completed in 1996 representing the biggest privatisation exercise in the Malaysian health system. Each consortium awarded a monopoly in a particular geographical zone of responsibility.⁸³ Five hospital support services, which together accounted for 14 per cent of the MOH budget, were privatized to three corporations – Faber Mediserve Sdn Bhd, Radicare (M) Sdn Bhd, and Tongkah Medivest Sdn Bhd – after which MOH hospital expenditures went up by 3.2 times. The cost of these services reportedly went up from RM 143 million in 1996 to RM 468.5 million in 1997 and RM 507.9 million in 1999.⁸⁴ A private company, SIHAT,⁸⁵ was subsequently contracted by the government to oversee and monitor these three companies, incurring additional costs.⁸⁶ This was an external monitoring and evaluation agency that to support Kawalselia, the regulatory unit of the MOH, which only had eight staff members and was insufficiently equipped.⁸⁷

Faber Mediserve, a wholly owned subsidiary of the Faber Group, was a 60 per cent subsidiary of Renong, a major conglomerate associated with UMNO. Faber brought in international expertise by “sub-contracting specialized work to companies with U.S. involvement.”⁸⁸ In the

⁸⁰ Barraclough, *op. cit.*, p. 347. See also Chee and Barraclough, *op. cit.*, p. 30.

⁸¹ Chee Heng Leng, *op. cit.*, p. 7.

⁸² “Boustead Acquires Pharmaniaga for RM534 million, News Release, 11 June 2010, http://www.boustead.com.my/v2/misc/media_releases/NR2010/mr110610.html. Retrieved on 16 October 2015.

⁸³ The privatized services include waste management, cleaning, linen and laundry, facility engineering maintenance, and bio-mechanical engineering maintenance. These three corporations would be responsible for the ownership, management and operation of hospital support services in medical institutions as well as the general, district and nucleus public hospitals under the Ministry of Health. See Barraclough, *op. cit.*, p. 347.

⁸⁴ Phua, *op. cit.*, p. 67.

⁸⁵ Hospital System for the Monitoring of Standards or Sistem Hospital Awsan Taraf, a private consultancy comprising Kejuruteraan Kota Aman, Paramount Merge, and QSTD-SIHAT. See Barraclough, *op. cit.*, p. 348.

⁸⁶ Chee, 2004, *op. cit.*, p. 7, and Nambiar, *op. cit.*, 2009.

⁸⁷ Nambiar, *op. cit.*, p. 31.

⁸⁸ *Ibid.*, p. 348.

Tongkah Medivest consortium, Mokhzani Mahathir, the son of the then Prime Minister Mahathir, was the Managing Director. Mokhzani also subsequently acquired a controlling interest in the publicly listed private hospital corporation Hospital Pantai Berhad. Radicare, which won the most lucrative sector containing the biggest hospitals was originally awarded the contract as Asia Lab, a company owned by two Malay entrepreneurs, Sulaiman Aris and Azmi Jaafar, both had links to UMNO and had earlier worked for Musa Hitam, the former Deputy Prime Minister.⁸⁹

None of the companies, however, had a background in the provision of the services that they were supposed to provide, and all three companies had to undergo a restructuring process subsequent to the 1998 economic crisis due to mismanagement.⁹⁰ For the government to have invited bids from companies with no prior experience in a particular sector “raises questions about the selection of such concessionaires.”⁹¹ The selection process, with no specific reason given for selecting firms, has raised questions on why such concessionaires were chosen.⁹²

Firms without an industry track record were selected in this instance, without a transparent display of the selection criteria to the public.⁹³ The standing of the other bidding firms was not publicized in relation to these firms. In terms of the health support services, there were lapses in the case of cleaning services. Staff members did not follow guidelines and procedures, particularly when handling hazardous and potentially risky situations. Also planned preventative maintenance was not conducted according to schedule and the monitoring of equipment was not in accordance to prescribed guidelines.⁹⁴

Again, direct links to the government and indirect links through political patronage serves to explain why such companies were selected. The potential for conflict-of-interest is also present because the state is involved in both the private and public sectors in which the primary welfare function of the state cannot reconcile with private sector interests of generating profits. This has been succinctly summarized by Chee and Barraclough:

⁸⁹ *Ibid.*, p. 348.

⁹⁰ Nambiar, *op. cit.*, p. 29.

⁹¹ *Ibid.*, p. 31.

⁹² *Ibid.*.

⁹³ *Ibid.*.

⁹⁴ *Ibid.*, p. 32.

The Malaysian state is ... intricately involved in private sector healthcare: directly through the state economic development corporations and the state investment holding companies, and indirectly through political patronage of well-connected companies that are beneficiaries of healthcare privatization. ... Insofar as health care provision is a primary welfare function of the state, state involvement in private healthcare as well may well be seen as a conflict of interests. ... [A]ssigning to the MOH the two conflicting functions of ensuring population health as well as private hospital (and medical tourism) industry development reflects most clearly its contradiction.⁹⁵

Even before the launching of the Privatization Master Plan (PMP) in 1991, private hospitals that started or expanded after the early 1980s “were either owned and controlled by elites from the ruling coalition and retired government bureaucrats, or jointly with capitalists enjoying links with them.”⁹⁶ This expansion of private ownership in the overall health expenditure began to rise in 1982 “from 5.8% in 1981 to 7.6% in 1982 and rising fairly rapidly from then on to reach 30.6 percent in 2004...”⁹⁷ Interestingly, Rasiah, Noh and Tumin (2009) pointed out that the increase towards privatisation took place well before the launching of the Privatisation Master Plan (PMP) and it was meant only to “formalise a lucrative platform that had increasingly attracted crony profiteers.”⁹⁸ Powerful interest groups operating within and outside the administration were already driving the government to privatize activities that were lucrative even before a policy framework, action plan, and timetable espoused by the PMP for the implementation plan had begun.⁹⁹

On a state level, the Kumpulan Perubatan Johor (KPJ), a subsidiary of the Johor Corporation (previously known as Johor State Economic Development Corporation), represented one such group which had been operating since 1981 before the PMP was launched. It was an irony because the KPJ became one of the most prominent investors in private hospitals “when national policy dictated a retreat from government ownership of commercial enterprises.”¹⁰⁰ The KPJ now operates 25 hospitals in Malaysia, two hospitals in Indonesia, one hospital in Bangladesh and also owns a sizeable share in a hospital in Thailand.¹⁰¹ KPJ Healthcare has

⁹⁵ Chee and Barraclough, *op. cit.*, p. 31.

⁹⁶ Rajah Rasiah, Abdillah Noh and Makmor Tumin, “Privatizing Healthcare in Malaysia: Power, Policy and Profits”, *Journal of Contemporary Asia* 39, no. 1 (February 2009), p. 58.

⁹⁷ *Ibid.*, p. 57.

⁹⁸ *Ibid.*, p. 58.

⁹⁹ *Ibid.*, p. 58.

¹⁰⁰ Chee and Barraclough, *op. cit.*, p. 30.

¹⁰¹ KPJ Healthcare Berhad Website, A Member of the Johor Corporation Group, “Corporate Profile: About Us”, <http://kpj.listedcompany.com/profile.html> . Retrived on 14 September 2015.

also ventured into other healthcare-related industries including senior healthcare, laboratory services, marketing and retailing pharmaceuticals, hospital support services, and healthcare education. This investment arm of the Johor government has become Malaysia's leading owner of private hospitals.

Federally, Khazanah Nasional Berhad, an investment arm of the government, acquired a 30.68 per cent controlling share of Pantai Holdings in August 2006.¹⁰² This was when Khazanah intervened to forestall a corporate takeover of Pantai Holdings by the Singapore-listed Parkway group. Khazanah has emerged as the controlling shareholder of the second largest listed private healthcare provider in the world.¹⁰³ Khazanah's healthcare subsidiary (IHH Healthcare Ltd) has consolidated its control of both Pantai and Parkway, and also acquired Turkey's largest private hospital group Acibadem in a joint listing in the Kuala Lumpur and Singapore stock exchange.¹⁰⁴

In recent years, Khazanah has therefore emerged as the major shareholder in private health enterprises, "allegedly with strategic and synergistic considerations in mind but possibly also preferential support for GLCs benefiting from major outsourcing concessions."¹⁰⁵ Khazanah, through its wholly owned subsidiary Integrated Healthcare Holdings (IHH), has assets in Fomena, Pantai Holdings, Pharmaniaga (entity supplying pharmaceuticals and medical disposables to government hospitals and health facilities), and the International Medical University (67.5 per cent stake) Malaysia's first private medical university.¹⁰⁶

Effectively, this means that the Malaysian government and its GLCs own the regular Health Ministry facilities, corporatized hospitals (which include the IJN; and university teaching hospitals of the University of Malaya, Universiti Kebangsaan Malaysia, and Universiti Sains Malaysia), and private hospitals (Pantai chain of hospitals and Gleneagles hospitals in Kuala Lumpur and Penang, operated as commercial hospitals with Khazanah as a controlling

¹⁰² Chan Chee Khoon, "Re-inventing the Welfarist State? The Malaysian Health System in Transition", *Journal of Contemporary Asia* 40, no. 3 (August 2010), p. 454.

¹⁰³ Chan Chee Khoon, "The Malaysian Health System in Transition: The Ambiguity of Public and Private", Occasional Paper No. 26 – August 2014, Municipal Services Project, p. 8.

¹⁰⁴ This was reported to be the third largest IPO in the world in 2012. See *ibid.*, p. 8.

¹⁰⁵ Chan, 2013, *op. cit.*, p. 164.

¹⁰⁶ *Ibid.*.

shareholder; and the KPJ chain of hospitals controlled by the Johor government through its corporate arm, the Johor Corporation).¹⁰⁷

Having their finger in the private and public healthcare pie would mean that problems could potentially arise. As Chan (2014) points out, this has entailed “conflicts of interest, as the state wears multiple hats and attempts to reconcile sometimes divergent priorities in the public and private healthcare sectors.”¹⁰⁸ Chan gave the example of the National Heart Institute (IJN) and the attempted acquisition by Sime Darby Ltd, a GLC. Sime Darby submitted a proposal to the Ministry of Finance to acquire 51 per cent of the IJN.¹⁰⁹ An investigative report in *The Star* noted substantial fee differentials for comparable procedures at the public IJN and Sime Darby’s Subang Jaya Medical Centre (SJMC)¹¹⁰, with prices 50 to 100 per cent higher than the IJN.¹¹¹

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.¹¹²

Even staff at the IJN opposed the take-over:

Over the last 7 years of operation, out of a total of 35 consultants, only 7 have left IJN. ... Currently, 75% of IJN consultants have been in their posts for more than 10 years. All of us are salaried based on a different payscale than that of the MOH (Ministry of Health) though not on par with the private centres. As proven from our consultants’ attrition rate and longevity in serving this institution, it is logical to surmise that on the whole we are happy with the current scheme and proving it by remaining with IJN. ... 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.¹¹³

¹⁰⁷ Chan, 2013, *op. cit.*, pp. 165-166.

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*, p. 9.

¹¹⁰ Sime Darby is the controlling stakeholder.

¹¹¹ *Ibid.*, p. 9-10.

¹¹² *Ibid.*, p. 10.

¹¹³ “IJN doctors: Don’t make us scapegoats (Updated)”, *The Star Online*, 19 December 2008.

<http://www.thestar.com.my/story/?file=%2F2008%2F12%2F19%2Fnation%2F20081219151718>. Retrieved 30 September 2015. See also Chan (2014), *op. cit.*, p. 10.

Privatisation of Health Services in Public Hospitals

Chan points out that there has been a continuing exodus of senior and experienced staff from “the public to the private sector, reflected in the lopsided distribution of specialists, 70% of whom currently practice in the private sector.”¹¹⁴ In August 2007, the Putrajaya Hospital and the Selayang Hospital, then the two newest public hospitals, began to “offer to “full-paying patients” preferential access to consultation and treatment by specialist of their choice, in an executive or first-class facility.”¹¹⁵ This was introduced as a means to create additional incentives for specialist doctors to remain in the public sector and to stem their outflow.

However, the Coalition Against the Privatisation of Health Services came together in 2005 to campaign against the privatisation of publicly provided health services. It pointed out while only 30 per cent of specialists were employed in the government sector; they had to serve 70 per cent of hospital admissions throughout Malaysia. In addition, specialists in public hospitals also had teaching, training and mentoring responsibilities in addition to their clinical and ward duties. Private patients in these public hospitals would unavoidably claim and disproportionate attention and would compromise further the quality of services received by the regular patients, overburdened as it was already by the chronic understaffing in the government sector.¹¹⁶

Privatisation and the Cost of Medicines

Zaheer U D Babar *et. al.* (2007) note that high medicine costs in Malaysia were brought about because of high mark-ups in the private healthcare sector. The sample of medical entities studied by the authors include twenty public hospitals, thirty-two private sector pharmacies, and twenty dispensing doctors’ clinics from four geographical regions between 2004 and 2005.¹¹⁷

In private pharmacies, branded products (known as innovator brands) were on average priced 16 times higher than the recorded international reference prices, while generics were priced about 6.6 times higher.¹¹⁸ Dispensing doctors’ clinics also applied higher prices, 15 times

¹¹⁴ Chan, 2010, *op. cit.*, p. 450.

¹¹⁵ *Ibid.*, p. 451.

¹¹⁶ *Ibid.*, pp. 451 to 452.

¹¹⁷ The geographical regions were Kuala Lumpur, Penang, Johor Bahru, and Kota Bahru.

¹¹⁸ Zaheer U D Babar, Mohamed I M Ibrahim, Harpal Singh, Nadeem I Bukhari, Andrew Creese, “Evaluating Drug Prices, Availability, Affordability, and Price Components: Implications for Access to Drugs in Malaysia”, *PLoS Medicine* 4, issue 3 (March 2007), p. 466.

higher than recorded international reference prices, and 7.5 times for generics. For retail pharmacy, mark-ups were 25 to 38 per cent for innovator brands and 100 to 140 per cent for generics.¹¹⁹

The authors also made the observation that Malaysia practiced a free market economy and a “price deregulation system” in which “manufacturers, distributors, and retailers set medicine prices without governmental control”. Prices have however “escalated even faster than prices in the developed world, and are higher than international prices, indicating high medical costs...”¹²⁰ Although the government has been providing free medicine in public hospitals, the authors have highlighted that “patients are increasingly asked to buy their own medicines...”¹²¹ Other reasons why patients of public hospitals bought their own medicines included the non-availability of medicines and long waiting hours to obtain medicines from public hospitals.

In terms of availability, median availability in the public sector was very low, only about 25 per cent of the generic drugs were available.¹²² As there was poor availability of generics in the public sector, patients may have been “forced” to buy these medicines from private pharmacies or clinics.¹²³ Better availability in the public sector would have put pressure on the private sector to lower generic prices. Also it was noted that the dispensing doctors tended to prescribe generics but charged excessive mark-ups for these drugs compared to the branded equivalent.¹²⁴

The overall high prices in Malaysia, compared to reference prices, might be due to a relatively unregulated system. Private sector prescribers cost six to eight times international bulk purchase prices.¹²⁵ A pricing policy was needed, and the authorities need to incorporate this into the national drug policy. This was also supported by Chan (2010): “Malaysia ... has a very opaque procurement system in the public sector involving some form of negotiated pricing

¹¹⁹ *Ibid.*, p. 466.

¹²⁰ *Ibid.*, p. 467.

¹²¹ *Ibid.*, p. 467.

¹²² In the private pharmacies, the median availability was 43 percent for lowest price generic equivalents, 18 percent for most-sold generic equivalents, and 39 percent for innovator brands. In dispensing doctors’ clinics, the availability was 45 percent for lowest price generic, 15 percent for most-sold generic equivalents, and 10 percent for innovator brands. See *ibid.*, p. 469.

¹²³ *Ibid.*, p. 470.

¹²⁴ *Ibid.*, p. 471.

¹²⁵ *Ibid.*, p. 472.

with periodic price adjustments, and an essentially *laissez faire* pricing system in the private sector (unregulated, but not necessarily a free market).¹²⁶

National Health Insurance Scheme

The national health insurance scheme proposed for Malaysia may create a potential for regulation of the healthcare system through the leverage exercised by the state as a “non-profit, publicly operated single-payer purchaser of healthcare.”¹²⁷

The proposed national health financing scheme which was announced by the MOH on 2 February 2010 met with diverse responses. Chee and Por (2015) argue that this could be one of the most contentious issue in healthcare in the last three decades. This was not the first time that such a health plan has been announced. Plans for setting up a national health financing scheme date back to the Mid-Term Review of the Fourth Malaysia Plan (1981-1985). In the Seventh Malaysia Plan (1996-2000), the official policy was also directed towards privatisation, corporatisation and the setting up of a national health financing scheme.¹²⁸ ‘1 Care’ represented a renaming of this national health financing scheme, using the ‘1 Malaysia’ branding of the current administration under Prime Minister Najib Razak as a catch-phrase.¹²⁹

The rationale for a restructured national health system based on social health insurance is largely presented as a need to achieve an ‘integrated delivery system’ that enables services to be obtained from both the public and private sectors. The public sector has so far been playing a very important role in providing for healthcare for majority of the Malaysians through the taxation system. Primary health clinics have also been provided by the government for most of the country, including clinics in the rural sector. As Chee and Por note that “[w]hile private sector general practitioners (GPs) are the mainstay of primary care in urban areas, hospitals and specialist services were for the most part provided by the government.”¹³⁰

The role of the private healthcare sector could potentially be increased. In terms of the transformational changes in Malaysian healthcare, Chee and Por note that over the last three to

¹²⁶ Chan, 2010, *op. cit.*, p. 458.

¹²⁷ *Ibid.*, p. 459.

¹²⁸ Chee and Por, *op. cit.*, p. 312.

¹²⁹ *Ibid.*, p. 312.

¹³⁰ *Ibid.*, p. 313.

four decades, the private share of healthcare financing has increased even as total health expenditure has grown. By 2004 private health expenditure overtook public health expenditure, and in 2009, it reached 55.4 per cent of total health expenditure, and total health expenditure as a percentage of GDP grew from 2.9 per cent in 1997 to 4.6 per cent in 2009 before falling to 3.6 per cent in 2011.¹³¹ The share of total health expenditure from out-of-pocket payments grew from 28.7 per cent to 41.7 per cent between 2002 and 2011, while private prepaid plans grew from 5.6 to 8 per cent. Private health expenditure in turn expanded from 40.2 per cent to 54.3 per cent.¹³² These facts suggest that a social health insurance system could possibly be implemented in the context of the Malaysian health system.

The proposed restructuring of the healthcare system would “essentially be a single centralised fund functioning as a social insurance” where premiums from both the employer and employee would be mandatory while the government would pay premiums for the poor, disabled, elderly (sixty years and above), government pensioners and civil servants and their dependents.¹³³ The government has also assured the public that the premiums would be community-rated and progressively structured, based on income.¹³⁴ The fee-for service system common in insurance schemes will be replaced by payments based on diagnostic-related groups and capitation to control costs escalation.¹³⁵ To control demand, the payments will be tied to a referral system to rationalize the use of specialist care. There would also be an option to incorporate co-payments which may be paid out-of-pocket or through an option to buy extra coverage from private health insurance.¹³⁶

To date, the National Health Plan (MOH, 2010) provides the most details of the financing scheme to date, however “there is much that is unclear.”¹³⁷ For example, the amount that will be deducted from the payroll to finance the monthly premiums has been one issue of concern. The number of GP visits allowed to the healthcare facility is another concern; there was speculation that the number of visits would be capped at six per year. Although the imposition of healthcare premiums will present an additional financial burden, 1Care if well planned and

¹³¹ *Ibid.*, p. 313.

¹³² *Ibid.*, p. 314.

¹³³ *Ibid.*, p. 314.

¹³⁴ *Ibid.*, p. 314.

¹³⁵ As Chee (2004), *op. cit.*, p. 3, has pointed out, a health system dominated by private health insurance may lead to costs spiraling because of ‘moral hazard’, ‘supplier-induced’ demand and overhead.

¹³⁶ Chee and Por, *op. cit.*, p. 315.

¹³⁷ *Ibid.*, p. 315.

implemented, would help to regulate the pricing of healthcare services and medicines which would then ease the pressures on the healthcare.¹³⁸

The system of healthcare financing in a country influences to a large extent issues of healthcare accessibility, equity and universal coverage. The public health system, based on taxation, to a large extent is a primary welfare source for the country. Nevertheless, privatisation of the healthcare sector and the expansion of the private sector, and lax regulations have all worked to strengthen the private sector. The 1Care health financing scheme proposes to change the taxation-based financing structure to one that is based on compulsory social health insurance. Safeguards must be in place to ensure that abuses are minimized.

Currently, there are three positions held in response to the 1Care proposals. There is the Federation of Private Medical Practitioners' Associations of Malaysia (FPMPAM) of rejecting 1Care and maintaining the status quo, there is Coalition Against Health Care Privatisation (CAHCP) consisting of civil society members who not only reject 1Care but would also like to roll back privatisation, and the MMA consisting of practitioners from the public and private sectors who support the 1Care proposals and engaging policymakers in the process of financing the scheme.¹³⁹

A reversal of privatisation is unlikely because of state involvement and a further expansion of the public sector will be subject to fiscal considerations and sustainability. Hence, it appears that the third option will be the likely path that policy makers will take. National healthcare insurance would involve more administration and regulation over financing, the disbursement of such services as well as pricing of health services. That the social health fund is subject to abuse by corrupt forces, could be counteracted by strong safeguards attached to the fund itself and to the institutional processes of accounting and audit.¹⁴⁰

If acceptability and affordability is to be achieved in the social insurance scheme, then public interests and costs should be taken into account by the regulatory bodies. The processes that determine user charges and prices must also involve feedback from the public. Costs and

¹³⁸ *Ibid.*, p. 318.

¹³⁹ *Ibid.*, p. 317.

¹⁴⁰ *Ibid.*, p. 320.

pricing must be clearly explained and justified either by a comparison with other countries or by case studies of countries with a similar background or experience.

Stakeholders from different backgrounds must be involved in the consultation process. The cost and benefit considerations of any policy initiative should also be clearly laid out for all stakeholders.

9. Conclusion

It appears that the direction of the Malaysian healthcare sector will be one where the public sector will still continue to play an important role in providing universal healthcare. However, in the coming years, the financing burden will increasingly shift from a taxation-based system of healthcare provided mainly by the public sector to one where the national insurance scheme will increasingly become important to finance the health needs of the population provided by both the public and private healthcare sectors.

What is important also is to find ways to improve the management of public healthcare, to look for ways to continue to reduce waiting times, and also to find ways to pay better salaries to medical staff in the hospital. In this respect, corporatisation may be the way to go for some segments of the healthcare sector.

The regulatory role of the government should continue to be strengthened to create an environment that can capture the efficiencies of competitive healthcare enterprises while deterring the abuses that commercial entities may resort to in seeking to maximize profits. There should continue to be positive discrimination in favour of the socially disadvantaged to ensure that healthcare remains accessible to those segments of the population that need it the most. What is important also is accountability, transparency, and an open and fair tender system that will not benefit yet another well-connected interest group but selection should be based on the criteria of experience, knowledge, and management capabilities. There should be clear criteria for judging performance. This should be used to judge both the effectiveness of the policy as well as the groups involved in the delivery of the healthcare service.

Importantly, there must also be strong enforcement to ensure that regulations are adhered to, and that there are also enough staff with the relevant expertise to carry out effective monitoring

and enforcement measures. Where there are gaps in the current regulatory structure, this should be quickly addressed by lawmakers and regulators to ensure that healthcare is delivered effectively to the public. It is one thing to suggest that privatisation and the social healthcare insurance scheme can be the panacea to resolve rising demand. What is equally important is to ensure that the appropriate institutions are in place.

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