Two duelling slogans, ‘1Care for 1Malaysia’ and ‘Tak Nak [Reject] 1Care’, provide a succinct representation of what can arguably be considered the most contentious issue in healthcare for Malaysian society spanning the last three decades. The tagline ‘1Care for 1Malaysia’ invokes the health plan that was prepared by the Ministry of Health (MOH) for the Tenth Malaysia Plan (2011–2015) (MOH 2010). The health plan is a comprehensive overall policy document that sets the vision and direction for the nation’s healthcare sector. Central amongst the various programmes described in the document is a statement of intent for a ‘restructured Malaysian health system’ (ibid.: 51) that revolves around the establishment of a long-awaited social health insurance scheme.

‘1Care’ refers to this proposed national health financing scheme. Its announcement by the MOH at the Tenth Malaysia Health Plan Conference on 2 February 2010 met with diverse responses, with the most vocal resistance coming from the Citizens’ Healthcare Coalition (CHC), which organised a series of seminars between February and June 2012 to garner support for a stand against the plan, and a ‘Tak Nak 1Care’ campaign initiated through the Internet.

This is not the first time that the Malaysian public has been informed of such a proposal to reform healthcare financing. Plans for setting up a national health financing scheme have been publicly made known several times within the last three decades. The first time that a national health financing study was announced was in the Mid-Term Review of the Fourth Malaysia Plan (1981–1985). The Sixth Malaysia Plan (1990–1995) proposed governmental support for the growth of private health services, but it still approached the issue of financing cautiously, reporting that the national health financing study that was carried out under the Fifth Malaysia Plan would be further reviewed while waiting for the completion of a National Health Plan Study in 1992 (EPU 1991: 358). By the time of the Seventh Malaysia Plan (1996–2000), however, official policy unequivocally charted the direction of healthcare as toward privatisation, corporatisation and the setting up of a national health financing scheme (EPU 1996a: 544). ‘1Care’ is therefore merely a renaming of what used to be referred to as the national health security fund, using the ‘1Malaysia’ branding of the current administration under Prime Minister Najib Razak.

Throughout the entire policy process, numerous consultants’ reports have been commissioned but never publicly released, and official announcements have been lacking in details.
Nevertheless, it became clear from early on that the financing scheme would be based on a social health insurance model. From the 1980s onward, international organisations such as the WHO and World Bank have been strongly advocating social health insurance as the financing mechanism by which countries should achieve universal coverage of their populations (World Bank 1987, 1993). Viewed in this light, the institution of a social health insurance scheme in Malaysia would have been congruent with international trends. Furthermore, when compared with countries such as Taiwan and Thailand, it is the delay in implementation rather than its enunciation that surprises. How can we understand the official rationale to restructure healthcare financing in this country and, concomitantly, the underlying forces and tensions that hold it in abeyance?

In this chapter, we use this central question to arrive at an understanding of the current status of healthcare in Malaysia. We begin by giving an overview of the transformation in healthcare provision and financing over the last half century or so, focusing mostly on the changes that have come with the privatisation policy of the mid-1980s. This is followed by a more detailed discussion of the issues and contesting arguments surrounding the proposed restructuring of national health financing. Third, we investigate the tensions and vested interests underlying the contestations in the context of the politics of healthcare. Finally, we point to regulatory shortcomings in the current shaping of Malaysian healthcare which face the danger of being overlooked while the politics over the healthcare financing issue is being played out.

Transformational changes in Malaysian healthcare

The official rationale for the ‘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 public and private sectors’ (MOH 2010: 51–52). Malaysian healthcare provision was for a long time (through the 1960s and 1970s) dominated by governmental healthcare services funded through central treasury funds. Its large network of public health clinics makes primary care available through most of the country, including rural areas. While 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 government.

This pattern started to change from the 1980s onward, in parallel with the institution of the government’s privatisation policy, which led to the privatisation of the government’s drug manufacturing, procurement and distribution centre in 1994, and of five hospital support services in 1996. Meanwhile, the economic and policy environment allowed for a rapid growth of private hospital and specialist services. In 1980, for example, the private sector’s share of hospital beds was 5.8 percent (MOH 1980); by 2000 it had grown to 24.8 percent, stabilising in the following decade at around 25 percent (Nooraini et al. 2011: 7). Where, before, specialist services were concentrated in the government sector, the percentage of specialists in the private sector grew until it reached 43.2 percent in 2008–09 (Lim et al. 2011: 1). The imbalance is particularly acute in certain specialties; for example, only one-fifth of cardiologists are working in the public sector (Lim et al. 2011: 1).

Likewise, over the last three to four decades, the private share of healthcare financing has increased even as total health expenditure has grown. In 1983, private health expenditure was 24 percent of total health expenditure, which was estimated to be 2.8 percent of GNP (EPU 1996b: 18). By 2004, private expenditure overtook public expenditure, and in 2009, it reached 55.4 percent of total health expenditure; meanwhile, total health expenditure as a percentage of GDP grew from 2.9 percent in 1997 to 4.6 percent in 2009 before dipping down again to 3.6 percent in 2011 (Chua and Cheah 2012: 3; WHO 2013).
The increasing share of private health expenditure is due largely to the growth in out-of-pocket payments and private health insurance. In the ten years between 2002 and 2011, the share of total health expenditure from out-of-pocket payments grew from 28.7 to 41.7 percent, while that from private prepaid plans grew from 5.6 to 8.0 percent, both in tandem with the expansion in private health expenditure from 40.2 to 54.3 percent (WHO 2013). The increased frequency and spread in the use of private health insurance is clearly reflected by nationally representative survey data from the ground. Using data from national health and morbidity surveys, Zurina and Jones (2012: 164) estimate that healthcare payments that are wholly or partially made by insurance rose from 4.2 percent (of total number of observations) in 1996, to 20 percent in 2006.

The changes in healthcare provision and financing outlined above are in line with the shift in national policy in the mid-1980s from welfare-oriented to the ‘caring society’ (Chee and Barraclough 2007). Contrary to what images of societal solidarity the moniker ‘caring society’ might give rise to, it is in fact an enunciation of the retrenchment of the welfare role by the state, concomitant with an exhortation for welfare to ‘revolve not around the state or the individual but around a strong and resilient family system’. 1

Along with other changes in Malaysian society, in particular the rise in national income, increase in urban population, and ageing of the population, 2 the governmental policy environment and its corollary action and inaction led to a transformation of the healthcare system from one that was essentially cross-subsidised through national tax funding to one that is increasingly financed through private means and hence not subject to cross-subsidisation. Policy retrenchment of the governmental welfare role has been translated into a retreat from governmental healthcare provision (stated in the Seventh Malaysia Plan), leading to an increasing reliance on the private sector, where healthcare access is differentiated by the ability to pay, particularly for hospital and specialist care.

The 1Care scheme and doctors’ responses

Official documents have repeatedly laid out the main problems faced by the government healthcare sector, namely, ‘shortage of skilled personnel, movement of health professionals from the public sector to the private sector, inadequate expertise in some critical areas, and difficulty in placement and retention of doctors and nurses in more remote areas’ (Lim et al. 2011: 1). The different levels of remuneration for doctors and specialists in the private and public sectors cannot be reconciled, leading to the intractable problem of doctors leaving the public sector for the private sector. The proposed restructuring of the national healthcare system is meant primarily to address this problem of the bifurcation between public and private healthcare services, and aims at an integration between the two (MOH 2010: 51–52).

The unified healthcare financing system that has been announced will essentially be a single centralised fund functioning as a social health insurance. Premiums from employer–employee contributions will be mandatory, while the government will pay the premiums for the registered poor, disabled, elderly (sixty years old and above), government pensioners and civil servants and their dependants, up to a maximum of five. In fleshing out some of these details, the deputy director-general of health, Maimunah A. Hamid (2010), reassured the public that premiums will be community-rated and progressively structured, based on income.

A healthcare system that is based on financing through health insurance with a fee-for-service payment mechanism is linked to cost escalation. 3 The MOH policy document addresses this concern by explaining that the 1Care fund will replace the current fee-for-service system with other types of payment mechanisms based on diagnostic-related groups
To control the demand side, these new payment systems will be tied to a referral system to rationalise the utilisation of specialist care. Furthermore, the new scheme will incorporate co-payments, which may be paid out-of-pocket or through an option to buy extra coverage from private health insurance (MOH 2010: 52–53).

Although the national health plan (MOH 2010) provides the most detailed exposition of the financing scheme to date, there is still much that is unclear. Public concern obviously revolves around the amount of premium that would be extracted from payroll deduction. Since this detail was not spelt out when the 1Care fund was presented, public unease was expressed when a leak led to speculation, placing it at 10 percent, with a maximum cap of six GP visits a year (Malaysian Insider 2012). An MOH official had to clarify that the 10 percent was actually a ballpark figure of current average healthcare spending by Malaysians each year and that six was the average number of times a person would visit a healthcare facility, while emphasising that implementation of the scheme was not yet imminent and that eleven technical working groups with members drawn from professional bodies, the government and academia were still involved in drawing up a blueprint for cabinet approval (Edwards and Lim 2012).

One of the organisations in the coalition spearheading the ‘Tak Nak 1Care’ campaign is the Federation of Private Medical Practitioners’ Associations of Malaysia (FPMPAM). Founded in 1989, it is the largest private practitioners’ association with over 5,000 members, and the most widely represented, with seven state-level association members. As spelt out by the president, its position is a conservative one that calls for ‘limited reform’ by way of improving the management of public healthcare, but otherwise maintaining the status quo (Chow 2011). It opposes the 1Care financing scheme on the basis that it is modelled after the National Health Service (NHS) of the United Kingdom, citing the problems of accessibility (long waiting lists), lack of choice (patients have to register with doctors for care) and failure in containing costs (Chow and Ng 2011). According to the FPMPAM’s arguments, the proposed insurance body, functioning as a ‘middle-man’, will add a layer of bureaucracy, thereby increasing costs, while the premiums will be an additional tax burden for the citizens.

Citing a 2002 consultancy report, the FPMPAM president called for the outsourcing of public hospital ambulatory outpatients to ‘the existing robust GP system thereby releasing the public system to concentrate on secondary and tertiary care’ (Chow 2011). The UK NHS has a similar system of contracting care out to GPs. It would seem therefore that the FPMPAM’s objection is not to the ‘NHS model’ per se, but more narrowly focused on the capitation payment mechanism that the NHS uses to remunerate GPs. Furthermore, in terms of overall costs of healthcare, the NHS type of healthcare system results in lower costs when compared with healthcare systems that are based on social health insurance, while both the NHS and social health insurance systems result in lower costs than the largely private-market type of healthcare system prevalent in the United States. Although the emphasis of the FPMPAM’s criticism is the removal of patients’ choice (for those who can afford to pay) and increasing costs, its main objection is more specifically to the part of the 1Care scheme that is envisaged to place controls and limitations on the private outpatient (both GP and specialist) sector through the proposed payment mechanism.

Different groups of doctors would be affected in different ways by a social insurance scheme, hence doctors’ support for or opposition to the proposed scheme could depend on their various positions, and may be for different reasons. As seen above, private medical practitioners have been against it because of their vested interest in retaining the existing public–private mixed system, with doctors in the private sector paid on a fee-for-service basis. Likewise, specialists who believe that they benefit from the current lack of a referral system.
in the private sector (which means that patients bypass GPs to consult specialists on a fee-for-service basis) would oppose the proposed scheme. On the other hand, doctors in the government services who could look forward to higher levels of remuneration in a new financing scheme would be likely to support it.

Hence, the Malaysian Medical Association (MMA), with about 13,000 members from both government and private sectors, GPs as well as specialists, has taken a different position from the FPMPAM. The MMA position is set out in its paper, ‘Health for All’ (MMA 1999), which in principle supports the national healthcare financing scheme, and calls for active engagement in the policy process so as to exert influence and ensure good governance in the new scheme (Koh 2011).

**Three discernible positions**

Current opposition to the proposed fund is only the latest in a long series of civil society opposition to governmental measures to privatise public health services and reform national healthcare financing (Chee and Barraclough 2007: 208–17). The 1997 Citizens’ Health Manifesto, issued by the Citizens’ Health Initiative, a loose grouping initiated by the MMA, Consumers’ Association of Penang (CAP) and academics in Universiti Sains Malaysia, and endorsed by a long list of NGOs, unions and individuals, had called for a moratorium on the privatisation of healthcare and for more governmental transparency and greater civil society involvement in the policy process of national healthcare financing reform.

On the eve of the 1999 general elections, a successful campaign was waged against the corporatisation of government hospitals (Chee 2008: 2153–54). The opposition coalition at that time opposed the creation of a national healthcare security fund on the basis that the fund created, estimated to be second in size only to the Employees’ Provident Fund (EPF), could be abused by the ruling regime, which had been accused of using the EPF to bail out politically linked companies (Gomez and Jomo 1997: 195; Jalleh 2005). Furthermore, throughout the time period when it seemed as though the management of the national health security fund could be outsourced, politically well-connected companies – some supported by the hiring of retired officials formerly highly placed in the health ministry – vied for this management role. The statement that the 1Care health fund will be publicly managed may be read as a strategic response to a long-standing criticism that it will benefit yet another politically well-connected ‘rentier-type’ management corporation (MOH 2010: 51–53).

In 2004, the media reported on a range of measures introducing private practice into government hospitals, including the setting up of private wings and allowing government specialists to engage in private practice after office hours, as well as on a consultant study for the implementation of the national health security fund which would incorporate a role for private insurance (Chee and Barraclough 2007: 213). In response, eighty-one civil society members formed the Coalition Against Health Care Privatisation (CAHCP) and issued the People’s Proposal, which called for consultation and full disclosure by the government in its formulation of the national health financing scheme; an increase in the government health budget to 5 percent of GDP; that the proposed national health authority be created by an act of parliament; the strengthening of the public health sector; and that any essential health package provided by the national health insurance fund minimally include all treatment options currently available in government clinics and hospitals (Aliran Monthly 2006; CAHCP 2006; Pillay 2005).

In response to the current 1Care proposals, the CAHCP has now taken a stronger position, calling for a pull-back from privatisation. This would involve a freeze on private hospital
expansion (i.e. the government should not approve any new private hospitals nor any increase in the number of beds in existing private hospitals), and the government’s taking back outsourced hospital cleaning and technical services; manufacturing, supply and distribution of drugs and pharmaceutical supplies; and compulsory health screening of foreign workers. Parallel to these demands, the CAHCP also calls for the government health budget to be increased and service conditions for healthcare workers to be improved – in particular, calling for a separate service commission to be set up so that doctors’ remuneration could be released from the constraints of the Public Services Department and substantially increased (Keruah 2012).

Summing up, therefore, there are now three discernible positions in response to the 1Care proposals, namely, the FPMPAM position of rejecting 1Care and maintaining the status quo; the CAHCP position of not only rejecting 1Care but going further, to roll back privatisation; and the MMA position of supporting the proposals and engaging in the process of formulating the financing scheme. While the CAHCP and the FPMPAM positions appear similar because both reject the 1Care proposals, however, the difference between them is clearly reflected in the alternatives they propose and the consequences that flow from each.

The FPMPAM position basically calls for the status quo to be maintained, the consequence of which is that the current trend of privatisation and marketisation of healthcare provision and financing will continue. Since forces in society do not remain static, the growth of the healthcare market can only lead to the increasing strength of private hospital providers and private health insurance. Inequities will increase in the face of the widening gap between public and private healthcare. In contrast to the FPMPAM, the CAHCP is in fact calling for a reversal of thirty years of privatisation and closing the gap between the private and public healthcare services by putting the brakes on private hospital care. It would simultaneously put more resources into government health services in order to improve service conditions and salaries of doctors and other healthcare workers.

It is important to note that while countries such as Thailand and South Korea have turned to social health insurance from a more private-dominated system of financing, Malaysia is coming to it from the other end, that is, from taxation-based funding (Lee 2012). Analysts have pointed out that compared with other countries and WHO criteria, governmental healthcare expenditure is still low in relation to GDP (Chua and Cheah 2012; Ramesh and Wu 2008). Seen in this context, the CAHCP’s proposal is entirely viable, although the details will have to be further examined. Nevertheless, it requires political will, and therein lies the crux of the matter. A reversal of privatisation is possible but highly unlikely, at least in the foreseeable future, due to the numerous challenges that such a reversal would entail.

Obstacles to the reversal of healthcare privatisation would be presented by vested interests that benefit from the status quo. The privatisation trend of the last few decades has led to the creation of corporate bodies with interests in outsourced government contracts, privatised governmental entities, and the private healthcare delivery sector with its corollary industries. Vested interests are lodged not only within capitalist ownership and professional management of these private sector bodies, but also within statist capitalist forces, such as sovereign wealth funds that own private healthcare facilities (Chee 2008; Chan 2010). For example, Malaysia’s investment agency Khazanah holds the majority share ownership of Parkways, one of the largest transnational corporations that own and manage hospitals throughout Asia, including Malaysia, and the state of Johor’s economic development corporation owns KPJ Healthcare, another large hospital-ownership and management entity.

It is not only the investment arm of the state that has stakes in private healthcare corporations, however. Policy-makers of both federal and state level governments and at least one part of the MOH bureaucracy view the medical tourism industry as an instrument for economic
development and a source of foreign exchange. The medical tourism industry serves to expand the private healthcare market and is a major source of revenue for a substantial number of private healthcare providers. Interests in the growth of medical tourism are therefore inter-twined with interests in the growth of private healthcare services; hence a moratorium on the expansion of private hospitals will also decelerate the current trend of increasing foreign patient numbers.

**Two viable choices**

From our reading of the various responses, we have presented three positions vis-à-vis the proposed 1Care national healthcare financing scheme. From the perspective of citizen-users of public healthcare, there really are only two viable choices, namely, either to reject 1Care and roll back privatisation and private sector growth, or to accept the scheme and actively engage in the process to fight for better terms under the health plan. The FPMPAM position of maintaining the status quo does not provide a sustainable solution, because it means that the current trend of growth in private healthcare will continue. With the healthcare market’s expansion from the efforts of the medical tourist industry, the gap between private and public sectors will grow increasingly larger, with detrimental effects for those who depend on public healthcare.

The CAHCP’s solution of rolling back privatisation and placing a limit on private hospital growth means that the government’s role in healthcare provision would have to be increased and strengthened. In theory at least, if government healthcare of acceptable quality is easily accessible, with acceptable waiting times, the private sector will remain small, and the presumably low fees in the government sector will act as floor prices, to keep charges in the private sector down. It has been argued that governmental provision of hospital and specialist care in a healthcare system acts as an effective cost containment mechanism for total healthcare expenditures (Ramesh and Wu 2008). From the perspective of overall cost, equitable access and universal coverage, this option is most desirable for the majority of citizen-users of healthcare, but is politically difficult to achieve.

A social health insurance scheme will involve higher overall costs compared with the present public system, because it will necessarily involve more administration and regulation, as well as higher remuneration to doctors in the public services. On the other hand, in the tentative proposals of the 1Care scheme, control over pricing in the private sector will be exercised not only directly through legislation, but also through the financing and payment mechanisms of the social health insurance fund, which will act as a single payer. The proposed referral system, as well as the capitation and DRG payment methods, are essential mechanisms to help prevent the inappropriate and excessive use of healthcare which has been shown to occur under social health insurance schemes (Wasem et al. 2004). If not controlled, over-use will lead to cost escalation, and finally come full circle back to users, in the form of higher premiums.

The imposition of healthcare premiums will present an additional financial burden for households in the immediate and short term. If well planned and implemented, however, it should result in regulated pricing of healthcare services as well as medicines that would ease inflationary pressures on healthcare costs in the longer term.

Compared with the current de facto trend of an increasing dependence on private insurance to allay increasing out-of-pocket payments, a social health insurance will provide a more equitable system of healthcare financing. There is cross-subsidisation on a national basis in a social health insurance scheme (and also in a tax-funded national health service) that is absent
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in a healthcare system dominated by private insurance and out-of-pocket payments. The concept of cross-subsidisation, from the healthy to ill, across time and nation, is the fundamental basis of solidarity in a national healthcare system.

Regulation

When the government announced the implementation of a health financing scheme, along with its withdrawal from the provision of medical services, its stated intention was to increase its regulatory and enforcement roles (EPU 1996a: 544). This reflects a recognition that with the proposed change in healthcare financing, as well as increased privatisation, including the corporatisation of government hospitals, the exercise of regulatory oversight would be more demanding and complex.

The Private Healthcare Facilities and Services Act 1998 (Act 586) and Regulations 2006 (PHFSA) were implemented only after more than twenty years of rapid private sector growth. A recent study (Wan Abdullah and Lee 2011: 102) evaluating its implementation in the private hospital sector found that ‘full compliance of these regulated corporate private hospitals remained a challenge’. Under this Act, the statutory power of the director-general of health to grant a licence of operation or to close a health facility has been greatly expanded compared with under previous legislation. This study found, however, that the powers of the MOH to carry out effective regulatory intervention are limited due to lack of enforcement capacity, in terms not only of manpower, but also of adequate information to regulate medical practice in corporate private hospitals, and that the MOH enforcement team was ‘over-stretched and over stressed physically and mentally’ (Wan Abdullah and Lee 2011: 102).

Two empirical observations from this study serve to illustrate, however, that these difficulties stem from conflicts of interest that are structurally derived. The first observation pertains to the PHFSA regulation that holds the private hospital or health facility responsible for the employment of qualified health professionals. To comply, the hospital has to appoint a medical director from among its senior consultants to be the licensee or ‘person-in-charge’. The researchers in this project found that even though the position comes with material incentives, senior clinicians are reluctant to undertake this task because it is a challenge for the person-in-charge to exercise independent decision-making that may be (and usually is) in conflict with corporate policies and business decisions. In one of their study hospitals, the senior clinician who had previously been the person-in-charge resigned from the post, and was replaced by a junior doctor-employee due to cost-containment considerations. Eventually, the hospital was found to be in violation of the law for allowing an unregistered practitioner (not holding an annual practising certificate) to practise medicine at its premises. Regardless of the actual reason that led to this particular instance of legal infraction, it is obvious that the employee-doctor would have been in an even more difficult situation with regard to making hospitals give priority to medical considerations over business ones.

A second empirical observation from this study illustrates that effective regulation requires a larger context of good governance. The researchers cite a case of a prominent clinician owning a private healthcare facility that was in violation of the medical professional code of practice due to its ‘hard-selling entrepreneurial initiatives’ (Wan Abdullah and Lee 2011: 101). When its application for licence renewal was temporarily suspended because of non-compliance with regulations, the facility continued to operate for a year without a valid licence, until its licence was renewed by ‘invisible hands’, that is, through political connections. This case reflects the intertwined political and vested interests that can work to confound state attempts at regulation.
Even while the healthcare financing scheme is being debated, and PHFSA regulations are slowly being implemented, the fast-changing healthcare system is being shaped by practices that are in the process of being institutionalised. One example to illustrate how this could be problematic is the issue of over-treatment in private hospitals. Over-treatment can be motivated by a variety of reasons, such as profit maximisation or the practice of defensive medicine to prevent litigation. Incentives to over-treat may be further built into the system if regulatory mechanisms are not in place to prevent it. An example of this would be situations in which consultant specialists in private hospitals also have ownership interests in expensive equipment (such as MRI scanners) which accrue to them a monetary return on a fee-for-service basis. Their being in a position where they can directly increase the use of this equipment gives rise to a conflict of interest with an incentive to over-treat. The conflict is between their role as doctors in ensuring that the equipment is used only when medically necessary, and the investor’s interest in recuperating costs. Some, but not all, hospitals have policies and good practices to guard against these kinds of situation. We give this example to illustrate that there are areas that urgently require the attention of the regulatory authorities. 15

Conclusion

In this article, we assess the current state of healthcare financing and the contestation surrounding it in Malaysia. The stakes are high because the system of healthcare financing in a country influences to a large extent issues of healthcare accessibility, equity and universal coverage. The taxation-based public healthcare system is a primary welfare source for the people of this country. Nevertheless, privatisation of the healthcare sector, expansion of private hospitals, and increase in use of private health insurance and out-of-pocket expenditures have all worked to strengthen the private sector, which continually drains the public sector of medical expertise.

The 1Care national health financing scheme proposes to change the taxation-based financing structure to one that is based on compulsory, social health insurance. Three positions exist in response to this proposal: (1) reject the change and maintain the current taxation-based financing in the public sector, leaving the private sector to private (insurance or out-of-pocket) financing; (2) reject the change and roll back privatisation, that is, strengthening the current taxation-based financing of the public sector and controlling the expansion of the private sector; and (3) accept the change and actively engage in the policy process.

We have argued that the first position of maintaining the status quo is not viable, because the current trend of private sector expansion will continue to lead to an erosion of public healthcare. To actualise equitable and accessible healthcare with universal coverage through a taxation-based healthcare system, the expansion of private secondary and tertiary care has to be controlled. If this cannot be achieved, the option of a social health insurance would be more equitable than de facto growth in private (insurance and out-of-pocket) financing.

The argument that a social health fund is open to abuse by corrupt forces in power is one that can be addressed only by strong safeguards attached to the fund itself and to the institutional processes of national accounting and audit. As previously discussed, even straightforward application of legal regulations can be circumvented by corrupt political intervention. Institutional safeguards are necessary whatever system of financing is in place, and have to be protected through the political process. It may well be that a taxation-based dominant public healthcare sector would be better and less subject to abuse compared with a social health insurance scheme. If no fundamental transformation occurs in the political and economic structures, however, Malaysians may no longer have the privilege of choice.
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Notes
1 It is the seventh of nine challenges outlined in ‘Vision 2020’, introduced in 1991 by the then prime minister, Mahathir Mohamad. Originally titled ‘The Way Forward’, the vision document articulated Malaysia’s goals to become a fully developed nation by the year 2020. See Prime Minister’s Office of Malaysia (2013).
2 GNI per capita increased from US$1,820 in 1980 to US$9,800 in 2012 (World Bank 2013); urban population from 2,797 million persons or 26.7 percent in 1970 (MOH 1980) to 20.09 million persons or 71.0 percent in 2010 (Department of Statistics 2010); the elderly, defined as those above 65 years of age, rose from 602,734 persons or 3.84 percent in 1985 (Department of Statistics 1985) to 2.02 million or 6.95 percent in 2011 (Department of Statistics Malaysia 2013).
3 For a discussion on rising healthcare costs in countries with social health insurance, see Figueras et al. 2004: 117.
4 The argument is that healthcare providers who are paid on a fee-for-service basis will have an incentive to increase the utilisation of their own services, which they can do because they have more medical knowledge than the user/patient. Payment mechanisms based on DRGs or capitation remove this incentive.
5 Although not explicitly spelt out, the co-payment mechanism is meant to act as a disincentive for ‘over-use’ of healthcare, but it seems that this mechanism would be rendered ineffective as such if co-payments are also covered by private insurance. See Wasem et al. 2004: 241.
6 The other visible partner is Dr T. Jayabalan, who is a politician with an opposition party and member of the Penang State Assembly.
7 We do not mean to imply from this that their arguments are therefore invalid. Some of their arguments and concerns could very well be legitimate and well founded. This caveat pertains to the above discussion of the FPMPAM position as well.
8 In the current system, doctors who have a specialist certificate can function as both GP and specialist, that is, as GPs, they can refer patients to other specialists, while as specialists, they can also be referred patients by others. According to a key informant, these doctor-specialists fear that they will lose the privilege of this dual role in the referral system that will be instituted in the new financing scheme (interview by Por Heong Hong with key informant, 12 January 2012).
9 Mary Cardosa, then MMA president, had admitted that it had been a difficult process for MMA to arrive at a position due to the different types of doctor who are members (interview by Por Heong Hong, 21 February 2012).
10 Not to be confused with the CHC.
11 We are heuristically delineating and labelling these three positions here so as to sharpen the issues for discussion and analysis. We do not imply that there are no other positions vis-à-vis the proposed national healthcare financing scheme, nor do we assume that there are no other organisations or individuals propounding these or other positions, nor that there could not be other alternative framings.
12 The FPMPAM opposes the corporatisation of government hospitals, and supports monitoring and controlling the cost of private hospital care through ‘appropriate market forces and regulatory machinery’ but is silent on the CAHCP’s position of rolling back privatisation (Chow 2011; Chow and Ng 2011).
13 The over-use of healthcare is largely attributed to supplier-induced demand. Patients, not having as much knowledge and expertise as doctors and being in a more vulnerable position when ill, depend on their doctors’ recommendations to ‘demand’ or use healthcare; while doctors have a self-interested tendency to increase demand on their patients’ behalf.
14 This is the only academic study evaluating the implementation of the PHFSA that we could find. This section uses the evidence in this study for its arguments.
15 There is currently no regulation or mechanism to prevent the proliferation of expensive medical equipment in the country or to rationalise its usage. The acquisition of expensive equipment is not controlled in the private sector. In 2010, 122,135 out of a total 170,010 MRI procedures were performed in the private sector. The usage rate in the urban centre of Kuala Lumpur is the highest: a total of 37,481 MRI procedures were performed in 2010, or 224 MRI procedures per 10,000 population. This is twenty times the usage rate of rural Terengganu, where nine MRI procedures per 10,000 population were performed in the same year (Sivasampu et al. 2012: 16).
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Bibliography


