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The Malaysian Health System in Transition: The Ambiguity of Public and Private

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Abstract

Malaysia offers an unusual case study where government agencies, at both federal and state (provincial) levels, have acquired controlling stakes in major for-profit healthcare enterprises. The Johor state government for instance, through its corporate arm the Johor Corporation, spawned a large diversified healthcare conglomerate (Kumpulan Perubatan Johor) which includes the largest chain of private hospitals (numbering 26) in the country. Meanwhile the Malaysian federal government's sovereign wealth fund Khazanah, through its healthcare subsidiary IHH Healthcare Berhad, emerged as the second largest listed private healthcare provider in the world (by market capitalisation, after the Hospital Corporation of America, HCA) when it added Turkey's largest private healthcare group Acibadem to its recently merged Parkway-Pantai chain of private hospitals in Malaysia and Singapore. Government-linked companies (GLCs) now control more than 40 percent of 'private' hospital beds in Malaysia. This novel situation raises intriguing questions: Is this a "nationalization" of private enterprises in essential human services, or an infusion of the logic of capital into the institutional dynamics of the state? How are conflicts of interests playing out, as the state juggles its multiple roles as (i) funder and provider of public sector healthcare, (ii) as regulator of the healthcare system, and as (iii) pre-eminent investor in the private health services industry?

Universalistic Entitlement to Public Sector Healthcare in Malaysia

While *healthcare* is not inscribed in the Malaysian constitution as a *human right*, Malaysian citizens have become accustomed to a *de facto* entitlement to publicly-provided and highly subsidized healthcare as an important element of social policy since decolonization in 1957.

In practical terms, this universalistic entitlement expands or shrinks depending on the level of funding allocated by the federal government, staffing levels and competencies in government health facilities, necessary equipment and treatment accessories, geographical access and timeliness of available

services, co-payments required, among other factors. In 2009, government healthcare expenditures amounted to 2.71 percent of gross domestic product (GDP), while private spending added another 2.25 percent (*Malaysian National Health Accounts, 2011*). Overall, user charges for the government-provided services amount to 2-3 percent of the Health Ministry's actual expenditures (*Safurah et al, 2013*), but these may not include occasional purchases of medicines and other treatment accessories not available in government health facilities.

Malaysian citizens may or may not avail themselves of this universalistic entitlement, but even those who do not do so benefit from its second order effects, insofar as the availability of subsidized publicly-provided healthcare (of a certain quality) acts as a fallback option - a restraining price bulwark - which helps to keep private healthcare charges within a more affordable range.

Presently, employees and pensioners in the public sector enjoy practically free access to publicly-provided healthcare as an employment benefit, with a tiered entitlement to inpatient ward class in accordance with their occupational grade within the civil service.

For non-civil servants, outpatient primary care in the urban areas entails a nominal payment of RM1 which covers consultation services, necessary investigations, and medicines. In the rural areas, there are no charges for government-provided primary care.

Patients who are referred to government specialist clinics are charged RM5 for each outpatient visit after the first referral visit (which is free)¹ and they are also charged for the necessary investigations.

Inpatient care at government facilities is also highly subsidized on a graduated scale, as indicated by the inpatient ward charges levied at the Kuala Lumpur Hospital:

Table 1: Daily Ward Charges, Kuala Lumpur Hospital

Ward	Government employee / Pensioner	Non-civil servant	Foreigner
1 st class: 1 bedded 2 bedded 4 bedded or more	RM10.00 / RM5.00 RM8.00 / RM4.00 RM6.00 / RM3.00	RM80.00 RM60.00 RM40.00	RM160.00 RM115.00 RM80.00
2 nd class	RM3.00 / RM1.50	RM30.00	RM60.00

¹ unless the patient is referred from the private sector in which case the consultation charge is RM30 for the initial visit

3 rd class	Free	RM3.00	RM40.00

US\$1 = RM3.3 (as of February 27, 2014)

In 2008, government health facilities accounted for 74 percent of hospital admissions and 38 percent of outpatient visits (*Country Health Plan, 10th Malaysia Plan 2011-2015*).

The Health Ministry's Rural Health Service began with a health centre in Jitra in 1953 and it has expanded rapidly to provide extensive primary care coverage. As of 1993, 93 percent of the population of Peninsular Malaysia lived within 5 km of a static primary care facility. For Sabah and Sarawak, the coverage was 76 percent and 61 percent respectively, and these figures would be higher if the non-static health facilities such as flying doctor squads and mobile health teams were included (*WHO Representative Office, Malaysia, 2006*).

Overall, this geographical coverage for primary healthcare is quite creditable, reportedly the second best in the world after Cuba. Indeed, Malaysia was notable in achieving much of Alma Ata's Primary Health Care goals via an institutionalized formal healthcare delivery system with minimal resort to health auxiliaries and community health workers such as were envisaged for more resource-constrained settings². In addition to vaccination, pre-natal care, post-natal care, maternal and child health programs, primary medical care with referral backup, health awareness and promotion, vector control of communicable diseases, the Rural Health Service also included elements of potable water supply, sanitary latrines, environmental hygiene, and the Applied Food and Nutrition Program³.

An Underfunded Public Healthcare Sector

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

At the present time, the government healthcare sector receives a yearly infusion of young inexperienced medical graduates who are required to serve

² but by the same token, also overly reliant on top-down approaches which fostered patron-client dependency

³ child immunisation coverage (2012): BCG (98.7 percent of infants), Diphtheria, Pertussis, & Tetanus - Hemophilus influenzae Type B (3rd dose, 97.6 percent of infants), Polio (3rd dose, 97.6 percent of infants), Mumps, Measles, Rubella (95.5 percent of children aged 1-2 yrs), Hepatitis B (3rd dose completed, 96.0 percent of infants). (*Health Indicators 2013, Health Ministry*). In 2011, infant mortality rate was 6.6 infant deaths per 1000 live births; maternal mortality rate was 25.5 maternal deaths per 100,000 live births; life expectancy at birth (2012) stood at 72.3 years for males, 77.2 years for females. By the year 2000, 98 percent of the urban population were served with reticulated systems from water treatment plants using all or some of the conventional treatment processes of aeration, coagulation and flocculation, sedimentation, filtration and chlorination. Almost the entire urban population in Malaysia was also served with reticulated sewerage system and septic tanks by local authorities. In the rural areas, as of 2009, 96.4 percent of houses were served with safe water supply, 62.6 percent with sullage disposal, 69.7 percent with solid waste disposal, and 97.9 percent had sanitary latrines.

a 4-year mandatory national service inclusive of the internship period. Some stay on out of a preference for public service, while others do so for the postgraduate training opportunities, but beyond the completion of their specialty training, there is a steady attrition of senior experienced staff over the duration of their contractual obligations. In the period 2005-2008 for instance, 1427 doctors left the government service, which translated into an annual attrition rate of 3 percent of staff strength over and above those entering retirement (*Country Health Plan, op. cit.*).

As a result of push and pull factors - remuneration, career prospects, complaints of ethnic discrimination, avoidance of government transfers - this perennial exodus of senior experienced staff from the public sector gives rise to a lopsided distribution of specialists for instance, 70 percent of whom (ref? Kumar?) currently practice in the private sector which accounts for 26 percent of total hospital beds (*Health Facts, 2013*). The outflow of government doctors, nurses, specialists, and technicians sets off a vicious cycle, as the understaffing translates into heavier workloads for those who remain, thereby further reinforcing the push factors. (Ironically, the escalating numbers of new medical graduates lately have exacerbated the shortage of experienced mentors and eroded the value of the internship experience). Meanwhile, the unrelenting promotion of medical tourism adds to the lure of private practice which increasingly services a clientele that is regional in scope. With the enduring outflow of staff, patients in the public sector can expect little relief from the long queues and harried service of stressed-out staff. Indeed, when the Prime Minister Najib Abdul Razak visited Singapore in 2009 for the APEC Summit, he was astonished to discover that more than half the medical specialists at Mount Elizabeth Hospital were Malaysian diasporic professionals.

Corporatizing the Public Healthcare Sector

In 1999, the Malaysian government announced a plan to corporatize its hospitals and other healthcare facilities, in part to stem the outflow of health professionals. The corporatized institutions would continue to be publicly-owned but would be vested with more operational and financial autonomy outside the strictures of civil service rules. This was designed to allow for more flexibility in salary scales, patient fees, procurements, and timely responsiveness to shifts in market demand and clients' preferences. Coming in the wake of the outsourcing of hospital support services and pharmaceutical supplies however, it aggravated public anxieties that clinical and hospital services would in due course be privatized. This quickly became an emotive issue in the run-up to the general elections of November 1999, and was quietly shelved.

Eight years passed before the issue re-emerged on a pilot scale in the form of opportunities for limited private practice in government hospitals. Effective August 1, 2007, Putrajaya Hospital and Selayang Hospital, two of the newer public hospitals with advanced treatment facilities for liver related illnesses, hand surgery, breast cancer, and endocrine diseases, began to offer to "full-paying patients" preferential access to consultation and treatment by

specialists of their choice, in an executive or first-class facility, and to be charged accordingly.

In justifying this departure from a previous practice based largely on priority of medical need, Health Minister Dr Chua Soi Lek stated that *“we are losing [hundreds of] our specialist doctors every year, who resign to join the private hospitals... We hope this approach will enable the hospitals to allocate some additional incentives for the specialist doctors [to remain in the public sector]...”* (Star, July 28, 2007).

Indeed, the introduction of the full-paying patient scheme followed upon an earlier proposal to establish full-fledged private wings in selected government hospitals, which was subsequently modified in the wake of reactions from diverse stakeholders.

In 2004, the Malaysian government had floated the idea of private commercial wings for existing government hospitals (Star, May 7, 2004). Government-employed doctors at the time had declared their support for *“the setting up of these private commercial wings [which] would not only supplement the income of specialists but would also generate income for supporting staff as well as for hospitals to further improve services. As more specialists would consider staying back in government service, the quality of care would improve. Private patients too would be able to enjoy better quality of health care at lower cost compared to the private sector at present. With such a set-up, health tourism would emerge as a natural consequence, thus setting up a cycle of generating more income for the government and boosting further improvement of health services. It is [SCHOMOS]’ sincere hope that these private commercial wings would be fully owned by the government so as to ensure a maximum win-win situation for the government, health providers as well as health care receivers.”* (undated memorandum, Malaysian Medical Association, Section Concerning House Officers, Medical Officers and Specialists [SCHOMOS], post-2004)

The *Gabungan Membantah Penswastan Perkhidmatan Kesihatan* (Coalition Against the Privatisation of Health Services)⁴, less sanguine about these prospects, has consistently opposed proposals for private wings or private patients on the grounds that:

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

⁴ a coalition of 70 non-governmental organizations that came together in 2005 to campaign against the privatization of publicly provided health services

as the system was by chronic understaffing of specialists in the government sector

Interestingly, the Association of Private Hospitals of Malaysia (APHM) was also opposed to the private wings proposal, perceiving a threat of price competition from a subsidized and publicly-owned service that was not solely intent on maximizing profits⁵:

“Dr Ridzwan Abu Bakar (president, APHM), commenting on the recent statement by Health Minister Dr Chua Soi Lek that his ministry was looking into the feasibility of setting up private wings in government hospitals to halt the brain drain of doctors and specialists (as well as follow-up reports that private hospitals were worried about competition from the private wings) said the association was not in favor of private wings. Dr Ridzwan stated that private hospitals welcomed competition from private wings but said a level playing field should be given to all players. “This means all players must be exposed to the same subsidies and business risks,” he said, adding that [the assumption that] private wings would help to retain specialists had yet to be proven as some might use the private wings as a “testing ground” before leaving for the private sector. He also said the association would propose that specialists in government hospitals be allowed to have limited private practice” (Star, May 16, 2004).

Equally interesting was the stance of the health insurance industry, whose wariness and ambivalence *vis-à-vis* private healthcare providers was well captured in a field interview with Dr Nirmala Menon, Senior Vice President of ING Insurance Berhad (Employee Benefits) and Ms Liew Sook Foon, Assistant Vice President, ING Insurance Berhad (Corporate Communications) conducted by Loh Foon Fong on February 9, 2004:

“What we would like to see in the public sector is improvement in the [healthcare] services, shortening of queues... [Our customers] purchase insurance so that they can get out of going to public hospitals... We would like people to go to public hospitals [when they need care] because it costs less for us, but once you buy an insurance, you almost never go to a public hospital. You always go to a private hospital. It’s a perception that Malaysians have that private equals better. Q: Do you educate them to inform them that private [healthcare] is not necessarily better? Yes, we do. In fact, we even have policies where we ask for less information if they go into a public hospital, we pay faster and we even have policies where we give them some money on [a] daily basis [for] hospital allowance if they get into the public hospitals but that doesn’t really matter. In fact, a lot of the good doctors are in public hospitals but because of the long queues, they don’t normally get treatment when they require it”.

Health insurers thus appear to have a schizophrenic attitude towards healthcare providers (and the state) – deteriorating public hospitals reinforces people’s felt need for private health insurance, but health insurers also

⁵ Chua: Private hospitals fear potential competition (Star, May 11, 2004)

complain endlessly about moral hazards and price gouging by private providers⁶ so much so they make incentive payments to policy holders to access the public hospitals when in need of care. Evidently, there's a limit to how much they want the public hospitals to deteriorate, not to the point where they can no longer function as a credible price bulwark, and occasionally as an actual provider for the middling classes. Going by their rhetoric, they want low-cost, no frills, "medically necessary", evidence-based care, which sounds engagingly like the original progressive vision of managed care (*Kuttner, 1998*). Under certain circumstances, they might even be supportive of subsidized, publicly-provided healthcare with moderate user charges or co-payments.

It would be stretching it to say that the insurance (and managed care) industry was instrumental in the push for private wings and/or private patients in government hospitals, but these were clearly options they favored given their testy relationships with fee-for-service healthcare providers in the private sector whom they invariably suspect of price-gouging, padding of bills, and unnecessary investigations and procedures.

The State as Entrepreneur in Healthcare

Amidst the exchanges provoked by the proposals for private wings and full-paying patients in government hospitals, a parallel development of arguably greater significance was gaining prominence.

In 1979, the Johor State Economic Development Corporation (the corporate arm of the Johor state government, later renamed as the Johor Corporation) marked its entry into the private healthcare industry with the incorporation of the Johor Specialist Hospital. Over the next 25 years, this inaugural venture grew into the largest chain of private hospitals in Malaysia (twenty six hospitals within the country, with another two in Indonesia) under the corporate umbrella of KPJ Healthcare Berhad. Indeed, KPJ is a publicly-listed healthcare conglomerate which offers not just inpatient care, but a diversified portfolio of services including hospital management, hospital development and commissioning, basic and post-basic training for nurses and allied health professionals, laboratory and pathology services, central procurement and retailing of pharmaceutical products, healthcare informatics, and laundry and sterilization services.

Meanwhile, Khazanah Nasional Berhad (the federal sovereign wealth fund, chaired by the Prime Minister), acquired in August 2006 a 30.68 percent controlling share of Pantai Holdings Berhad⁷, another large healthcare conglomerate with interests in private hospitals (9), clinical waste management, cleansing and maintenance services for government hospitals (linen and laundry, facilities engineering maintenance, biomedical engineering maintenance), managed care services, supervision of medical screening and registration of foreign workers in Malaysia.

⁶ Sunny Tan, health insurance industry representative at the Annual Health Dialogue with stakeholders hosted by the Minister of Health, June 11-13, 2001, Kuala Lumpur.

⁷ Khazanah Nasional Berhad media statement, 28 August 2006

Up until April 2001, Mokhzani Mahathir, a son of the serving Prime Minister at the time (Dr Mahathir Mohammad) was the chief executive officer of Pantai Holdings Bhd when he disposed of his 32.9 percent stake. On September 13, 2005, Parkway Holdings Ltd of Singapore in turn acquired a 31 percent stake in Pantai, making it the largest single shareholder in Pantai. Parkway itself had controlling stakes in five hospitals in Singapore and in Malaysia⁸. Following this acquisition, Parkway changed five of the seven board members of Pantai, replacing them with nominees of Parkway and those of its largest shareholder, Newbridge Capital Inc., a US-based investment fund which had acquired a 26 percent stake in Parkway in May 2005 (*BusinessWeek online, June 13, 2005*).

It was this acquisition by the Singapore-listed company (in turn, controlled by a US-based fund manager) which set off alarm bells in Malaysia (*Bernama.com, August 13, 2006*). At stake was not just the second largest private hospital chain in the country but also a beneficiary of lucrative outsourcing concessions for government hospital support services and foreign worker medical registration. A compromise was eventually struck which entailed Khazanah's intervention via a subsidiary Pantai Irama Ventures Sdn Bhd which acquired a 35 percent controlling stake of Pantai Holdings Bhd but which would allow Parkway to retain operational and management control of Pantai's hospitals for fifteen years⁹.

On April 30, 2008, Khazanah announced that it had paid RM1.23 billion for an additional 16.41 percent stake in Parkway¹⁰, thereby raising its total stake in Parkway to 20.79 percent. Two and a half years later, Khazanah raised its stake to 95 percent via a voluntary general offer¹¹ which brought to an end a bruising battle with Fortis (India) for control of Parkway, after efforts at a mutually acceptable compromise had fallen through (*Star, July 31, 2010*). Shortly after, Parkway Pantai Ltd was incorporated to merge Parkway and Pantai as a subsidiary under an overarching corporate umbrella for Khazanah's health sector interests, Integrated Healthcare Holdings Limited (IHH).

On April 7, 2011, Mitsui & Co acquired a 30 percent stake in IHH¹². With this cash injection, Khazanah proceeded with its acquisition of Turkey's largest private hospital group, Acibadem. Upon completion of the exercise, IHH would be operating more than 5000 licensed beds, with another 3700 beds in the pipeline. Khazanah's 70 percent stake in IHH would be reduced to 62.1 percent, Mitsui's share would decline to 26.6 percent, while the new Turkish shareholders Abraaj Investment Management Ltd and Acibadem founder Mehmet Ali Aydinlar and family would acquire stakes of 7.1 percent and 4.2

⁸ this Singapore Stock Exchange-listed health conglomerate also includes Parkway Shenton Pte Ltd, one of Singapore's biggest general practice, Medi-Rad Associates Ltd, a radiology service provider; Parkway Laboratory Services Ltd, a major provider of laboratory services, as well as Gleneagles CRC Pte Ltd. which offers clinical research services (e.g. drug trials) on a contract basis.

⁹ Khazanah Nasional Berhad media statement, 28 August 2006; *Malaysiakini.com, 30 August 2006*

¹⁰ Khazanah Nasional Berhad media statement, 30 April 2008

¹¹ Khazanah Nasional Berhad media statement, 17 August 2010

¹² *Parkway announces Mitsui as a strategic shareholder via Integrated Healthcare*, press release, Parkway Holdings Limited, April 7, 2011

percent respectively¹³. Fourteen months later (July 2012), IHH made its debut on the Malaysian and Singaporean stock exchanges in a concurrent joint listing which was billed as the third largest IPO in the world in 2012. This listing raised RM6.3 billion and established IHH as the second largest private healthcare provider in the world by market capitalisation (RM25.6 billion), after the Hospital Corporation of America (HCA)¹⁴. Khazanah's healthcare portfolio, which was reduced to a 45.7 percent stake in IHH after the IPO, accounted for 11.1 percent of Khazanah's total realisable asset value of RM134.9 billion in 2013 (*Khazanah website, 2014*). There are no published figures on the aggregated returns (taxes plus dividends) of Khazanah's health sector investments to the federal coffers¹⁵.

Domestically, these developments mean that the Malaysian government, in concert with GLCs (government-linked companies)¹⁶ at both federal and state levels, effectively own or operate three parallel systems of healthcare providers in Malaysia:

- the regular Health Ministry facilities (as well the health facilities of the Ministry of Defence)
- corporatized hospitals (Institut Jantung Negara, university teaching hospitals of Universiti Malaya, Universiti Kebangsaan Malaysia, Universiti Sains Malaysia)
- a huge "private wing": the Parkway Pantai chain of hospitals, operated as commercial hospitals with Khazanah's IHH as a controlling shareholder, similarly with the Kumpulan Perubatan Johor (KPJ) chain of hospitals, spawned by the Johor state government through its corporate arm, the Johor Corporation.

The Ambiguity of Public and Private

This raises a number of intriguing questions. Are the KPJ and Pantai hospitals *public* or *private*? Is this a progressive "nationalization" of private enterprises in essential human services, or an infusion of the logic of capital into the institutional dynamics of the state? Clearly, this fusion of state and capital is rife with conflicts of interest as the state - wearing multiple hats - attempts to reconcile sometimes divergent priorities in the public and private

¹³ Integrated Healthcare Holdings ranks among the top (*The Star Online, Business section, 25 January 2012*) <http://biz.thestar.com.my/news/story.asp?file=/2012/1/25/business/10444157&sec=business> (accessed on 31 January 2012.)

¹⁴ Malaysia's IHH jumps 14 percent as world's No.3 IPO debuts (*Reuters, July 24, 2012*) <http://www.reuters.com/article/2012/07/25/us-malaysia-ihh-ipo-idUSBRE86O03J20120725> (accessed on January 28, 2014)

¹⁵ for the period 2004-2013, Khazanah's entire portfolio contributed RM7.8 billion in taxes and dividends to federal revenues. This compares with RM68.3 billion in taxes and dividends in one year (FY2012) from the national oil and gas monopoly Petronas (*Petronas Annual Report, 2012*). In 2011, IHH paid RM87.8 in corporate taxes to the Malaysian government (*IHH media statement, July 3, 2012*).

¹⁶ GLCs are defined as companies that have a primary commercial objective and in which the Malaysian Government has a direct controlling stake. Controlling stake refers to the Government's ability (not just percentage ownership) to appoint BOD members, senior management, make major decisions (e.g contract awards, strategy, restructuring and financing, acquisitions and divestments etc.) for the GLCs either directly or through government-linked investment companies (*Khazanah website, accessed on 15 January 2014*). As of July 31, 2005, there were 57 GLCs which accounted for approximately RM261 billion or 36 percent and 54 percent of the market capitalization of Bursa Malaysia and of the benchmark Kuala Lumpur Composite Index respectively. With 400,000 employees, GLCs employ an estimated 5 percent of the national workforce. (*Putrajaya Committee on GLC High Performance*)

healthcare sectors. As Khazanah comes under pressure for instance, to secure commensurate returns from its costly acquisition of Parkway (*Star*, July 31, 2010), will the public sector suffer from a benign neglect? Will the poaching of public sector staff by the private sector continue unabated, or will it be subject to some restrictions? What safeguards will be put in place for impartial regulation, given the potential for regulatory conflicts of interest in the healthcare sector?

In the next section, we examine specific instances of public-private interactions in the healthcare system where these conflicts of interest may or have emerged.

Institut Jantung Negara (IJN, National Heart Institute)

The attempted acquisition of *Institut Jantung Negara* (IJN, National Heart Institute) by Sime Darby Ltd in 2008 is a revealing instance of the forces in play in this evolving situation.

In 1992, the IJN was hived off from the Kuala Lumpur Hospital and corporatized as a government-owned referral heart centre. One of the missions of this 430-bedded hospital was to provide high quality services in cardiovascular and thoracic medicine at medium cost. Civil servants and government pensioners would continue to receive treatment for heart ailments at IJN at government expense, as an employment health benefit, and low-income patients were eligible for fee waivers or discounts.

For Malaysian citizens who were not civil servants, patient charges at the corporatized IJN would be increased from the hitherto highly-subsidised rates, and IJN staff would be paid salaries markedly above the corresponding Ministry of Health scales. The IJN however would continue to be subsidised by public funds although not to the extent of 90-95 percent as was commonly the case for the regular Ministry of Health facilities.

The intention was that IJN should also act as a *price bulwark*, i.e. a more affordable fall-back option which could help restrain escalating charges at private hospitals such as the Subang Jaya Medical Center (SJMC).

In December 2008, Sime Darby, the controlling stakeholder of SJMC and one of the largest GLCs in Malaysia, submitted a proposal to the Ministry of Finance to acquire a 51 percent stake in IJN. Unlike KPJ and Khazanah's healthcare subsidiary, which launched new private hospital ventures ('greenfield' projects) or acquired existing ones ('brownfield' projects), Sime Darby was proposing to acquire the largest publicly-owned and operated referral heart center in the country.

The federal cabinet initially responded positively towards the proposed acquisition. In explaining the cabinet's stance, the prime minister-in-waiting (concurrently the finance minister, Najib Abdul Razak) alluded to demands from the IJN's medical staff for higher pay - to reduce the sizeable gap between public and private sector remuneration - and the likelihood they would leave IJN if their demands were not met. This prompted a statement

signed by 33 of IJN's 35 medical consultants which pointed out that "over the last 7 years of operation, out of a total of 35 consultants, only 7 have left IJN. Therefore, our consultants' annual attrition rate is only 3 percent and we have responded over time to promote our home grown talents to fill the voids accordingly. Currently, 75 percent of IJN consultants have been in their posts for more than 10 years...Whilst we have yet to get a clear picture of the proposed privatization by Sime Darby, we would like to reiterate our commitment to serve IJN in its current form and want to stress that the proposed privatization of IJN must not be seen as a response to our demands for better pay. The medical personnel of IJN are not at all involved, directly or otherwise, in the negotiations for the said privatization..."¹⁷

Meanwhile, an investigative report in the Star (December 18, 2008) noted the following fee differentials for comparable procedures at IJN and Sime Darby Medical Center Subang Jaya:

MEDICAL CHARGES COMPARISON		
	SDMCSJ*	IJN
Single bypass	RM40,000-RM50,000	RM25,000-RM30,000
Angioplasty	RM35,000-RM45,000	RM18,000-RM35,000

Sources: SDMCSJ and IJN * Sime Darby Medical Centre Subang Jaya

Evidently, Sime Darby, by acquiring IJN, hoped to establish a commanding presence in a lucrative medical specialty, and at the same time to absorb and thus neutralise a lower priced competitor.

In the ensuing public furore over this attempted takeover, the proposal was quietly shelved by the cabinet.

Targeting: The Persuasive Face and Generic Template for Privatization

Targeting as a policy choice (as opposed to universalism) is eminently compatible with the concerns of entrepreneurs and investors seeking profitable opportunities in service sectors which hitherto had been the domain of the public sector (Chan, 2006). With the devolution of social services to private enterprise, entrepreneurs in search of investment prospects would be primarily interested in the "market-capable" segments of society (if the state demurs from extending this effective demand, through public financing, to those without the disposable incomes). Seen in that light, targeting is also the persuasive face and generic template for the privatization of essential social services.

In Malaysia, the situation is further complicated by the fact that the state itself is massively invested in for-profit healthcare enterprises.

¹⁷ IJN doctors: Don't make us scapegoats (The Star, December 19, 2008)

As government-linked entities built up their stakes in the commercial healthcare sector, a succession of health ministers have argued - using a rhetoric of *targeting* - that Malaysians who could afford it should avail themselves of private healthcare services (suitably encouraged thus with tax rebates). This would allow the government to target its limited healthcare resources on the “really deserving poorer citizens”. Senior health ministry officers have likewise noted that *“an argument in favour of a two-tier system, however, is that while the private sector concentrates on illness management among better-off urban people (thus reducing government outlays on this group), this frees the public sector to provide health care for the poor. The opting out by the ‘better off’ from public health services, thus, could improve the capacity of the public health system to extend increased access to poor people”* (Safurah et al, 2013, op cit, p.90)¹⁸.

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

Indeed, government expenditures on healthcare, amounting to 2.7 percent of GDP in 2009, is far from extravagant. Whether this is tantamount to an implicit policy of benign neglect of the public sector - to encourage a migration of the “market-capable” to the private sector - is quite debatable. While health expenditures in the private sector have increased 4.4 fold between 1997 and 2009 (*Malaysian National Health Accounts, 2011*), there has been a parallel increase in government health expenditures so that the private sector share has remained steady at about 45 percent of total health expenditures.

National Health Insurance?

Is there an alternative to this emerging two-tier healthcare apartheid? The Malaysian government’s answer to this is a proposed national health insurance scheme designated as 1Care. This would entail mandatory employer and employee contributions to a publicly-managed health insurance fund, along with patient co-payments and supplementary federal allocations, which would finance a defined benefits package. Among other things, 1Care was envisaged as a vehicle which could open up access to underutilized capacity and specialist expertise in the private health sector (*Abu Bakar et al,*

¹⁸ this is a remarkable echo of Jessica Einhorn’s call (2006) to wind down the World Bank’s lending arm for middle-income countries, the International Bank for Reconstruction and Development (IBRD) which followed upon the recommendations of the Meltzer Commission (US Congress, 2000) for a triage of borrower countries: debt cancellation, performance-based grants for the most destitute of highly-indebted countries, as opposed to the more “credit-worthy” borrowers with access to capital markets, who should be weaned from multilateral lending agencies and henceforth be serviced by private lending sources (the privatisation of the IBRD, as it were, by divesting to private capital markets its development lending to “market-capable” middle-income countries).

1992), subject to a standard fee schedule applicable to all providers. Would private facilities and practitioners be allowed to opt out of the scheme, if they chose to concentrate on more lucrative niche markets (e.g. affluent patients and medical tourists)? Or would they be prevailed upon to undertake their 'national service', given the pervasive public ownership of the for-profit healthcare sector?

An alternative scenario, which relies on more progressive taxation regimes to improve universal access to quality care on the basis of need, which dispenses with much of the administrative and transactional costs of managing 1Care's eligible pool of beneficiaries and provider payment systems, is notably absent from the options under consideration.

Regulatory Environment

In Japan, the term *amakudari* (literally, the "descent from heaven" of Shinto gods to earth) is employed as a metaphor for the retirement of senior civil servants into organizations which fell under their jurisdiction during their tenure as civil servants. This recalls the familiar problems of 'the revolving door' and regulatory capture. The retired officials often help their new employers secure government contracts, circumvent regulatory oversight, and generally benefit from preferential treatment from the bureaucracy. Senior civil servants approaching their retirement may also look forward to *amakudari* as a reward for discretionary favours proactively bestowed upon their future employers. Either way, these post-retirement placements encourage corruption and undermine an impartial regulatory role for the government. To cope with this, the penal code in France for instance imposes a three year wait before a retiring official can accept a potentially compromising position in the private sector.

Quite apart from any aspirations that an official may have for a coveted retirement appointment, the regulatory official in Malaysia faces the additional complication that a regulated entity may be a GLC with influential government or political connections. This would not be unusual, given that GLCs in 2005 accounted for approximately 36 percent of the market capitalization of the Kuala Lumpur stock exchange, coupled with the interpenetrating intimacy of 'political business' in Malaysia which is well documented (*Gomez, 2002*). In the securities industry, the Institute of International Finance observed in its 2006 report on Malaysia that "*despite its operational independence, the Securities Commission (SC) is perceived as being influenced by the MoF by a cross-section of market participants and is considered to be a weak regulator*". In 2011, amidst a controversial takeover of the property developer Eastern & Oriental (E&O) by the government-linked conglomerate Sime Darby, an SC task force had determined that Sime Darby was obliged to make a general offer for E&O shares after it had built up a triggering threshold of 30 percent of E&O's equity. The task force however was overruled by the regulator's top authorities, a move that reinforced unease over the widely perceived coddling of large state-controlled companies by the regulator at the expense of minority shareholders, during this corporate takeover (*The Malaysian Insider, Jan 30, 2012*). Terence Gomez (2005) has likewise analysed the recent history of corporate governance in Malaysia, citing

another instance of the Securities Commission's inconsistent treatment of Phileo Allied's shareholders when the bank was sold, in contrast to the leeway afforded to Tajuddin Ramli (a close associate of the finance minister) when he offloaded his controlling stake in Malaysian Airlines System back to the Malaysian government in a bailout-cum-renationalisation following a failed privatization of the national carrier.

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

Notwithstanding the health ministry's regulatory powers over the location of new private hospitals (Private Healthcare Facilities and Services Act, 1998), it has yet to exercise this discretion to prioritize underserved areas.

This Act also empowers the health minister to regulate professional charges for consultations and procedures performed by doctors, but not the charges levied by private hospitals for usage of ward, operating theatre, other institutional facilities, nursing time, medical disposables and treatment accessories. Hospitals also receive 10-15 percent of the professional charges as an administration fee.

Concluding Remarks

The Malaysian state has an unusual characteristic born of its recent history. In 1970, in the wake of post-election ethnic rioting and a brief period of emergency rule, a New Economic Policy (NEP) was promulgated with the twin goals of reducing poverty and reducing inter-ethnic disparities, most notably between the predominantly Malay indigenous (*bumiputra*) community and a sizeable ethnic Chinese minority. One of the indicative targets of the NEP was to increase the *bumiputra* ownership of incorporated share capital from 2.4 percent in 1970 to 30 percent by 1990. Given the small size of the Malay business and shareholding class at the time, this ambitious task of restructuring share ownership inevitably fell to the state. *Bumiputra* trust agencies were duly created to acquire and to manage massive holdings of corporate equities from which were spawned unit trust funds which could reach a broader base of eligible *bumiputra* beneficiaries. In parallel with these initiatives were efforts to foster the emergence of a *bumiputra* commercial and industrial community (BCIC, i.e. a Malay bourgeois elite) which could take on leading roles in a diverse range of government-acquired or government-spawned commercial enterprises. Within two decades, Malaysian government trust agencies and GLCs had acquired sizeable if not controlling stakes in the commanding heights of the national economy (finance and

banking, plantations and agribusiness, oil and gas, heavy industry, media and broadcasting, infrastructure and construction, power generation and distribution, postal services and telecommunications, transportation, leisure and hospitality, among other sectors).

In this manner, the Malaysian state, going beyond its more traditional *welfarist* and *developmentalist* roles, took on the character of an *entrepreneurial state* as well.

The health ministry is not entirely unaware that its multiple roles can give rise to divergent priorities in the healthcare sector:

The financing challenge is to agree on a scheme for fair and sustainable funding, whether through an increased share of general revenue or through the establishment of a social health insurance scheme. Malaysia has the capacity to expand its tax-funded health care system. The government is also considering an alternative strategy of setting up a long-debated national social health insurance scheme, but by the end of 2011, the government had reached no decision. A related financial challenge is to institute payment methods for health care providers that reward cost-effective service delivery. The regulatory challenge is that the government needs to strengthen its governance of the private sector in order to ensure quality and safety and fair charges. It also needs to establish more transparent regulation of clinical performance, as the Ministry of Health, as the major employer, is not an independent and external regulator. The structural challenge is to determine the balance between public and private sector delivery and to engage in a more productive partnership between public and private sectors. The administrative challenge is to consider whether a centralized health system has served its purpose or whether the community would be better served by more decentralized and responsive public facilities (Safurah et al, 2013, op cit, p.91)

In this paper, I have described in some detail the state's ventures into for-profit healthcare by governmental entities at both federal and state (provincial) levels. The salient points which have emerged are the following:

- the state is juggling multiple hats as (i) funder and provider of public sector healthcare (ii) as regulator, and (iii) as pre-eminent investor in for-profit healthcare, along with the inherent conflicts of interest
- public sector healthcare is woefully underfunded and is plagued by a chronic shortage and continuing outflow of senior experienced staff, thus affecting the quality of its care and its ability to restrain the escalation of charges in the private sector
- whether there is a *de facto* policy of benign neglect of the public sector is unclear, but a succession of health ministers have argued that those who can afford to should avail themselves of private

healthcare, so that the government can conserve its modest resources for the 'truly deserving poor'

- this seductive logic (of the targeted approach) will hasten the arrival of a two-tier healthcare system, deluxe priority care for the rich, and a rump, underfunded public sector for the rest
- the alternative scenario, a more progressive taxation regime to improve universal access to quality care on the basis of need, seems to be off the radar screen (hobbled in part by public skepticism over the unaccountable stewardship of public financial resources)
- the potential for regulatory conflicts of interest (regulatory capture, the 'revolving door') has not been addressed
- there is little evidence that the state is exercising its ownership prerogatives in commercial healthcare enterprises to pursue a balance of social vs. pecuniary objectives (e.g. cross subsidies, playing a price restraining role in the manner envisaged for the IJN) beyond cosmetic CSR initiatives

It has been argued that public ownership of commercial enterprises is quite compatible with superior economic efficiency as well as gains in consumer welfare (*Jomo & Tan, 2009*).

For this paper, I have examined the involvement of government-linked agencies in the commercial healthcare sector not so much from an efficiency perspective, but from a rights and equity perspective. The conclusion that emerges from this investigation is that public ownership of commercial healthcare assets in Malaysia may not work in favor of the equitable provision of healthcare on the basis of need. Indeed, it may undermine it.

In the post-2008 environment, as the opposing political coalitions in Malaysia approach parity in electoral strength, there are signs of a stepped-up pace of privatisation and divestment of publicly-owned corporate assets to well-connected private individuals and entities, in anticipation of fluid scenarios in the rotational exercise of governmental power at both federal and state levels¹⁹. This may have been a consideration in the aborted privatisation of the National Heart Institute shortly after the watershed elections of 2008. If this trend of divestment continues, we may see a publicly-owned commercial healthcare sector become increasingly privately-owned.

¹⁹ Economic Transformation Programme Annual Report 2012. *Reducing Government's Role in Business* (p.293-296). Putrajaya: Prime Minister's Dept; Khazanah, PNB to divest assets (*The Edge Financial Daily, February 10, 2012*) <http://www.theedgemaalaysia.com/highlights/200693-khazanah-pnb-to-divest-assets.html> (accessed February 3, 2014);

Table 2: Malaysian Health System (1999-2012)
Public & Private Providers

	1999		2012	
	Public	Private	Public	Private
Hospitals	128	225*	147	251*
Beds	37255	9498	42707	14165
Nurses	20914	6322	56089	28879
Midwives/Rural Nurses	6731	180	22917	301
Doctors	8723	6780	27478	11240
Dentists	803	1106	2664	1894
Pharmacists	401	1917	5908	3744

Note: * “private hospitals” include private hospitals, maternity centres, nursing homes, and hospices. For 2012, there were 209 registered private hospitals (of the 251 facilities).

Source: Ministry of Health, Malaysia (2006, 2013).

Table 3:



Total Health Expenditure by Source of Financing by Public and Private Sectors, 1997-2009

Year	Public	%	Private	%	Total
1997	4,540	56.4	3,504	43.6	8,044
1998	4,879	55.8	3,873	44.2	8,752
1999	5,424	55.9	4,288	44.1	9,712
2000	6,479	55.7	5,156	44.3	11,635
2001	7,669	58.2	5,513	41.8	13,182
2002	8,310	60.0	6,278	40.0	14,588
2003	10,856	59.0	7,543	41.0	18,399
2004	11,092	55.7	8,820	44.3	19,912
2005	10,227	50.8	9,904	49.2	20,131
2006	13,216	54.6	11,012	45.4	24,228
2007	14,098	53.4	12,291	46.6	26,389
2008	16,524	54.0	14,077	46.0	30,601
2009	18,401	54.6	15,291	45.4	33,692

Source: MNHA: Health Expenditure Report: Revised Time Series (1997-2008) & Health Expenditure Report (2009)



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