

Markets and Healthcare Services in Malaysia: Critical Issues

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Abstract: This paper examines the critical issues facing healthcare in Malaysia. It starts by reviewing the dominant arguments on ownership and healthcare provision, viz., neoclassical, evolutionary and heterodox and the politics of interest groups. Given the imperfections and asymmetries associated with healthcare, as well as its properties as a social good that should reach everyone, the paper adopts evolutionary and heterodox arguments, and the views of political scientists on civil society. It then explores out of pocket payment trends in the world. It is obvious that out of pocket payments have increased dramatically in the developing countries when government funding still dominates healthcare financing in most developed countries. Malaysia has experienced a rapid shift from welfare-oriented healthcare practices until the 1980s to privatization thereafter so that the private share of healthcare reached 55.6 per cent in 2007. A combination of falling resources and brain drain confronting public hospitals, with an expanding supply of private providers explains the increasing shift toward private healthcare in Malaysia. The paper finishes with calls for increasing government budget for healthcare, and using merit as the basis for promotion in public hospitals, and the strengthening and enforcement of healthcare legislations for all providers.

Keywords: government, healthcare, Malaysia, markets, social good, welfare

JEL classifications: I11, I18, I31, L3

1. Introduction

Economists have argued that when social returns exceed private returns, the use of non-market modes of allocation and coordination will be necessary to solve market failures (Arrow, 1962).¹ The specificity of healthcare as a service defined by demand-supply conditions that are imperfect and asymmetric on the one hand, and requires connectivity to all persons on the other hand makes the good a very special one (Arrow, 1963; Baumol, 1980, 1988; Weisbrod, 1988). The fundamental question to address, then, will be what policies governments

should adopt to ensure simultaneously that on the one hand, it is accessible to all, and on the other hand it is effective in delivering outcomes. Fundamental to such a question is the ownership issue confronting hospitals.

Three types of ownership distinguish hospitals in Malaysia, *viz.*, government public hospitals, privately owned hospitals, and non-profit private hospitals. Whereas government funded public hospitals and philanthropic non-profit private hospitals – driven by civil society organizations from various backgrounds – have had a long existence, despite their more recent past, private for profit hospitals have been growing the fastest in most developing countries. Consistent with the concept and spirit of development, public hospitals have been built and funded by Governments to carry out virtually all types of treatment either free or at subsidized rates so as to reach everyone irrespective of their class status (see Rachlis, 2007: 2). The philanthropic segment of private hospitals have not only been small, a number of them have increasingly started operating for profits as these hospitals try to compete in factor markets to retain doctors, nurses and technologists. Indeed, the highest shares of private healthcare expenditure in overall healthcare expenditure in 2006 were recorded by developing countries. Such trends beg the question of whether healthcare services reach the majority of populations in poor countries where significant segments of the people do not enjoy the monetary capacity to participate in private healthcare markets. It is also important to investigate the drivers of privatization of healthcare services. Of critical importance here is whether private hospitals are inherently superior in allocating and utilizing resources to meet the needs of the population than public hospitals, or are weaknesses in the delivery system of public hospitals driving the upper and middle class patients to private hospitals?

While healthcare privatization is continuing unabated, actors championing healthcare privatization perceive that the healthcare sector can be made more efficient and effective through the injection of better management and institutional flexibility. Though this objective is disguised by claims that privatization is driven by the urge to unleash the creative faculties of productive destruction to raise efficiency and quality of healthcare services for patients while relieving the government of scarce funds,² the dramatic proliferation of for profit hospitals in Malaysia far exceeding the pace recorded by developed countries has raised concerns. The privatization process has expanded without a concomitant growth in welfare instruments to ensure that the needs of the disadvantaged will not be compromised. The charges levied by most private hospitals are so exorbitant that those surviving just above the poverty line become debtors when faced with serious ailments requiring treatment that is either no longer available in cash-strapped public hospitals or because the specialists who could treat it have moved to lucrative private hospitals (see Heaney, 1995: 9; Jeyakumar, 2009).

Any attempt to screen ownership-based healthcare services of hospitals would require an assessment of the theories underpinning the different arguments and global privatization trends. Thus, this paper seeks to discuss the critical issues that ought to be examined in healthcare privatization using Malaysia as the anchor. The rest of the paper is organized as follows. The second section reviews critical theoretical arguments. Section three assesses healthcare privatization trends in the world. Section four discusses the drivers of healthcare privatization in Malaysia. Section five evaluates social options. Section six presents the conclusions.

2. Theoretical Considerations

Three broad theories have been dominant in explicating the provision and performance of healthcare provision, *viz.*, neoclassical, evolutionary and heterodox, the politics of dominant interest groups. The ascendancy of the role of markets can be traced to the decline of the welfare state in developed countries. Evolutionary and heterodox arguments remain significant in continental European countries where the welfare state has either become stronger as in Denmark, Sweden, Norway and Finland, or has survived the neoliberal onslaught as in France and Germany. Those using the politics of power argument share a number of things in common with the evolutionary and heterodox exponents, but emphasize the need to check the influence of concentrations of power in state decisions. Civil society is often viewed as the option to redress such asymmetries in society.

Neoclassical Arguments

Using marginal utility against marginal price, neoclassical economists argue that markets will be the most efficient allocator of economic goods and services, including healthcare. This has led neoclassical economists to claim that control of the economy by market forces with governments providing followship complementarities is the best way to ensure the most efficient service delivery and optimal responsiveness of production structures.³ Crowded hospitals, long waiting times and falling quality of service in public hospitals drove many to believe that governments should reduce their role in the provision of healthcare. Hence, the logic of the market and the private sector was embraced by the Reagan administration in the United States and the Thatcher government in the United Kingdom as they pushed aggressively to wind down the welfare state.

However, the market framework does not differentiate health as an essential good that faces substantial asymmetries where humans cannot make decisions on the basis of marginal costs and marginal utilities. The argument

here is that social goods like healthcare ought to be out of the realm of privatized goods because when such a good like healthcare is being privatized, it tends to screen people, particularly the poor from access primarily due to high treatment costs that surpass their affordability.

A social good like healthcare is demand inelastic, it is a necessity that no matter the cost, individuals in need of the services are left with no option but to either pay whatever may be required, or refrain and suffer the concomitant effects as a consequence of its unaffordability. It is apparent that healthcare delivery in Malaysia is highly lucrative following the increasing rise and proliferation of private for profit healthcare providers in contrast to a withering public healthcare sector. Signs of preponderance of private healthcare providers over public healthcare providers are currently widespread with poor patients caught in a critical dilemma. This underscores the conviction by many studies that healthcare privatization is a serious infringement on democratic governance, as patients are caught in a gridlock and thus, it predisposes them to comply with dictates of doctors and hospitals (see Schlesinger *et al.*, 1987; Weisbrod, 1988: 52, 1998: 26-27).

Evolutionary and Heterodox Arguments

Because healthcare is a uniquely different good as identified by Arrow (1963), Baumol (1980, 1988) and Weisbrod (1988) its production and distribution will have to be examined through a broader set of socio-political and economic lenses than normal economic goods such as cameras and cars. By and large evolutionary and heterodox economists embrace such logic. Evolutionary economists in addition also call for a scrutiny of the service taking account of its specificity. Because each sector is considered different – where the sources of learning and innovation, demand-supply structures, and target groups differ – evolutionary economists encourage the use of inductive research to map the drivers of growth and change in the healthcare sector. Also, although institutions are important, the manifestation of their influences on meso-organizations and the expectations of consumers over their roles will be different from those of normal economic goods.

The significance of institutions and through their influence, the operations of meso-organizations in the conduct and performance of economic agents has been well researched by industrial organizations (e.g. Scherer, 1983), evolutionary (Nelson and Winter, 1982; Freeman, 1987; Rasiah, 2004; Nelson, 2008) and new institutional (Coase, 1937; North, 1990; Williamson, 1973) economists. Industrial organization exponents carry the structure, conduct and performance (SCP) sequencing of causality in the operations of firms. Although the term structure in the accounts of industrial organization exponents often does not go beyond market structure (e.g. concentration,

distribution of firms, and demand and supply conditions) (see Scherer, 1983), it can be considered to embody the influence of institutions and meso-organizations. The new institutional economists address the role of institutions, including coordination modes in transactional allocations, but consider that markets are always the superior institution in achieving the most optimal outcomes (Coase, 1937; North, 1990; Williamson, 1973). Evolutionary economists share the same definitional coordinates on the term institutions, but believe that the choice and mix of important drivers of institutional change is conditioned by time and space with economic specificity (and in this case healthcare services) being the key determinants (see Nelson and Winter, 1982; Nelson, 2008). It is because of the openness of change that evolutionary economists often prefer inductive rather than deductive methodologies to capture the drivers (see Nelson, 1993; Malerba, 2005; Malerba *et al.*, 2008).

Because of the asymmetric and imperfect nature of demand-supply relations, as well as the unique properties of healthcare services that contain treatment and solutions for diseases and problems that must reach those in need of it, the role of non-market institutions and subsidies becomes far more important than markets where firm-driven allocations are often sufficient. The significance of non-market modes of coordination also justifies the use of the evolutionary framework to examine the provision of healthcare.

Interest Groups and Civil Society

Since the work of Polanyi (1957) and Miliband (1972), there has been recognition that powerful interest groups often capture the state to meet their own demands thereby denying the disadvantaged access to important social goods. The advocates of such state and market failures look to civil society as the only alternative to redress such a problem. Civil society is basically the unison of individuals and groups on the basis of trust, mutual agreement and cooperation, all in the quest to enshrine formed ideals against values and ideologies that inhibit social freedom and interests. It is strategically the ability of citizens to articulate and organize requests for good governance. It is composed of the totality of voluntary civic and social organizations and institutions that form the basis of a functioning society, as opposed to the force-backed structures of the state (regardless of that state's political system) and commercial institutions of the market (see Fukuyama, 1995; O'Connell, 1999; Edwards, 2004).

Civil society is usually understood as the social arena that exists between the state and the individual or household and thus, lacks the coercive or regulatory power of the state and economic power of the market, but provides the social power and influence of ordinary people to cushion or review a socio-economic and political terrain to one that best suits the interests of

society. In addition, civil society has the common core of meaning as the medium through which a social contract is negotiated, pressed for, debated with the centres of political and economic authority (Kaldor, 2003: 16-17).

From the preceding attributes, it is discernible that civil society tilts towards ensuring and protecting the interests of the common people, particularly those that are predisposed to unfair state and market treatment. It is the association or body that stands in between the state and market, identifying all issues and policies that do not serve the interests of society and hence, responds through either outright repudiation or selfless and voluntary service to cushion the effects that state and market pose to society, thus denoting social capital and counter hegemony.

Social capital as a concept had its roots in the ideas of an early classical theorist, Tocqueville (1862) who admits that without ideas held in common, no society can subsist as there will be no common action, and without common action, there may still be men, but there is no society. What this brings to light is that in order for society to exist and prosper, it is required that all minds of citizens be rallied and held together by predominant ideas, which is only feasible when each individual sometimes draws his opinions from the common source, and consents to accept certain matters of belief at the hands of the community. Tocqueville's (1862: 8) submission translates civil society as a self-conscious political society and a society which is not exclusively dependent on the state but an independent body of interests that identify the needs of society and take liberal and austere measures to realize these needs. Other scholars refined further the concept of social capital. For instance, Putnam (1995) sees it as connections among individuals, social networks and the norms of reciprocity and trustworthiness that arise from them. Fukuyama (1995: 38) demonstrated the real essence of social capital in strengthening the knot of relationships among people which ultimately paves way for solidarity that is indispensable for social co-existence.

Gramsci (1992) opposed hegemonic state apparatuses or political society supported by and supporting a specific economic group, coercing via its institutions of law, police, army and prisons to get society's consent to a policy. Counter hegemony is the panacea for state hegemony and this depends on intellectual activities that would produce, reproduce, and disseminate values and meanings attached to a conception of the world attentive to democratic principles and the dignity of mankind (see Holub and Gramsci, 1992: 5). This practically implies a society that stands up to authorities through social means, pressuring them to align policies with societal expectations. As such, civil society assumes the crucial role of defending people against the state and market, thus formulating democratic will that influences the state.

Civil society in healthcare refers to the participation of the common people, but particularly those either displaced or detached from power of

the state – who collectively seek to have their common needs registered in government healthcare policies. They are an integral part of the healthcare system and in democratic societies they strongly influence healthcare access and performance. Civil society participation in healthcare is premised on voluntary acts of healthcare services provision, finance contribution, care giving and assuming crucial roles in the development of policies that shape healthcare systems. These roles are two-sided – i.e. mounting pressure on authorities first, for state accountability and responsiveness to healthcare concerns and second, increased response to inputs from civil society. The manner in which the state responds to these changes and the extent to which civil society actors are recognized and included in health policies and programmes are some of the critical factors that determine the course of public policy (WHO, 2001).

Hence, the proliferation of private healthcare units is driven by both weaknesses of the public healthcare providers to effectively discharge healthcare services and profit driven motives of the private healthcare providers. The consequences of these forces for healthcare development include a dramatic jump in brain drain from public to private hospitals, growing scarcity of specialists to treat the poor and rising treatment costs. Since the state and market are the protagonists to all these trends, civil society groups have become the last resort in a number of countries. However, the role of civil societies is often conditioned by the political space allowed by governments, and hence, even the most conscientious civil society organizations may not be able to advance the redressing of disparities in the provision of healthcare services.

3. Privatization Trends

Apart from small clinics and a limited number of philanthropic hospitals, large healthcare providers were started traditionally by governments in most parts of the world. Large scale hospitals targeting for profit objectives were promoted by the developed countries by those who felt that private ownership will be the most efficient and effective in meeting demand supply conditions. The welfare state that grew after the Second World War (1939-45) on the back of rapid growth and structural change began to disintegrate as a slowdown set in towards the end of the 1960s giving rise to increasing unemployment, and in the early 1970s, also high inflation (Kaldor, 1985; Pierson, 1994). Stagflation – stagnation and inflation – reduced the role of Keynesian economics and gave rise to increasing influence of neoclassical economics in the leadership of the United States and the United Kingdom (Friedman and Friedman, 1980).

Falling interest in Keynesian economics and the rise of neoclassical economics saw leaders *viz.*, Ronald Reagan of the United States and Margaret

Thatcher of the United Kingdom aggressively shaving away government spending on welfare.⁴ However, some continental European countries – e.g. Denmark, Finland, France, Norway, Sweden and Germany – continued to pursue strong welfare principles and thus, continued to target a significant share of their budget to meet welfare-oriented activities such as education and health. Also, despite the contraction of welfare-oriented spending, healthcare financing in countries such as the United Kingdom and Australia remained high. Public pressure has largely been instrumental in holding back any aggressive attempt to privatize healthcare provision in the United Kingdom.

Although healthcare privatization arguments and plans evolved in developed countries as governments targeted all welfare programmes to reduce government expenditure since the late 1970s, it has gained the most currency in the developing countries. It is difficult to establish private ownership of healthcare in the developing countries because of a variety of reasons. Out of pocket payments are available, but some of these payments are actually claimed later from employers that include the government. Also, a number of services in government hospitals are privatized – e.g. cleaning, medicine and food.

Data on the private share of overall healthcare expenditure is provided by the World Health Organization (WHO). We assume in the paper that the data supplied by the WHO is a sufficiently rigorous estimate of ownership. Despite a slight decline in some countries, the private share in overall healthcare expenditure is highest among developing countries (see Table 1). This is the case even with the changing communist regimes of Cambodia, China, Laos and Vietnam, and democratic India. In other words, private healthcare has expanded far more in the transitional economies than in the developed countries. Government support for healthcare in Denmark, Finland, Norway, Sweden and United Kingdom has remained high over the period 2000-2007. The United States' share of 54.5 per cent was still lower than the 55.6 per cent of Malaysia in 2007. Government funding of healthcare was even much less in Bangladesh, Cambodia, China, India, Myanmar, Pakistan, Philippines and Vietnam than in the United States. Putting it bluntly, less developed economies are relying more on profit-driven private operators than on public operators.

The evidence shown in the table dispels the logic that the more developed countries are, the higher will be the role of markets in driving the provision of healthcare as government spending still accounted for over half of the healthcare expenditure in most developed countries. As can be seen, developed countries generally show the smallest share of out of pocket payments. The fact that even democratic and transitional countries that have wide segments of poor people such as India, China, Cambodia, Laos and Vietnam show high out of pocket payment share in healthcare expenditure, suggests that markets

Table 1: Private Share of Healthcare Expenditure, 2000-2007 Periodically (%)

	2000	2004	2007
Australia	33.2	32.5	32.5
Bangladesh	62.0	71.9	66.4
Cambodia	77.5	74.2	71.0
China	61.3	62.0	65.3
Denmark	17.6	17.7	15.5
France	20.6	21.6	21.0
India	75.5	82.7	73.8
Indonesia	63.4	65.8	45.5
Italy	27.5	24.9	23.5
Japan	18.7	18.7	18.7
Laos	67.5	79.5	81.1
Malaysia	45.7	41.2	55.6
Mongolia	19.3	33.4	18.3
Myanmar	86.6	87.1	88.3
Pakistan	78.7	80.4	70.0
Papua New Guinea	18.3	15.7	18.6
Philippines	52.4	60.2	65.3
Republic of Korea	55.1	47.4	45.1
Russia	40.1	38.7	35.8
Singapore	63.8	66.0	67.4
Sri Lanka	52.1	54.4	52.5
Sweden	15.1	15.1	18.3
Thailand	43.9	35.3	26.8
Timor-Leste	29.1	21.1	15.4
United Kingdom	20.7	13.7	18.3
United States	56.8	55.3	54.5
Vietnam	69.9	72.9	60.7

Source: Compiled from WHO (2006, 2008, 2010).

appear to be more operational in the poorer countries because of systemic failure of healthcare systems. We examine the drivers in greater detail using Malaysia as a case in point in the next section.

4. Drivers of Healthcare Privatization in Malaysia

The development of healthcare services in Malaysia can be divided into two regimes: the first focused on meeting social objectives of the entire population and the second on meeting allocational and profit-seeking motives. The nascent state after independence focused on healthcare as a public service that should reach the broad masses in the country. From a social-oriented approach but focused on the main urban locations and where British commercial interests were spread in the 1950s and 1960s (for example, dispensaries in plantations), the government embarked on extending these services to people living in rural areas and states classified as underdeveloped by the government especially from 1971 following the launching of the New Economic Policy (NEP). Private providers existed but without any significant participation in the overall provision of healthcare services in the country. However, aggressive efforts to change the economic power structure of the country from the late 1970s, but particularly from the early 1980s, led to healthcare becoming a major platform for profit seeking. Interestingly, the poverty alleviation prong of the NEP that was launched in 1971 appeared to fade in significance from the early 1980s. Corporate restructuring targeted at creating an ethnic Malay or Bumiputera bourgeoisie enjoyed greater policy emphasis from the 1980s.

Public Focus

Healthcare services evolved originally with highly welfarist orientation in Malaysia until the 1970s. With the exception of a handful, the major hospitals in the country were operated by the government. While the state and district hospitals were constructed in urban locations, the government built smaller hospitals and dispensaries in rural locations to spread healthcare services to as many people as possible. In accordance with the Fees Act of 1951, the government established an effective public healthcare system that helped raise healthcare standards while keeping charges low.

The early Malaysia Plans recognized that the improvement of the population's health is integral to socio-economic development and raising economic productivity while maintaining equity. The initial NEP period of 1971-1981 witnessed extensive public expenditure targeted at expanding the provision of healthcare to rural areas and poor states. Ethnic restructuring initiatives were among the drivers in the government's provision of healthcare

services for rural areas in which Bumiputeras constituted the majority of the population (Malaysia, 1971). Strong focus on public provision ensured that healthcare spending as a share of GDP expenditure in Malaysia hovered around 5.6-6.5 per cent in the period 1971-1981 (Malaysia, 1986).

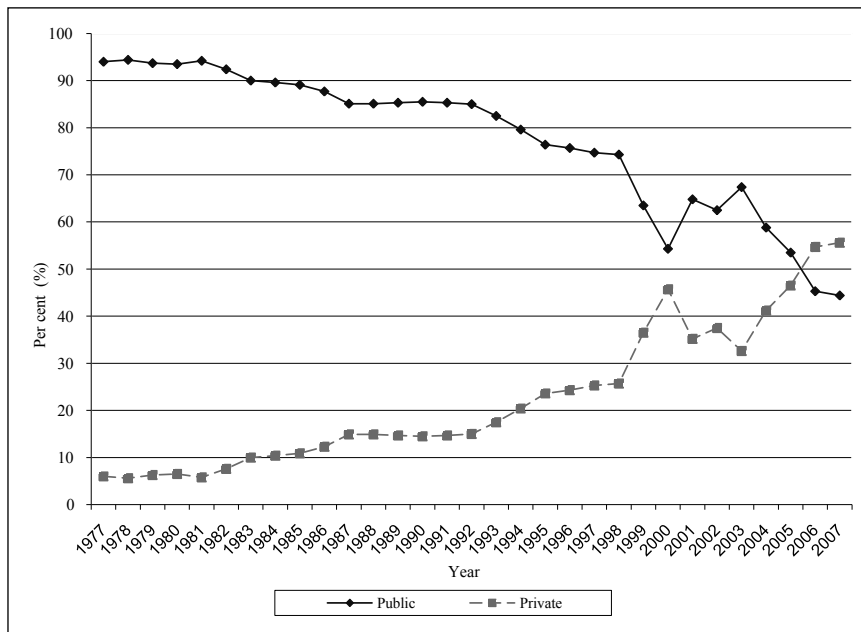
Early Privatization

The share of private ownership in overall healthcare expenditure began to rise from 1982, increasing from 5.8 per cent in 1981 to 7.6 per cent in 1982 and rising fairly rapidly from then on to reach 30.6 per cent in 2004 (see Figure 1). Policy focus by then had shifted towards expanding the private sector, including in the provision of public utilities such as power, water and healthcare (Rasiah and Ishak, 2001). The government's share of overall healthcare financing fell from 1982 as state development corporations and other government-linked conglomerates started acquiring private hospitals in the country. Although the nominal operating expenditure of the Ministry of Health increased from RM0.8 billion in 1980 to 2.5 billion in 1996 and 6.4 billion in 2004,⁵ the annual average government expenditure on healthcare in constant 1990 prices grew at 11.9 per cent in the period 1977-82 whereas it only grew at 5.4 per cent per annum over the period 1983-2004.⁶ The commensurate annual average growth rates in private healthcare expenditure were 17.6 per cent and 14.2 per cent respectively in the two periods. The launching of the Privatization Master Plan (PMP) in 1991 after it was drafted in 1988 (Malaysia, 2001: 183-201) formally included healthcare for private ownership. Twelve public hospitals were among 149 agencies identified for privatization in Peninsular Malaysia. The *Mid-Term Review of the Sixth Malaysia Plan* published in 1993 indicated that:

While the government will remain a provider of basic health services, the role of the Ministry of Health will gradually shift towards more policy-making and regulatory aspects as well as setting standards to ensure quality, affordability and appropriateness of care (Malaysia, 1993: 244).

Serious problems faced by public hospitals accentuated the privatization process. The appointment of management and hiring of staff without a significant criterion of merit, as well as the slowing down of wage rise affected staff morale. Disgruntled professionals and semi-professionals began to leave public to enjoy higher salaries and working conditions in the private hospitals. The slashing of the share of healthcare expenditure in the government's budget further undermined the quality of services provided by public hospitals. Hence, despite treating the bulk of patients in the country, public healthcare expenditure began to contract gradually as the private share began to rise (see Figure 1). Whereas until the 1970s a small group of people

Figure 1: Public and Private Healthcare Expenditures, Malaysia, 1977-2007



Source: Compiled from Ministry of Health Data.

seeking quick service or privacy, or those preferring particular treatment offered by philanthropic hospitals accounted for a small share of healthcare services, demand for private healthcare began to enjoy massive support of the middle class and even the poor as the state of the art equipment and more experienced doctors began to move to private hospitals.

Hence, a combination of deteriorating quality standards of public hospitals and powerful interest groups operating within and outside government drove the expansion of private hospitals in Malaysia. Indeed, quasi-government forays led by these interests were behind the participation of Kumpulan Perubatan Healthcare Johor (KPJ), a subsidiary of the Johor State Economic Development Corporation, which started operations in 1981 (see Chee and Barraclough, 2007). KPJ was listed in the Kuala Lumpur Stock Exchange (KLSE) in 1994 and in 2005 had 17 private specialist hospitals located in major towns in Malaysia. Another group active in the private healthcare market is Sime Darby Medical Centre, which set up the Subang Medical Centre (SMC) in 1985. SMC had a bed capacity of 375 and facilities to treat on average 1,500 outpatients annually in 2005.

With the aggressive promotion of private healthcare by the government, smaller private operatives too began to mushroom – for example, the

Kumpulan Mediiman, a healthcare group division of Terengganu Darul Iman Medical group of companies, owned by Terengganu State Economic Development Corporation (Rosnah, 2007). This group is also behind the setting up of the Kuantan Medical Centre and Kelana Jaya Medical Centre (Rosnah, 2007: 98). While some non-profit private healthcare operators have continued to treat the disadvantaged, others such as Lam Wah Yee reregistered their status from the late 1980s to pursue profits.⁷

Even the Fees (Medical) Order 1982 of the Fees Act of 1951 providing medicines and treatment to all Malaysians for free or at a nominal price, was amended and replaced allowing a government firm to register as a private establishment to sell drugs.⁸ Treatment and medical prescriptions in government hospitals increasingly required payments through insurance or private treatment schemes. Although subsidies were stated for Malaysians who could not afford private insurance or whose employers are unable to cover the costs, preferential treatment given to private payees often left disadvantaged Malaysians waiting in long queues.

Increased Privatization

The formalization of privatization quickened the proliferation of profit-based private hospitals from the 1990s. Parkway Holdings expanded throughout Malaysia from the 1990s. Pantai Holdings has since the 1990s become one of the biggest healthcare providers in Malaysia, with attempts in 2010 to own around 51 per cent of shares in the Pantai Hospitals chain. Khazanah already has significant ownership rights in India's Apollo Hospital chain. Listed at the KLSE in 1997, it operated seven hospitals with a capacity of 1,000 beds in 2005. With its recent acquisition by the Malaysian government investment vehicle Khazanah Nasional, the healthcare provider has embarked on further expansion of its participation in healthcare provision. Khazanah Nasional also acquired majority control of the International Medical University in 2006.

Changes in government policy helped further the expansion of private healthcare providers. For example, enjoying control over the largest forced savings institution, i.e. the Employees' Provident Fund, the government instituted reforms in 1994 to allow contributors to draw up to 10 per cent of their balances for medical treatment. Further steps taken by the Ministry of Health to privatize healthcare included the outsourcing of a range of services in public hospitals. For example general medical stores and laboratories were privatized, followed by laundry, cleaning, management of clinical wastes and biomedical engineering.

From the mid-1990s the Malaysian government also encouraged the corporate sector and philanthropic bodies⁹ to venture into certain healthcare services by providing RM308 million in 1998 to a "social action plan" and

distributed RM98 million to 51 welfare institutions under its “caring society” policy. In addition, new taxation policies were introduced granting individuals tax relief on contributions of up to RM20,000 made to approved health-related welfare and community projects. The government laid out further in its Seventh Malaysia Plan (1996-2000) corporatization plans to further privatize several aspects of governance in public hospitals (Malaysia, 1996) supposedly to increase the efficiency of services, retain qualified and experienced human capital while switching gradually its role from the provision of healthcare services to regulatory and enforcement functions. Because the expenditures of public hospitals on privatized services are captured in the government share of expenditures, the actual private share of overall healthcare expenditure is higher than the share as compiled by the government. The promotion of healthcare as a major tourist attraction expanded further markets for private providers in the 1990s. Subang Medical Centre is increasingly targeting rich tourists who contributed RM0.9 Billion of revenue in Malaysia in 2005, an amount expected to rise to RM2 billion by 2010 (Malaysia, 2006). In fact, medical tourism has become an important business in Asia since the 1990s and has seen aggressive expansion. Under the Ninth Malaysia Plan, the government has targeted more private sector initiatives to promote Malaysia as a healthcare hub for both traditional and modern medical treatment (Malaysia, 2006). The consequences of these developments are likely to include a further outflow of doctors, laboratory technologists and nurses from public to private healthcare establishments. The private healthcare providers enjoyed 45 per cent of the doctors, 22 per cent of the beds, 26 per cent of the admissions and 54 per cent of the overall expenditure when the commensurate figures for public healthcare providers were 55 per cent, 78 per cent, 74 per cent and 46 per cent respectively (Malaysia, 2010: 271). Hence, the demand-supply deficits in healthcare human capital resources in rural regions and the poor states in Malaysia is expected to be further aggravated (see Krishna, 2003; Jeyakumar, 2009). Private hospitals do not reveal numbers of negligent cases, but according to the Medical Protection Society of Malaysia (a society that offers legal support and advice involving clinical negligent cases among others, to private medical practitioners) it is seeing the highest number of negligent cases in areas of obstetrics and gynecology. It may not be overly presumptuous to postulate that there are negligent cases in other areas as well in the private sector.¹⁰ Besides negligent cases, private healthcare operators have also been accused of being overly concerned with profits at the expense of medical care. For example, Malaysia’s Minister of Health reprimanded private healthcare providers in 2007 for charging excessively and conducting unnecessary medical tests and consultations, saying that the “rates are going up by the day and are profit-driven” (*New Straits Times*, 10 December 2007). In fact, the Health Ministry’s enforcement team nabbed 19 bogus doctors and

closed 29 private clinics for various offences in 2007. Concerned with the increasing numbers of negligent cases, the President of the Malaysian Medical Association raised ethical issues regarding private medical practitioners saying that duty should come before profit. He was reacting to public concerns that private healthcare practitioners would not conduct the necessary tests if they were not covered by insurance, underlining yet again that the private healthcare sector is overly driven by profits.¹¹

5. Conclusions and Policy Implications

In light of the arguments and evidence amassed above, it is important that we accept that resources and the quality of service provided by public hospitals in Malaysia must be improved. While private operators should continue to be allowed, healthcare must be treated as a social good and hence, must be reflected in all policy measures. Unless welfare instruments such as government supported health insurance schemes for government employees are targeted at the disadvantaged, and there are robust legislation and enforcement of procedures to bind private practice to socially acceptable standards, the Singapore and Netherlands framework of expanding private healthcare expenditure may not be very helpful for Malaysia. Since there are no welfare support programmes in Malaysia resembling those in Singapore and the Netherlands, the alternatives we are suggesting are targeted towards strengthening existing mechanisms.

The arguments obviously call for Government funding of healthcare in Malaysia to be raised to around 10 per cent of overall government expenditure so that public hospitals will enjoy enough resources to provide service comparable to developed countries.¹² These resources should be targeted at raising remuneration of personnel, more medical equipment, greater access to pharmaceutical drugs and materials, as well as quality building support. In addition, the government should introduce and implement merit-based promotion personnel policies in public hospitals. The Tenth Malaysia Plan aims to do that, but it is critical that it is actually implemented (Malaysia, 2010). There must be stronger legislation and enforcement of good social codes of conduct binding healthcare providers to respect patient rights. Private healthcare providers should also be subjected to stringent healthcare standards.

To effect the changes required it is essential to re-orientate healthcare provision in Malaysia to take account of the service as a social good that should reach everyone, and policy making should bring together stakeholders from the different segments of the country's population.¹³ In addition to the government and the private healthcare sectors, it is also critical that civil society champions the voices of the disadvantaged for them to have enough space to be heard.

Notes

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1. This market failure argument is different from the new institutional cost logic advanced by Coase (1937) and Williamson (1973). The latter considers markets as the superior coordination mode that defines the space for other modes in circumstances when the transactions costs can be lowered through use of other coordination modes.
 2. Political economists strongly contend that privatization is a premeditated strategy by a cabal of powerful interest groups to appropriate profits and consolidate their grip on the most vital sectors of the economy (see Rasiah *et al.*, 2009).
 3. Neoclassical economists strongly reject government interference of any sort in the economy, but support their role solely as providers of basic infrastructural facilities. Government involvement is often seen distorting and contagious to growth of economic systems (see Friedman, 1986).
 4. Despite serious efforts to cut down welfare expenditure government spending continued to soar in the United States as Reagan expanded the military budget.
 5. Obtained from data used in Figure 1.
 6. Computed from data used in Figure 1 and using GDP deflators.
 7. Authors interviews in 2007.
 8. The cost of outpatient treatment in Ministry of Health hospitals was set at RM1, while a specialist consultation cost RM5. Ward charges ranged from RM80 in a single air-conditioned room to just RM3 in a third-class shared ward.
 9. In 1995, the Ministry of Health established a register of social and non-government organizations which were willing to volunteer their services to government hospitals and for home nursing support.
 10. Some other cases involved the use of intravenous needle filled with antibiotics that was wrongly inserted to the muscle instead of the blood vessel. It might also be added that the high rate of negligent cases recorded in the public as well as the private sector could be attributed to a well informed public as well as the availability of channels to lodge medical complaints (see *New Straits Times*, 12 November 2007).
 11. These cases of profiteering and malpractices were reported in rapid succession, underlying problems of exorbitant charges and at the same time a private healthcare sector that is driven by medical insurance rather than patient's needs (see *New Straits Times*, 4 and 5 December 2007).

12. Shortfalls in government funding are actually implied in the Tenth Malaysia Plan when comparisons are made of costs across countries (Malaysia, 2010: 270).
13. See Jomo and Chowdhury (2009), Rasiah (2009) and Aulich (2010) for a lucid account of the role of public private partnerships in shaping society-based development.

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