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**RE-THINKING THE STATE AND HEALTH CARE IN
PENANG**

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ABSTRACT

RE-THINKING THE STATE AND HEALTH CARE IN PENANG¹

The Federal Constitution of Malaysia decrees that with the notable exceptions of land matters and matters pertaining to the Islamic religion, all other areas which are subject to governmental jurisdiction fall under the federal purview. Notwithstanding this, the Johor state government operates through its corporate arm, the Johor Corporation, a diversified healthcare conglomerate which includes the largest chain of private hospitals distributed throughout the country (Kumpulan Perubatan Johor), a veritable mini-Ministry of Health but operated along largely commercial lines. Should the Penang state government explore the feasibility of a non-profit, publicly-owned version of the Kumpulan Perubatan Johor? A modest chain of state-owned (and operated?) medium-sized hospitals which could provide medium-cost healthcare and at the same time serve as a price bulwark against even steeper price increases in the for-profit private sector? Hospitals aside, what are other potential interventions that the state government could consider, to improve population health in Penang within the existing (and foreseeable) political, economic and jurisdictional contingencies? Improved urban management of the (social) ecology of dengue propagation and transmission?

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1. MALAYSIA: A FEDERAL-UNITARY STATE?

Malaysia as a polity exhibits a very highly centralised federal structure which in practice makes it more like a unitary state.² The Federal Constitution decrees that with the notable exceptions of land matters and matters pertaining to Islam, all other areas which are subject to governmental jurisdiction fall under the federal purview.³

In particular, state governments are not empowered to directly collect income taxes and corporate taxes, nor export, import and excise duties, and they are also largely restricted from borrowing internationally. They have to depend on revenues from forests, lands, territorial waters, mines, petroleum and gas royalties, the entertainment industry, and most importantly, transfer payments from the central government. Along with this centralised financial control, the federal government has authority over external affairs, defence, internal security, justice (except civil law cases among Malays or other Muslims and other indigenous peoples which are adjudicated under Islamic and traditional law), federal citizenship, commerce, industry, labour matters, communications, transportation, health, education and other matters.

Such being the case, it is commonly held that state governments in Malaysia have such limited jurisdiction and responsibilities (and in most cases, such limited independent sources of revenue)⁴ that Dr Toh Kin Woon (Penang state executive councillor, 1995-2008) has often remarked that “you could shut down the Penang state government and not many people would notice it”.

Indeed, the recent trend in the federal-state balance of jurisdiction has been towards greater federalisation rather than devolution, as indicated by instances such as:

- municipal clinics being absorbed into the Ministry of Health
- nationalisation of petroleum and gas resources, and assertion of federal discretionary powers over the royalties due to state governments (*Terengganu’s “wang ehsan”*)⁵

² Conversely, one could argue that Malaysia in 2009 has a surfeit (multiplicity) of state governments. Not as dramatic as in the case of the state of Perak where a constitutional crisis continues to simmer as rival claimants to governmental power pursue their options through legal and political channels, Penang is “blessed” with an unelected parallel “shadow government” which unashamedly receives federal allocations (e.g., for tourism development) which should properly be channeled to the legitimately constituted state government elected in March 2008. A federal allocation of RM25 million for instance, promised to Penang after its listing as a Unesco World Heritage Site in 2008, has been diverted to Khazanah Nasional Berhad instead. (*The Star, 20 September 2009*).

³ Sabah (North Borneo at the time), upon attaining self-government as part of the decolonization process, negotiated a 20-point agreement as a basis for its entry into what would be the Federation of Malaysia on September 16, 1963. An analogous 18-point agreement provided the basis for Sarawak’s concurrent entry into the federation. Both agreements allowed for considerable autonomy for the two territories in the areas of immigration, the civil service, education, and development and finance, but this autonomy has been eroded over the years.

⁴ The annual operating budget of Universiti Sains Malaysia for instance was double that of the Penang state government in 2008.

⁵ Terengganu was ruled by PAS from 1999-2004 when the federal government controversially re-designated Terengganu’s oil and gas royalties as “*wang ehsan*” (“goodwill money”) subject to federal discretion and control.

- erosion of the state autonomy agreed to as part of the terms of accession of Sabah and Sarawak into the Federation of Malaysia
- sewage disposal services, traditionally a function of local authorities, which went through a process of centralisation, privatisation, nationalisation over the period 1996-2004, after a failed attempt at centralisation-cum-privatisation by Indah Water Konsortium (IWK)⁶
- the National Water Council proposing to rebalance the jurisdiction over water management away from the states, as one response towards mismanagement by some state water authorities and their privatised counterparts.

2. THE JOHOR CORPORATION AND KUMPULAN PERUBATAN JOHOR

Against this backdrop, we nonetheless have the striking instance of the Johor state government which operates through its corporate arm, the Johor Corporation, a diversified healthcare conglomerate which includes the largest chain of private hospitals distributed throughout the country (*Kumpulan Perubatan Johor, KPJ*), a veritable mini-Ministry of Health but operated along largely commercial lines.⁷

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, KPJ Healthcare Berhad grew into the largest chain of private hospitals in Malaysia (nineteen hospitals wholly or partially owned or managed by KPJ, with another six in Indonesia, Bangladesh, and the Middle East), and along the way was listed on the main board of the Kuala Lumpur Stock Exchange on 29 November 1994. With paid-up capital of RM 191 million and assets of RM1,021 million (plus shareholders' funds in excess of RM430 million), KPJ has expanded into a publicly-listed health conglomerate which offers not just medical and specialist inpatient care, but a diversified portfolio of services including hospital management, hospital development and commissioning, nursing training, health sciences and continuing education for healthcare professionals, pathology and other technical services, central procurement and retailing of pharmaceutical products.

Meanwhile, at the federal level, Khazanah Nasional Berhad, the investment holding arm of the Government of Malaysia, acquired on 28 August 2006 a 30.68 percent controlling share of Pantai Holdings Berhad⁸, the largest healthcare conglomerate in Malaysia with interests in private hospitals (8 in number, 1,086 beds and 368 physicians - the second

Meanwhile, the PAS-led state government in Kelantan is currently pressing its claims for RM1 billion in royalties from oil production 150km off the coast of Kelantan, which began in 2004.

⁶ IWK took over the sewerage services from all local authorities in Malaysia except for those in Kelantan, Sabah, Sarawak and the Majlis Perbandaran Johor Bahru.

⁷ C. K. Chan, "Re-inventing the Welfarist State? The Malaysian Health System in Transition", *Journal of Contemporary Asia* (in press, 2010).

⁸ Khazanah Nasional Berhad media statement, 28 August 2006

largest private hospital chain in Malaysia), clinical waste management, cleaning and maintenance services for government hospitals in the southern states of Negri Sembilan, Malacca and Johor (Tongkah Medivest), management, administration and consultancy services for hospitals and medical centres, medical diagnostic services (medical laboratory services, imaging, etc), radiotherapy services, educational and training programs in healthcare and related fields, managed care, geriatric, rehabilitation and convalescent care, supervision of medical screening and registration of foreign workers in Malaysia (Fomema), telemedicine services, cardiac catheterization services, and lithotripter services.⁹

In April 2001, chief executive officer of Pantai Holdings Bhd. Mokhzani Mahathir, a son of the serving Prime Minister at the time (Dr Mahathir Mohammad), disposed of his 32.9 percent stake to Lim Tong Yong who succeeded him as CEO. 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, which became Southeast Asia's largest private healthcare provider, also has controlling stakes in three hospitals in Singapore (East Shore Hospital, Gleneagles Hospital, and Mount Elizabeth Hospital), two in Malaysia (Gleneagles Medical Centre, Penang, and Gleneagles Intan Medical Centre, Kuala Lumpur) and a cardiac centre in Brunei besides operating a hospital in Kolkata in joint venture with Apollo Hospitals Enterprise Ltd.¹⁰ 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.,¹¹ a US-based fund manager which had acquired a 26 percent stake in Parkway on 26 May 2005.¹²

It was this acquisition by the Singapore-listed company (in turn, controlled by a US-based fund manager) which set off alarm bells and provided the political opposition in Malaysia with an opportunity to castigate the Malaysian authorities for their regulatory and strategic oversight.¹³ Amidst the red faces and embarrassment of allowing the largest health care conglomerate in the country (a beneficiary of major outsourcing concessions for government hospital support services and foreign worker medical registration, not to mention the second largest private hospital chain in the country) to slip into foreign hands, a compromise was eventually struck which entailed Khazanah's intervention to acquire a 51 percent stake in Pantai Irama Ventures Sdn Bhd, with the remaining 49 percent going to Parkway in a reshuffling of corporate equity which would see Pantai Irama holding a 35 percent controlling stake of Pantai Holdings Bhd. Aside from a lucrative margin accruing to

⁹ Pantai Holdings Berhad (Company No. 11832-K, incorporated in Malaysia) and its Subsidiary Companies: Financial statements for the year ended June 30, 2003. Kuala Lumpur Stock Exchange annual audited accounts, 2003. In April 2001, two and a half years before Dr Mahathir stepped down as Prime Minister, Mokhzani Mahathir disposed of his entire stakes in *Tongkah* and *Pantai*. Mirzan Mahathir, another son of Prime Minister Mahathir Mohamad, had a 25.8% stake in the Lion Group, another conglomerate which operated the Mahkota Medical Center in Malacca state. The Lion Group also has plans to build hospitals in Kuala Lumpur, Ipoh and Seremban, and eventually, possibly in China.

¹⁰ The 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.

¹¹ Established in 1994 by Texas Pacific Group and Blum Capital Partners.

¹² *Business Week*, 13 June, 2005.

¹³ "Gov't concedes mistake, says Husam", *Malaysiakini.com* (accessed on 30 August 2006).

Parkway from the share swaps, operational and management control of the hospitals would remain with Parkway for fifteen years.¹⁴

This may have been an unplanned purchase and contingency forced upon the Malaysian government (as far as timing), but Khazanah has nonetheless emerged in the last four years as a major shareholder in private health enterprises in Malaysia, allegedly with strategic and synergistic considerations in mind, but possibly also preferential support for government-linked companies benefiting from major outsourcing concessions. At the present time, Khazanah has interests in Fomema, Pantai Holdings Bhd., Pharmaniaga (fifteen year concession for supplying pharmaceuticals and medical disposables to government hospitals and health facilities), a 13.2 percent stake in Apollo Hospitals Enterprise Ltd (India),¹⁵ as well as a recently-acquired 67.5 percent stake in the International Medical University (IMU), Malaysia's first private medical university.¹⁶ On April 30, 2008, the Pantai-Parkway saga came full circle when Khazanah announced that it had paid RM1.23 billion for an additional 16.41 percent stake in Parkway,¹⁷ thereby raising its total stake in Parkway to 20.79 percent.

Indeed, it appears that the Malaysian government in concert with GLCs (government-linked companies) at both federal and state levels in effect owns and operates three parallel systems of healthcare providers:

- 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 Pantai chain of hospitals, operated as commercial hospitals with Khazanah as a controlling shareholder, similarly with the Kumpulan Perubatan Johor (KPJ) chain of hospitals, controlled by the Johor state government through its corporate arm, the Johor Corporation.

¹⁴ Khazanah Nasional Berhad media statement, 28 August 2006, *Malaysiakini.com* (30 August 2006).

¹⁵ Khazanah Nasional Berhad media statement, 3 August 2005.

¹⁶ Khazanah Nasional Berhad media statement, 30 November 2006. Founded by a team of academicians in 1992, IMU today has an enrolment of over 1,800 students in medicine, pharmacy, nursing, and postgraduate programs in medical sciences and community health, in partnership with 25 medical schools in Australia, Canada, Ireland, New Zealand, United Kingdom and United States of America.

¹⁷ Khazanah Nasional Berhad media statement, 30 April 2008.

Are the KPJ and Pantai hospitals *public* or *private*? Is this a “nationalization” of private enterprise space, or an extension of the logic of capital into strategic adjuncts of the state? What contending interests and policy conflicts are being engendered, exacerbated, or attenuated by these developments?¹⁸ What balance between social vs. economic (profit maximising) objectives is desirable on the part of public owners?

It is worth emphasizing that even if the profits and returns accruing to the KPJ and Pantai hospitals are redistributed via cross-subsidies to poorer patients (not much evidence of this), or through corporate taxes and more diffuse channels of the Johor Corporation (Amanah Saham Johor?) and Khazanah (the various Amanah Saham schemes?), there are still concerns arising from the well-known market failures of private health care markets which introduce distortions and inefficiencies (not to mention inequities) into the healthcare subsector as a whole.

3. AN EFFICIENT MARKET IN HEALTHCARE?

The arguments in favour of healthcare privatization rest on the allocative efficiency of the market. Remarkably, this persists despite repeated market failures and the fact that important pre-requisites for efficient markets are often not met for the microeconomics of health care:

- the health care consumer is often disadvantaged relative to the healthcare provider (*information asymmetry*),¹⁹ further compounded by imperfect information and uncertainty (*stochastic occurrences, treatment efficacy*) in healthcare markets²⁰
- there is often no alternative provider in sparsely populated areas²¹
- low patient volume (in small or medium-sized facilities) can lead to degraded skills of medical specialists and poorer patient outcomes (*medical equivalent of economies of scale*)²²

¹⁸ The Malaysian health ministry’s hospitals as well as the teaching hospitals of medical schools are plagued with a perennial outflow of senior experienced staff to the private sector as well as to foreign emigration, due to push and pull factors. This chronic understaffing in the public sector, which has compelled the Health Ministry to resort to foreign hires, will undoubtedly be worsened by stepped-up efforts to develop the medical tourism subsector, and by continued poaching of public sector staff trained at public expense. On the other hand, the emergence of private hospital chains may allow for some degree of rationalization in the acquisition and use of expensive medical equipment. In the early 1990s for instance, there were reportedly more MRI scanners in the Klang Valley area (metropolitan KL) than in all of Australia.

¹⁹ U. E. Reinhardt, “Can efficiency in health care be left to the market?”, *Journal of Health Politics, Policy and Law* 26 (5) (2001), pp. 967-992.

²⁰ K. J. Arrow, “Uncertainty and the welfare economics of medical care”, *American Economic Review*, vol. 53, no.5 (1963), pp. 941-73.

²¹ See for example, K. J. Khoo, “Health Care in Sarawak: Model of a Public System”, *Health Care in Malaysia: The Dynamics of Provision, Financing, and Access*, edited by H. L. Chee & S. Barraclough (London: Routledge, 2007).

²² See for example, E. L. Hannan, M. Racz, T. J. Ryan, et al., “Coronary angioplasty volume-outcome relationships for hospitals and cardiologists”, *The Journal of the American Medical Association*, vol. 277 (1997), pp. 892-898.

- wasteful or inappropriate use of resources (*over-treatment and under-treatment*),²³ depending on the payment incentives in healthcare financing
- reduced access for poor patients (*more an issue of equity*)²⁴

Beyond theoretical considerations, the peer reviewed literature also reports many instances where profit-driven healthcare empirically falls short in comparison with not-for-profit healthcare, across a range of outcome measures.²⁵ Public sector healthcare of course is not without problems and may not always outperform the private sector, but the reverse is demonstrably false, and to continue dismantling the public healthcare sector out of an obsessive faith that market-based solutions will invariably deliver higher efficiency and lower unit costs, is clearly unwarranted.

4. PUBLIC-PRIVATE INTERACTIONS: IJN AS PRICE BULWARK

When the *Institut Jantung Negara* (IJN, National Heart Institute) was hived off from the Kuala Lumpur Hospital in 1992 and corporatized as a government-owned referral heart centre, one of its explicit missions was to provide high quality services in cardiovascular and thoracic medicine to Malaysian citizens 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.

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 fallback option which would serve as a *competitive price check* against steep price increases in the private healthcare sector (such as the Sime Darby Medical Center in Subang Jaya).

²³ Abu Bakar Suleiman, Wong Swee Lan, A. Jai Mohan, et al., "Utilisation of Specialist Medical Manpower", Report from a collaborative study by the Ministry of Health and the Academy of Medicine, Malaysia, 1992 - 1993 (1993).

²⁴ H. Wadee & L. Gilson, "The Search for Cross Subsidy in Segmented Health Systems: Can Private Wards in Public Hospitals Secure Equity Gains?" in *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, edited by Maureen Mackintosh and Meri Koivusalo (Basingstoke: Palgrave Macmillan, 2005).

²⁵ S. Woolhandler & D Himmelstein, "When Money is the Mission: The High Costs of Investor-Owned Care", *New England Journal of Medicine*, vol. 341(1999), pp. 444-446; P. Devereaux, P. Choi, C. Lacchetti, et al., "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals", *The Canadian Medical Association Journal*, vol. 166 (2002), pp. 1399-1406; S. Woolhandler, T. Campbell, and D. Himmelstein, "Costs of Health Care Administration in the United States and Canada", *New England Journal of Medicine*, vol. 349 (2003), pp. 768-775; Donald Light (editor), "Comparative Studies of Competition Policy", *Social Science & Medicine*, vol. 52, no. 8 (special issue, April 2001); The *PLoS Medicine* Debate: Is Private Health Care the Answer to the Health Problems of the World's Poor? (Kara Hanson, Lucy Gilson, Catherine Goodman, Anne Mills, Richard Smith, Richard Feachem, Neelam Sekhri Feachem, Tracey Perez Koehlmoos, Heather Kinlaw). *PLoS Medicine* November issue, vol.5 (2008), pp. 1528-1532; P. S. Heller, "A Model of the Demand for Medical and Health Services in Peninsular Malaysia", *Social Science & Medicine*, vol.16 (1982), pp.267-284.

We do not have systematic, disaggregated data to evaluate whether the IJN is in fact exerting such a price restraining effect, but we do note that the Star (December 18, 2008) for instance included the figures below as part of its investigative reporting into the attempted acquisition of a controlling share of IJN by Sime Darby in December 2008:

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

If these figures are comparable between the two institutions and are not seriously misleading, one might even ask, going beyond IJN, if this bulwark function could be generalised as a strategic role that subsidised, publicly-provided healthcare could play in the Malaysian healthcare system, as a price brake against ever-escalating fees and charges levied by a profit-driven private healthcare sector, and as a benchmark for quality?

It is for this reason that the continued existence of well-funded, widely accessible quality healthcare provided by the public sector is in the interests of *all Malaysian citizens*, regardless of whether they patronise the public or the private healthcare sector. Good quality, no frills, needs-based healthcare - funded and provided by the public sector - should therefore be supported by all, not just by those who cannot afford the charges of the private healthcare market.

In Singapore, the government's strategically located and well-equipped polyclinics account for only 20% of primary healthcare on the island, but their subsidised outpatient services seem to provide sufficient price competition to help restrain fee increases amongst the private clinics. In Hong Kong, well-remunerated and adequately-staffed public sector healthcare achieves a similar effect. It is noteworthy that both territories enjoy among the highest levels of population health indices worldwide, at quite modest levels of national health expenditures (Singapore 3.5% GDP; Hong Kong 5.5% GDP) which bracket Malaysian expenditures (4.2% GDP).

5. QUESTIONS FOR BRAINSTORMING, OR FURTHER INQUIRY:

In re-thinking the role of the state in healthcare in Penang, I would like to propose the following for further reflection and deliberation:

- Can we reconceptualise the role of the Penang state government in health development as going beyond that of facilitator, i.e. creating the enabling environment for market-driven healthcare? The Johor state government has given us one answer to that question – the state government itself becoming an economic actor in the form of a profit-seeking health entrepreneur.
- Should the Penang state government (or the Penang Development Corporation) explore the feasibility of a non-profit, publicly-owned version of the *Kumpulan Perubatan Johor* for Penang? A modest chain of state-owned (and operated?) medium-sized hospitals which could provide medium-cost healthcare and at the same time serve as a price bulwark against even steeper price increases in the for-profit private sector?
- Financing: can the state government leverage on its jurisdiction over land matters to generate the necessary financing for a realistic business plan, within the existing (and foreseeable) political, economic and jurisdictional contingencies? What can we learn from other financially viable and successful state enterprises such as *Perbadanan Bekalan Air*?
- What are other potential (non-land) sources of financing which the state government might be able to tap for such an enterprise? A state-operated health insurance scheme to generate the cash flow for a business plan to seek project financing? What can we learn from the Selangor state government's *takaful* (insurance) scheme which was launched in October 2008 which also promised free medical care worth RM3500 for Selangor citizens aged 60 years and above?²⁶ In terms of a learning curve, does it make sense to begin with a health insurance scheme, with a later consideration of a healthcare provider role for the state government? Are there potential synergies in the form of a teaching hospital in partnership with the Penang Medical College?
- What are the *pros* and *cons* of using political parties, rather than state governments as the institutional bases for non-profit private ventures in health care (and education?). For instance, we see many more party-based initiatives in tertiary education, rather than concerted efforts to establish state universities in the mould of, say, US state (land grant) universities. What can we learn from the existing (or past) engagements of state governments with (tertiary) educational ventures, ranging from equity participation to a role as owner-operator?
- Should we explore the possibilities and feasibility of *a consortium of state governments* – pooling resources, land and resource-based revenues, royalties, and educated and skilled human resources (such as Penang loyalists, retired

²⁶ ["Basket of goodies for Selangor folk"](#), *The Malaysian Insider* (25 July 2008).

professionals with accumulated experience, who have hands-on experience in managing hospitals, who are knowledgeable about the local healthcare market, who have experience running health insurance schemes, social and professional and business networks, etc) as expanded institutional bases for collaborative regional ventures in educational, health and other services?

- Hospitals aside,²⁷ what are other potential interventions that the state government could consider to improve population health in Penang within the existing (and foreseeable) political, economic and jurisdictional contingencies? An example might be the improved urban management of the (social) ecology of dengue propagation and transmission?
- How should efforts in this direction and at this level be balanced against efforts to turn things around at the federal level, i.e. to rehabilitate educational and other service institutions within the federal public sector? What degree of duplication at federal, state, and other levels might be acceptable or desirable in any subsequent effort to de-centralise, de-federalise, or devolve jurisdiction over these (public) service sectors?

6. CONCLUDING REMARKS: PATHWAYS TOWARDS DECENTRALISATION?

The existing lopsided balance of federal vs. state jurisdiction has been an effective tool of central control thus far, sustained by the uninterrupted incumbency of a ruling federal coalition anchored by its dominant partner, UMNO. Whether by design or otherwise, the periodic rotation and redistribution of UMNO's top leadership positions among its regional support bases have blunted what might otherwise have been more pronounced centrifugal tendencies in federal-state power configurations.

In the aftermath of the March 2008 general elections, some re-alignments were anticipated, between KL and the states ruled by the Pakatan Rakyat coalition, but were also discernible in BN-ruled states.

In Terengganu state, where the control over royalties from petroleum and gas seems to have inflamed factional infighting within UMNO Terengganu, the royal house stepped in with a proposal for a sovereign wealth fund to receive and to manage these revenues and accumulated assets.

The Terengganu Investment Authority (TIA) was duly established on February 27, 2009 with a projected fund size of RM11 billion. RM6 billion would be raised through bond

²⁷ In this paper, we have adopted a relatively restricted scope for the definition of *healthcare*, largely confined to medical and health facilities and the care provided by their personnel. Social and environmental determinants of health however remind us that there is only a modest overlap between *health* and *healthcare* (in the narrow sense). Health interventions therefore should be guided by a social ecological perspective of health and disease and should not be unduly restricted to immediately antecedent determinants.

issues in the capital markets collateralised by its annual royalties from Petronas, while the remaining RM5 billion would be raised with the backing of a guarantee from the federal government.²⁸

The TIA however also had an unintended effect, i.e. setting a precedent whereby a state government could leverage on a guarantee provided by the federal government to raise investment capital from local and international financial markets for development projects over which the federal authorities may exercise only limited control.

In its inaugural RM5 billion capital-raising exercise in May 2009, TIA's thirty-year Islamic bonds were oversubscribed, attracting tenders from local and foreign investors whose bids exceeded RM8 billion within two days of its launch. As if to drive home the point, the Penang state government immediately requested a similar federal guarantee for a RM5 billion capital-raising exercise to finance priority development projects in the state.²⁹

In July 2009, Prime Minister Najib Abdul Razak, fresh from talks with leading officials of Abu Dhabi's sovereign wealth fund Mubadala Development, announced that the TIA would be federalised and renamed as 1Malaysia Development Berhad (1MDB).³⁰ It would be wholly owned by the Ministry of Finance Inc (MoF Inc) and would report directly to the prime minister. Meanwhile, the management of Terengganu's oil and gas royalties would revert to the pre-TIA status quo, leaving unresolved for the moment the discretionary use of Terengganu's oil and gas royalties by an incumbent state government, an issue that had fomented much dissension and shifting alliances within its ranks.

This reversal by the federal authorities might have been a pre-emptive move to forestall further requests from other states for their own investment funds (which might weaken federal control over development financing):

By becoming a [federal] sovereign wealth fund, 1MDB will have Malaysia as its priority instead of just one state, according to a source. It puts all states on equal footing at a time when there are a couple of states that are tinkering with the idea of establishing their own state-based investment funds. Establishing the 1MDB will also do away with the [pressure on the] Government to provide further guarantees for other state-based funds.

*The Star
July 22, 2009*

²⁸ The governance structure of TIA would have the Menteri Besar of Terengganu (MB Inc) holding 100 percent of ordinary shares (the Ministry of Finance Inc and the TIA Foundation would be issued one preference share each, entitling them to nominate one director each and to 10 percent of TIA's annual profits), the Sultan of Terengganu would chair a board of advisers, and a management team of professionals would be reporting to a board of directors (www.theedgemalaysia.com 18 & 19 May 2009). The Singapore Straits Times (July 15, 2009) reported that a key architect of TIA was Joe Low, a Penang-born businessman described as a member of Najib Abdul Razak's inner circle and also as an adviser to Sultan Mizan Zainal Abidin of Terengganu.

²⁹ "Now Penang wants its Sovereign Wealth Fund", <<http://www.theedgemalaysia.com/commentary/14923-now-penang-wants-its-sovereign-wealth-fund.pdf>> (accessed 26 May 2009).

³⁰ "Terengganu Investment Authority to be federal body", *The Star* (22 July 2009).

Additionally, it could also reassure TIA's co-investors in Malaysian ventures (such as Mubadala's participation in a RM6.26 billion property development project in Pulau Bidong, Terengganu) that the investment vehicle for a joint venture would be insulated from local political uncertainties and discontinuities such as may erupt in states like Terengganu.

Meanwhile in Selangor, the state government was exploring its options vis-à-vis *zakat* (Muslim religious tithes) as a potential source of development finance for the state.³¹ Since *zakat* contributions are currently deductible against federal income taxes, this could be yet another intriguing attempt at fiscal devolution which relies on the state's jurisdiction over Islamic affairs. The challenges are daunting though, given the parties involved and the potential stakes, not to mention Selangor's religious pluralism.³²

In East Malaysia, Sabah and Sarawak, accounting for 52 out of Barisan Nasional's 137 parliamentarians, have become crucial swing states in the federal power equation post-March 2008, providing leverage for increased development allocations as well as cabinet positions and political office, if not for reinstated autonomy.

If a durable two-coalition system emerges and over time approaches parity in electoral strength, there might eventually be less resistance to some degree of devolution, in anticipation of fluid scenarios in the (rotational) exercise of federal and state governmental power. This is unlikely to be a smooth process, and might well entail, as Dr Nungsari Ahmad Radhi envisages, an over-extended, centralised federalism forced to cede *de facto* jurisdiction at the periphery, when it overreaches in its ambitions relative to the resources that it can muster.

In 2008, Petronas' payments to the federal government (RM72.5 billion as dividends, taxes, and export duties) accounted for 45 percent of federal revenues in that year. Whether Petronas can continue to be a major source of federal largesse may increasingly depend on its foreign operations, which contributed 30 percent of its revenues in 2007, as domestic reserves of oil and gas are progressively depleted. Not surprisingly, this heavy reliance on Petronas' revenues has also prompted repeated calls for widening the tax base.³³

In 1999, the Indonesian parliament (*Dewan Perwakilan Rakyat*) enacted *Undang-Undang Pemerintahan Daerah No. 22 Tahun 1999* (Law No. 22, 1999 on Local Government) which devolved substantial responsibilities in public works, health, education and culture, agriculture, communications, industry and trade, capital investment, environment, land, cooperatives, and human resources to local governments while retaining security and defence, foreign policy, monetary and fiscal matters, justice, and religious affairs as central government prerogatives.

³¹ "Selangor plans to bypass federal government with new tax system", *The Malaysian Insider* (13 July 2009).

³² "MB cadang orang bukan Islam bayar zakat perdagangan", *HarakahDaily.Net* (13 July 2009); "Zakat only for helping Muslims and nothing else", *Bernamea* (19 August 2009).

³³ "Malaysia needs to implement new taxes, says IMF", *www.theedgemaalaysia.com* (17 August 2009); "Govt. must reform tax; introduce GST or VAT says MIER", *The Star* (18 August 2009).

It is tempting to link this with Indonesia's declining oil production (since 1998) and its status as a net oil importer (since 2004). Notwithstanding oil and gas revenues contributing 33 percent of the central government's revenues from 1997-2000,³⁴ the main impetus for Indonesia's decentralisation came from the 1997 financial crisis and the demise of Suharto's autocratic regime, which released pent-up demands for regional autonomy especially from its resource-rich provinces.

Depending on the adequacy of revenue sharing arrangements between central and local authorities in Indonesia, we might witness mounting pressures for the devolution (or sharing) of *revenue raising powers* (local taxation), to accompany the devolution of governmental responsibilities for meeting citizen needs and expectations.

In Malaysia, the possible emergence of a national health (insurance) fund (in effect, a supplementary tax in the form of payroll deductions plus matching contributions from employers and the self-employed) may provide an opportunity to lobby for the decentralization of aspects of the financing (and provision) of healthcare. The Canadian model for national health insurance for instance comes to mind, where provincial and federal authorities have shared responsibilities along with the commensurate powers of taxation for the financing of healthcare.

There is little dispute that certain health functions and health facilities such as peak referral institutions, control of communicable diseases (immigration and trade-related health matters, quarantine), equalisation grants and cross-subsidies to poorer states, bulk procurement of pharmaceuticals, medical disposables and accessories, National Institutes of Health (research and the deployment of its outputs), international health engagements, etc., should remain as federal health prerogatives.

But there is no compelling reason why the Penang Hospital for instance should not be restructured to be a devolved institution reporting to the Penang state government, along with a devolved system for the allocation of requisite financial resources.

Indonesia required a financial crisis to catalyse the devolution of a highly centralised and militarised unitary state. What will it take for us in Malaysia to rebalance the existing jurisdiction between federal, state, and local governments?

³⁴ Etisham Ahmad & Eric Mottu, "Oil Revenue Assignments: Country Experiences and Issues", *Fiscal Policy Formulation and Implementation in Oil Producing Countries*, edited by Jeffrey M. Davis, Rolando Ossowski and Annalisa Fedelino (Washington, DC: International Monetary Fund, 2003), p.225.