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**RE-INVENTING THE WELFARIST STATE? THE MALAYSIAN  
HEALTH SYSTEM IN TRANSITION**

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## **ABSTRACT**

### **RE-INVENTING THE WELFARIST STATE? THE MALAYSIAN HEALTH SYSTEM IN TRANSITION**

*This paper begins with a theoretical perspective on privatisation which links it with systemic tendencies towards over-accumulation in the global capitalist economy. To analyse health system dynamics, the health system is conceptualised as an articulation of component sub-systems (provision, financing, treatment accessories, support services, research and product development, education and training, etc). These sub-systems are increasingly brought within the circuit of capital, in the process re-configuring the fine structure of the system along with its built-in incentives and disincentives which interactively modulate the system's overall operating characteristics. The paper ends with an update on the evolving role of the Malaysian state as provider, as financier, as investor, and as regulator of the health system.*

**KEYWORDS:** healthcare, privatisation, welfarist state, welfare state, Malaysia, political economy.

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## 1. INTRODUCTION

In the early 1970s, a post-World War II economic boom which had extended over a quarter of a century in many capitalist countries came to an end. With the slowdown in the industrialised economies of the North, and the ensuing stresses upon existing social accommodations, Keynesian economics and the welfare state increasingly came under attack for its inability to deal with persistent “stagflation” (Lindberg and Maier, 1985). Supply-side economists regarded high taxes and the prevailing balance between capital and labour (“labour market rigidity” and a “misguided” social contract entailing a “full employment squeeze on profits”) as key obstacles which discouraged investment and caused economic stagnation (Mundell, 1962). Interestingly, aspects of this analysis were shared by some left-wing economists (Glyn and Sutcliffe, 1972), and disputed by others (Brenner, 1998; Foster, 1999).

Meanwhile, anti-statist views became pervasive among influential development financing institutions such as the World Bank and the International Monetary Fund (IMF). Neo-liberal analysts settled upon *dirigiste* developmentalist states as leading culprits for the economic travails and chronic indebtedness of many Third World countries (with lesser attention to the adverse effects from volatile petroleum markets, escalating interest rates in debt servicing, and global recession and declining terms of trade in the 1970s). Prominent among their prescriptions were “structural adjustment” and “downsizing” of “inefficient, wasteful and corrupt” state enterprises and institutions to make way for a more efficient allocation of economic resources by a free market. Even when markets were fallible, it was nonetheless asserted that they were still superior to the state as an economic institution, consistently outperforming the latter which was portrayed as an inefficient synthesiser of information, prone to regulatory capture and corruption, and liable to be held hostage by influential constituencies in electoral politics (Krueger, 1974; North, 1981).

In both cases, the retrenchment of the state (at any rate, a curtailment of its welfarist and regulatory functions) to allow for an expanded, minimally-regulated market swiftly became the ruling orthodoxy in much of academia, and among influential multilateral development lenders.<sup>1</sup> These policies (the neo-liberal “Washington Consensus”) were in due course extended to the healthcare sector as well, a social service which had been provided on a non-commercial, publicly-funded (or publicly-subsidised) basis to many communities in developed and developing countries (World Bank, 1993).

Health security of course is just one aspect of social protection and risk management in society’s efforts to deal with uncertainty. The modern welfarist state acts importantly as a pooler of risks and as a conduit for cross-subsidies (not always progressive), in coping with the catastrophic and burdensome events which occasionally befall its less fortunate citizens. Socialised resources (taxes and other public revenues) have been deployed to finance safety nets in healthcare, in social security for the unemployed, the retired and the disabled, and have provided relief in instances where neither the individual nor her/his family and social support network could cope with the consequences of catastrophe. The modern state, in

short plays a crucial role as an insurer and risk manager in coping with uncertainty (Barr, 2001).

## 2. AN EFFICIENT MARKET IN HEALTHCARE?

The argument in favour of healthcare privatisation rests 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) (Reinhardt, 2001), further compounded by imperfect information and uncertainty in healthcare markets (Arrow, 1963);
- there is often no alternative provider in less densely populated (rural) areas (see, for example, Khoo, 2007);
- 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) (Hannan, et al., 1997);
- wasteful or inappropriate use of resources (over-treatment and under-treatment) (Suleiman, et al., 1993), depending on the payment incentives in healthcare financing; and
- reduced access for poor patients (an issue of equity) (Wadee and Gilson, 2005).

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 (Devereaux, et al., 2002; Woolhandler, et al., 2003; Kuttner, 2008).

### 3. DESPERATELY SEEKING MARKETS

If market-driven healthcare is unpersuasive on efficiency grounds, let alone on equity grounds, what might explain its continuing, uncritical acceptance among its enthusiasts and promoters?

Max Planck famously said that a new scientific paradigm triumphs not by convincing the majority of its opponents, but because its opponents eventually pass on. Fixations aside, the neo-liberal stance perhaps could also be usefully examined from the perspective of an over-accumulation of capital (and its corollary, demand deficit).

In the late 1990s, production over-capacity in the global economy received increasing attention (Greider, 1997), including prominent coverage in the mainstream as well as business press<sup>ii</sup>. Currently, there is little dispute over the existence of these gluts although views differ as to whether these are cyclical downturns and transient disjunctures, or more chronic manifestations of deep-seated instability and systemic dysfunction. In the terminology of the neo-Keynesian French Regulation School, this would be an instance of “regulation failure” and crisis of the existing regime of accumulation.<sup>iii</sup>

Indeed, these imbalances between accumulation and consumption, reinforced by growing inequality in income and wealth, appear to be worldwide and increasingly acute. Global production over-capacity, massive increases in speculative financial flows, property and asset bubbles (now extended to oil, food, and other commodities), volatile swings in appetite for risk among investors, historically low interest rates alternating with credit crunches, and resurgent militarist Keynesianism suggest a systemic glut of capital ceaselessly seeking out profitable outlets for deployment and redeployment.

This calls to mind the work of Paul Sweezy and his colleagues, who over the course of a half century elaborated a theory of capitalist stagnation drawing upon the Marxist and Keynesian traditions in their analyses of monopolistic capitalism and the generation, realisation and absorption of surplus value (Sweezy, 1956; Baran and Sweezy, 1966). In the later versions, they gave increasing attention to financialisation (Magdoff and Sweezy, 1987). This is a process where over-accumulated capital in mature capitalist economies extended its circuits into financial services and risk management, feeding upon and in turn encouraging the perception and designation of risk as a staple of modern life (Beck, 1992) and the commodification of “risk reduction” options in diverse forms extending from derivatives and swaps to annuities and insurance for health and welfare security, genomics-based “predictive” medicine, and so on. With the ascendancy and hegemony of finance capital, it was not surprising that the underlying imbalances between over-accumulated capital and consumption was addressed via monetarist approaches, in contrast to a more integrative and systemic neo-Keynesian perspective which considers income and wealth disparities as important macroeconomic determinants of aggregate demand and of stable and “sustainable” economic growth.

In the same vein, the neo-liberal agenda of privatisation, market creation and market deepening, and retrenchment of the welfarist and developmentalist states, is arguably sustained by over-accumulated capital seeking to extend its circuits into hitherto non-commercial public sector domains as expanded arenas for continued accumulation:

As profitability in manufacturing has declined because of international competition, corporations have turned to services as an alternative source of profit. According to the European Commission “The service sector accounts for two thirds of the [European] Union's economy and jobs, almost a quarter of the EU's total exports and a half of all foreign investment flowing from the Union to other parts of the world.” In the USA, more than a third of economic growth over the past 5 years has been because of service exports. The World Bank has calculated that in less-developed countries alone, infrastructure development involving some private backing rose from US\$15.6 billion in 1990 to \$120.0 billion in 1997... With the backing of powerful coalitions of transnational and multinational corporations, the race is on to capture the share of gross domestic product governments currently spend on public services (Price et al., 1999: 1889)

Hence we might consider globalisation in these terms: technology-enabled, continuing outward impulse of capital, driven by saturated mature markets (over-capacity, declining rates of profit) and the search for competitive advantage (in production and in control of natural and human resources), and for emerging markets. And privatisation as: the inward impulse, cannibalising the welfarist state, market creation and market deepening, extending the circuit of capital into a hitherto non-commercial public sector domain.

In its ceaseless search for opportunities for profitable deployment and redeployment, globally mobile capital has thus contributed to the undermining of the welfarist state through these modalities:

- globally mobile capital in search of low-cost labour, competitive tax regimes and tax havens, which fosters a “race to the bottom” and thereby reduces the fiscal capacity of states. Besides lower corporate taxes, runaway firms also leave behind unemployed workers and reduced income tax receipts, even as the need for unemployment benefits rises;
- neo-liberal trade policies which reduce custom duties as a source of state revenues;
- an overriding concern of globally mobile *finance capital* with inflation and balanced budgets in the countries where it circulates. Wary of activist Keynesianism, it imparts a deflationary bias to national economies, demanding fiscal discipline to reduce public spending and budget deficits through its threat of withdrawal and flight;<sup>iv</sup>

- widening imbalance between accumulation and consumption (fuelled by increasing disparities in wealth and income), manifested as over-capacity and demand deficit. To cope with the excess accumulation, pressure builds up to extend the circuit of capital into new arenas for accumulation, encroaching into a hitherto non-commercial public sector domain, i.e. privatisation and dismembering the welfarist state; and
- currency and financial crises in Asia, Russia and Latin America at the turn of the 20<sup>th</sup> century, which induced countries to build up and maintain large foreign exchange reserves as a buffer against volatile capital flows and speculative currency attacks. This however diverts financial resources away from domestic investment and public expenditures, and ends up as reverse capital flows which are invested in “safe haven” assets and securities principally in affluent countries (see Chandrasekhar and Ghosh, 2006).

#### **4. HEALTH SYSTEMS IN EVOLVING WELFARIST STATES**

In the area of health security – coping arrangements for managing the health risks of individuals and populations – the state as well as private enterprise may play multiple roles in the provision and financing of health care. Typically, welfarist states may try to operate and regulate a pluralistic (public-private) mix of health care providers which in combination with a health financing system, achieves some degree of coverage of health care services for their citizens and other eligible residents.

To analyse in more detail health systems undergoing transitions, it is useful to decompose a health system into its constituent components. We can then proceed to conceptualise how these various sub-systems articulate together along with the fine-structure of its built-in incentives and disincentives which interactively modulate the system’s operating characteristics. In particular, we wish to discern how this fine structure might be dynamically reconfigured as these sub-systems are increasingly brought within the circuit of capital.

These component sub-systems include the following:

- Hospitals, clinics and other treatment facilities
- Nursing homes and long-term care facilities
- Testing & diagnostic facilities
- Health professional services
- Health administration services
- Pharmaceuticals, medical supplies & disposables
- Hospital design, construction, and equipping
- Hospital support (maintenance) services
- Insurance, managed care, HMOs
- Telemedicine

- Training, education and research
- Medical informatics (incl. medical registration)

This list is by no means comprehensive insofar as parallel (or integrated) systems of traditional and complementary medicine may also be a significant presence in Asian and other countries, not to mention an even broader conception of health systems as implied by a social ecological perspective on health and disease.

In addition, key operational parameters of these sub-systems also need to be considered, whether they are publicly owned or privately owned, whether they are needs-driven or demand driven, the systems for reimbursement of health services provided, modalities for financing of biomedical research and product development, associated patent regimes, and so on. The diversity, and hybrid character of possible combinations, defy easy classification and obliges us to reconsider earlier categories whose meanings have become more ambiguous as we move from a systems-wide perspective to one grounded on articulated, functional sub-systems.

In particular, the binary polar opposites - state vs. market, public vs. private - are no longer adequate as analytical categories for understanding the dynamics and operational characteristics of health systems, in the era of “public-private partnerships.” “Public” and “state,” “private” and “market” are less and less coterminous, and there is furthermore conflation in meanings between issues of ownership (public, private) as opposed to *modus operandi* of enterprises (commercial vs. non-commercial; needs-driven vs. demand-driven). To help in clarifying these conceptual categories, it might be useful to think along four cross-cutting axes for the functioning of health sub-systems:

- Ownership of providers (public, private)
- Commercial vs. non-commercial *modus operandi* (demand-driven, needs driven)
- Financing of health care (public, private)
- Payment systems to healthcare providers (fee-for-service, prepaid or capped payments).

Schematically, we could capture the possible combinations with a multidimensional matrix, although it would be challenging to go beyond a two-dimensional graphical representation, such as the example in Table 1 which maps the intersection between ownership of providers and financing of health services. The matrix in Table 1 captures many aspects of the Malaysian health care system, but there are obvious omissions when it is applied to a country such as the United States for instance, where almost half of national health expenditures are publicly funded (Medicare, Medicaid, uniformed services, veterans, other federal and sub-federal public agencies) but are spent on goods and services provided by the private sector.

INSERT TABLE 1 ABOUT HERE

Nonetheless, the matrix may be useful for purposes of a systematic inventory of possible combinations (cellular structures), and for characterising the typology of national health systems in terms of its constituent components drawn from this inventory. One could also develop a feel for the operating characteristics of the system, from an appreciation of the dynamics associated with stylised cells and interactions within larger articulated aggregations, and how health care reforms might re-configure the fine structure of the system along with its built-in incentives and disincentives which interactively modulate the system's overall operating characteristics.

## 5. MALAYSIA: EVOLVING ROLE OF THE STATE IN HEALTHCARE

*Applying this conceptual schema to the evolving role of the Malaysian state, we focus in particular on its roles as provider, as financier, as investor, and as regulator in the health system.*

### **As a Provider**

Malaysia has a pluralistic system where health care is provided by the government, by the for-profit private sector, and by a non-profit private sector, while financing comes from taxes and other public revenues, user charges and co-payments, employment health benefit schemes as well as donations (in cash or in kind). Recent trends in the distribution of health personnel suggest a modest shift back in favour of the government sector, in the years 1999 – 2006 (see Table 2).

INSERT TABLE 2 ABOUT HERE

These aggregate figures however belie a continuing exodus of senior and experienced staff from the public sector to the private sector, reflected in the lopsided distribution of specialists, 70% of whom currently practice in the private sector. The government sector receives a yearly infusion of young and inexperienced medical graduates who are required to serve a three-year mandatory national service beyond 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.

Effective 1 August 2007, the Putrajaya Hospital and the Selayang Hospital in Selangor, two of the newest 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 about 50% or about 100 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]...” (cited in *The Star*, 28 July 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 a quick response to the Prime Minister’s 2004 budget speech announcement that private commercial wings were being planned for existing government hospitals, government-employed doctors 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], c. 2004)

The *Gabungan Membantah Penswastan Perkhidmatan Kesihatan* (Coalition Against the Privatisation of Health Services), a coalition of 70 non-governmental organisations that came together in 2005 to campaign against the privatisation of publicly provided health services, is less sanguine about these prospects, and has consistently opposed both proposals on the grounds that:

- only 30% of specialists are employed in the government sector, but they serve 70% 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; and
- 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 as the system was by chronic understaffing 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 subsidised and publicly-owned service that was not solely intent on maximising profits. Dr. Ridzwan Abu Bakar, its president was cited in a newspaper report, saying:

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 (*The Star*, 16 May 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 an interview with Dr. Nirmala Menon, Senior Vice President (Employee Benefits) at ING Insurance Berhad and Liew Sook Foon, Assistant Vice President for Corporate Communications at the same company conducted by Loh Foon Fong on 9 February 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.

When asked if the company educates its customers that private healthcare is not necessarily better, the response was:

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 complain endlessly about moral hazards and price gouging by private hospitals so much so they make incentive payments to policy holders to access the public hospitals when in need of care. Evidently, there is 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 middle classes. Going by their rhetoric, they want low-cost, no frills, “medically necessary,” and evidence-based care, which sounds engagingly like the original progressive vision of managed care (see Kuttner, 1998). Under certain circumstances, they might even be supportive of subsidised, 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 favoured 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 insurance industry, along with for-profit private hospitals and the medical profession are obviously influential players with their respective priorities and preferences in the ongoing policy reform processes. Consequently, their mutual interactions and tensions, and their tactical approaches as they position themselves to advance their respective interests, are key ingredients in an analysis of health care reform processes in Malaysia.

### **As an Investor**

Amidst the sustained 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. This was injected into KPJ Healthcare Berhad, which was incorporated in 1993 as the Johor Corporation’s healthcare division, and has since grown into the largest chain of private hospitals in Malaysia, with 19 hospitals wholly or partially owned or managed by KPJ, with another six in Indonesia, Bangladesh, and the Middle East. On 29 November 1994 it was listed on the main board of the Kuala Lumpur Stock Exchange. The Johor state government thus became, through its corporate arm, the controlling shareholder of a veritable mini-Ministry of Health, albeit one which was operated along purely commercial lines despite its predominantly public ownership. This raises interesting questions: Are KPJ hospitals public? or private? Is this a “nationalisation” of private enterprise space, or an extension of the logic of capital into strategic adjuncts of the state?. With paid up capital of RM 191 million and assets of RM1,021 million and shareholders’ funds in excess of RM430 million, KPJ has expanded into a publicly-listed health conglomerate which offered 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 arm of the Government of Malaysia, acquired a 30.68% controlling share of Pantai Holdings Berhad on 28 August 2006, (Khazanah, 2006a). With interests in nine private hospitals (1,409 beds), it is the second largest private hospital chain in Malaysia. Combined with its diverse portfolio in the private health services sector, Pantai Holdings Berhad is the largest healthcare conglomerate in Malaysia. Its health and medical related interests span: clinical waste management; cleaning and maintenance services for government hospitals in the southern states of Negri Sembilan, Malacca and Johor (outsourced to Tongkah Medinvest, a Pantai subsidiary); 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 (outsourced to Fomema, another Pantai subsidiary); telemedicine services; cardiac catheterisation services; and lithotripter services.

Up until April 2001, Mokhzani Mahathir, a son of Mahathir Mohammad, the serving prime minister at the time, was the chief executive officer of Pantai Holdings Berhad when he disposed of his 32.9% stake to Lim Tong Yong who succeeded him as CEO. On 13 September 2005, Parkway Holdings Ltd of Singapore in turn acquired a 31% stake in Pantai, making it the largest single shareholder. 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. 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 fund manager which had acquired a 26% stake in Parkway on 26 May 2005.

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 lapse in regulatory and strategic oversight (*Malaysiakini.com*, 30 August 2006). Amidst the red faces and embarrassment of allowing the largest health care conglomerate in the country that had been a major beneficiary of 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. This entailed Khazanah's intervention to acquire a 51% stake in Pantai Irama Ventures, with the remaining 49% going to Parkway in a reshuffling of corporate equity which would see Pantai Irama holding a 35% controlling stake of Pantai Holdings Berhad. Aside from a lucrative margin accruing to Parkway from the share swaps, operational and management control of the hospitals remained with Parkway for 15 years.

This may have been an unplanned purchase and contingency forced upon the Malaysian government, 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. As of 2008, Khazanah had interests in Fomema, Pantai Holdings, Pharmaniaga (15-year concession for supplying pharmaceuticals and medical disposables to government hospitals and health facilities), a 13.2% stake in Apollo Hospitals Enterprise Ltd (India) (Khazanah, 2005), and a 67.5% stake in the International Medical University (IMU), Malaysia's first private medical university (Khazanah, 2006b).<sup>y</sup> On 30 April 2008, the Pantai-Parkway saga came full circle when Khazanah announced that it had paid RM1.23 billion for an additional 16.41% stake in Parkway, thereby raising its total stake in Parkway to 20.79% (Khazanah, 2008).

### **As a Financier**

In 1983, US-based health consultants Westinghouse Health Systems, working with a Malaysian Health Ministry task force on health services planning, estimated that the public sector accounted for 75% of total national health expenditures (and 90% of hospital beds). Health Ministry expenditures as a proportion of GNP remained fairly stable in the early 1980s (1.56% of GNP in 1979; 1.51% of GNP in 1983) while total national health expenditures amounted to 2.6% of GNP in 1983. In the following decade, government health expenditures edged nearer to 2% of GDP, whilst private expenditures also steadily increased along with an expanding private health sector. In 1996, the Health Ministry conducted a second national health and morbidity survey which indicated that out-of-pocket expenditures (1.28% of GNP) had exceeded Health Ministry expenditures (1.02% of GNP, a surprisingly low figure, even when calculated relative to GDP, 1.07 percent). Table 3 shows World Health Organisation (WHO) figures for Malaysian health expenditures from 1997 to 2003.

INSERT TABLE 3 ABOUT HERE

In reviewing data reported for public and private health expenditures for Malaysia, it is important to keep in mind several caveats that impact the data:

- government expenditures on health are made not just by the Health Ministry, but also by the Ministry of Education (teaching hospitals, school health and dental services), Ministry of Defence (military hospitals and other health services), Ministry of Home Affairs (Jabatan Hal Ehwal Orang Asli hospitals and clinics, eventually absorbed into the Health Ministry), and local government authorities (municipal clinics) many of which were also absorbed into the Health Ministry;
- employment health benefits in the private sector are not captured by out-of-pocket expenditures of surveyed households, similarly with direct payments

from insurers to healthcare providers for services provided to patients and beneficiaries;

- health services paid for by public donations (in cash or in kind) and philanthropy;
- the definition of “health expenditures” was in flux in 2001 as the Health Ministry was gearing up to adopt a system for national health accounts which would be in line with standardised international reporting formats which were being formulated; and
- government expenditures on health are routinely generated by an existing institutionalised mechanism, but corresponding figures for the private sector are available only for baseline years when reliable sample surveys were conducted. Figures for other years presumably are extrapolated from these baselines under various assumptions.

With these qualifications, we note first that government health expenditures in 1997 had regained its lead over private health expenditures (see above), and this remained so at least until 2001. This was a consequence of the Asian currency and financial turmoil in 1997 which led to economic distress among sectors of the Malaysian population including the middle classes. Along with their shrinking disposable incomes, there emerged an underpatronised excess capacity in the private hospital sector, partially alleviated by vigorous promotional efforts in the regional medical tourism market, and a corresponding overload for the public sector. The 30% drop in per capita health expenditures over the period 1997-98 also reflected the drastic devaluation of the Malaysian ringgit relative to the US dollar during the Asian economic crisis.

Second, prepaid and risk pooling plans account for less than 15% of private health expenditures. Out-of-pocket payments by households for private health care may be overestimated if it included payments which were reimbursable wholly or in part by the insuring parties. Even so, the (still) modest share of insurance in household healthcare expenditures largely reflects the government’s predominant role as risk pooler through its provision of publicly-financed and accessible healthcare. Indeed, as long as credible, competent health care of quality is widely available from the public sector, it will constrain not just the market potential for private medical underwriting, but also act as a fallback option and price bulwark against even steeper price increases levied by private health care providers. It is for this reason also that health advocacy groups such as the Citizens’ Health Initiative have repeatedly emphasised that it is in the interests of everyone to support the continuance of well-funded, highly-subsidised, and widely accessible healthcare competently provided by the public sector, whether they utilise public sector health care or not (*The Sun*, 27 January 2001).

Notwithstanding the ambiguities surrounding some aspects of the national health accounts, Malaysia’s national health expenditures are low, whether by comparison with countries at similar levels of economic development, or by comparison against WHO

recommended norms (5-8% of GDP). In the last two decades, no fewer than a dozen studies have been commissioned on aspects of the organisation and financing of healthcare.

In all these studies, there was consensus, extending to most stakeholders as well, that national health expenditures should be increased, but less agreement on the means for achieving this. The proposed scenarios have ranged from a national health security fund drawing upon payroll deductions plus employer contributions, and contributions from the self-employed, topped up with federal government contributions and “sin” taxes on tobacco and alcohol, to an earmarked value-added tax (VAT) which would pay for an essential health benefits package delivered through primary care trusts which would also act as gate keepers to higher levels of care provided by public and private facilities. In both scenarios, the national health fund would be publicly-owned, although certain management functions could be outsourced.

Meanwhile, health care advocates are wary of additional payroll taxes or a regressive VAT. They argue instead for increased health expenditures from existing general taxation along with further allocations from Petronas’ oil and gas revenues, utilising also a portion of the foreign worker levy (RM2 billion annually) to extend the same health entitlements to foreign workers (Coalition Against the Privatisation of Health Services, 2006).

### **As a Regulator**

The Malaysian government performs a variety of health-related regulatory functions including registration of health care practitioners and accreditation of their training institutions and training courses, registration of medicines for safety and efficacy, promulgating standards for food safety and quality, public sanitation, environmental and occupational health and safety, control of infectious diseases, and so on. Nonetheless, up until the Private Healthcare Facilities and Services Act 1998, the private health care sector was very lightly regulated and there was a protracted phasing-in period with the Act’s enforceable regulations promulgated only in 2006 (Wan Abdullah, 2007).

In the pharmaceuticals area, public sector procurement of medicines and other disposables was outsourced to a government-linked company in 1996 for a 15-year period (Pharmaniaga, in which Khazanah has a controlling stake), with provisions for negotiated prices for the pharmaceuticals supplied. In the private sector however, pharmaceuticals are priced at levels that “the market will bear.” Medicine prices consequently have been reported to escalate even faster than in the developed world, and for some items are priced even higher than in affluent countries.

In 2004-05, Zaheer UD Babar and colleagues (2007) conducted a survey in four regions of peninsular Malaysia comparing the prices of 48 medicines from 20 public sector facilities, 32 private sector retail pharmacies and 20 dispensing doctors’ clinics with international reference prices (IRPs) for the respective items. In private pharmacies, the median price ratio for innovator brands was 16 times higher than the IRPs, while generics

were 6.6 times higher. In dispensing doctor clinics, the figures were 15 times higher for innovator brands and 7.5 times for generics.

Various approaches to regulating pharmaceutical prices have been adopted in different countries. France and Italy regulate drug prices directly through price control while Australia and Ontario in Canada use cost effectiveness data in pharmaco-economic analyses and reference pricing to determine the prices of drugs subsidised by the public sector. Germany and Japan cap their reimbursements for drugs provided to beneficiaries under their respective social insurance schemes. In the UK, the National Pharmaceutical Pricing Authority controls the prices of branded prescription medicines by regulating the profits that companies can make on sales to the NHS. In the Netherlands, the government introduced a reference-pricing system in 1991, and wholesalers were forced to lower their prices by an average of 20% in 1996. In India, essential drugs cannot cost more than twice the cost of production, and the maximum retail price and local taxes must be included in a drug's final printed price.

The underlying principle in many of these countries is "cost-plus pricing," meaning negotiated prices between the manufacturer and the national authority, based on raw material costs, production costs, marketing costs, and a reasonable allowance for profit. The Canadian Patented Medicines Prices Review Board, in its periodic sessions with health care providers and suppliers of medical inputs, sets maximum introductory prices for newly patented medications, with controlled allowances for future price increases based on consumer price index adjustments.

Malaysia on the other hand has a very opaque procurement system in the public sector involving some form of negotiated pricing with periodic price adjustments, and an essentially *laissez faire* pricing system in the private sector (unregulated, but not necessarily a free market).

Interestingly, the Malaysian government attempted a different modality of "regulation" in 1992, when the cardiology and cardiothoracic departments were hived off from the Kuala Lumpur Hospital and corporatised as a government-owned referral heart centre, *Institut Jantung Negara* (National Heart Institute or IJN). The IJN was conferred a very high degree of operational and management autonomy, and one of its explicit missions was to provide high-quality cardio-thoracic and cardiological services at medium cost to citizens. For non-civil servants, patient charges at the corporatised 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% as was commonly the case for the regular Ministry of Health facilities.

The intention was that IJN should also act as a fallback option and a price bulwark which would serve as a competitive price check against steep price increases in the private sector. This "competitive regulation" by public sector providers appears to operate in Hong

Kong and Singapore as well, although no systematic evaluations have been conducted thus far to assess its cost-effectiveness in maintaining price bands, in reining in the inefficiencies of market imperfections and market failures, and more generally in nudging the healthcare sector towards preferred structural configurations and practice standards.<sup>vi</sup>

If and when a publicly-operated national health insurance scheme is introduced in Malaysia, the potential scope for regulation of the health care system will be considerably broadened through the leverage exercised by the state as a non-profit, publicly-operated single-payer purchaser of health care.

Meanwhile, the draft Malaysian National Health Policy, with an eye towards the growing regional health care market, lists as one of its three main thrusts, efforts “to improve the Malaysian health industry’s innovativeness and competitiveness in the local, regional and global health arena” (MNHP, 2007: 8). Item A3.1 in particular states that “the government and all regulated bodies shall review and amend existing laws. Government should work towards self regulation by the health industry”(MNHP, 2007: 8). At a national consultation in June 2007 in Kuala Lumpur, civil society representatives expressed their reservations about this, stating that the health care sector was prone to market failures and market inefficiencies, quite apart from the inequities of market-driven healthcare. Instead of deregulating such imperfect markets, they urged that the regulatory role of the government should be maintained and strengthened to create an operational environment which could capture the efficiencies of competitive healthcare enterprises, and at the same time could deter the unethical abuses that commercial entities may resort to in seeking to maximize profits. In short, the policy goal was to operate and to regulate a pluralistic (public-private) mix of health care providers which in combination with an equitable health financing system, could bring about universal access to health care for all Malaysian residents on the basis of need (FOMCA, 2007).

## 6. THE WELFARIST STATE IN THE AGE OF GLOBALLY MOBILE FINANCE CAPITAL

In his paper presented at the World Bank-sponsored Arusha Conference on “New Frontiers of Social Policy” in December 2005, Columbia University’s Elliot Sclar (2005: 1) stated that “in terms of infrastructure and public services, the real issue is enhancing the organisational capacity of governments to make competent ‘make or buy’ decisions”. Implicit in this is the presumption that there is a continuing and perhaps unchanged, role for the state in the financing of public services. The state is not about to withdraw entirely from public financing, but it is also clear that entrepreneurs and investors are keen not just on the provision of commercially viable public services (including health care), but are also actively scouting for profitable opportunities in the financing of these services.

Some years back, I commented at *Malaysiakini.com* (28 August 2000) that:

the privatisation of healthcare provision in principle is still compatible with public financing of healthcare (via a tax-supported national health trust fund, national health insurance, or some such arrangement). The privatisation of risk management however is the lifeblood of the insurance (and financial services) industry, and this industry would look favourably upon the market opportunities emerging from a reduced role for government in social insurance and social protection, i.e. in the management of uncertainty

Of late, the privatisation of risk management seemingly has gone global, in regard to various threatening flu pandemics. One proposal for risk management that was floated for the World Health Organisation’s flu vaccine stockpiles - since flu vaccines have a shelf-life and potential donors might balk at the recurrent costs of continual replenishments - was to use the donated cash resources to buy insurance coverage instead from a willing underwriter. If and when an outbreak of pandemic flu emerged, the financial payout could then be used for pandemic responses including the purchase of pre-pandemic vaccines and immediate advance purchase orders of the pandemic strain vaccine. Quite apart from the chaotic scramble for vaccines in a pandemic outbreak, this improbable proposal would have been a casualty of the turmoil and severe stresses currently afflicting the global financial and risk management markets.

It is also noteworthy that Gordon Brown, when he was the UK’s Chancellor of the Exchequer opted for an International Finance Facility (IFF) to raise \$50 billion annually from developed countries, in the decade up to 2015, to support the Millennium Development Goals (MDGs). The IFF would issue bonds in the international capital markets backed by legally binding long-term donor commitments. The development aid thus mobilised would be disbursed through existing multilateral and bilateral channels, while the bondholders

would be paid through future donor payment streams upon maturity of the bonds. This of course is the Private Finance Initiative (PFI) writ large, an approach pioneered in the UK which amounts to a form of deferred public financing which accommodates the needs of private financiers while conveniently allowing politicians to defer payment streams to the future even as they cater to more immediate electoral or other demands.<sup>vii</sup> Not coincidentally, the City (London's financial district), vying with Wall Street to be the pre-eminent global financial hub, accounted for 10% of UK's GDP in the years preceding the global financial crisis.

In contrast, President Lula de Silva of Brazil, joined by President Jacques Chirac of France leaned towards an alternative mechanism for MDG financing which relied upon global taxes on international currency transactions (a Tobin tax) and on arms sales. Variations of this proposal extended these global taxes to carbon-use, air travel, and profits of multinational corporations. This clearly would be doubly disadvantageous to the financial services industry – a tax on financial transactions, on top of lost opportunities for lucrative services and margins in bond issuance and bond underwriting.

The examples above illustrate the intensification of finance capital's thrust into development financing, risk management, and the financing of the production as well as the consumption of public services, which were traditionally the domains of the public sector at scales from the national to the global. Another example below illustrates how the policy influence of globally mobile finance capital is mediated not just through the leverage of the Bretton Woods institutions' neo-liberal dictates and structural adjustment programs (SAPs), but also through the operations of global capital markets and the ratings agencies.

As with other middle-income sovereign borrowers from the international capital markets, the Malaysian government is also under pressure to get its macroeconomic indicators "right" (by Bretton Woods institution criteria), so as to obtain favourable credit ratings from agencies such as Moody's and Standard & Poor's (a market-enforced SaP, so to speak), hence its determination to reduce its fiscal deficits from the pump-priming levels during the Asian economic crisis (5.8% of GDP in 1998) to 3.5% by 2006 (*The Edge*, 27 June 2006). Indeed, this has been a constraint on social expenditures and extends to potential contributions from publicly-owned corporations as well. In 2006, after posting record profits from the prevailing high oil and gas prices Petronas (Malaysia) president and CEO Hassan Marican, was queried as to why the national oil and gas monopoly could not increase its contributions to Malaysian government coffers to allow for increased social subsidies and relief from escalating domestic prices for energy. He explained that "we need the cash for our capital expenditure...Petronas is a [Fortune 500] global company, it's rated by agencies, it has papers [bonds] out there in the capital market, so you have to maintain that credibility... we could lose our investment grade or ratings..." (*Malaysiakini.com* 3 July 2006).

Petronas came on-stream in 1974, and soon thereafter was producing an exportable surplus, which helped Malaysia avoid the worst of the energy and debt crises of the 1970s and 1980s. It also allowed Malaysia to limit the Bretton Woods institutions' neo-liberal policy dictates such as structural adjustment. But it is now clear that neo-liberal policy

dictates and influence also operate through global capital markets and ratings agencies, constraining not just the public expenditures of sovereign borrowers, but also potential contributions from their publicly-owned corporations.

## 7. CONCLUDING REMARKS

Entering the second decade of the 21<sup>st</sup> century, we note two novel trajectories of welfarist states as they evolve under conditions of the dominance of globally mobile finance capital.

In the East Asian region, the interpenetration of state and capital has assumed novel forms, with the accumulation of huge foreign exchange reserves and sovereign wealth funds such as those managed by the China Investment Corporation, Singapore's Temasek, Malaysia's Khazanah, and their counterparts among oil and gas exporting countries in the Middle East. As capital and state merges, in the process blurring the boundaries between 'the public' (ownership of equity) and 'the private' (commercial *modus operandi* of enterprises), it is appropriate to ask again: is this a "nationalisation" of private enterprise space, or an extension of the logic of capital into strategic adjuncts of the state? What contending interests and conflicts are being engendered, exacerbated, or attenuated? What balance between social vs. economic (profit maximising) objectives is desirable on the part of public owners? The Malaysian government for instance owns and operates public hospitals, but it also has controlling stakes in the private hospital sector. The health ministry's hospitals and the teaching hospitals of state 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 sub-sector, and by continued poaching of public sector staff trained at public expense. On the other hand, the emergence of private hospital chains may also allow for some degree of rationalisation 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 of metropolitan Kuala Lumpur than in all of Australia.

The second noteworthy trajectory of course is the return of the interventionist state with a vengeance, in the heartland of neo-liberalism and beyond. Triggered by the collapse of the US housing "sub-prime" bubble in 2007, the ensuing turmoil in global financial markets led to massive state intervention to rescue imprudent *investment* banks, insurance companies and other financial intermediaries. In truth this was welfarism more for the benefit of risk-taking investors and the financial services industry, as opposed to depositors in a commercial bank or individuals, households, and employees suffering from the "collateral damage" inflicted upon the real economy. The unprecedented scale of the rescue measures - fiscal stimulus and massive deficit spending, expansionary monetary policy, and institutional bailouts by governments and central banks - is now stoking fears of runaway

inflation and has prompted Niall Ferguson (2010) to invoke the spectre of sovereign default, the mother of all bubbles inflated by the desperate injection of liquidity to deal with the serial collapses of earlier bubbles. Notwithstanding the monetarist measures, neo-liberalism stands discredited as an economic paradigm. In the search for alternatives, the question which neo-Marxists and neo-Keynesians alike have grappled with re-emerges: Is capitalism unavoidably a debt-fuelled binge in a never ending struggle to stave off underlying tendencies of stagnation and demand deficit? Is there truly no better alternative to this terrifying roller coaster ride, this careening between boom and bust, such as Margaret Thatcher famously declared to be the case: “there is no alternative”?

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**Table 1: Malaysian Health System: Ownership of Providers & Financing of Health Services**

		<i>Ownership of providers</i>	
		<i>Public</i>	<i>Private</i>
<i>Financing of health services</i>	<i>Publicly funded:</i> entitlements (citizens, govt employees), donations and (co)payments	Formal public sector: Rationed, free or highly-subsidised services	Non-profit providers: voluntary services, donations, paying patients, internal cross subsidies
	<i>Privately funded:</i> self-paid private employers, co-payments	Publicly-owned commercial providers, private wards/patients	Privately-owned commercial providers

**Table 2: Malaysian Health System (1999 – 2006): Public & Private Providers**

	1999		2006	
	Public	Private	Public	Private
Hospitals	128	225*	140	223*
Beds	37255	9498	38625	11637
Nurses	20914	6322	34598	13044
Midwives/Rural Nurses	6731	180	16090	577
Doctors	8723	6780	13355	8602
Dentists	803	1106	1368	1572
Pharmacists	401	1917	889	3403

Note: \* “private hospitals” include private hospitals, maternity centres, and nursing homes. For 2006, there were 121 registered private hospitals (of the 223). The rest were maternity centres and nursing homes.

Source: Malaysian Health Ministry (2006).

**Table 3: Health Expenditures, Malaysia (1997-2003)**

	1997	1998	1999	2000	2001	2002	2003
Total health expenditure (% GDP)	2.8	3.0	3.2	3.3	3.7	3.7	3.8
Government health expenditure (% of total health expenditures)	53.5	51.6	51.2	52.4	55.8	55.4	58.2
Government health expenditure (% of government expenditures)	6.1	5.1	6.5	6.5	6.4	6.6	6.9
Prepaid & risk-pooling plans (% of private sector health expenditures)	n/a	5.8	12.2	11.9	14.1	14.2	13.7
Out-of-pocket payments (% of private sector health expenditures)	100.0	94.2	75.0	75.4	73.5	73.6	73.8
Per capita health expenditure (US\$)	129	99	112	130	138	146	163

Note: These figures are WHO estimates from data derived or extrapolated from an expanded version of this template which were sent to member states during the consultation process in the preparation of World Health Report annex tables.

Sources: World Health Organisation (2003; 2006).

## NOTES

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<sup>i</sup> I have used the term *welfarist state* as a looser term to distinguish it from welfare states, which have formal entitlement schemes of varying degrees of coverage for employment security, health security, retirement and elderly security etc (best typified by Nordic-type social democratic systems). With or without formal entitlements, most modern states (are expected to) play a role in coping with uncertainty faced by their citizens, whether arising from social, natural, or created environments. This risk pooling function (to reduce welfare insecurity) I call the welfarist aspect of modern states, one of the composite aspects that modern states can express - developmentalist, corporatist, regulatory and coercive, repressive, militarist, social-reproductionist, etc. Malaysia, for instance, is not a welfare state in the Nordic mould, but its public health care system is quite accessible for most citizens. Its redistributive, affirmative action-type policies are also welfarist, albeit ethnically differentiated.

<sup>ii</sup> Citing the opinions of corporate figures such as Jack Welch, then chairman of General Electric, the *New York Times* (16 November 1997) reported that “Business executives and international investors who built today's global economy now fear that it might backfire...The Asian financial turmoil may be the first stage of a developing worldwide crisis driven mainly by a phenomenon called overcapacity: the tendency of the unfettered global economy to produce more cars, toys, shoes, airplanes, steel, paper, appliances, film, clothing and electronic devices than people will buy at high enough prices”.

<sup>iii</sup> Lipietz (1987) argues that “there are long periods of time when things work, when the configuration of social relations that defines capitalism, for instance, reproduces itself in a stabilized way. We call such a continuing system a regime of accumulation. This refers, of course, to economics but this can be extended to politics, diplomacy, and so on... we have to think [also] about the ways this regime of accumulation is achieved... individual expectations and behavior must take shape so that they are in line with the needs of each particular regime of accumulation. There are two aspects of the process. The first operates as habitus, as Bourdieu would say, in the minds of individuals with a particular culture and willingness to play by the rules of the game. The other operates through a set of institutions [which] may vary widely, even within the same basic pattern of social relations. Wage relations, market relations, and gender relations have, for example, changed a lot since they first developed. We call a set of such behavioral patterns and institutions a mode of regulation...”. If we add an element of periodicity, it calls to mind Kondratieff waves (business cycles) and the periodic build-up (and dissipation or destruction) of over-accumulated capital and excess capacity.

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<sup>iv</sup> Utsa Patnaik (2003: 1) discusses the deflationary bias of finance capital thus: “the emergence and dominance of highly mobile and fluid global finance capital in the wake of the oil-shocks of the 1970s and the largely successful attempts of this finance capital in moulding economic policy agendas worldwide... [it expresses largely] the interests of capitalists who deal in money to make profit [which] have always been substantially different from the interests of capitalists who are engaged in material production for profit on the basis of borrowed money. Financiers are creditors, and creditors above all wish to prevent inflation, which erodes their returns: they wish to maintain high real interest rates and want complete freedom to move their finances in and out of countries in search of the highest returns, which are mainly speculative in nature...”. Patnaik adds: “Deflationary economic policies combined with the removal of all national barriers to its free movement thus forms the core of the policy agenda of finance capital.” See also Patnaik (2004).

<sup>v</sup> Founded by a team of academicians in 1992, IMU 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.

<sup>vi</sup> 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 of the private clinics. In Hong Kong, well-remunerated and adequately-staffed public sector healthcare arguably 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) (Chan, in press).

<sup>vii</sup> For the 9<sup>th</sup> Malaysia Plan, 10% of the plan’s financing (amounting to RM20 billion) was to come from PFI schemes which would finance the construction of schools and health facilities among other projects.