EXPLAINING *1CARE*:

ITS PROPOSALS, RATIONALE AND FEASIBILITY

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INTRODUCTION

Determining the most effective health financing system to enable Universal Coverage (UC) is of central concern to national policymakers worldwide. UC allows the delivery of healthcare for all citizens regardless of income. For the World Health Organization (WHO), it constitutes a fundamental human right, and is seen as a key step in reaching the health Millennium Development Goals (MDGs)[1].

For those countries that already provide UC, policy-makers must focus on finding ways to raise the quality of services provided and make delivery more economically efficient. Restructuring should pursue *allocative* efficiency – targeting funds and resources to the activities which will return the most gains – and *technical* efficiency – using those resources (including equipment, drugs and staff) to generate the greatest output.

Malaysia already provides UC for a relatively low level of government spending. Motions to reform the healthcare system therefore cite the need to raise the standard of universal healthcare and make the allocation and expenditure of resources more efficient.

On 11 August 2009, the Malaysian Ministry of Health (MOH) presented a document to the Prime Minister and Economic Council proposing a reform package for the health sector, entitled *1Care for 1Malaysia (1Care)*. The following paper places this proposal in the framework of international universal healthcare objectives and the Malaysian national context, and assesses its viability amid growing controversy in Malaysia.

The International Context of Universal Coverage

Different countries have approached the goal of UC in different ways, and with varying results. Broadly speaking, of the roughly 200 countries in the world, national health systems reveal a wide variation based upon local market conditions and institutional frameworks. This makes deriving cross-country comparisons problematic, and a panacea health system elusive.

Nonetheless, social health protection schemes across all nations share one common aspect: a system of risk-pooling. Risk-pools involve funds being collected from many people, who all share the risk that they could become sick at some point, meaning that effectively many healthy people are subsidizing the few sick people who need to draw heavily upon health sector resources.

Risk pools can be financed in two ways, either by general tax (often called the Beveridge Model) or by Social Health Insurance (SHI) (sometimes called the Bismarck Model). In the former, the government allocates a portion of the general tax revenue to finance universal healthcare. In the latter, contributions are gathered from both employers and employees, and the government, and then all pooled into a health insurance fund, which is then used to provide universal healthcare. In this system, contributions are means-calculated, with the government contributing for those who cannot afford to pay[2].

Countries such as the UK, Spain, most of Scandinavia, New Zealand and Cuba all operate variations of a Beveridge Model. Under this system most hospitals are owned by the government and the result is

[1] http://www.who.int/en/
[2] http://www.who.int/en/

a low cost per capita for treatment, since the government has the capacity to control charges and services.

excited

The Bismarck model can be found in countries such as Germany, France, Belgium, the Netherlands, Switzerland and Japan. In these countries (unlike the USA) it is the law that every citizen must be covered by insurance, and at least a basic level of insurance is offered on a not-for-profit basis. Doctors and hospitals tend to be private (Japan for example has more private hospitals than the USA) and tight regulation enables the government to control costs, as in the Beveridge Model.

Other countries, such as Canada, Taiwan and South Korea employ a National Health Insurance Model (NHI), which is a mixture of the Beveridge and Bismarck, using private providers but deriving payment from a government-run insurance programme that every citizen pays into. Since there is no need for marketing, these universal insurance programmes tend to be simpler to administer than for-profit insurance, as well as cheaper. The single government payer also tends to have much power to negotiate for lower prices (in Canada for example, pharmaceutical prices are very low).

Finally, it should be noted that some poorer countries cannot provide any kind of mass medical care, and therefore provide neither the two former models, nor a mixture of the two. In such countries, medical care is only possible for those who can afford it.

Malaysian Healthcare now: Situation Analysis

The Malaysian healthcare system is well-recognized internationally for providing a wide range of access to primary and promotive care, for a relatively low cost. Like many middle and higher income countries, healthcare services are delivered by a mixture of a tax-subsidized public sector and a for-profit private sector. Within this combination it is then possible to discern "essentially four different types of hospitals: public sector, for-profit sector, corporatized (formerly public and non-profit, but now fully government-owned and profit-orientated) and for-profit 'private sector' hospitals partially or fully owned by the government"[3]. Currently, based on their financial status or insurance package, Malaysians have the option to choose whether to go to a government-owned clinic or a private facility for treatment.

The government-run public system is funded through revenues from taxation, and guarantees universal access to healthcare, for nominal fees[4]. The cost of this public health service is modest by international standards. That said, government expenditure still accounts for 59% of total health expenditure in the country[5].

In general, the Malaysian healthcare system provides a high quality of services, and 'fairly' (in the sense that no one is excluded from medical provision on account of socioeconomic capacity). A report from 2002 shows that the overall performance of the health services is "remarkably good", especially considering it only devotes 4.6%[6] of GDP to health, compared to 6% of most industrialized

[3] Simon Barraclough and Kai-Lit Phua, "A Strange thing happened on the way to the market: privatization in Malaysia and its effects on the healthcare system", in Kronenfeld, Jennie Jacobs, *Access to Care and Factors that Impact Access,* Emerald Books, 2011, 232

[4] William Savedoff, "Tax-based financing for health systems: Options and experiences", Discussion Paper, World Health Organization, 2004, 12

[5] Ibid

[6] Figure as of 2002, Donald S. Shepard et al., "Healthcare reform initiatives in Malaysia", Schneider Institute for Health Policy, October 16, 2002

countries[7]. Nevertheless, popular dissatisfaction and the perception of a large disparity between public and private sector facilities have led to a discrepancy in resources. At present, 65% of the population attends public sector facilities, which is served by just 45% of all registered doctors and 25-30% of specialists[8], just one consequence of the so called 'brain drain' from the public to the private sector.

The amount Malaysian citizens are spending on their healthcare is also growing, while government spending on health continues to rise but still remains lower than other Upper Middle Income Countries. Between 2001 and 2009 private expenditure rose from 41% to 44% as a proportion of total health expenditure, whereas in other Upper Middle Income Countries, it decreased from 52% to 45%. Furthermore, out-of-pocket (OOP) health expenditure in Malaysia accounted for 76.8% of private expenditure on health, and for 33% of total health expenditure in 2009.

[7] Shepard et al., 4
[8] David K.L. Quek, "The Malaysian Health Care System: A Review",

1CARE – A JUSTIFIABLE REFORM?

To assess the viability of *1Care* it is necessary to understand how the current Malaysian healthcare system will be altered by the new proposal, and the rationale given for such changes. The MOH has been keen to stress that *1Care* is "nowhere near its final stages"[9], so the following critique is based on what is, officially at least, still a provisional concept paper. The official source of information on 1Care is the MOH document that was proposed in August 2009, *1Care for 1Malaysia: Restructuring the Malaysian Health System.* The provisional nature of the paper makes it both vague and unspecific, leaving it open to misinterpretation, and making it the centre of controversy for both media and civil society groups. With this in mind, the following section seeks to summarise and clarify the central proposals given in the official MOH document to enable a more informed discussion of the issues surrounding it.

Understanding 1Care: What are the Principal Components?

a) Financial restructuring

According to the MOH proposal[10], financing for 1Care will be derived from a combination of two sources: (a) a mandatory Social Health Insurance (SHI) contribution, calculated on a sliding scale as a percentage of income, to be extracted from the employer, employee and the government; and (b) a governmental contribution (derived from general taxation) that would cover MOH activities and the SHI premiums for registered poor, disabled, elderly (those over 60), government pensioners and civil servants (+ five dependents).[11]

The proposal details two options for determining the funding contribution of employees and employers: either ⅔:⅓ or 50:50, employer to employee , with the former as the preferred option. The concept paper states that SHI premiums "are estimated at 9.5% of household income". The funds from the employer and employee would be collected directly as monthly salary deductions.

Under the proposed system, 62% of health financing would come from the SHI fund, financed equally by private contribution (31%) and general taxation (31%); 23% would come from private spending; and 15% would come from general taxation for the new public health functions. Private spending would be necessary for dispensing of drugs, dental treatment and voluntary top-up of the private insurance.

Medical services will be finaced by capitation with mixed case adjustments based on the health profile of the community. There will also be additional incentives for reaching performance targets - akin to a pay for performance system(P4P) - and inducements for working in less desirable locations.

The Concept Paper predicts that government spending on health will increase marginally from 2.11% in 2007 to 2.85%, but government subsidizing of healthcare will drop from 17.9% to 15.6% in the same period. Meanwhile, overall spending on health will rise from 4.7% to 6.2%.

[9] MOH representative, in Nur Shakinah Ab Karem, "Health Ministry: Clarifications on 1Care Article", *Malaysiakini*, 14th February, 2012

[10] "1Care for 1Malaysia. Concept Paper, Ministry of Health", *Ministry of Health Malaysia,* 11 August 2009

[11] The government is yet to decide which specific health model it will use for the *1Care* system, although the blueprint was supposed to become available two years after the 2009 proposal (http://www.themalaysianinsider.com/malaysia/article/1-care-blueprint-ready-in-two-years-says-liow)

b) Governance restructuring

Aside from the financial consequences, 1Care proposes to alter the governance structure of the Malaysian health system. The new arrangement detailed in the MOH concept paper proceeds as follows: at the top level (beneath Parliament and Cabinet) sits the MOH, alongside 'Independent Bodies', 'Central and Other Government Agencies' and 'Professional Bodies'. Beneath this layer, comes the National Health Financing Authority (NHFA), and finally, beneath this is sits the New Public Health Function (NPHF). The NPHF presides over 'public health services', 'other health services', 'policy and regulation' and 'the Malaysian Healthcare Delivery System (MHDS)'. Broadly, it will have the functions of developing and reviewing national level policy, legislation related to healthcare provision and marketing, and monitoring the performance of autonomous bodies.

The MOH will be streamlined to focus principally on governance and stewardship, while the function of delivering patient care is to be transferred to the "autonomous" MHDS. The MHDS is described as an integration of several regional/state authorities that will be responsible for addressing the health needs of their local area.

Under its supervision, the Primary Health Care Trust (PHCT) (also an autonomous agency which is accountable to the MHDS) is responsible for administering personal care and purchasing primary healthcare services from the independent contractors – or 'Primary Health Care Providers (PCHP)' – such as dentists and pharmacies. The PHCT also commissions services from both public and private secondary care providers, such as hospitals. The PHCT and other autonomous bodies under the MHDS will be run by their own management board and have the authority to remunerate staff based on performance and operate on a not-for-profit basis.

According to the Concept Paper, the PCHPs will become the "foundation" of the health services, comprising of medical practitioners such as dentists, nurses, paramedics, of both public and private clinics. They will often perform the role of family doctors and dentists, and function as gatekeepers to secondary and tertiary care, for example at hospitals.

The funds derived from mandatory SHI contributions and the general tax will be publicly managed on a not-for-profit basis, under the National Health Financing Authority (NHFA). These funds will then be disbursed to the regional/state authority. The NHFA will work in close collaboration with the MHDS and PCHT to design benefits packages and monitor the fiscal performance of agencies in the MHDS. Overall, the NHFA will be accountable to the MOH.

c) Impact on service delivery for patients

Under 1Care, the thrust of services would be on primary health care, with a strong focus on preventative care and early intervention. Healthcare will be provided by the Private Healthcare Providers (PHCP) (independent contractors), and family doctors who would also act as a gatekeepers, referring patients onto clinics and hospitals where necessary. For patient administration, it is proposed that the entire population be registered to a specific PHCP, according to the location of their home, work or school. Drugs would be dispensed by independent pharmacies.

What is the Rationale behind 1Care?

Various justifications have been given for reforming the healthcare system. Below, in a discourse analysis of the MOH concept paper, the five central rationalizations presented in the MOH paper are presented and scrutinized.

a) The principles of equity, solidarity and fairness

The rationale behind *1Care* is to "ensure universal coverage for the health care needs of the population, based on solidarity and equity"[12];the principles of fairness and equality are repeated throughout the Concept Paper. The MOH argues that the distribution of healthcare facilities in Malaysia is currently unbalanced, with private centres concentrated mainly in urban areas, and specialist services predominantly available in larger towns. As a result rural communities receive a comparatively lower quality of service, leading to "a discrepancy of health outcomes between urban and rural populations"[13].

In addition to the urban/rural divide, the MOH also contends that there is a great disparity between public and private sector services. It is argued that as incidences of medical tourism rise, this could further exacerbate the gap between the two sectors, as foreign patients are willing to pay increasingly higher fees. Furthermore, the growing phenomena of 'brain drain' from the public to the private sector exacerbates the discrepancy between private and public sector healthcare quality, by depleting the stock of high quality staff in the public sector. It is hoped that this drain of public sector workers would be assuaged by the new financial incentives offered by corporatized private hospitals.

Analysis

Nevertheless, the benefit of the existing system is that patronage of private healthcare by those who can afford it (affluent local and foreign clientele) in theory leaves more public healthcare facilities available for public healthcare consumers[14]. One of the principal arguments against the proposed scheme is given by the Coalition Against Healthcare Privatization (CAHP), a coalition of 81 NGOs, trade unions and political parties, which questions the need for creating a new national healthcare system, as opposed to just strengthening the existing tax-based system. Others echo this argument that the interests of the general populace would be better served by preserving and re-enforcing the existing public healthcare system.

Furthermore, critics of 1Care charge that the present healthcare system is in fact already both inequality-reducing and pro-poor, since the poorest quintile receives significantly more than 20% of the total subsidy[15]. This is achieved because it is well balanced between enabling those who can afford it to pay for high quality healthcare services, and providing a safety net for the poor in the form of the Social Security Organization (SOCSO). The success of this balance is itself explained by Malaysia's rising national income, which means that as earnings and spending levels rise, the health needs of the higher income groups can be met and additional programmes can be targeted to the needs of the poor[16].

This argument is backed up by a WHO report carried out in 2002, which determined that Malaysia in general achieves a "remarkably high and equitable health status at a relatively low cost". Moreover, the Health Adjusted Life Expectancy (HALE) at birth is comparable to that of industrialized countries. This is an impressive accomplishment considering the Malaysian government devotes less of its GDP to the health sector than other industrialized countries[17].

This report concluded that the country should "proceed with limited reform", focussing on improving management, to create better working conditions for staff and enhance responsiveness to patient needs. The report did not suggest that Malaysia should set up a system of universal health insurance

[12] "1Care for 1Malaysia. Concept Paper, Ministry of Health", *Ministry of Health Malaysia,* 11 August 2009
[13] "1Care for 1Malaysia. Concept Paper, Ministry of Health"
[14] HL Chee, "Ownership, control and contention: challenges for the future of healthcare in Malaysia", *Social Sciences and Medicine,* 2008, Vol. 66, 2152
[15] Owen O'Donnell "The incidence of public spending on healthcare: comparative evidence from Asia", *World Bank Economic Review,* Vol 21 (1)
[16] Ibid
[17] Shepard et al.

to cover public and private provision, arguing that it would place too much emphasis on curative services, and be too inflationary. The report contends that the availability of insurance would lead to various problems, such as making it too easy for private providers to hike up fees and increase the range of services available, even when this wasn't needed[18].

Furthermore, using Kakwani's Progressivity Index, Chai Ping Yu et al. show that the new NHI system is noticeably less progressive and would be less equitable than the current one. The current one is both equitable and progressive because it is associated positively with income[19].

b) *1Care* would lead to greater efficiency and autonomy

The discourse analysis of the MOH concept paper reveals repeated emphasis on the goal of achieving greater efficiency and autonomy in the health sector through the proposed restructuring. This is anticipated through the incorporation of public and private providers under the new MHDS: "horizontal integration between the public and private sectors and vertical integration between the various levels of care within the health care delivery system...will promote greater technicaland allocative efficiency"[20]. Moreover, at the functional level, staff and facility performance is expected to be enhanced by a pay for performance scheme.

Analysis

The rationale that a pay for performance (P4P) scheme would lead to better service quality and efficiency needs considering. P4P payment structure in the healthcare sector is a relatively recent phenomenon, making literature and research on the subject preliminary[21]. A World Health Report published by the WHO in 2010 concluded that it is very difficult to assess the viability of the P4P scheme since the evidence concerning P4P is either weak or unavailable. Although this doesn't preclude the notion that P4P could be made to work, there is also no evidence as to whether other undetected issues might also arise as a consequence. For example, the P4P could impact on equity depending on how it is structured: the measures used to calculate rewards could lead practitioners to favour certain patients over others[22]. Ultimately, it is clear that P4P is a growing practice around the world, but since measuring its impact remains problematic, there is no empirical data to prove whether or not it will improve efficiency. Ultimately, what will be important is *how* the P4P programme is implemented, something which relies on strong foundations accountability and legitimacy at all levels of the governance and administrative structure.

The financing of healthcare through the proposed capitation payments system also requires analysis. Lee shows that the Thai experience of capitation payments in establishing a new system of healthcare in the early 2000s was largely successful. This payment method avoided the escalating costs that arise from a fee-for-services system. Under the capitation payments scheme, the remuneration of primary healthcare providers (in Malaysia's case the PCHPs) is based on the number of patients registered for a defined period of time. This has several benefits, including controlling costs, and favouring preventative care and the prescription of low-cost medicine[23]. A system based on capitation payments also avoids the 'moral hazard' of services being overused without legitimate cause. Nevertheless, while Lee lauds the achievements of the Thai SHI and capitation system and even recommends it for Malaysia, he notes several prerequisites that could preclude its successful

[18] Shepard et al., 4

[19] Chai Ping Yu, "Reform towards National Health Insurance in Malaysia: The equity implications", *Health Policy,* Vol 100, 2011

[20] "1Care for 1Malaysia. Concept Paper, Ministry of Health"

[21] Richard M Scheffler, "Pay for performance (P4P), Programs in Health Services: What is the evidence?", World Health Report, WHO, 2010

[22] Ibid, 8

[23] Nathaniel Lee", Social Health Insurance in Malaysia – Lessons from Thailand and South Korea", *Kajian Malaysia,* Vol 30 (1), 2012

transference: political and social support, support from the medical community, and regulatory monitoring.

In Thailand, the new capitation-based SHI formed the basis of the 2001 victory for the Thai-Rak-Thai Party, and therefore had considerable support from both the general public and the medical community. Conversely, in Malaysia one of the principle criticisms that has been levied at the *1Care* proposal is that many of the relevant stakeholders have not been consulted in its creation. Many doctors have raised objections over the SHI, but many feel their concerns are not being heeded. Furthermore they contend that the stakeholders that are invited to discuss the proposals are not fully representative of the medical profession, or do not provide comprehensive feedback on issues surrounding the SHI. For Lee, support from the medical community is essential so that staff feel properly remunerated. This is especially important if public institutions will be expected to compete with private providers. As a result, such popular discontent could present a significant stumbling block in the path to success for the Malaysian SHI.

c) Aligning healthcare with 'upper-middle income nation' standards

Lastly, 1Care forms part of the broader national objective of attaining higher income nation status by 2020. The MOH concept paper contends that Malaysia's health care financing system is currently more in line with those of lower or lower-middle income countries, making reform imperative to bring the healthcare sector in line with this key national target.

As national incomes rise and lifestyles evolve, consumer expectations surrounding healthcare services change. Not only do the wealthy want better services for the money they spend, but there is the sense that a collective rise in living standards and national wealth should also be reflected in the standard of public services.

The rapid progress of economic development also has implications for demographic composition. Better health facilities result in an increase in the elderly as a proportion of total population. From a healthcare perspective, this leads to a rise in the prevalence of ill-health, notably chronic problems which require long term and palliative care. The elderly are more predisposed towards serious health conditions which are also more costly.

Analysis

Such trends are not peculiar to Malaysia, but are the concern of developed and rapidly developing nations worldwide. As has already been discussed, every nation approaches tackling these issues in a different way, according to its specific cultural, political and market conditions. In this sense, to assert that there is a model healthcare system for middle or higher income nations that Malaysia should aspire to is problematic. The goal is rather attaining universal healthcare with a financing model that functions effectively in the specific national context given.

Furthermore, other nations that have altered their healthcare financing system to facilitate UC and those which already have a functioning SHI model similar to *1Care* all share some common features which are absent in Malaysia. Most notable in Malaysia is a heightened public suspicion surrounding the government's motivation for the reforms, something which does not appear to such a crippling extent in other countries. The cause for this can be directly linked to a perception of high corruption and political scandal[24] and the pervasiveness of 'rentier capitalism'.

The term 'rentier capitalists' refers to people whose incomes are high solely as a result of privileges obtained through political connections. The growth of this kind of capital can be traced back to the privatization policy instituted in 1983 under the Mahathir administration, which increased and

[24] See Transparency International's Corruption Perception Index

diversified business opportunities. As a result, a system of political patronage was created which led to the allocation of state assets to politically well-connected private entities, thus creating a "mutual dependence between the business elite and the political rulers"[25].

The privatisation of state assets began to have a significant impact on the health sector in 1994, when the government drug procurement and distribution centre was privatised to Southern Task (M)Sdn Bhd, a subsidiary of an UMNO-linked company. Also at this time, three companies were awarded 15 year contracts for healthcare support services, expected to generate annual revenue of RM600 million. Perhaps the largest politically connected healthcare conglomerate in Malaysia is Pantai Holdings, which owns seven hospitals in Malaysia as well as three government contracts through its subsidiary companies.[26] Although following the 1997 financial crisis many of the large companies under the control of rentier elites were bankrupted and taken back by state companies, there is still a perception that a system of political patronage persists in the healthcare industry, and would threaten the legitimacy and accountability of the arrangement proposed under *1Care*.

As a result, various critics have questioned the government's integrity and motivation for altering healthcare financing, drawing attention to government support for the private hospital sector. They argue that the Malaysian government has not hidden its proactive efforts to develop the healthcare industry, and in particular has encouraged private sector growth through various tax incentives[27]. State support of the private hospital sector is particularly clear in the MOH's promotion of medical tourism following the 1997 Asian financial crisis. Under the Health Industry Branch of the Corporate Policy and Health Industry Division (created in 2005), there exist departments on health services, products and tourism, which are all mandated to promote the health industry through financial incentives[28]. Opponents argue that the government is promoting the interests of the healthcare provider industry, which are in direct conflict with those of the public, in order to pursue private gain.

Opponents also draw attention to how the dual role of the government as regulator and industry-operator under the *1Care* proposal would limit its accountability. The state would act as intermediary and regulator between healthcare providers, financing bodies and users, while at the same time being a provider through the corporatized hospitals, and an investor-owner in the private hospitals through the Government-Linked Companies (GLC). Critics argue that the state will not be able to play the part of a strong regulator while it also has vested interests as an investor due to its lack of independence[29].

Finally, concerns have been raised about how such a large fund can be managed with efficiency and accountability. *1Care* is estimated to be second in size only to the Employees Provident Fund (the compulsory national retirement savings scheme). Opponents to the scheme, including the opposition front in the 1999 elections, have questioned whether the government and rentier capitalists can be trusted with such a large amount of money[30].

d) Responding to the unsustainable rise in the cost per capita of healthcare

Malaysian policy-makers have noted an average annual increase in the per capital health budget of greater than 10%, and argue that financing for healthcare should therefore be moved out of the government budget[31]. Nevertheless, analysts point out that Malaysia's rapid economic growth over

[25] HL Chee, 2150
[26] Ibid
[27] See HL Chee, 2152
[28] Ibid
[29] HL Chee, 2145
[30] HL Chee
[31] William Savedoff, 13

recent years has in fact enabled income and tax levels to keep pace with the rate of health expenditure rises, and consequently remains a relatively small share of GDP[32]. Furthermore, by international standards, overall health expenditure in Malaysia is much lower than in other upper middle income countries.

[32] Ibid

CONCLUDING REMARKS

Studies show that the Malaysian health system is currently able to provide a good quality of universal healthcare, with a fair distribution of access. Through the present financing scheme, which mixes public and private sectors, health coverage is provided to Malaysian citizens for only ??% of GDP, compared to 6% in most industrialized countries.

The proposed *1Care* reform package will entail a restructuring of finance, governance and service delivery. The aspect of the planned reform which has attracted the most concern amid controversy in the media is the impact that it will have on national taxes: citizens are concerned that they will have to pay more for their healthcare under *1Care*.

The official MOH paper is provisional and unspecific on many important aspects, which has generated much of the aforementioned confusion and anxiety. This paper sought to clarify why the MOH has proposed the changes detailed under *1Care*, and then analyse if these official explanations are indeed viable.

Overall, the proposal to reform healthcare is critically hampered by a lack of detailed research and data on current healthcare provision in Malaysia. This makes reform problematic on many levels. Lack of adequate data in the public domain means that the public cannot come to a reasoned decision of whether or not they endorse the proposals, and policy-makers are themselves unable to base their proposals on adequate evidence.

Based on the analyses and evaluations in the preceding sections, the following conclusions and policy recommendations are put forward:

- **More research is needed to justify changes**
  Much more research is necessary to substantiate the claims that are used justify these plans elaborated under *1Care*. Specifically, data must be collected to show how the present health system is utilized, what its weak areas are, where it is under strain, in order to show where any reforms should be targeted.

  Higher quality research and statistical data will enable both the healthcare consumers and the policy-makers to determine what kind of healthcare system would align best with Malaysia's specific requirements. Without proper data to explain the need for the reforms, they cannot be justified.

- **Publish data**
  This research described above should be placed in the public domain by the government, aided by the print and online media. The purpose of this is to inform the general public about how the present health system is functioning and their human right to universal healthcare. Only with greater knowledge can citizens properly evaluate what health system they want, and thus exercise their democratic right to attain it.

  In 2000 the Chilean healthcare system was reformed to provide universal coverage under the *AUGE Plan*, which made explicit guarantees to provide better access to treatment, financial protection and efficiency of delivery. The plan responded to problems that are akin to those voiced by the MOH to justify its proposed reforms: good average health indicators, but poor ranking in terms of equality, with the low-income segments of society being served by the

public sector, and the rich utilizing private sector services; and a changing epidemiological profile of the population as a result of lifestyle changes, aging and urbanization[33].

But, importantly, in Chile, before the proposal for reform could be made, working groups were established, that involved trade union members, academics, physicians and service providers. The MOH also invested in publicity to generate a more active participation from the public, and "make them aware…of the right to demand universal healthcare"[34]. Hence all interested parties were consulted in the drafting of the proposal, ensuring it reflected the concerns of these stakeholders and could enjoy a better reception once published. And even when the Chilean Medical Association opposed the reforms, going on strike in 2002, there was space for public discourse which enabled human rights rhetoric and civil society groups to mediate the dispute and come to an agreement.

As a result, in Chile, people were both made aware of their human and democratic right to the healthcare system they desire and need, and also empowered by a richness of data and public debate to inform these opinions. It is proposed that before *1Care* is ratified, a similar platform for public debate, based on data, research and the concerns of key stakeholders, be established.

- **Greater government transparency**
  As has been discussed, much of public and media distrust regarding the stated benefits of *1Care* stems from the perception of undisclosed interests relating to governmental support for the private hospital sector. These ties make certain proposals, such as the dual role of the government as regulator and industry-operator, seem unfeasible given perceived conflicts of interest.

  The World Bank's *Worldwide Governance Indicator* measures the effectiveness of national governments around the world. On the indicator for *Voice and Accountability*, Malaysia is ranked low at the 32nd percentile, and the country's standing for *Political Stability* has been dropping since 2005, from the 62nd to the 43rd percentile[35].

  It is necessary that positive inroads are made into achieving a greater level of government transparency. Granting civil society the right to access government documents and proceedings, allows for public oversight and results in a higher level of trust in government policy and initiatives. Openness in government results in public participation in political processes and enhances democracy. This has benefits both for the people who are able to contribute to the creation of policies that represent their interests, and also for government through the establishment of a more secure and trusted environment for its governance. Transparency must become a national asset rather than an administrative burden.

- **Some possible alternatives to *1Care***
  Given the lack of data relating to public health and healthcare services in Malaysia, in suggesting alternatives to *1Care* we are faced with similar problems to the *1Care* proposal itself: lack of information on which to base recommendations.

  Perhaps a more reliable place to start therefore is in isolating some key problems with the current system that have been highlighted repeatedly in the media and the MOH report.

[33] Eduardo Missoni and Giorgio Solimano, "Towards Universal Health Coverage: the Chilean Experience", 25
[34] Ibid
[35] Kaufmann, Daniel et al., "The Worldwide Governance Indicators", Policy Research Working Paper 5430, The World Bank, Development Research Group, September 2010

Nevertheless, caution should still remain regarding an absence of published data on which these are based. Identified weak areas include: brain drain from public to private sector, and from Malaysia to other countries; changing epidemiological population profile resulting from aging, urbanization and lifestyle transformation due to higher incomes and living standards.

It is proposed here that, rather than an overhaul of the current healthcare financing system, these challenges can be met by a series of smaller, independent policy initiatives, which target the specific issues at hand *directly*, with measurable KPIs and a mapped timeframe for achieving publicly stated goals. Such initiatives could include:

1. Increasing funding for better primary and secondary prevention of chronic diseases for middle-age groups[36], with the expected outcome of minimizing the future demand for more expensive services. In 2001, Malaysia spent only 18% of funds on prevention and primary care, with 47% going on curative medical care[37]. Earlier intervention to promote a healthy aging population could minimize the burden of this demographic shift on the healthcare system. Such interventions should target risk factors such as tobacco use, diet, alcohol abuse and physical inactivity. Such risk areas can be tackled through public awareness campaigns and counselling, and other social methods. These can prevent chronic issues from developing later in life, and are relatively much cheaper and less traumatic than providing invasive medical treatment once the condition has become chronic. In Thailand for example, an additional 2% "sin tax" was imposed on tobacco and alcohol, and various campaigns were launched to promote well-being via a transformation of social values and lifestyles. In the period 2003-4 to 2008-9, the percentage of regular smokers dropped from 45.9% to 38.7%, and in the same period hypercholesterolemia declined from 87% to 73%[38]

2. Rather than reforms which will affect both the public and the private healthcare system, the public sector alone should be the primary focus of change. In line with a WHO report of 2002, it is proposed that both the integrated regionalized health services, and specialized medical institutions in the public sector be corporatized[39]. The corporatized unit would then monitor and reward performance, which would create a salary scale to better reward staff and reduce brain drain.

   The corporatized units would be paid by the MOH through a combination of a fixed budget based on capitation, and performance rewards[40]. Funds would come from two areas: a continuation of the general subsidy from tax revenues, and an expansion of the Employee Provident Fund (EPF)[41].

   The idea is to expand the EPF so that it covers all hospitalization in public facilities[42]. The private sector can continue to operate on a full-payment basis, providing a benchmark for quality of services for the public sector[43].

[36] Viroj Tangcharoensathien et al., "Universal coverage scheme in Thailand: equity outcomes and future agendas to meet challenges", World Health Report, WHO, 2010, 9
[37] Shepard et al, 5
[38] Srithamrongsawat, Samrit, "Funding health promotion and prevention – the Thai experience", World Health Report, WHO, 2010, 8
[39] Shepard et al, 6
[40] Shepard et al, 10
[41] Ibid
[42] Shepard et al, 11
[43] Shepard et al, 12

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