Privatising Healthcare in Malaysia: Power, Policy and Profits

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ABSTRACT This article examines the hypothesis that interest groups are behind the increasing privatisation of healthcare services in Malaysia. The evidence supports the instrumentalist argument that powerful interest groups seeking profits, rather than real concerns for allocative efficiency, have been the prime drivers of healthcare privatisation in Malaysia. Not only have private healthcare expenditures risen more swiftly than government healthcare expenditure but, from 1982, public funds have also been used to purchase private services from public hospitals. However, unlike simple class analyses, class contention manifesting through alliances between politicians, bureaucrats and capitalists has been a major force behind healthcare privatisation in Malaysia. The source of these developments can be traced to power wielded by the government to quicken the creation of a Bumiputra capitalist class that began to gain momentum from the late 1970s.

KEY WORDS: Healthcare, public, private, power, policy, Malaysia

Inspite of mounting arguments explaining the inability of market forces to allocate and co-ordinate healthcare resources effectively (see Evans, 1997; Freund and McGuire, 1999; Light, 2000; Weisbord, 1988), the privatisation of health-related services continues to expand unabated in developing economies. The expansion of profit-driven private healthcare originated in developed economies, but it has expanded most sharply in developing economies. The share of private healthcare in total healthcare expenditure in Malaysia exceeded that of the UK, Sweden, Italy and Germany in 2004. It is this paradoxical development that is attracting considerable research attention, attempting to identify the forces behind the process (see Chee and Barraclough, 2007).

Whereas public hospitals are set up to meet social objectives by providing healthcare to all, irrespective of patients’ ability to pay, private hospitals are usually driven by the search for profits and hence are limited in the range of specialisations they offer (see Baumol, 1980, 1988). Given the lack of an effective way for markets to clear, owing to information asymmetries, most private hospitals are likely to seek higher than normal treatment costs. In addition, because payments are central to the operations of profit-based private hospitals, ailments that typically involve the poor, such as tuberculosis, malaria, cholera and typhoid, are seldom provided by them.