Aspects of healthcare policy in Malaysia: Universalism, targeting, and privatization
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What is This?
countries. Thus, to devote even 1.0 percent of GDP for the basic social protection package would require considerable fiscal readjustment, which would also be very politically challenging.

The report and the chapter have performed a valuable service in providing a basis for a more sophisticated discussion of policy options for integrating social sector policies and programmes into development strategies. The onus is now on policy-makers and other stakeholders in individual countries to reconfigure social policies and programmes to achieve better outcomes, consistent with economic and social development.

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**Aspects of healthcare policy in Malaysia: Universalism, targeting, and privatization**

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**Universalism and targeting: Different phases in a capital accumulation cycle?**

The UNRISD report *Combating Poverty and Inequality: Structural Change, Social Policy and Politics* (2010) suggests that in some countries, severe economic downturns affecting large numbers of organized formal sector employees may oblige the state – sometimes in the form of authoritarian populism – to intervene to contain social tensions and to prevent a systemic breakdown. The 2008 global financial crisis is a reminder that the correlation of social forces is a key element in determining whether this results in more universal social protection, or takes the form of corporate welfare in an attempt to restore systemic function.

In this article, I address additional aspects of the political economy of universalism and targeting, which encompass targeting as the persuasive face and generic template for privatization; privatization as an expression of capital over-accumulation, and hence over-accumulated capital as a motive force for targeting and the demise of community (universalism). In a sense, universalism and targeting may represent different phases of a capital accumulation cycle in its roller-coaster trajectory through booms and busts.

Drawing upon the example of Malaysia, this article also argues for more attention to interactions between the public and private sectors in a more holistic view of a health system in transition, when addressing targeting, universalism and healthcare access. Indeed,
in East and Southeast Asia, where sovereign wealth funds are increasingly active as commercial investors in the services sector, the very notion of public and private becomes ambiguous as ownership gets conflated with modus operandi in the affected services.

In an earlier commentary, I argued that targeting as a policy choice is eminently compatible with the concerns of entrepreneurs and investors seeking profitable opportunities in service sectors, which hitherto had been the domain of the public sector (Chan, 2006). With the devolution of social services to private enterprise, entrepreneurs in search of investment prospects would be primarily interested in the ‘market-capable’ segments of society (if the state demurs from extending this effective demand, through public financing, to those without disposable incomes). Seen in that light, targeting is also the persuasive face and generic template for the privatization of essential social services, persuasive because it draws upon considerable intuitive appeal.

In this commentary, I further suggest that the neoliberal push for privatization could be regarded as one manifestation of capital over-accumulation. If globalization could be considered as a technology-enabled continuing outward impulse of capital, driven by saturated mature markets and the search for competitive advantage (in production and in control of natural and human resources) and for emerging markets, privatization would be the inward impulse – cannibalizing the welfarist state, market creation and market deepening, extending the circuit of capital into hitherto non-commercial public sector domains.

The Malaysian health system in transition: Public–private interactions

While healthcare is not inscribed in the Malaysian constitution as a human right, Malaysian citizens have become accustomed to a de facto entitlement to highly subsidized publicly provided healthcare as an important element of social policy since independence (1957). In practical terms, this universalistic entitlement expands or shrinks depending on the level of funding and other resources allocated to the public sector.

Of late, a succession of health ministers have argued – using a rhetoric of targeting – that affluent Malaysians who can afford private sector charges should avail themselves of private health services (suitably encouraged thus with tax rebates). This would allow the government to concentrate its limited health resources on the ‘really deserving poorer citizens’.

This is a remarkable echo of Jessica Einhorn’s call to wind down the World Bank’s lending arm for middle-income countries, the International Bank for Reconstruction and Development (IBRD) (Einhorn, 2006), which followed upon the recommendations of the Meltzer Commission (2000) for a triage of borrower countries: debt cancellation and performance-based grants for the most destitute of highly indebted countries, as opposed to the more ‘credit-worthy’ borrowers with access to capital markets, who should be weaned from multilateral lending agencies and henceforth be serviced by private lending sources (the privatization of the IBRD, as it were, by divesting to private capital markets its development lending to ‘market-capable’ middle-income countries) (Chan, 2008).

Less apparent in the calls to privatize healthcare for the middle classes in Malaysia is the fact that Malaysian government agencies, at both federal and state levels, are heavily invested in the commercial healthcare sector. In effect, they now own or operate three parallel systems of healthcare providers:
• The regular Health Ministry facilities (as well the health facilities of the Ministry of Defence);
• Corporatized, publicly owned hospitals (National Heart Institute, university teaching hospitals);
• The Pantai chain of hospitals (the second largest in the country), operating as commercial hospitals with Khazanah (the Malaysian sovereign wealth fund) as a controlling shareholder, similarly with the KPJ chain of hospitals (the largest), controlled by the Johor state government through its corporate arm, the Johor Corporation.

This novel situation, rife with conflicts of interest, raises intriguing questions for health and social policy in Malaysia:

• What are the implications of these developments for universal coverage?
• Are KPJ and Pantai hospitals public (in the sense of ownership), or private (in the sense of commercial modus operandi)?
• Is this a ‘nationalization’ of private enterprise space, or an extension of the logic of capital into strategic adjuncts of the state?
• What contending interests and policy conflicts are being engendered, exacerbated, or attenuated?
• What balance between social vs profit maximizing objectives is desirable on the part of public owners?
• Is there evidence that the profits and returns accruing to the KPJ and Pantai hospitals are progressively redistributed via cross-subsidies to poorer patients, or through corporate taxes and more diffuse channels of Khazanah and Johor unit trust funds?

Malaysian citizens may or may not avail themselves of publicly provided universalistic entitlements, but even those who do not do so benefit from its second-order effects, insofar as the availability of subsidized public sector healthcare (of a certain quality) acts as a fallback option – a restraining price bulwark – which helps to keep private healthcare prices within a more affordable range.1

In Singapore, the government’s strategically located and well-equipped polyclinics account for only 20 percent of primary healthcare on the island, but their subsidized outpatient services seem to provide sufficient price competition to help restrain fee increases among the private clinics. In Hong Kong, well-remunerated and adequately staffed public sector healthcare achieves a similar effect.

With the changing structure of ownership of the healthcare sector, these public–private interactions in a pluralistic healthcare system need to be reanalysed for their implications for universalism and targeting in healthcare access.

Note
1. The political implication is that it is in the interests of all Malaysian citizens to support the continuance of widely accessible, publicly subsidized, adequately resourced, no frills healthcare of quality, regardless of whether they patronized the public sector or not.
The global politics of poverty alleviation in the context of a multiple crises

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For those who have been critics of the Bretton Woods driven social policy agenda in the period from the 1980s till recently, the UNRISD report *Combatting Poverty and Inequality: Structural Change, Social Policy and Politics* comes like a breath of fresh air blowing away all the old nostrums of ‘targeting’ and ‘leakages’ and ‘inclusion errors’, and reasserts the essential validity of the universalism argument, giving emphasis again to the essential role of the state in overseeing such a policy. It is fitting that whereas the controversial World Bank’s World Development Reports (WDRs) of 1990 and of 2000 dominated the international debate about world poverty and how to reduce it, the Bank left the stage clear in 2010 to in effect give space to UNRISD and also to the UN-DESA’s ‘Rethinking Poverty’ report.

That having been said, the problem with the UNRISD report, like most UN documents, is that it is trapped within a paradigm of advice to governments and is unreflective of its own part in the system of global social governance and the global debate about poverty alleviation within and between international organizations. It is also trapped within a methodological nationalism, seeing problems as located within countries requiring solutions to be found within them. It reinforces the current fashion, echoing the wish of many in the Global South to come out of aid dependency, by arguing that ‘a