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SOCIAL HEALTH INSURANCE IN MALAYSIA – LESSONS FROM THAILAND AND SOUTH KOREA

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The rising cost of healthcare in Malaysia has had a detrimental effect on access to care. In 2009, the major sources of financing for national healthcare expenditures were via government subsidies and out-of-pocket expenditures. Although social security schemes are in place to ease government spending, these schemes have not been inclusive enough to significantly alter expenditure trends. The suggestion for a national social health insurance (SHI) scheme was put forth in the 1996 Seventh Malaysia Plan. SHI schemes have formed the basis for successful health system financing initiatives in various countries. South Korea and Thailand are two Asian countries that have undergone progressive economic development and successful transitions to SHI-based schemes. Drawing from the experiences of these two countries, certain recommendations can be made to create a positive environment for a transition to a SHI-based healthcare system in Malaysia. These intertwined criteria include enabling appropriate institutional capacities, directly addressing the rising cost of healthcare, and ensuring the continuity of universal coverage of care.

Keywords: Malaysia, health policy, reform, insurance

INTRODUCTION

Reforming and implementing effective healthcare reform continues to be a major issue worldwide. Typically, reform has entailed a re-examination of the mechanisms of health financing and delivery of healthcare as major areas of change. Healthcare financing is the activity of raising or collecting revenue to pay for the operation of a healthcare system, which has conventionally been categorised as based on taxation, social health insurance, private health insurance and out-of-pocket payments (Yu, Whynes and Sach, 2007). Regardless of which financing system is employed, the system must be robust enough to attain and sustain increased, ideally universal, coverage whilst addressing the inevitable issues that accompany improved access to health, such as an ageing population (World Health Organization, 2010a).

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The Malaysian healthcare system continues to be separated into two providers: a tax-subsidised public sector and a for-profit private sector. However, several factors continue to plague the achievement of equity in healthcare. Four major avenues of funding serve as healthcare financing sources for both sectors (Kananatu, 2002).

Table 1: Healthcare finance sources for public and private sectors

Public sector	Private sector
• Taxes – income, sales, etc. • Out-of-pocket payments	• Contributions to formal employed sector pension packages such as the Employee's Provident Fund (EPF) and the Social Security Organisation (SOCSO) • Private insurance schemes • Out-of-pocket payments

Source: Kananatu, 2002.

Although Table 1 suggests a system with an adequate balance of financial sourcing, several factors skew this conclusion. Private sector health providers, who are mainly concentrated in urban, densely populated areas, represent a major barrier for access to health for a majority of people with inadequate financing (Ismail and Rohaizat, 2002). As a result, the increasing trend of needing out-of-pocket payments to afford private care along with the migration of human resources from the public to the private healthcare sectors constitute a huge burden to establishing equity in access to healthcare. This paper discusses several alternatives that could be pursued to bring better equity to healthcare access.

The 2010 World Health Report presents several models of health financing for universal coverage by employing the experiences of various member countries. These models are described as paths to universal health coverage, which may be implemented irrespective of a country's current level of economic development. The system adopted by Thailand, which saw the introduction of universal coverage in 2002, has experienced vastly improved service coverage and protection against the financial risks of ill health despite spending considerably less on healthcare than higher income countries (World Health Organization, 2010b). Similarly, the system implemented in the Republic of Korea aims at expanding existing health coverage schemes but has encountered slower progression towards universal coverage compared to Thailand.

These experiences, which can be transposed onto the current Malaysian healthcare system, will serve as vital benchmarks for policy changes to achieve healthcare reform in Malaysia. This paper will describe the historical background of the current healthcare system, which has led to the status quo, and compare this to the development of the Korean and Thai healthcare systems through the

use of social health insurance schemes. Both South Korea and Thailand share common historical development milestones with Malaysia and represent future developmental pathways that will need to be addressed in any potential Malaysian healthcare reform effort. By evaluating the failures and successes of Thailand and South Korea in striving towards universal coverage, the path to an improved Malaysian healthcare system may be found.

BACKGROUND – THE MALAYSIAN EXPERIENCE

Shortly after independence, Malaysia experienced the development of public sector-led equitable health programs that helped raise the standards of living across the country. However, the 1990's saw the aggressive expansion of a market-driven divestment of previous state-managed health enterprises as promulgated by then Prime Minister Mahathir bin Mohamad's "Malaysia incorporated" policy (Barraclough, 2007). Although replacing the state delivered health system was never intended, the shift in social policy altered the structure of healthcare delivery.

Government incentives for investments into private healthcare by the late 1990s accelerated growth in regard to the quality of services and increased demand for private healthcare providers. Tax-incentives were provided to private corporations to invest in healthcare; such as in the case of government-led efforts to increase health tourism (Kananatu, 2002; Chee, 2007). Government-led privatisations of state-owned health enterprises, such as the 1994 privatisation of the main public drug manufacturing and distributing service Government Medical Stores (Barraclough, 2007; Chee, 2008) and the corporatisation of National Heart Institute and University of Malaya Medical Centre in 1993 and 1998, changed the provision of health services to the public health sector (Chee, 2007).

However, the growth of the private sector heralded a move towards more regressive financing trends in the healthcare financing structure. In 1983, the government contributed 76% of the total healthcare expenditure (Ismail and Rohaizat, 2002). By 2009, national healthcare expenditure statistics showed that the government subsidised a much lower fraction, 44.8%, of the health sector costs and the balance, 55.2%, was financed by the private sector (World Health Organization, 2009). The majority of private finance sources were out-of-pocket payments (73.2%) and a minor component was private insurance payments (14.4%) (World Health Organization, 2009). National Health Account data from 2009 shows that government health expenditures (RM14,653 million) were almost matched by out-of-pocket expenditures (RM13,182 million), a trend which has continued for more than ten years (Table 2). Out-of-pocket payments

are well known as an especially regressive means of funding healthcare and are anathema to promoting equity in access to healthcare (Wagstaff and van Doorslaer, 1992; Wagstaff et al., 1999; Leive and Xu, 2008).

Table 2: Expenditures on healthcare (1995–2009)

Year	Total expenditure on health (Million RM)	General government expenditure on health (MOH and social security funds; Million RM)	Private expenditure on health (private insurance, not-for-profit and out-of-pocket; Million RM)	Out-of-pocket expenditures (Million RM)
1995	6,727	3,307	3,419	2,619
1996	7,880	4,134	3,746	2,869
1997	8,097	3,999	4,098	3,139
1998	8,854	4,506	4,348	3,252
1999	9,605	4,920	4,685	3,514
2000	11,331	5,936	5,395	4,068
2001	12,287	6,860	5,428	3,991
2002	13,340	7,392	5,948	4,377
2003	19,479	10,992	8,487	6,147
2004	21,200	10,606	10,595	7,959
2005	21,575	9,658	11,916	9,022
2006	24,779	11,045	13,734	10,050
2007	28,022	12,457	15,565	11,390
2008	31,141	13,373	17,768	13,002
2009	32,649	14,635	18,014	13,182

Source: World Health Organization, 2012.

The growth of the private sector also saw a steady, sustained migration of human capital away from the public sector. In 2000, 46.2% of all doctors were in the private sector but were responsible for only 20.3% of overall patients, whereas the remaining 53.8% of doctors were in the public sector and were responsible for 79.7% of patients (Ismail and Rohaizat, 2002). By 2004, there was no significant change in the healthcare situation; 48% of all doctors were in the private sector and were responsible for only 21% of all patients (World Health Organization, 2007). This migration of human capital from the public to the private domain has been most notable at more specialised levels. For instance, between 1999 and 2001, the number of oncologists in the private sector was about twice that in the public sector, and over 70% of specialist services in radiotherapy, magnetic resonance imaging, CT scanning, mammography, and cardio-thoracic procedures were in the private sector (Chee, 2007). Migration of

human capital contributed to the imbalance in the delivery of care, with a disproportionate amount of the burden being placed on the public healthcare sector compared to the funding that it received (Barraclough, 2007).

Measures were taken to ensure equity and ease government spending by enhancing and introducing additional social security schemes such as the addition of employer provided health benefits through the Employee's Provident Fund (EPF) and setting up the Social Security Organization (SOCSO). However, these efforts have not been entirely successful [they account for only 0.9% of government expenditures in its 2009 healthcare budget; (World Health Organization, 2009)] and they involve very restrictive access requirements. These measures outsource health related claims on a risk-rated basis to third-party payers that provide reimbursements for specific illnesses only.

1. The EPF applies to only those employed in the formal sectors and only minimises the amount cost to the user because its "catastrophic illness" fund is limited to 10% of the member's savings set aside for this fund. The fundamental objective of the EPF is to meet old age pension income requirements, which under the current structure are reported to be insufficient (Drimer, 2005). Adding a health provision to EPF coverage only serves to potentially decrease pension pay outs. Family members are also not covered. Additionally, the EFP is directly partnered with a private institution, Life Insurers Association of Malaysia (LIAM), which directly subjugates the equitable nature of the scheme by introducing profit incentives (Khoon, 2007). This fund ceases its coverage upon retirement of the member (New Straits Time Online, 2009).

2. The SOCSO covers only employment related trauma and illness (Kananatu, 2002). Employed individuals who earn less than RM3,000 are eligible for this scheme, making it a viable low-income option. However, this fund also ceases its coverage upon retirement and its coverage is limited as it does not include non-work related ailments for family members (Kananatu, 2002).

Similar to other countries, Malaysia has also experienced the trend of rising costs in its health budget. This development has been accentuated by other negative tendencies. Noteworthy is the fact that the health budget – as a percentage of the total national budget – has shifted only slightly (5.22%–6.61%) from 1980 to 2001 when compared to a precipitous rise (an annual average of 25 per cent) in the total budget, from approximately RM900 billion in 1980 to RM5.7 trillion in 2001 (Barraclough, 2007; Lit, 2007). Indeed, Malaysia's national health accounts show that it spent a relatively small, constant amount on healthcare as a percentage of the country's GDP per year, as shown in Table 3, and significantly

less than other countries of similar economic development levels, as shown in Table 4 (Chee, 2008). Although there are several justifiable reasons for the rise in cost of healthcare [such as an ageing population (Palangkaraya and Yong, 2009)], of equal concern is the impact of the government promoted policy of privatisation. This policy has had the adverse effect of increasing out-of-pocket payments by those unable to afford private healthcare insurance, whilst not addressing the imbalance in the quantity and quality of human capital between the public and private healthcare delivery systems.

Table 3: Total health expenditure and health care cost inflation, Malaysia, 1997–2003

Year	Per capita at international dollar rate	Percentage increase over previous year	Percentage of GDP	Health care cost inflation
1997	237	–	2.8	3.7
1998	237	0.0	3.0	6.1
1999	257	8.4	3.1	3.0
2000	297	15.6	3.3	2.0
2001	345	16.2	3.8	2.9
2002	–	–	–	2.4
2003	–	–	–	1.7

Note: Data extracted from World Bank's National Health Accounts; available for Malaysia from 1997 onward only.
Source: Lit, 2007.

TOWARDS SOCIAL HEALTH INSURANCE

The government's Mid-term Review of the Fourth Malaysia Plan (1984) had commissioned a report (Chee, 2008) on future healthcare system considerations, from which the possibility of incorporating a system based on the concept of social health insurance (SHI) was introduced. It was not until the Seventh Malaysia Plan (1996), following the failed initiative to corporatise state hospitals, that the introduction of this SHI scheme was seriously considered under the guise of the National Health Financing Authority (NHFA) (Chee, 2008; Ismail and Rohaizat, 2002; Lit, 2007; Rohaizat, 2004). To date this initiative has not been completed for implementation.

Table 4: Government expenditure and total health expenditure in 2001 for countries with comparable gross national income per capita (in purchasing power parity international dollars)

Country	GNI per capita (2002)	Government health expenditure (as % of total government expenditure)	Total health expenditure (as % of GDP)
South Africa	9,810	10.9	8.6
Chile	9,420	12.7	7.0
Latvia	9,190	9.1	6.4
Trinidad/Tobago	9,000	6.4	4.0
Mexico	8,800	16.7	6.1
Costa Rica	8,560	19.5	7.2
Malaysia	8,500	6.5	3.8
Russia	8,080	10.7	5.4
Botswana	7,740	7.6	6.6
Uruguay	7,710	14.9	10.9
Brazil	7,450	8.8	7.6
Bulgaria	7,030	9.3	4.8
Thailand	6,890	11.6	3.7
Namibia	6,880	12.2	6.7

Source: Lit, 2007.

This NHFA initiative proposed the restructuring of the healthcare financial system from a tax-based plan to a compulsory, government-subsidised insurance scheme purchased on the basis of each person's ability to pay. This scheme essentially represents a social health insurance model in which universal coverage depends on raising adequate funds from a sufficiently large pool of individuals, which can be supplemented with donor support and general government revenue. There are advantages to be gained from a socially based insurance model that a country with a fast growing economy, such as Malaysia, could benefit from. These advantages include:

1. Ameliorating the inevitable rise in health care costs: An SHI scheme could provide a good portion of funds to ameliorate the need to raise user out-of-pocket expenses following a general healthcare reform, especially if government hospitals are to be corporatised (Chee, 2008).

2. Offering a greater choice in providers of services: Users could have a wider array of choices, including the option of private healthcare.

3. Steady and sustainable source of finance: Premiums would be based on ability to pay with a contribution by employers.

4. Avoiding risk-rating: Risks are spread between those with high needs for health services and those with low needs. Those in "safe" occupations are made to cross-subsidise those in occupations subject to a greater health risk. The costs of covering dependants are spread among those currently with no risks and those with many. Based on the ability to pay, the higher paid cross-subsidise the lower paid individuals (Abel-Smith, 1994).

Some of the biggest issues facing Malaysia today are the unequal distribution of healthcare benefits, rising healthcare costs, and the strain on public healthcare institutions. Therefore, an SHI scheme should primarily seek to address the growing imbalance in healthcare delivery by allowing more of the population to access the service of their choice, thereby equalising the demand of service based on immediate accessibility and not ability to pay. However, this requires that the country address a few key issues if Malaysia is to transform its healthcare finance policy from a tax-based one to an SHI scheme.

Enabling the appropriate institutional capacities: An appropriate integration of private and public health care is needed. The inherent friction created by any government-promoted investments in private healthcare sectors without proper regulatory measures or safeguards must be addressed. This is exemplified by the protracted escalation of pharmaceutical prices after the outsourcing of public sector procurement of medicines to Pharmaniaga, a government-linked company, in 1996. Issues of competition and equity have to be addressed (for example, a single insurer or multiple insurance providers; open tenders for the procurement of drugs and medical paraphernalia) to build an effective and viable delivery system based on insurance and risk-pooling. It is clear that programs such as the SOCSO and the EPF should not be the basis for enabling this aim because these organisations have very different objectives. What should be the regulatory role for the political and non-governmental civil sectors?

Addressing the rising cost of healthcare: There is a need to re-assess the nature of for-profit healthcare within the framework of continued government-subsidised schemes. How should counteracting pressures stemming from the needs of an ageing society and the eventual reduction in the workforce be better balanced?

Ensuring the continuing universal coverage of healthcare: As an SHI system is implemented, policy measures must be sustainably introduced to maintain and expand the health coverage to a universal level.

The following is an analysis of the experiences of two countries that have both implemented SHI schemes from which Malaysia may draw lessons. Table 5 presents cross-country highlights of the major healthcare indicators and systems of Malaysia, Korea and Thailand.

Table 5: Comparative country profiles

	Malaysia	Korea	Thailand
Population	27 million (2008)	48.6 million (2008)	67.4 million (2008)
Live births per woman	2.7 (2006)	1.17 (2002)	1.7 (2005)
Infant mortality rate per 1000 live births	12 (2004)	5.3 (2003)	21 (2005)
Life expectancy at birth (male/female)	69/74 (2006)	75.74/82.36 (2006)	67/73 (2004)
Total health expenditure as a percentage of GDP	4.3% (2008)	6.6% (2008)	4% (2008)
Government health expenditure as a percentage of total health expenditure	44.1% (2008)	54.9% (2008)	75.1% (2008)
Total health expenditure per capita (USD PPP)	320 (2008)	1,820 (2008)	323 (2008)
Practising physicians per 10,000 population	7.0 (2002)	16 (2003)	2.8 (2002)
Health Finance	Tax-based finance system and employee social insurance schemes for public health, small amount of private health insurance schemes	National Health Insurance Corporation (a single social health insurer)	Multiple National Insurance schemes for different social sectors (social health insurer)
Health Delivery	For-profit private provider and tax-subsidized public delivery systems	Majority private delivery system	Majority (~ 80%) public delivery system, minority private delivery system
Political System	Constitutional Monarchy with rotating monarch	Presidential system, single chamber (National Assembly)	Constitutional Monarchy

Source: Muhamad Hanafiah, 1996; Kwon, 2005; World Health Organization, 2006a; 2006b; 2006c; 2008a; 2008b; 2009; Population Reference Bureau, 2009; Peabody, Lee and Bickel, 1995; Gertler, 1998.

The Republic of Korea

South Korea (henceforth Korea) experienced a major economic boom due to its export driven economic policies in the 1960s and 1970s following the Korean War (Kwon, 2005). One major accomplishment paralleling the economic success of the country was the rapid implementation of the National Health Insurance (NHI) programme with relative universal coverage. In the 1970s Korea had no national plan for health insurance; only 8.8% of the population had appropriate health coverage and health care accounted for 2.8% of GDP with government providing 12% of the finances (Peabody, Lee and Bickel, 1995). By 1991, 30% of Korea's health care expenditures were from public funds, and health care outlays had risen to 7.1% of GDP (Peabody, Lee and Bickel, 1995). This economic development is very similar to the successes that Malaysia had achieved, with one crucial difference: the historic contexts of these two systems are strikingly different. Malaysia's system was founded on the British welfare-state model and consequently had a powerful public driven sector. Korea, on the other hand, historically had a smaller investment in the public healthcare sector and consequently was forced to design a healthcare system that would allow greater accessibility to an established private sector.

It must be noted that Korea established the NHI only when it had reached a certain point in its economic development – a point that Malaysia is fast approaching. The timing of such a political manoeuvre can be a very important factor (Gertler, 1998); if the correct conditions are met, Korea offers an excellent prototype for Malaysia to follow to maintain effective universal health coverage while expanding the role of the private sector.

Experience of the NHI

One lesson to draw from Korea is how they provided universal health coverage by using effective sequencing in coverage for different social sectors. The Health Insurance Law in 1968 and subsequent economic revision of health policy laws from 1977 to 1981 led to the systematic progression of health insurance coverage for the entire population. Traditionally, SHI policies have first been established in the urban formal sector, and the NHI followed this path. This formal sector now forms 10.4% of the population under the NHI. Coverage was then extended to include those in the industrial and agricultural sectors (36% of the NHI), the poor (3–4%) and, finally, the self-employed (50.1%). The creation of subdivisions in these main classifications facilitated wider extension of coverage; for example when it was reported that there was good coverage in urban self-employed sectors but not in rural sectors, a classification was established specifically for the self-employed living in rural areas. The NHI programme is fairly representative

of the major groups in society (Kwon, 2005; Yang, 1996). As of 2007, 96.3% of the total population (47.82 million people) are covered by the NHI, while 3.7% (1.85 million people; mostly the poor) are benefiting from the Medical Aid Programme (World Health Organization, 2010c).

Korea also offers another lesson about the value of a single insurer system. Originally there were separate insurers for each social sector. However, several problems were identified under this system. First, while family units were generally covered under one insurance policy, there were also cases of "double-enrolment" with other concurrent policies (Peabody, Lee and Bickel, 1995). Second, most specific sectors were too small to benefit from an effective risk-pooling mechanism (Kwon, 2003). Third, there were major differences among insurance companies in the setting of contribution rates for the same benefits, leading to horizontal inequity. For example, contributions for the self-employed were dependent on the sizes of households, incomes and properties as opposed to the contributions of the employed, which were solely dependent on income (and furthermore were 50% paid by the employer).

Therefore, in 2000, all health insurance societies were merged into one single national health insurer. There has been a large stabilisation of contribution levels across all social levels, a drastically increased risk-pool and establishment of an element of bargaining power for the NHI as the sole purchaser relative to health care providers (Kwon, 2005; 2003).

Another interesting lesson can be drawn from the approach used by Korea to control rising healthcare costs. Health care providers in Korea were originally reimbursed solely on fee-for-services basis. Although this system seemed simple, it could also be exploited by increasing the volume and intensity of services while favouring high margin treatments, thereby distorting the supply of medical specialities over time. To ameliorate such health cost inflation, Korea used pilot schemes for different reimbursement plans by targeting specific provider groups mainly on a voluntary basis. The pilot over time allowed the assessment of the specific plan's effectiveness in controlling cost inflation while obtaining feedback from patients on whether their medical needs were satisfied and feedback from providers on whether payments were commensurate. Effective reimbursement plans were then extended to other providers.

One such pilot tested the diagnosis-related group (DRG) payment system, which offered a lump sum for a patient's stay in hospital based on several diagnostic criteria (Kwon, 2005). The DRG pilots have generally been successful, resulting in shortened hospital lengths-of-stay, decreases in unnecessary antibiotic use and a reduction in number of clinical tests ordered (Kwon, 2003). This has not had a negative effect on the quality of care based on unchanged levels in hospital

complications and re-operation (Kwon, 2005). However, a DRG system does present certain limitations (such as the problem of "creeping," where an ambiguous diagnosis may present an opportunity to choose the one which brings a higher reimbursement to the healthcare provider), (Abel-Smith, 1994; Kwon, 2005) which may require a strong institutional regulatory presence in Malaysia to suppress (Abel-Smith, 1994).

Thailand

In 2001, the Thai-Rak-Thai (Thais love Thais) Party won a landslide victory on the platform of the "30 baht treatment for all" ($1 = 35.97 baht in 2001). This political victory led to the initiation of a push for universal and affordable coverage at a primary healthcare level. Previously, there were four main public health risk protection schemes (Towse, Mills and Tangcharoensathien, 2004).

1. Civil servants medical benefit scheme – Introduced in the 1960s for civil servants and their dependents.

2. Low income card scheme – Introduced in the 1970s for low income families and individuals, the elderly, children under 12 years and people with disabilities.

3. Voluntary health card scheme – Predominantly rural, introduced in the 1980s and funded through equal matching of household and Ministry of Public Health payments.

4. Social security scheme – Introduced in the 1990s for formal sector workers only. Mandatory for all private firms with more than one employee.

Initially, the government tried to merge these schemes into a single national insurance system to eliminate overlap. This consolidation attempt was met with resistance by formal sectors benefiting from the dual coverage (Towse, Mills and Tangcharoensathien, 2004). Therefore, to fund the 30 baht scheme and increase coverage, the voluntary health card and low income card schemes were merged into the Gold Card Scheme and divided into two tiers; one which was exempt from the 30 baht co-payment and another which included it (Suraratdecha, Saithanu and Tangcharoensathien, 2005). The National Health Act (NHA), passed in 2002, now provides government with the power (via the National Health Security Office) to regulate the quality and financial elements of these schemes.

Experience of the NHA

Thailand is a middle-income country, experiencing steady economic growth with well-developed infrastructure (World Health Organization, 2006a). It shares similar traits with Malaysia such as a large investment in public health institutions and a well-developed primary care infrastructure, particularly in rural areas (Green, 2000). However, Thailand and Malaysia differ in that the various Thai health insurance schemes have allowed Thailand to develop a much more extended health coverage network across the population, which facilitated the progression towards universal coverage by taking advantage of the already existing financial infrastructure. In a similar manner, schemes such as the Gold Card have helped to expand health insurance to the uninsured in both urban and rural areas (Suraratdecha, Saithanu and Tangcharoensathien, 2005). Malaysia's experience with the EPF and SOCSO may be of value when planning an extension in the development of a national health insurance infrastructure, with particular reference to establishing a set co-payment charge that is financially agreeable across all social groups (Pannarunothai, Patmasiriwat and Srithamrongsawat, 2004). Additionally, progression towards universal coverage could never have been achieved in Thailand had there been a reliance on the formal sector to contribute the majority of the premiums (Tangcharoensathien, Wibulpholprasert and Nitayaramphong, 2004). Controversially, in Thailand, tax-revenues formed a major source of financing to subsidise health insurance policies. Malaysia may benefit by having a strong tax-based financing system in place from which to reallocate resources.

The Thai experience indicates that in establishing a new system of healthcare financing, the challenge is reforming the delivery of healthcare to suit the new system (Towse, Mills and Tangcharoensathien, 2004). The aim must be to establish a form of payment to providers to avoid unnecessary waste of resources. Methods to avoid the inherent escalation of costs stemming from growing (sometimes unnecessary) utilisation brought on by a fee-for-services system have been widely discussed in the literature (Abel-Smith, 1994). One of these methods is a system of capitation payments, whereby primary healthcare providers are remunerated based on number of patients registered for a defined period of time (Abel-Smith, 1994), which has been shown to be effective in controlling costs while maintaining quality (Berwick, 1996). It has also been shown that a system based on capitation may encourage providers to take on mainly young healthy patients compared to fee-for service payments that favour ill patients. This problem could be countered by scaling payments for each patient on the basis of age, gender and geographical location. Overall, the strength of capitation is in supporting preventive care and prescription of inexpensive medicine, thereby contributing to stemming health care costs.

Thailand's experience with capitation has shown its effectiveness at cost containment through influencing provider behaviour and is something that Malaysia may want to consider exploring. Additionally, a capitation-based payment system may avoid an associated risk in overuse of services (so-called "moral hazard"), especially by Gold Card users (Abel-Smith, 1994; Suraratdecha, Saithanu, Tangcharoensathien, 2005), while avoiding under-usage if promoted alongside an employee-choice healthcare policy (Tangcharoensathien, Wibulpholprasert, Nitayaramphong, 2004). The Thai experience shows us that a combination of several factors is absolutely key to the success of this type of policy move; amongst these are the following: (Green, 2000; Tangcharoensathien, Wibulpholprasert, Nitayaramphong, 2004; Mills et al., 2000).

1. Adequate political and social support: Government transparency can aid this process by informing the insurance purchaser of any benefits.

2. Adequate support from the medical community: Members of the medical community must feel properly remunerated. This is particularly important when considering the role of for-profit providers within a context where public institutions must be given the chance to compete.

3. Good regulatory and quality monitoring: A base quality assurance level for private and public institutions must be established.

CONCLUSION

Based on these countries' experiences, there are several recommendations that can be made regarding the feasibility of implementing an SHI scheme in Malaysia.

Enabling the Appropriate Institutional Capacities

The following measures help provide a positive environment for SHI policies.

Introduction of the appropriate regulatory measures and institutions: A properly regulated healthcare system is important if there is to be stability in transitioning between healthcare finance systems. The lack of a regulatory framework and legislative protection is well described in Malaysia (Nik Rosnah, 2005; 2007). The Thai experience shows that SHI policies can improve equity in healthcare delivery by moving to regulate both private and public institutions equally. It is recommended that a mixture of incentives and imperatives be employed by

introducing quality-control accreditation and universal legislation, respectively (Kumaranayake, 1997).

Regulation and expansion of the SOCSO and EPF programs: The Korean experience has shown that the expansion of coverage of existing risk-pooling insurance schemes can help to consolidate institutional capacity and social acceptance. Possibly the addition of schemes that provide coverage to the self-employed (as in Korea), rural populations (as in Thailand) and public sector employees (Yu, 2007) may be considered. Expansion of insurance coverage sequentially and sector-by-sector is the most effective way to avoid double-coverage whilst improving equity. Conversely, existing schemes such as the SOCSO and EPF programs must be independently regulated to remove risk-profiling tendencies. One such strategy is de-linking national insurance schemes from private partnerships (i.e., the current EPF-LIAM scheme) to remove profit incentives. However, on the other hand, the experience of the NHI in Korea has shown it may be more effective to have one super health insurance fund so as not to have undue conflicts in objectives.

Working towards a national SHI scheme: The implementation of a single SHI scheme on a national level as in Korea can have a variety of positive effects on the integration of private and public health institutions. The increase in the patient outlay burden and increasing migration to private providers would help alleviate stretched public institution resources. Additionally, the monopsony given to a national system allows for bargaining powers that can be used as an effective check on private healthcare providers, especially in systems that employ a fee-for-services scheme. These checks and balances can take several forms, such as establishing fair terms for treatment, limiting the use of unnecessary diagnostic or treatment options to maximise efficiency and improve quality of care.

Political and civil support: The Thai experience (and general international consensus) shows us that political will backed by popular support can be helpful in breaking down barriers created by market-driven health policy. Sufficient transparency in government policymaking, along with effective outreach to and input by civil society sectors are recommended during the restructuring process.

Addressing the Rising Cost of Healthcare:

The following measures are recommended ways for SHI schemes to address the rising cost of healthcare.

Amelioration of the inherent growth of cost by a fee-for-services system: Based on Korean and Thai experiences, it is recommended that any SHI scheme base their method of payment to healthcare providers on a system composed of a combination of diagnostic-related groups for diseases of high prevalence in tertiary care and capitation in primary care. This method may be challenged by powerful private healthcare lobbies, so good evidence should form the basis of such a policy.

Exploring a co-payment system: To avoid moral hazard and the associated rise in healthcare costs, a system of a nominal co-payment can be introduced similar to that of the 30 baht scheme, although this must be further examined and discussed as it can unnecessarily raise the levels of out-of-pocket payments (Rohaizat, 2004).

Ensuring Continuing Universal Coverage of Care

Reliance on current government tax revenue to fund subsidies for insurance schemes: A strong tax-based source of revenue can allow for an effective switch to an SHI system and provide a good infrastructure for continuing government subsidies of insurance schemes (Gertler, 1998). This tax revenue will have the added effect of containing the cost of healthcare.

Consider encouraging the formation of locally run insurance schemes: Establishing local insurance schemes can help prepare areas for eventual integration into a national scheme with the promise of an obvious benefit of increased risk-pooling. In the interim, these local insurance schemes can act as additional healthcare finance sources until the appropriate expansion of a national SHI scheme takes hold.

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