Full Paying Patient Services in Malaysia: A Counter-Hegemonic Response from a Civil Society Organization

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ABSTRACT

The movement of specialists from public hospitals to private hospitals is a major problem plaguing the government of Malaysia. In order to find a solution to this problem, the Malaysian government has taken many steps to reduce the migration of specialists, the Full Paying Patient Services (FPPS) scheme being one of those said steps. However, these measures have received a wide range of reactions from various parties, including civil society organizations (CSOs), which include the Coalition Against Healthcare Privatization (CAHP). This study aimed to examine the justification behind the government's implementation of these services, and to explain the responses of civil society organizations, thus providing a deeper understanding of CSOs responses toward governmental policies and initiatives. Employing Gramsci's counter-hegemony and Habermas' communicative rationality theory, and using CAHP as a case study, this study utilized a qualitative approach (through an interpretative lens), which benefited from secondary data as well as primary data through interviews. Besides that, this study revealed that, despite the many objections conveyed by the CSOs, many of them fell on deaf ears, and the efforts made by CSOs at best, were only able to delay the implementation of these services.

Keywords: Full Paying Patient Services, Counter-Hegemony, Response, Civil Society Organization, Malaysia

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INTRODUCTION

The role of the market as a definitive, efficient, and allocative mechanism of goods and services is non-debatable when it comes to economic goods and services. However, essential goods, such as education, transportation, and healthcare, are non-economic goods that are non-excludable, thus they must reach all of society. For these goods and services, the state is the better alternative mechanism, hence more investment is expected from the state to distribute essential goods, such as healthcare.

The commercialization of the healthcare sector is on the Malaysian government's agenda, not only as a step toward responding to new demands, but also to reducing government cost. After the previous Minister of Finance, Dr. Mahathir Mohamad's, speech in Parliament on the 12th of September, 2003, the idea for implementing Full Paying Patient Services (FPPS) was introduced during the presentation of the 2004 budget. The government's limited ability to pay high salaries to physicians had led the government to agree with the concept of establishing private wings in government hospitals. This move, as highlighted by the then Minister of Finance, was to enable doctors in government services to earn an additional income, thus motivating them to remain serving in government hospitals (Ministry of Finance Malaysia, 2003).

This idea was seconded by the Health Minister at that time, Dr. Chua Soi Lek. He announced that the pilot project for such services was to be implemented in early 2005. It was later asserted by the then Director-General of Health, Dr. Ismail Merican, during a press conference after the opening of the workshop 'Empowerment of the Medical Profession in the New Millennium' at the J.W. Marriot Hotel in Kuala Lumpur on January 7, 2006, that two hospitals had been shortlisted for the pilot project. The two hospitals were Hospital Putrajaya and Hospital Selayang ("Specialist to Go", 2006).

Introducing such a service, which provides opportunity for specialists to earn an additional income, according to the government, helps overcome the problems of "brain drain." Though, from one point of view, it might help in overcoming the problem, from another perspective, these services seem to pose several other problems. Any attempt to understand the distribution

of essential goods, such as healthcare, must not look at the state-market interplay alone, but the role of civil society in the political economy as a whole. It has long been debated that, while the state is potentially tyrannical, the market is potentially predatory.

Anticipating and recognizing potential state-market problems, several groups began to voice their concerns. One of the most important civil society organizations, which has been championing this cause since its inception, is the Coalition Against Healthcare Privatization (CAHP). This umbrella organization believes in the logic of welfarism, thus believing that the idea of healthcare commercialization should be put on hold. The detriments FPPS pose to the Malaysian healthcare system will be expounded on in detail in this paper. These potential problems act as one of the motivators to why this study on FPPS was carried out.

FPPS has a few main features. Among them is that the patient can choose their preferred specialist. They will also be able to enjoy upgraded ward facilities. Besides that, the patient will also enjoy a lesser waiting time for treatment. However, all the facilities provided are dependent on the resources, fields of expertise, and existing facilities of each individual hospital. This article will be organized as follows: first, a discussion on the theoretical considerations of civil societies will be explored, followed by an explanation on the method used followed by the government's justification for implementing the FPPS. Subsequently, the Coalition's concerns will be discussed, ending with their objections and recommendations.

THEORETICAL CONSIDERATIONS AND METHOD OF STUDY

When the state succumbs to market pressure, its important role as a provider of welfare services to society, such as healthcare, is affected. Evidence, such as in the case of the USA, where the market was used as an instrument of the healthcare sector, proves that this can result in the emergence of problems involving accessibility, affordability, and equity (Rothman, 1993; Turpin, 2007; Guseva, 2014). When the power of the state in Malaysia was used to launch many commercial projects related to essential goods such as healthcare, it was expected that the hegemony of the state would

be opposed or countered by the people, and in such situation civil society organizations were expected to play their role in countering the state hegemony (Ramasamy, 2004; Chee & Barraclough, 2007).

The concept of hegemony was popularized by Antonio Gramsci. For Gramsci (1971, 1995; Mouffe, 1981), state hegemony can be derived from two sources: coercion and consent. Through education, people are gradually consenting to the dominant logic. In capitalistic states, Gramsci saw the mutual reinforcement of both power and profit, which created hegemony within a society. Hence, state education is a mechanism for the government to legitimize their policy. Counter-hegemony is a method whereby people may develop ideas and discourse to challenge the patterns and behaviors of dominant beliefs and assumptions in society, from one party to a different party. Gramsci's writing on counter-hegemony is an extension of Marxist thinking.

The commercialism of healthcare is an example of market dominance, since even the state has to succumb to the pressures of profit orientation. In this type of a situation, Gramsci suggested that organic intellectualism naturally occurs when leaders who belong to the people work for the interests of the people. Therefore, they see countering state hegemony as a duty to guarantee that power is given back to the state. In such a theoretical construct, the role of the CAHP can be understood without denying the importance of other approaches, such as social capital (Bourdieu, 1986; Coleman, 1988; Putnam, 1993) and communitarianism (Sandel, 1984; Avineri & De-shalit, 1992).

Any civil society actor, such as non-governmental organizations (NGOs) and social movements, can effectively work in different environments, such as in associational life, good society, and public spheres; the three models of civil society put forward by Michael Edwards (2020). Welfarism is a type of good society, or ethical society, which civil societies, such as what a coalition, aims for. A coalition is also a type of association which provides face-to-face communication for networking. This article, however, will focus to the public sphere model of civil societies.

Many researchers based their studies on Jurgen Habermas' work on civil societies, which also employed the public sphere model, although

some aspects of Gramsci's work undoubtedly contributed significantly to the development of the logic of the Public Sphere Theory (Michael Edwards, 2020). According to Habermas (1984, 1987), people can argue and negotiate in this sphere, and through deliberative or dialogic discourse, new ways of thinking may emerge and lead people to a more beneficial consensus. Habermas proposed the concept of communicative rationality and communicative actions, in which individual knowledge and experience are insufficient, and must be communicated in public to be viable solutions.

While it is true that civil society organizations like a coalition may benefit from the potential space the public sphere offers, the same sphere may face its own internal structural problems. Inequality of voices between and among groups due to the hierarchy of power and asymmetry of information are among the crucial problems which often cause the space to be used to further state hegemony. In some cases, civil society organizations may utilize open confrontations, such as demonstrations, in which violence may even be approved of as a method of getting their voices heard and, more importantly, gaining international attention (Skocpol, 1979). Consent is not the only option for the state because, as Gramsci has pointed out, coercion is also a possible approach. In this sort of approach, the police and army are ready to support state decisions and actions while using the consent method, such as through education and media, hand-in-hand with coercion. Through the eyes of counter-hegemony and communicative rationality, this article intends to explain the dynamics of a coalition's role in counter-hegemony.

This study employed a qualitative approach through an interpretative lens. The information was taken from secondary data derived from the Coalition. These included the Coalition's minutes of meetings, paperwork, newspaper cuttings, journals, and other such material. A review was also made for the governmental documents issued by the Ministry of Health (MOH). Content analysis was the main method used, while primary data was obtained through interviews with Coalition leaders. Interviews were done to gain additional information that was not available in the secondary data.

An example of secondary data from the Coalition is the resolution given to the Prime Minister titled, '*Resolusi Terhadap Sistem Kesihatan Kepada YAB Dato Seri Abdullah Badawi Perdana Menteri Malaysia: Jangan Memusnahkan Hospital Awam Batalkan Skim Rawatan Swasta di*

Hospital Kerajaan,' dated 10th August, 2007. The coalition also issued a memorandum to the government in 2010 on this issue. Another memorandum was delivered to the Minister of Health with the title, '*Memorandum Kepada Menteri Kesihatan: Batalkan Skim "Full Paying Patient*"'. In addition to those, there were also the government's national plan (5-year governmental national plan), budget speeches, and a circular from the Director-General of Health, dated 19th March, 2015, which were held in Putrajaya. Documents like the '*Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Pesakit Bayar Penuh) 2007 (Semakan 2015)*' and many other documents were also referred to.

The data obtained from an in-depth interview was also used in this study to compliment the secondary data. Among the informants, were the leaders of the Coalition. They were asked, among other questions, for their opinions with regard to the latest decision made by the government to expand this program in 2017. Questions were also presented on the rationale behind their critical approach, particularly their use of counter-hegemony. The data from these interviews were transcribed and analyzed into multiple themes to better understand the overall approach taken by the CAHP.

WHY MALAYSIAN PUBLIC HOSPITALS NEED FPPS: GOVERNMENT VIEWS

What is Full Paying Patient Services (FPPS) ? As an effort to keep medical specialists in public hospitals, the FPPS was introduced as a scheme which offers patients treatment from specialists of their choice and additional facilities at a very competitive price. According to the government, the implementation of FPPS is based on several justifications (MOH, 2020). For the government, this scheme will benefit all parties, including patients, medical officers, and the government. There are at least four factors highlighted by the government to justify their move to implement the FPPS.

The Malaysian government was facing a serious problem of experienced medical specialists migrating from government hospitals to private hospitals. This was due to the government's own policy, especially in the '80s when they encouraged the establishment of private hospitals and at the end of the '90s, when they promoted health tourism. This caused

an outflow of experts to the private sector. For example, in 1990, 370 vacancies involving doctors and 170 physicians in government hospitals was recorded, and most of these vacancies were due to the "brain drain" to the private sector (Malaysia, 1991:350). In 1995, a total of 4,277 doctors, or 45 percent of the total profession, was recorded in the public sector, a minority compared to the 5,277 doctors, 55 percent, in the private sector (Malaysia, 1996:542). From the total, 60 percent of specialist doctors were found to be serving in the private sector (Malaysia, 1996:542). Moreover, during the 6th Malaysia Plan (1991-1995), there were 1,137 medical officers and 108 specialists who resigned (Malaysia, 1996: 542). Thus, the FPPS was introduced as one of the government initiatives to maintain specialist in government hospitals.

Next, this service is also able to provide opportunities for patients who can pay higher to get services faster. This is in line with the government's aspiration of improving health services. The third factor highlighted by the government to justify the implementation of the FPPS was that it provides an opportunity for specialists in government hospitals to earn an additional income. Finally, the government believed that these services can optimize the subsidies allocated in the healthcare sector for poorer and more vulnerable patients, in which any patient who can afford to pay extra can choose these services as an option. The government believed that the FPPS would also increase government income.

FPPS: THE COALITION'S CONCERNS

The Coalition's concerns over this service are many, and in this paper we only discuss three which are the most significant, which are as follows:-

Increased Workload for Government Medical Specialists

Firstly, the Secretary of the Coalition, Jeyakumar, was worried that the implementation of these services will increase the workload of the specialists in government hospitals, since they have to treat FPPS patients in addition to non-FPPS patients (personal communication, March 8, 2016). For CAHP, this clearly shows a large clinical burden being incurred due to the small number of physicians in the government hospitals. Increased workload

limits their ability to treat non-FPPS patients. The need for work after office hours and on weekends can also pose several other issues, such as tiredness and loss of focus. The Coalition's concern for this issue, for example, was raised during the dialog session which was held with the Director-General of Health on the 14th of March, 2006. The Coalition highlighted this issue during that session:-

> *"..... Currently, only 30% of specialist doctors in Malaysia serve in government hospitals, and their workload is too heavy, as 70% in-patients in Malaysia are still treated in government hospitals....."*
>
> (CAHP, 2006: 1)

Equity Issues

The Coalition is aware that these services are voluntary and that it is up to the patients to choose whether or not to join. If they opt otherwise, the patients are still treated under normal circumstances. However, if they can afford it, then they may choose a specialist to treat them. Thus, this highlights the nature of the program's biases and disclaimer of patient rights, especially for the lower-income groups. The FPPS is a program that emphasizes one's ability to pay, and, for the Coalition, it denies the right of access for patients and affects equity. This, thus, reflects that economic incentives are more important considerations to the government than clinical and humanitarian considerations. In an interview with the Coalition's secretary, Jeyakumar, the approach taken by the government by describing it as an approach taken to overcome staff migration only was criticised. However, the government has not solved the issue comprehensively or holistically. From the Coalition's secretary's point of view, this approach eventually victimizes patients from disadvantaged groups and deny them their rights (personal communications, March 28, 2016).

Effects to the Quality of Service

The Coalition's secretary was of the view that the existence of this scheme will affect the quality of the patients' treatments, especially those who are not involved with the FPPS (personal communications, March 28, 2016). This is because most of the senior and experienced specialists will

be focused on treating FPPS patients rather than non-FPPS patients. This is simply because they earn an extra income from the FPPS patients. The Coalition is also concerned about the plight of young specialists who are forced to undertake work that should be the responsibility of experienced specialists (personal communications, March 28, 2016). This results in younger and less experienced specialists handling complex cases, which should be given to senior specialists who are, instead, occupied treating paying patients. Hence, the CAHP is of the opinion that the quality of treatment will potentially be affected as a result of less experienced and young specialist doctors handling most medical cases. At the same time, the Coalition secretary was worried that this situation will lead to stress building up among younger doctors, which, in turn, influences their clinical decision-making skills, thus placing the lives of patients in danger (personal communications, March 28, 2016).

Besides these three, other important concerns of the Coalition regarding the implementation of the FPPS are the effects to the training and competency improvement program, dissatisfaction among healthcare staff, the issue of healthcare as a public utility, and the transparency of the government. However, the discussion on these issues are beyond the scope of this paper. In dealing with these concerns, the Coalition applied several approaches which included press statements, dialogs, memoranda and petitions, picketing and demonstrations.

COALITION'S RECOMMENDATIONS

CAHP did not only conduct the activities and programs to manifest their objections to the implementation of the FPPS; they also proposed recommendations to the government on the issue. There were six suggestions proposed by them.

First, the Coalition urged the government to either defer or revoke the implementation of the FPPS at government hospitals. This motion was done through various media. Jeyakumar, the secretary of the Coalition, while presenting a motion on this matter at the annual general meeting of the Malaysian Medical Association (MMA) in 2005, urged the government to postpone its implementation. The motion, titled, '*To Deter the Institution*

of Private Practice in Government Hospitals,' reflected a more diplomatic attitude, where the government was urged to practice caution before taking concrete action, with a profound review of its effects (MMA, 2005).

Secondly, it was proposed to the government to conduct a full study evaluating the effectiveness of the implementation of private wing schemes in University Malaya Medical Centre (UMMC) and University Kebangsaan Malaysia Hospital (UKMH), which are similar to the FPPS, before implementing it in government hospitals. The study was to focus on several aspects, such as the allowance received from teaching during ward rounds by specialist doctors, as well as the comparison of their allowance before and after the FPPS was implemented at those particular hospitals. The study would also focus on several other aspects, for example, the welfare benefits received from the presence of specialist doctors in public clinics, since most of the patients in those clinics are not involved in the FPPS.

Thirdly, without denying that the government's plan to implement this program was inspired by the idea of improving the income among doctors in the public sector, the Coalition believes that this was not the sole solution for that. On the other hand, the Coalition believes that only a few of the physicians or specialist doctors benefited from this implementation, while the majority did not. Hence, Jeyakumar, in a press release to the media on the 7th of August, 2006, quoted through '*The Sun,*' urged the government to seek alternatives to address the issue. Among the proposals submitted to the government, was one to increase the expenditure for the health sector from around 1.9 percent of the gross domestic product (GDP) to 4 percent, or around RM21 billion per annum (proposed figures based on the year 2006 budget).

Fourth, to overcome specific problems involving the issue of the medical scheme in government services, the Coalition, like the MMA, believes that the establishment of a Special Service Commission for medical staff in the public sector is needed. This motion was mooted by Jeyakumar while presenting a motion of the scheme at the annual general meeting of MMA in Melaka in 2005. A special commission for health staff will facilitate the effort to increase and improve the salaries and allowances of doctors and other staff.

Fifth, the Coalition urged the government to be more open, and ready to face and hold discussions with various stakeholders. CAHP, as stated through a statement to the media on the 14th of February, 2006 (Khoon, 2006), expressed its willingness to discuss and provide appropriate input to the government regarding the area of the transformation of the healthcare system of the country. Besides that, the CAHP also hopes that the government will be willing to be more transparent in discussing with relevant stakeholders, non-public organizations and the civil sector, the best strategies and approaches to making reforms in the healthcare sector, including on this issue.

Sixth, the proposal was also submitted by the CAHP so that the government would take appropriate action to establish a Royal Commission specifically to examine all matters and issues related to the national health system. The Commission is seen by the CAHP as the best approach to taking into account the input from various parties related to health system issues. All findings and recommendations from this Commission are proposed to be placed in the formulation of the national health policy.

GOVERNMENT'S RESPONSE AND ACTIONS

The allegations that FPPS would cause work overload among specialists were said not to be true. Then Deputy Minister of Health, Dr. Hilmi, denied that specialist doctors would face higher burdens following their involvement in the services. This could be assured because the number of patients who would be treated by them would be determined and based on the statistics of the participating hospitals, wherein only 30 percent of the patients would be involved ("Health Ministry: Those", December 22, 2016).

The Coalition's argument that the FPPS tends to cause access and equity issues, especially among the poor, was also denied by the government. This was as mentioned by the former deputy Minister of Health, Dr. Hilmi, in response to reporters on October 22nd, 2016, in Ipoh. Instead, he explained that the FPPS was only a choice, especially among patients who are able to pay and wish to receive premium treatment from their chosen doctors. The program will never deny non-FPPS patients, since a fee of RM1 to outpatients still remains (Asrin, 2016).

Claims that the quality of service would be affected by the implementation of the FPPS program were also countered by the government. Again, Dr. Hilmi, in response to a journalist on the 21st of December, 2016, assured the people that the quality of health services for patients in government hospitals were not affected by the implementation of these services. The monitoring of service quality was done through a control system introduced specifically for this purpose, wherein a limit on the number of patients who could be treated at a time under these services had been imposed ("Health Ministry: Those", December 22, 2016).

The Coalition raised their concerns over the training programs for new doctors and prospective specialists. They were worried that the instructing specialists would have limited time to focus on the training programs, since they would be busy treating FPPS patients. In this regard, Dr. Hilmi explained that FPPS would never ignore the existing training programs to new doctors and potential specialists. This was because, according to FPPS regulations, the specialist doctors involved in this program were limited in terms of the number of patients that they could treat. The treatment time was outside office hours and weekends. Thus, it did not neglect the aspect of training.

On the other hand, the FPPS program, according to the government, is an incentive for experienced specialists to remain in government hospitals and not migrate to private hospitals. This is because they are given financial incentives when treating patients under the FPPS. Therefore, this encourages specialist doctors in government hospitals to remain, and, thus, help the training and teaching initiatives ("Health Ministry: Those", December 22, 2016). The government also denied that they did not open space to the Coalition to raise their views on this issue. Instead, according to the government, several consultations, and dialogs, as mentioned before, had already been held.

Despite protests from the Coalition, the government proceeded with the FPPS expansion program. The government, by letter of '*Medical Development Division,*' dated 7th October, 2016, announced the expansion of this service to eight hospitals, effective from 1st January, 2017. The hospitals with ambulatory treatment equipment were the general hospitals of Kota Bharu, Kuala Terengganu, Kuantan, Temerloh, Ipoh, Kuala Lumpur,

Klang, and Seremban. In addition to those, the next phase would involve 32 other government hospitals, although no date had been specified. Hence, this clearly shows that the government is committed, and will remain committed, to the FPPS.

DISCUSSION AND CONCLUSION

The commercialism of healthcare is a process of transferring the state's role into the hands of the market. Hence, its expected problems, such as affordability, accessibility, and equity, can be felt in this country. While the government may have their own wisdom in launching the FPPS in an effort of keeping medical specialist services in public hospitals, there are many unresolved issues, as highlighted by the Coalition in this article. According to the Coalition, the FPPS will contribute to more negative effects instead, such as the neglect of poor patients, especially those who are unable to participate in the FPPS. They argue that this program will also lead to an increased workload for medical specialists. Thus, the Coalition proposed to the government to cancel these services.

CSOs' efforts, both through social capital and counter-hegemony strategies on issues concerning healthcare, should be more widespread and involve more actors, not only among the CAHP, but other groups such as the MMA and other private healthcare associations. Through social capital, the bridging efforts among CSOs will increase the pressure placed on those in power by employing counter-hegemonic strategies, doubling the amount of people speaking out against hegemony and creating a bigger impact. Although such stratagem occasionally exists within CSOs, different ideologies, such as socialism versus capitalism, impede the potential outcome of such force.

This article calls to the government to have the door of negotiation open to more CSOs, so that the management of healthcare in this country may be more effective, and the running of private hospitals be more efficient. Government investments on the management of healthcare and services through the FPPS will only be meaningful if the voices of many segments of society, especially those from expert groups, are prudently considered.

In a nutshell, the CSOs efforts fell on deaf ears when the government proceeded to announce that the Phase 2 of the implementation of these services would take place in 2017. This top-down announcement obviously denied the involvement of other stakeholders, including civil society organizations. In short, although the concerns of the CSO were in many ways important and relevant, the discussion between these two opposing sides have to be put on the same table to expect better solutions. The study on the effectiveness of these services had once been tabled in Parliament in 2007, in response to questions raised by YB Jeyakumar to the then Minister of Health, Liow Tiong Lai. Jeyakumar criticized the findings, deeming them to be biased and not done based on appropriate methodology, since only those involved in the scheme had been selected as respondents. Since then, there have been no reported studies on the effectiveness of these services until the government announced its expansion in 2017. The extent of success, the problems, and the challenges of these services cannot be ascertained. The Ministry of Health is advised to appoint an independent consultant for this purpose, so that any problems or issues can be identified and dealt with. Otherwise, academicians should look into this topic and conduct further research on the FPPS scheme in Malaysia. Regardless, every policy, program, and initiative introduced by the government, especially involving healthcare, should prioritize the people.

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