HEALTH CARE REFORM INITIATIVES IN MALAYSIA

Report of a consultation with the Planning and Development Division
Ministry of Health, Malaysia

By

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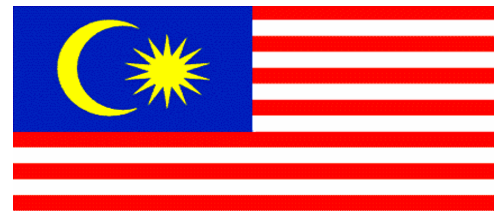

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Acknowledgments
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Overview
Three consultants supported through the Manila office of the World Health Organization visited Malaysia from Sept. 29 through October 10, 2002. They were Prof. Donald Shepard of Brandeis University; Dr. William Savedoff of the Stewardship and Health Financing section of WHO Headquarters, Geneva, and Associate Professor Phua Kai Hong, a Malaysian on the faculty of the National University of Singapore. Their purpose was to conduct hands on training with officials of the planning section and related units of the Ministry of Health, and to advise the Ministry on reforms in the organization and financing of health services in Malaysia. They were joined by Dr. Jose Suaya, MD, MPH, MBA, of Brandeis University, who, while not supported by WHO, also contributed to the hands on training.

After gathering some data on Sept. 30, the consultants led 3 days of training sessions on Oct. 1 through 3, covering principles of cost-effectiveness analysis, experiences of health reform in SE Asia, health systems evaluation, alternative models of corporatization, and calculation and interpretation of break even analyses. The instructors introduced three tools of economic evaluation: cost minimization, cost-benefit analysis and cost-effectiveness analysis, describing each method, its uses and limitations, and giving an example of its use. As part of the cost-effectiveness analysis, the instructors introduced the concepts of QALYs (quality adjusted life years) and DALYs (disability adjusted life years), and reviewed the discounting for future benefits and costs. The instructors then described the technique of break-even analysis and its uses. They analyzed with the class examples with various scenarios of fixed and variable costs of services and of revenues obtained from the user fees alone and in combination with subsidies lump sum and per-unit based subsidies. They briefly described demand curves and price elasticity of demand. Finally, they reviewed the use of Excel for conducting many of these analyses, including the creation and interpretation of tables and graphs for breakeven analyses.

Next, the group assembled diagnostic data about the costs and performance of the Malaysian health system. The Power Point presentations and Excel workbooks from these training sessions are being distributed on a CD by Dr. Norliza Noordin.

On October 8, the consultants and their counterparts in the Ministry of Health organized an all-day seminar on Health Reform Initiatives in Malaysia (see Appendix A for agenda). The consultants recommended that many of the preventive, curative, and support functions of the Ministry be transferred to three groups of corporatized units,

oriented around general health services for a each state of Malaysia, specialized services, and selected technical services.

The consultants were given the opportunity to summarize their recommendations in a meeting on Oct. 9 with Dr. Ismail, and a meeting of 10 senior officials (including the Director General hosted by the Secretary General. The narrative in the remainder of this report summarizes the presentation, while the Power Point slides from this presentation are attached as Appendix B.

Diagnosis of the Malaysian Health System

The consultants started from the premise that the main goals of the Malaysian health system, and any possible reforms, would be to improve the health status of the population, to improve the responsiveness of health services to the population, and to improve the financial fairness of funding for the health system. In general, the available evidence demonstrates that the Malaysian health system achieves remarkably high and equitable health status at relatively low cost. Popular dissatisfaction and the persistence of an active private sector raise questions about the public health services' responsiveness. Since public services are currently provided at very low cost, the system is probably very "fair" in the sense that no one is excluded from receiving care on the basis of ability to pay. On the other hand, the perception that private care is better quality, or the greater convenience of private care, lead a large number of people to pay for services that they could otherwise get for free or at highly subsidized rates.

As a framework for examining the strengths and weaknesses of the Malaysian health care system and possible needs for reform, the consultants recommended using the concept of economic efficiency. Efficiency has two components. Allocative efficiency entails producing the right types and quantities of health promoting behaviors, and producing the right types and quantities health services. Technical efficiency entails Producing public health, primary care services and medical services efficiently, with appropriate inputs, appropriate quantities, and appropriate prices.

Data compiled by the World Health Organization show that the overall performance of the Malaysian health care system is remarkably good. One indicator, the "Health Adjusted Life Expectancy" (HALE) at birth, is comparable to that of industrialized countries--about 63 years. This accomplishment is remarkable, however, because Malaysia devotes only 3 percent of its GDP to health, compared to about 6 percent for most industrialized countries and 14 percent for one of them (the United States). Other indicators reveal a similar story. Maternal mortality rates in Malaysia have fallen ten fold over the last 3 decades.

Malaysia also rates well on the distribution of health characteristics among segments of the society. That finding is illustrated by the difference between male and female life expectancy. When both genders are given equal access to preventive and curative health services, women tend to do better. This pattern is found in Malaysia, where women live from 2.7 to 3.7 years longer than men. Malaysia falls in the same category as countries

that have incomes 5 times higher, such as Canada and the United States. When these international comparisons were placed against the perceptions of public officials that the country's public health system is unresponsive and demoralized, one emerges with the diagnosis of a health system with many strengths, but areas for improvement. Survey data also show that overall utilization rates of ambulatory health services vary little by income group.

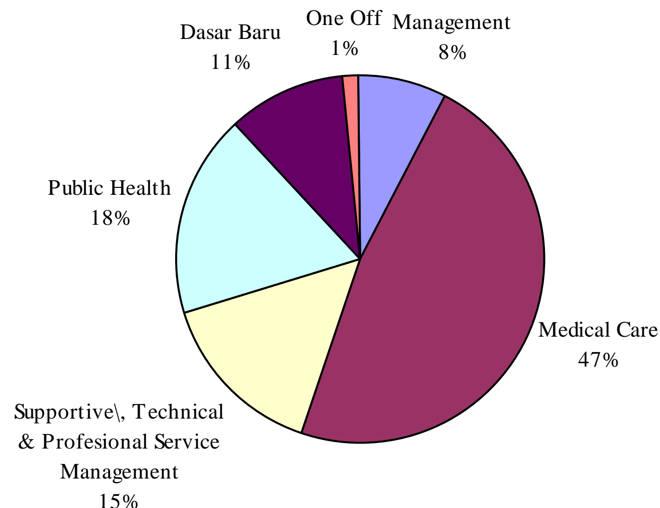
The recommendations that emerged from this diagnosis were for the country to proceed with a limited reform. This reform should improve the management of public health services so that they can provide better working conditions for their staff, fill critical vacancies, enhance responsiveness to the population's needs and wants, and maintain an equitable basis for financing health services.

The reform should also aim towards both allocative and technical efficiency. Allocative efficiency entails producing the right types and quantities of health promoting behaviors, and producing the right types and quantities health services. Technical efficiency is producing public health, primary care services and medical services efficiently, including appropriate inputs, appropriate quantities, and appropriate prices. The technique of cost-effectiveness analysis can assist in achieving allocative efficiency. A World Bank study of health interventions in developing countries found that many preventive and primary care interventions were relatively cost-effective.[1] Care at secondary hospitals could also sometimes be cost-effective, such as chemoprophylaxis for tuberculosis. Care at tertiary hospitals was generally not very cost-effective, however.

Figure 1 shows the actual allocation of resources within the Malaysian Ministry of Health. For 2001 47% of the funds went towards curative medical care, compared to only 18% for public health (prevention and primary care). In any reform, the goals should be to maintain, if not increase, the share going to public health and to maximize the resources, skills and motivation of the personnel delivering those public health services.

[1] World Development Report 1993: Investing in Health. Washington, DC: World Bank and Oxford University Press, 1993.

Recommended Structure
A forthcoming book on health reform[2] identified four alternative organizational structures



used in reforming health organizations: Budgetary Units, Autonomous Units, Corporatized Units, and Privatized Units. The latter structures are distinguished by more autonomy to the management of the unit, more exposure to market conditions, and a greater share of revenue coming from non-budgetary sources.

In applying these concepts to the Malaysian Ministry of Health (MOH), the consultants reviewed MOH functions and suggested that functions could be devolved into corporatized entities in cases where the entity delivered a set of well-described, measurable services and had the potential for reasonable revenue generation. On that basis, the consultants recommended that the MOH:

- Corporatize integrated regionalized health services (non-profit, government-owned)
- Corporatize specialized medical institutions (e.g. national referral hospitals)
- Select which technical functions should be corporatized (e.g. Food Quality Control and Drug Quality Control).

Corporatization with monitoring and incentives is designed to overcome two problems with the current MOH structure. First is a shortage of resources. Compared to other countries, Malaysia devotes a small share of both its government budget and its GDP to

[2] Alex Preker and April Harding, *Innovations in Health Care Deliver: Corporatization of the Public Sector*. Washington, DC: World Bank, 2002.

health; yet, as Government seeks to rebuild the country's economic growth, it is reluctant to devote substantial additional public resources to health. The corporatized structure will allow shifts, particularly for curative medical care and some regulatory functions, to non-budgetary sources. Secondly, it will allow for flexibility. For types of personnel for which government salaries are far away from market conditions, the corporatization will allow for a more realistic salary scale. Based on shares of unfilled posts, this discrepancy seems to apply most at the bottom and top of the position hierarchy. At the bottom, medical assistants in government in major towns are underpaid compared to compared to earnings from factory work for comparably skilled workers. At the top, senior specialists are reported to earn 10 times government salaries in the private sector.

At the seminar on Oct. 8, the consultants recommended that the corporations for integrated health services be organized on the basis of the 14 states. Based on subsequent discussions, the consultants revised this recommendation to the regional level. The revision was based on the need for efficiency and skilled management personnel. The consultants felt that creation of by-laws, personnel structures, recruitment of outstanding management personnel, monitoring and auditing, might all be difficult in the short run for 14 states, but would be easier for 3 to 6 regions.

Despite this creation of corporatized units, several key functions should remain within the MOH. These include developing health policy, developing and enforcing performance measures, and allocating public subsidies among Ministry functions and these corporatized entities.

Once units are corporatized, they must be given a management structure designed for effective governance. This entails independent boards of directors with representatives appointed by different Ministries, local government, professional associations, independent experts, and community and consumer representatives responsible for appointing CEO, and open sessions and reporting requirements.

One of the key strengths of the present MOH, which must be carefully preserved in the corporatized structure, is the sense of public mission among the staff. To maintain this sense of "public mission" among staff, the top management should be chosen who share this vision, and the by-laws and procedures should reinforce the goal that the purpose of the corporatized units is still to attend to the population and improve health status as shown by the kinds of performance targets

Finally, to ensure that the corporatized unit achieves both allocative and technical efficiency, it will be key to monitor and reward its performance appropriately. To do this, the MOH should establish mechanisms for objective measurement of performance for each corporatized entity, which can be MOH staff in some cases or contracted external reviewers in others. Specifically, performance needs to be rewarded in the following dimensions:

> •Efficiency: reduction in unit cost•Quality of service: technical quality (e.g. case fatality rate) and satisfaction•Cost recovery: shift financing away from government subsidy

•Health: maintain and improve public health functions

The consultants' recommended structure for top management is a Chief Executive Officer appointed by the Board with expertise in both management and the specific focus of the corporation. He or she should be appointed with a renewal three-year contract, with annual review by the responsible ministry (e.g. MOH or Ministry of Education).

Performance measurement is a key component of the consultants' recommendations to ensure that the higher salaries and costs of a corporatized unit are justified by improvements in both the quality and quantity of output. Performance measurement should have both objective and subjective components. The objective components compare each corporatized unit against a series of objective indicators, agreed in advance. The calculation of these indicators could be done either by the Ministry directly, or through a further contracted evaluator, depending on the capacity of the Ministry. If the latter were chosen, the following procedure might be used. First, the Ministry of Health contracts with an evaluation contractor to measure performance of each corporation in relation to its peers each year. The measurement of indicators relies on data supplied by the corporation, but is audited on a sample basis by the evaluation contractor. Next, the evaluation contractor corrects the data for errors in reporting and tabulation, with penalties for systematic bias. Third a weighted index is calculated that combines the component indicators into an overall score.

For those components of performance than cannot be easily measured through objective indicators, a subjective procedure is proposed. The consultants' proposal builds on the procedures for evaluating education in Commonwealth countries. First, the MOH appoints an external examiner each year, similar to those in universities. The external examiner comes from a similar area or institution not covered by the corporation, such as

- Another state for state health corporations
- Another specialized hospital for specialized hospital corporations.
- Another country for national corporations

The external examiner visits the corporation, observes management and field functions. Using these visits, the external examiner compares achievements against norms in the field. He/she reports findings to MOH and the corporation.

A key factor in our recommendation is the linkage of performance to consequences. Specifically, we suggest that performance should affect salary increments in proposed structure for Malaysia through a regime like the following:

- Overall corporation performance determines <u>average</u> salary increment for staff of unit for the next year
- Peers and supervisors in corporate unit evaluate each worker's performance based on position description.Board evaluates performance of top management.
- Individual salary increment and promotions depend on individual performance relative to the corporation.Deficient or redundant staff can be transferred or terminated.

gives flexibility to recruit, motivate, and retain appropriate staff, but skilled and transparent management required to ensure these advantages.

To better guide future recommendations on corporatization, the consultants examined available experience within Malaysia's health sector. Two examples were prominent, the University of Malaya hospital, and the National Heart Institute (IJN in Malay). According to clinicians at the University hospital, the corporatization that was started just prior to the economic crisis in 1997 has never been fully implemented. Thus service fees and cost recovery remained low, while salaries and incentives have also not changed.

At IJN, the corporate structure and an able chief executive officer have allowed the institution to function as designed. Costs of sophisticated treatment (e.g., heart surgery or angioplasty) are apparently less than the same treatment would have cost overseas, and the increase in unit costs has been moderate. On the other hand, the total costs to the MOH of supporting IJN (which appear as revenues to that corporation) have risen substantially. According to analysis published by Hussein et al (2002), the revenues of IJN have more than doubled (from RM 42 to 87 million) over the 4 years covered in her data (1993-1997).

The experience of IJN also demonstrates how continuous monitoring and refinement are needed to correctly define and incentivize the mission of a government organization. The government as the majority shareholder limited the number of private patients at IJN, so that they make up 24% of its revenue. The remaining revenue comes from government for serving civil servants and their dependents (52%) and the poor (24%). The consultants did not have the size of the respective denominator populations to calculate which of these two groups was using more heart care services.

Recommended Financing and Provider Payment

The consultants' key recommendations on financing are to increase the fee structure in public facilities in a cautious, selective, and equitable way; and to gradually expand a system of mandatory savings that could be used to pay health care expenses. This mandatory savings mechanism could be later extended to encompass premiums for a social insurance program. These recommendations appear to be closely aligned with cultural norms and political views that were voiced during the workshops and discussions: namely, that health care costs are a family responsibility; that differentiation of amenities is acceptable as long as the quality of medical care is the same (as promised by the proposal); and that current fees are very low.

Currently, the MOH recovers only 3% of its operating budget through fees, an amount which is well below the level of co-payments in many European health systems. As service fees are raised, prices of inpatient services should be differentiated by wards with different amenity levels (hotel services). Nevertheless, the quality of medical services should remain the same for all regardless of the fee paid. For inpatient services, price should vary by type of ward with exemptions available to the indigent on approval by a social worker. The consultants recommend that for inpatient care, the lowest fees should not exceed 10% of the economic cost, but the highest fees could can exceed 100% of costs and thereby generate an additional subsidy from the wealthier to the poorer.

To examine the unit costs under current budget allocations, the consultants needed to know the portion of hospital cost currently attributable to inpatient and outpatient services. The information available to the consultants, the government budgets, broke the costs down among clinical services, but did not distinguish between inpatient and outpatient care when a given hospital department served both groups of patients. To fill the data gap, the consultants used the concept of "Relative Value" of different types of hospital services from international experience. Those studies found that one outpatient visit costs 32% the cost of one inpatient bed day on average.[3] Studies from Malaysia around 1991, used by consultants to support the calculations of national health insurance at that time, were consistent with this ratio.

The consultants calculated that in the year 2000, the average ambulatory consultation outside of a specialized hospital (including the average prescriptions and laboratory services associated with that visit) cost RM 91, while the average inpatient say cost RM 1091 (or RM 286 per day). By contrast, the fee for an ambulatory visit, RM 1, has not increased in years and covers only 1% of the economic cost of an average visit.

The consultants recommended, based on experience in SE Asia, that the corporatized health units be paid by MOH on a combination of a fixed budget and their performance. The fixed budget, expected to represent 75% of their revenue, will be based on capitation adjusted for environmental factors. For example, corporations with a disproportionate share of facilities in remote rural areas would be paid a higher capitation rate to reflect the added qualifications needed to attract qualified staff to those areas. The performance, representing 25% of the revenue, will be based on the volume of activity (e.g. number and type of admissions and visits for patient care services) as well as on performance indicators related to goals of public health, and quality of services (e.g., responsiveness). For corporatized units that "serve" or regulate businesses (e.g. Food Quality and Drug Quality), the 25% performance-based revenue will come from service fees paid by those businesses.

Although participants in the discussions agreed that fees could and should be raised so that those who could contribute to the costs of care should do so, there was also, rightly, a concern that the fees should never become an obstacle to access for anyone. Therefore, fees should be a complement to the publicly funded services and mechanisms should be introduced to assure that families have the savings available to assist them when needed.

Therefore, to assist patients in paying the fees, particularly those for routine inpatient admissions, the consultants recommend two sources of funds. First is a general subsidy from tax revenues so that the charge for a bed in an open ward is set at only 10% of the economic cost of the service. In 2000, this basic charge for an average admission would have been RM 110. Allowing for the additional cost of enhanced services and inflation, the consultants project that the basic fee for an average inpatient admission would still be

[3] Shepard DS, Hodgkin D, Anthony Y. Hospital costs: a manual for managers. Geneva: WHO, 2000.

only RM 200. Only about 1 Malaysian in 16 is hospitalized in a public hospital in a year, and the basic user fees represents only about 1 week of wages for an average Malaysian.

To help pay this co-payment, the consultants recommend that for workers covered under the Employee Provident Fund (EPF) the scope of mandatory savings based on Account III should be expanded. Rather than being available only for catastrophic illness, as at present, the EPF should be available for all hospitalization in public facilities for the worker and (with the worker's written authorization, his family). The consultants recommend that each hospital have approved fee schedules and provide financial advice to patients on the choices around accessing the EPF. The EPF Account III would also be available for paying higher fees to upgrade to accommodation with more privacy (e.g. 4 or 2-bedded rooms) and amenities. The advice would be based on the balance, rate of replenishment, and expected demands for future hospitalizations of the Fund III so that workers would avoid depleting all of the savings funds available to them.

If a person did not have an EPF, or if his or her EPF Account III did not have an adequate balance to cover a hospitalization, the first expectation would be to access the fund of a family member. Second, the patient could pay directly without savings in many cases because the open ward fees will still be quite low. In an open ward, the fee represents only one week of earnings even for a low income person – an expense that should be acceptable in many cases. As a last resort, each hospital would have an indigent health fund with means test for patients truly unable to pay the fee for an open ward. In no case should the fees become an obstacle for access to care.

Once the expanded health savings fund has been in existence for a few years, so that fund balances and experiences with the system have accumulated, several features should be added. The consultants recommend first that the purchase of insurance for larger health expenses be offered. The premium would be paid automatically from the savings fund each year, so administrative expenses would be minimal. As several studies have been conducted in Malaysia about the projected costs of a national health fund for social insurance, this work could form the basis of the actuarial cost projections. The insurance could be offered by private companies under strict government regulation defining the "package" of services covered and the requirement that all applicants be accepted.

As a further extension, the consultants recommend that the savings scheme could later support private providers, who could be paid up to the limits paid to a public provider for the same type of bed for the same type of care, conditional on an adequate balance in the EPF. This step helps provide some quasi-public financing for the private sector, but under tight controls to reduce moral hazard. The fund being used belongs to the worker or his family, and the rate of withdrawal is controlled.

To support these policies, it is important for as many Malaysians as possible have an EPF, particularly the elderly. Thus, as workers retire they should be required to retain the balance of their EPF Account III, even as they are allowed to withdraw the balances of their other funds. For workers not covered, government might offer incentives for them to start such a fund, such as matching their contribution up to, say RM 200. Finally,

government could set policies to include persons in the informal sector, such as hawkers and taxi drivers. As part of the annual license renewal, government could require that they contribute a specified amount to the fund (depending on the profession) to cover the insurance premium and the co-payment on, say, one hospitalization per year. Similarly, farmers who sell cash crops exceeding a specified monetary value could also be required to contribute annually to savings funds.

A further recommended extension of the EPF would be an authorization to cover certain critical outpatient care, such as follow up care following an inpatient hospitalization. Examples would be care for diabetes or management of ischemic heart disease or congestive heart failure following a hospitalization. The coverage would be conditional on the provider demonstrating that he/she follows the latest professional standards for treatment of the condition (e.g. ensuring active follow up for prescription and adherence to appropriate generic medications, and participation in appropriate lifestyle activities around diet and exercise). Physicians might obtain a "certified" status on demonstration of good practices among their patients, a benefit to both the physician and his or her patients.

When fully implemented, the consultants' proposal calls for an expanded health care financing system integrating both savings funds and insurance. Given the current structure of the Malaysian economy, and its rapid rate of growth, we believe that coverage of the savings/insurance scheme could reach some two-thirds of the population (economically active workers in the wage, informal, and agricultural sectors and their dependents). For the remainder, those with high incomes would have the option of entering the mandatory savings scheme, and would pay for services based on the fee for the chosen ward. Those who are not covered and have low incomes would still be able to access care at heavily subsidized rates (for open wards) or for free if they are identified as indigent.

It is worth noting that we have not recommended that Malaysia begin with a system of universal and comprehensive health insurance to cover a mix of public and private provision. We believe that such a plan would place excessive emphasis on curative services and be too inflationary. The availability of insurance makes it easier for private doctors and hospitals to increase their fees and to increase the number and kinds of services provided -- even when these may not be medically indicated or cost-effective. By relying primarily on its public health services, corporatized but managed within established performance standards and appropriate budgets, Malaysia should be able to improve the responsiveness of care without facing an inappropriate shift of services toward curative care and high costs. The private sector will continue to operate, but on a full payment basis. It will provide a continuing benchmark for the quality of care in the public sector. To the extent that private insurance emerges to cover private health care services, the government will need to improve its regulations to ensure that this does not harm the public interest. Such regulations should ensure solvency of the insurer, honest treatment of the policyholder, and sensibly designed insurance (i.e., minimal exclusions for coverage).

In conclusion, the consultants believe that user fees can provide a valuable supplement to tax revenues in a national health system. These fees can create useful incentives to health corporations for productivity and to clients for prudent use of services. Mandatory savings funds allow more revenue from fees, particularly among those best able to pay. Nevertheless, for most public facilities, the main source will remain general tax revenue.

Special Issues

In the seminar on Oct. 8, 2002, the consultants discussed several special issues related to insurance regulation and gatekeeping. The gatekeeping issue arose again in the seminar with the Secretary General on Oct. 9. As the MOH moves towards creating corporate entities for specialized care, there will be pressures from patients and providers to provide more specialized care. As the MOH resources for such care may not be able to stretch as much as the demand, it will be critical to develop gatekeeping functions to ensure that the patients for whom the services are most cost-effective receive service. This is a preferable option to a waiting list, where some patients who would benefit substantially from a service must wait and might expire or develop complications in the interim. Other patients who, based on their medical condition, may derive less benefit from a service, may be ahead on a chronological waiting list. As an example from the US presented by Prof. Shepard showed, good gatekeeping can reduce costs and improve access at the same time. The key is evidence-based medical criteria and skilled and impartial medical staff to administer those criteria.

Seminar participants raised concerns about the existing civil servants' pensions and medical benefits. These could be addressed by protecting older civil servants under their original terms of service, or converted into monetary equivalents with EPF contributions for those who choose to have new terms and conditions in corporatizated units.

Next steps for the next year

Shadow corporatization. To build the recommended organizational structures, the consultants recommend that the MOH begin corporatization on a "shadow" basis for one state, one specialized hospital and one technical service within the next year. The MOH should develop a budget for each of those institutions as if they had been corporatized. The management should identify what changes would have been implemented if the unit were corporatized. The management should determine the net costs of the proposed changes (both savings and increases). This experience will help the MOH in setting appropriate budgets and subsidies for corporatized units as they are actually created, and can help avert unforeseen complications.

Create the financial foundation for expanded savings fundsThe MOH, working with the Ministry of Human Resources and the EPF Board, should modify the terms for the Account III of EPF to be used for all hospitalization in the public sector, and selected hospitalization in the private sector, not necessarily restricted to catastrophic illness. Government should ensure that retirees retain a minimum specified sum under Account III. Finally, through pilot efforts in selected cities, government should explore extension to informal sector through annual licensing (e.g. hawkers, taxi drivers) and gradually through other channels such as cooperatives. It is anticipated that the poor and indigent

without savings would continue to enjoy the highly subsidized rural health services or hospital services (“C” wards) financed through taxation.

Begin implementation

Finally, the MOH should begin implementation of a corporatized unit. The consultants recommend that it start with a technical service as it does not require financing from consumers, and can be supported through service fees. Examples are the departments responsible for Food Quality Control and Drug Quality Control. The consultants had the opportunity to confer with the director of Food Quality Control, Datin Dr. Harrison, who would be pleased to work with the MOH in corporatizing her department.

Appendix A: Agenda for Seminar on Health Care Reform Initiatives in Malaysia, 8 October 2002

0730 **Registration**
0800 **Welcome Address by Organizing Chairman**
Acting Director of Planning & Development Division Dr Padmini Denis
0815 **Official Opening by the Deputy Director-General of Health Malaysia (Research & Technical Support)**
Y. Bhg. Dato' Dr. Haji Mohd Ismail Merican
0900 **Tea**
0930 **Technical Overview**
Prof. Donald S. Shepard
0945 **Framework and diagnosis**
- Principles and goals (high health and responsiveness; low cost to country)
- Performance of Malaysian health system: an international comparison
- Strengths and weaknesses of the current Malaysian system
- Questions and Answers

Dr. William Savedoff
Rapporteur: Dr. Kalsom Maskon

1045 **Proposed reforms: structure**
Prof. Donald Shepard and Assoc. Prof. Phua Kai Hong
- Regional experience in corporatization and decentralization
- Corporate entities: 14 states, national and specialized institutions
- Provider payments
- Questions and Answers

Rapporteur: Dr. Noeli Mohs Nooesin

1145 **Financing and provider payment**
Prof. Donald Shepard and Assoc. Prof. Phua Kai Hong
- Required expenditure
- Sources of funds (taxes, savings fund from Employee Provident Fund, out-of-
- Questions and Answers

Rapporteur: Dr. Rohaizat bin Yon

1400 **Special issues**
Prof. Donald Shepard and Dr. William Savedoff
- Relationship with the private sector
- Regulation
- Gatekeeping and referral
- Administration
- Questions and Answers

Rapporteur: Dr. Hasnah Bibon

1500 **Tea Break**
1530 **Discussion**
Dr PadminiDenis
Rapporteur: Dr. Noorliza Mohd Noordin
1730 **Adjournment**

Appendix B: Power Point presentation to the Secretary General of Health, 9 October, 2002

The consultants had the opportunity for a one-hour presentation and discussion with the Secretary General of Health, with the Director General and other senior staff of the MOH in attendance. The 43 slides from this presentation are available in hand out form as a separ