Social Protection in Action: Building social protection floors for all

Country Brief: Malaysia

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Extending Social Health Protection in Malaysia: Accelerating progress towards Universal Health Coverage

1. Introduction

Malaysia has achieved broad access to health services at all levels of care, and relatively effective financial protection against catastrophic health spending, especially for the poor, with a modest level of government expenditure on health. Improvements in utilization and health outcomes since the 1960s have been achieved over the years, with spending on health services ranging from 2.0 per cent to 4.0 per cent of GDP (WHO 2000). Between 1990–2020, life expectancy at birth increased significantly (Malaysia Department of Statistics 2020c; Yu, Whynes, and Sach 2008). Malaysia's child mortality rates are comparable to high-income countries, with under-five mortality reducing by over 75 per cent and infant mortality by 70 per cent from 1965–1990. Infant mortality fell a further 62 per cent from 1990–2005 (Jarrah 2018; Yu, Whynes, and Sach 2008). Today, a rising burden of non-communicable diseases (NCDs), alongside population ageing, are the leading causes of illness and disability in Malaysia, though communicable diseases such as tuberculosis and (to a lesser extent) HIV/AIDS, are among the leading causes of death (Noor, Muzafar, and Khalidi 2020).

The main provider of health services in Malaysia is the national health care service under the Ministry of Health (MOH), which provides universal coverage to the population. Services in public facilities are tax-financed and are either free or subject to a small regulated user fee. In addition to the national health care service, over the past three decades, the private provision of health services has expanded, and out-of-pocket (OOP) spending has subsequently increased. With a view to improve financial protection, especially for marginalized populations, the Malaysian Government launched two programmes to complement the national health care service. Firstly, the Medical Relief Fund is in place, which provides financial assistance to fully or partially cover the costs of medical equipment and certain consumables which are not part of the implicit benefit package in MOH facilities. Secondly, the PeKa B40 scheme is implemented, which focuses on supporting low-income groups with NCD-related health care. In addition, the Ministry of Finance launched the MySalam scheme, which provides sickness cash benefits in cases of

hospitalization or critical illness for persons in the lowest income quintiles.

2. Context

Malaysia inherited its national health care service system from British colonial rule, with services predominantly provided in urban areas. Upon independence in 1957, health care services were expanded, especially for the poor and rural population, enabling Malaysia to achieve broad access to health services at all levels of care, and relatively effective financial protection against catastrophic health expenses for the poor. Since the 1980s, the Malaysian health system has transformed from a health system composed mostly of public facilities to one that also includes a large private sector, with the Government encouraging private investment and delegating health system activities such as drug distribution and hospital support services to private actors. To regulate the role of private providers in health service provision, Incremental policy changes were introduced, [1] including fees (Quek 2014).

The Fees (Medical) Order of 1982 regulated user fees for patients in government health facilities. The private sector (medical clinics, dental clinics and hospitals) is regulated under the Private Health Care Facilities and Services Act 1998, but this legislation was not enforced until the promulgation of 2006 Regulations, and was further amended by the Private Healthcare Facilities and Services (Private Hospitals and other Private Health care Facilities) (Amendment) Order of 2013, which includes user fee levels in its scope (Jaafar et al. 2012). The Private Health Care Facilities and Services Act requires Managed Care Organizations (MCOs) to register and provide information to the MOH. MCOs manage private health insurance coverage, which accounts for a very small share of health expenditure.

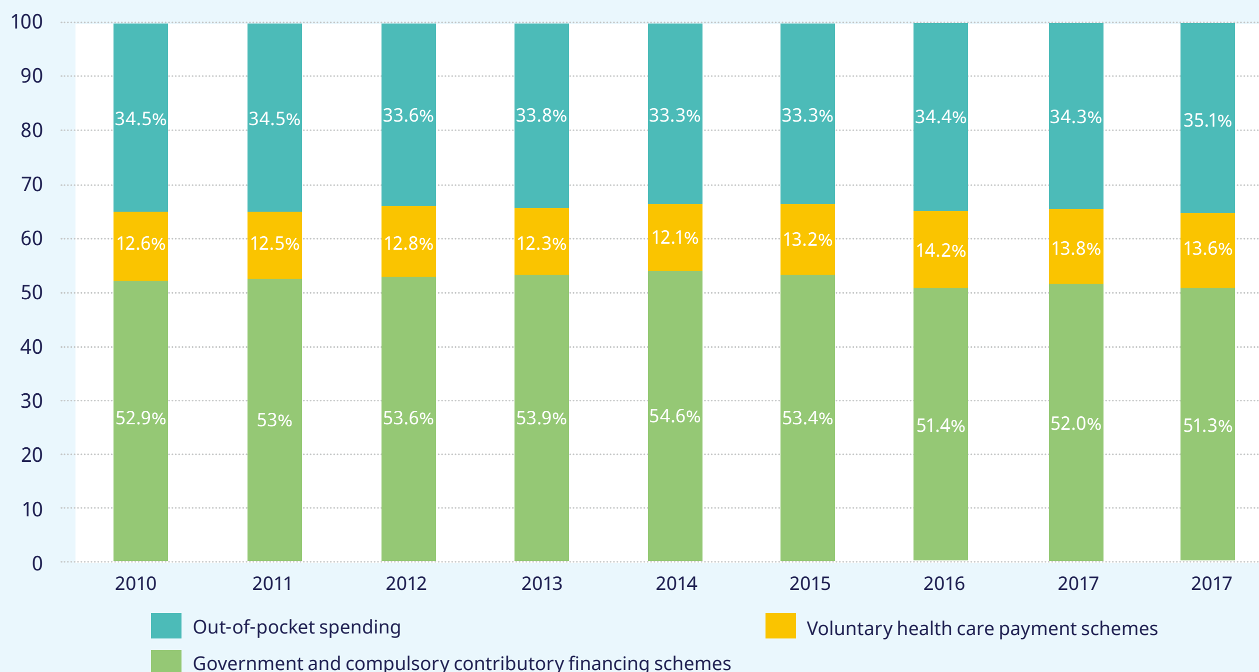
3. Design of the social health protection system

- Financing

Government health expenditure represented less than 2 per cent of GDP in 2018 (Croke et al. 2019; WHO n.d.). A significant proportion of health spending is funded through OOP payments (services at private facilities, as well as the small user fees charged at public facilities), private health insurance (representing around 7 per cent of current health expenditure), individual withdrawals from the Employee Provident Fund, and (in the case of occupational diseases and injuries) by the Social Security Organization (SOCSO) (Zainuddin et al. 2019). The share of income spent by households on health is relatively stable across wealth quintiles, with the highest proportion in the upper quintile.

[1] Private Health Care Facilities and Services Act, 1998 and Regulations, 2006, amended by the Private Health care Facilities and Services (Private Hospitals and other Private Health care Facilities) (Amendment) Order of 2013.

▶ **Figure 1. Health expenditure in Malaysia, 2010-2018**



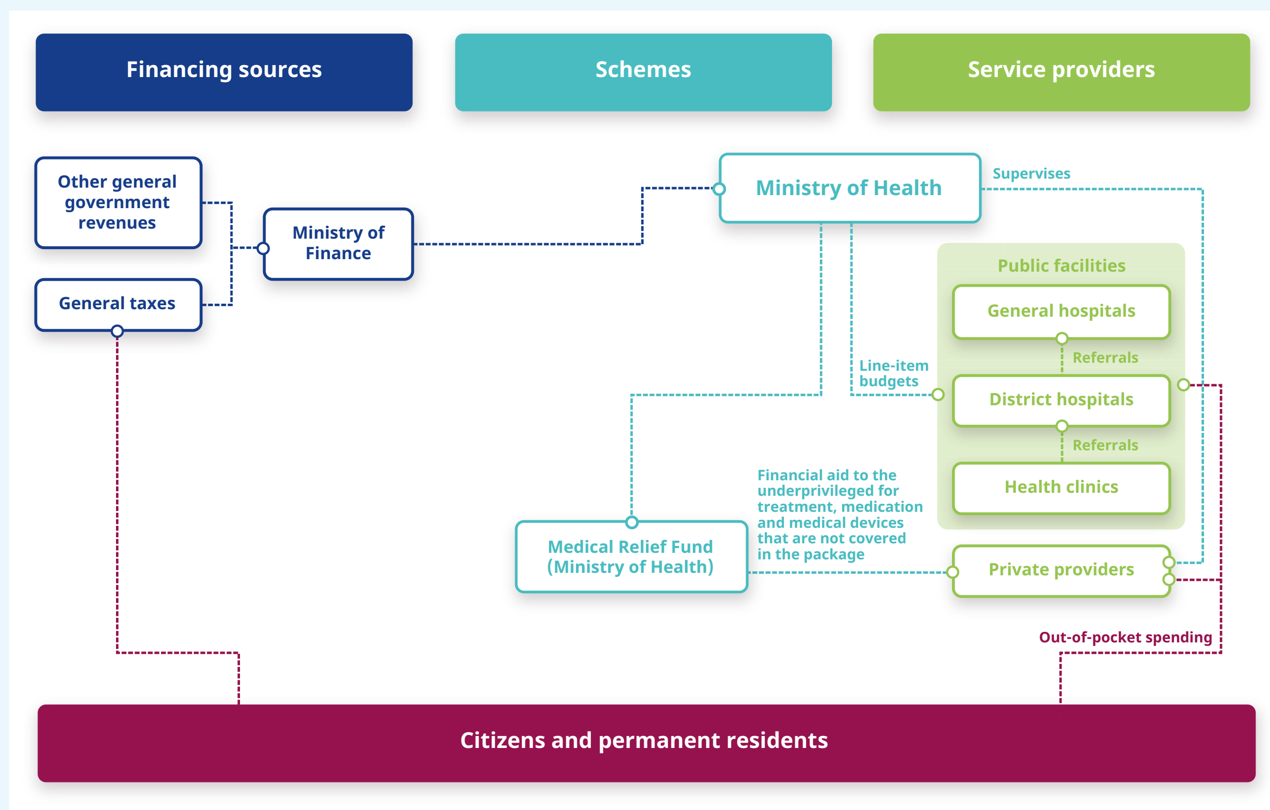
Source: Adapted from WHO Global Health Expenditure Database.

The national health care service and the Medical Relief Fund are financed by general taxes (direct and indirect) and non-tax revenues collected by the federal government and allocated to the MOH. The allocation of funds by the Treasury to the MOH is based on past spending combined with possible additional funds determined by estimated rises in the Consumer Price Index and projected needs by the MOH. The Treasury also provides additional funds for specific purposes, such as disease outbreaks (Jaafar et al. 2012). Total MOH revenue amounted to 745.8 million Malaysian Ringgit (MYR) in 2018, equivalent to US$171.3 million (Malaysia Ministry of Health 2018). The much smaller PeKa B40 scheme, which focuses on NCD-related health care [2] for low-income individuals is non-contributory and financed directly through the general government budget.

Figure 2 below provides an overview of the main financial flows of the system. Health care services provided in private facilities are primarily financed via OOP payments, corporate arrangements and, to a lesser extent, private health insurance. Voluntary prepayment arrangements represented 13.6 per cent of current health expenditure in 2018 and this share has slightly increased over the past decade. Expenditure from such schemes is mostly geared towards private hospital costs.

[2] The scheme focuses on 4 specific benefits:
1. Health screening
2. Health aid (assistance for purchase of selected medical equipment)
3. Cash incentives for completing cancer treatment
4. Transport incentives

Figure 2. Overview of main financial flows of the social health protection system in Malaysia



Notes for figure 2:

1. Care at private providers is primarily paid through OOP expenses, although some private insurance schemes exist. In addition, the second account of the EPF can be withdrawn for specific health expenses.
2. Medical care related to occupational diseases and injuries is managed by SOCSO.
3. The recently introduced MySalam programme offers cash sickness benefits to the B40 category in case of hospitalization or critical disease. MySalam is a form of insurance based on Islamic laws known as "takaful". [3]

Source: Authors.

- Governance

The MOH is the primary funder, provider and regulator of health services, and provides most of the country's health services (70.6 per cent of all admissions in 2016) (Malaysia Ministry of Health 2017). The national health service is organized at three levels: federal, state and district (Jarrah 2018). Policy-making, regulation and planning functions are centralized at the MOH. Health is primarily the responsibility of the federal Government, although state governments also play a role, especially in public health, through state health departments and district health offices (Atun et al. 2016). State health departments are organized in the same way as the central MOH's structure for each of the technical programmes. State and district hospitals are managed by state health departments. District health offices manage district-level public health, oversee regulatory, management and pharmacy functions, provide collective health services, and are responsible for critical service delivery units, including health centres and mobile clinics. The

[3] MySalam is non-contributory. The initial seed funding of MYR2 billion (US$459 million) for the mySalam trust fund was provided by Great Eastern Holdings Limited. The Government plans to increase the size of the trust fund over time with additional contributions from Great Eastern Holdings, other insurance companies and other financing sources (mySalam 2020).

MOH attempts to involve community groups in promoting population health, and community leaders are also appointed to advisory panels and/or boards of health clinics and hospitals (Jaafar et al. 2012).

PeKa B40 is administered by ProtectHealth Corporation, a not-for-profit entity established under the MOH. The MySalam scheme is operated by a takaful operator officially licensed under the Islamic Financial Service Act 2013. This is currently the Great Eastern Takaful Berhad, although other takaful operators may be appointed to administer the scheme in the future (mySalam 2020).

The Malaysian Social Protection Council (MySPC) is in place to address coordination between social protection schemes with representation from MOH, EPF and SOCSO. The SOCSO Board also provides an informal platform to facilitate coordination with the broader social protection system, since it includes representatives from different ministries including the MOH and other stakeholders, including employer and insured persons representatives (Social Security Organization 2021). [4]

- Legal coverage and eligibility

The entire population is eligible to access the national health care service. Malaysian citizenship or permanent residency is required to benefit from the subsidized system. Non-nationals who are not permanent residents, among whom include migrant workers on temporary work permits, can access public health services, but they do not benefit from financial protection and need to pay higher user fees for services (Ng 2019). [5] A subset of the migrant population is required by law to enrol into the Foreign Workers Hospitalization and Surgical Insurance scheme.

The MOH Medical Relief Fund (Tabung Bantuan Perubatan), which provides full or partial financial assistance to cover costs of medical treatments and drugs that are not available in government health facilities, determines eligibility on a case-by-case basis. The PeKa B40 and MySalam schemes both target the low-income population registered in the Bantuan Sara Hidup (BSH) programme, recently renamed Bantuan Prihatin Rakyat — a social assistance programme established by the Government in 2019. Eligibility for the BSH is performed through income tax data. The BSH register provides a platform to offer a coordinated set of social protection benefits (both health-related and income support) to the lower end of the wealth quintiles in Malaysia. The centralized registry is used by several social assistance programmes with a view to boost redistribution and reduce poverty and inequality. The PeKa B40 scheme is open for all BSH-registered individuals above 40 years of age, who must additionally undergo a health screening. Citizens of at least 40 years of age, and below the 40th percentile for household income in the country, as well as their spouses, are covered under the scheme. The MySalam scheme is more restrictive: BSH-registered individuals are eligible from the age of 18 if married, or 40 up to the age of 65, if single.

- Benefits

The national health care service system offers comprehensive services ranging from preventive and primary health care to tertiary hospital care (Jaafar et al. 2012). Preventive services offered include health screening for adult men and women, mental health screening for adult men and women, cervical cancer screening through pap smears, early detection of breast cancer through clinical breast examination and mammogram screening for women at high risk (Atun et al. 2016). Maternal health services include prenatal, antenatal and postnatal care (Malaysia Federal Government 2020). Long-term care is not covered, but the Government promotes an inter-sectoral and community-based approach to help the elderly living at home.

The Medical Relief Fund covers costs of drugs that are not supplied by government hospitals but registered with the National Bureau of pharmaceuticals, and costs of purchasing medical and rehabilitation equipment that is not provided by government hospitals (Malaysia Ministry of Health 2020a; Mybenefitsnews 2018).

PeKa B40, which focuses on NCDs, has a set benefit package including health screening, subsidized medical devices, and travel allowance. In addition, those receiving cancer treatment are provided with a cash incentive of MYR1,000 (US$250) upon completion of their treatment

[4] Employees' Social Security Act 1969, act 4, available at: https://www.ilo.org/dyn/travail/docs/1626/Employees%27%20Social%20Security%20Act%201969%20-%20www.agc.gov.my.pdf

[5] For example, while Malaysian citizens are charged MYR1.00 (US$0.25) for outpatient care at a health clinic, non-citizens are charged MYR40.00 (US$10) for the same service.

at MOH hospitals (Malaysia Ministry of Health 2020b).

MySalam provides cash support to cover indirect patient costs associated with hospitalization, offering a one-time MYR8,000 (US$1,850) payment upon diagnosis of one of 45 critical illnesses, as well as MYR50 (US$11.50) for daily hospitalization costs for up to a maximum of MYR700 (US$161) a year. This scheme was created because of the absence of a social protection scheme for sickness benefits in Malaysia, where only employer liability to cover paid sick leave for formal workers is in place.

- Provision of benefits and services

National health services are predominantly provided in public facilities. For devices, drugs and consumables that are not offered at subsidized prices by the network of public facilities under the implicit benefit package, patients can make a request to the Medical Relief Fund on a case-by-case basis. In 2018, the public health system consisted of 1,000 health clinics, 1,791 community clinics and 90 maternal and child health clinics. Malaysia also has a range of mobile clinics and provides services to 109 areas in the interior of Sarawak through the Flying Doctor Service. Private providers are mostly excluded from the network of providers under the national health care service system, except under the Medical Relief Fund in exceptional circumstances as mentioned above. The MOH engages in some contracting with the private sector to reduce waiting times in public facilities and to provide services not available in MOH facilities. Public health facilities and providers are paid through line-item budgets (Jarrah 2018). The MOH also purchases limited volumes of outsourced, mostly non-medical support services (Jaafar et al. 2012).

There are small co-payments for services provided in public facilities regulated by law, with exemptions for specific health care services in ante and postnatal care for mothers, outpatient treatment for infants, and inpatient care for persons suffering from certain infectious diseases, the registered poor, persons with disabilities and the elderly (Ng 2015). Malaysian citizens and permanent residents pay MYR1.00 (US$0.30) for a general outpatient consultation and MYR5.00 (US$1.50) for a specialist consultation. In comparison, non-citizens without permanent residency status pay user fees of MYR40.00 (US$9.50) for a general outpatient consultation and MYR60.00 (US$18.00) for specialist consultations.

PeKa B40 covers services at most government health facilities and at any private clinic that is registered with PeKa B40. All health clinics under MOH are automatically enrolled in the scheme. Around two thirds of registered clinics and laboratories performing screening services are private (Bernama 2020). Should further treatment or examination be required, private doctors will issue a PeKa B40 referral letter for a relevant government health facility (Ministry of Health 2020b). Under the programme, private providers are paid on a pre-negotiated fee-for-service basis while public providers are paid through a benefit-in-kind mechanism, due to public financial management rules which do not allow public facilities to retain funding.

4. Results

- Coverage

The population of Malaysia enjoys universal legal coverage through its subsidized public health care system, with three social assistance programmes in place to provide supplementary financial support to targeted population groups. However, gaps and challenges remain in relation to access and equitability, which limits effective coverage. Notably, the exclusion of those without Malaysian citizenship or permanent residency from the subsidized health system may prevent meaningful coverage of this group, who make up a large share of the population. in 2019, 9.7 per cent of Malaysia’s population were classified as non-citizens and in 2017 the majority of non-nationals were migrant workers without permanent residency (World Bank 2020; Malaysia Department of Statistics 2020b). Although a migrant-specific requirement is in place for employers to provide basic private accident insurance coverage for hospitalization and surgery at public hospitals, user fees for outpatient visits, charged at the higher non-citizen rate, are not covered.

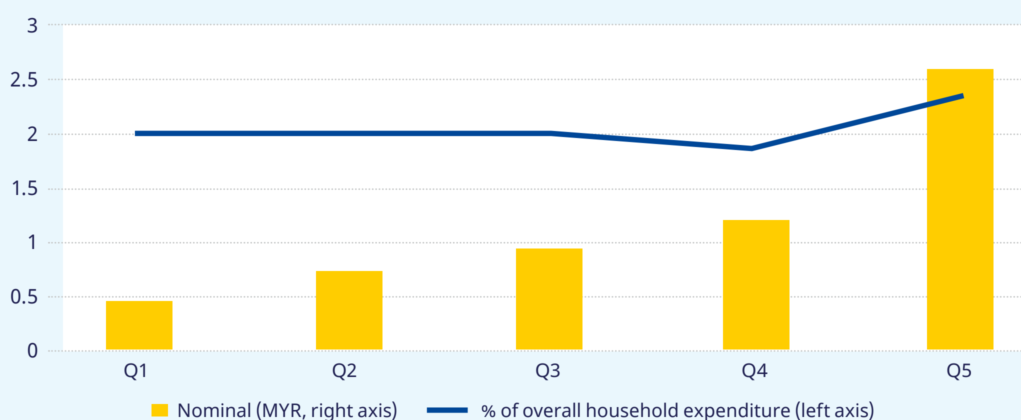
Furthermore, in relation to the PeKa B40 and MySalam schemes, there is some anecdotal evidence that the BSH register, which is used as an eligibility check for these and other social assistance schemes, may be subject to some

inclusion and exclusion errors, potentially resulting in coverage gaps among those eligible for support. This is due to the system's reliance on income tax data, which can often be incomplete or incorrect. Notably, in 2020, several Members of Parliament were surprised to have been sent cash handouts under the BSH scheme, with some returning their checks due to the fact that their income should place them above the means threshold (Arumugam 2020). As a result, many workers in the informal economy and their families, constituting the "missing middle", benefit only minimally from the existing social protection system. Although the BSH scheme has a wide scope, potentially covering up to 40 per cent of the population (in relation to the broader social protection system), the limited depth of the coverage offered has resulted in only a modest effect on overall inequality (World Bank 2018).

- Adequacy of benefits/financial protection

Incidences of catastrophic expenditure and impoverishment due to health care spending are relatively low (Atun et al. 2016). Although OOP spending is higher than in most high-income countries, it tends to be concentrated in Malaysia's richest households and is progressive in that its share of household budget increases with income. The poorest 60 per cent of the population account for only 20 per cent of OOP spending, while the richest 20 per cent account for 59 per cent of OOP spending (Rannan-Eliya et al. 2016). This pattern correlates with the growth of privately provided health services, which fall outside of the scope of the national health care service.

▶ Figure 3. Monthly household expenditure on health (by wealth quintiles, 2019)



Source: Adapted from Malaysia Department of Statistics (2020a, 101).

Notably, public facilities cannot refuse services to people who cannot pay (Jaafar et al. 2012). As outlined above, for devices, drugs and consumables that are not offered at subsidized price by the network of public facilities under the implicit benefit package, patients can make a request to the Medical Relief Fund on a case-by-case basis, or receive financial assistance from the PeKa B40. Through the Medical Relief Fund, MOH disbursed MYR469.8 million (US$107.9 million), equivalent to about 1.8 per cent of government health spending, in financial support to 54,288 eligible patients receiving treatment at the National Heart Institute, in addition to other forms of financial assistance, such as subsidies for haemodialysis or NGO support (Malaysia Ministry of Health 2018). In addition, MySalam offers income replacement in case of sickness. These three schemes can be viewed as attempts to adapt financial protection to the changing burden of disease. Such protection will be especially important for patients suffering from long-term, chronic or non-communicable diseases.

However, there remains some evidence that not all patients are provided with sufficient financial protection from health care costs. A study from 2017 found that the mean annual OOP spending

for ischemic heart disease in Malaysia was MYR3,045 (US$761). About 16 per cent of affected patients suffered from catastrophic health spending, [6] 29.2 per cent were unable to pay for medical bills, 25 per cent accessed savings to cope with spending on basic items, 16.5 per cent reduced their monthly food consumption, 12.5 per cent were unable to pay utility bills, and 9.0 per cent borrowed money to finance spending on basic items (Sukeri, Mirzaei, and Jan 2017). Similarly, a 2014 study found that the societal cost of treating tuberculosis was US$916.4 per patient, of which 79.4 per cent constituted patient costs for transportation, time away from work and so on (Atif et al. 2014). At the same time, broader coverage of patient costs associated with long-term treatments may introduce pressures on the overall health system's affordability. For example, a 2019 study found that the costs of hypoglycaemia for type II diabetes patients constitute 0.5 per cent of the total MOH budget (Aljunid et al. 2019).

On the whole, financial protection for health expenditures related to long-term care in Malaysia is limited, which is particularly concerning given currently restrictive eligibility criteria for the broader social assistance programme, EPF, which is in place to provide income security for the elderly. There are particular concerns that EPF savings, intended to help Malaysians who worked in the private sector through old age, may not be sufficient. [7] A study in 2016 found that only 22 per cent of the 54-year old active EPF contributors had MYR196,800 or more in their savings (corresponding to MYR820, or US$200 a month at current life expectancies) (Aiman 2019). This is a challenge that is likely to become increasingly prevalent within an ageing society, and it is not a gender-neutral issue, given that women live longer and also tend to have fewer opportunities to contribute to the pension system during active age.

As previously highlighted, the higher fees applied by the national health service providers for non-nationals who do not have permanent residency can be prohibitive for marginalized non-citizens seeking health care, such as low-skilled migrant workers and refugees. Accordingly, studies looking at the affordability of health care for migrants in Malaysia have found shortcomings in the financial protection offered to them. Notably, some migrants reported that their employers may initially pay for clinic visits, but that the costs are later deducted from their salaries (Loganathan et al. 2019).

- Responsiveness to population needs
    - Availability and accessibility

The higher co-payment fees required of migrants constitutes a significant barrier of access for non-citizens. Furthermore, as Malaysia does not officially recognize refugee status and requires citizens to report the presence of undocumented foreigners to the police, refugees face exceptional challenges in accessing health care (Malaysiakini 2020). There are also persistent inequities in access to health care and health outcomes related to ethnicity and socioeconomic status. For example, while overall health outcomes have been improving in Malaysia, the life expectancy of Chinese Malaysian males has consistently been several years higher than for Bumiputera Malaysian males since the 1980s. Meanwhile, life expectancy for ethnic Indian Malaysian males is two years lower than for Bumiputera Malaysian males, and, although the size of this gap has reduced over time, it has persisted since the 1980s (Atun et al. 2016).

In terms of utilization of health services among the population as a whole, the number of inpatient visits per capita per year decreased from 0.03 in 2000 to 0.02 in 2016, and the number of outpatient visits per capita per year decreased from 7.24 in 2000 to 5.01 in 2016 (IHME n.d.). In 2016, 29.4 per cent of all admissions were at private hospitals (Malaysia Ministry of Health 2017). This dual system of public and private service providers with a largely regressive financing stream for the private share of provided services poses a threat to equity in access; in turn this may decrease the buy-in of the upper-middle class to the tax-financed national health care service in the long run, to the benefit of privately-run and financed systems.

In terms of geographical availability of services, health facilities in Malaysia tend to be accessible, with the distribution of rural health services in Malaysia based on the size, need and population of the various districts and states (Ahmad 2019). However, in practice, there are significant inequities in the deployment of health facilities

[6] OOP spending exceeding 40 per cent of household non-food expenditures.
[7] Public sector employees have the option to contribute to the EPF, but before 1991 they had a separate pension system.

and health workers in rural, mountainous, and remote regions and there remain inequities in access. Specifically, 92 per cent of the urban population live within three kilometers of a health facility, compared with only 69 per cent of the rural population (Quek 2014). Furthermore, not all health facilities in rural areas are manned with adequately trained staff. They are usually managed by a rural health nurse, with sporadic visits (ranging from weekly to monthly) visits from a medical assistant or a doctor (Quek 2014). However, Malaysia's network of mobile health services and the Flying Doctor Service attempts to address inequities in access by delivering services in remote and hard-to-reach areas (Malaysia Ministry of Health 2018).

- Quality and acceptability

Practically all births (99.4 per cent) were attended by skilled health staff in 2015 (World Bank n.d.). As such, Malaysia's experience in reducing maternal mortality has been used to provide lessons to other developing countries, with researchers noting that the removal of financial barriers was a crucial step in achieving such reductions (Pathmanathan et al. 2003). This is reflected in the country's disease burden, with maternal and neonatal disorders falling from the third leading cause of premature deaths in 1990 to ninth place in 2017 (Noor, Muzafar, and Khalidi 2020).

In terms of patient feedback on quality of care and services, Malaysia does not have an independent complaints procedure available to the public such as an ombudsman (Jaafar et al. 2012). However, the National Health and Morbidity Survey (Malaysia Ministry of Health 2018) measures patient satisfaction, and indicates high levels of satisfaction with both public and private health services. Aspects of the system that people are less satisfied with include process-related quality (such as waiting times, availability of a private room or choice of doctor) in the public sector, and the cost of services in the private sector (Atun et al. 2016). Furthermore, shortages of some types of specialists at public facilities may result in long waiting times (Jaafar et al. 2012), and limited opening hours are also a source of dissatisfaction (Atun et al. 2016).

As per the Private Health Care Facilities and Services Act of 1998, private facilities are part of the national quality assurance programme (Yu, Whynes, and Sach 2008). The network of is composed of both for-profit and non-profit institutions, the former of which are ultra-modern facilities where client satisfaction is driven by the demands of a rising upper-middle class (Aliman and Mohamad 2016). Such facilities are attractive to employers and cater for the highest wealth quintiles who can afford high user fees or private health insurance premiums. As noted above, this has implications for equity in access. While price discrimination is practiced by some non-profit health providers, it is challenging to implement this in practice given the increasing competition from for-profit providers (Barraclough 1997; Yu, Whynes, and Sach 2008).

▶ 5. Way forward

Particular challenges for the future of Malaysia's social health protection system concern its adaptation to an ageing society, with an expected rise in the burden of NCDs and demand for long-term care services, for which the current national health care service remains poorly equipped. Furthermore, issues of access to income security in old age are likely to increase barriers of access to health care for older persons, as financial protection is already identified as an important determinant of care seeking behavior (Yunis et al. 2017). In addition, the dual system of service provision coupled with increases in income inequality may lead to more individuals opting to pay out-of-pocket for care at private facilities, which risks drawing staff and knowledge away from the national health care service towards better-paying private facilities. To make recommendations to the Government for a more robust social protection framework more broadly, Malaysia's Employee Provident Fund (EPF) has been working with the SOCSO under the Ministry of Human Resources to revive the National Social Well-being Blueprint (KWSP 2018).

The COVID-19 pandemic is a stark reminder of the interlinkages between individual and societal health. The historic approach of the Malaysian public health system, in which care for citizens and specific diseases is prioritized, may be less suitable under increasing public demand for social health protection, and changing perceptions of the issue. Broadening health care access to the migrant population, which has grown both in nominal and relative terms in the last decade (Malaysia Department of Statistics 2020b), will likely become increasingly crucial to preventing

the import and spread of communicable diseases in the country.

6. Main lessons learned

- The Malaysian health care system, comprised of a subsidized national health service directly providing care with small regulated user fees to the population, has led to broad access to health care services for the population.
- The majority of maternal health services are exempt from user fees and are provided at no cost to patients. This is identified as an important factor in Malaysia's success with regard to maternal and child health outcomes. Indeed, over 99 per cent of all births are attended by skilled health staff, and Malaysia's child mortality rates are comparable to high-income countries.
- With the expansion of the private health sector in the 1990s, OOP spending rose, which prompted the Government to explore solutions to improve financial protection. Nonetheless, the dual system poses a threat to equity. For example, higher-income individuals may prefer private facilities over the national health care system, increasing the competition for skilled medical staff.
- Recently-developed social health protection schemes focused on low-income groups have contributed to reasonable levels of equity in health care use and spending, although a focus on official tax records for income classification may exclude a proportion of the vulnerable population.
- Not all patients are provided with sufficient financial protection from health care costs. A focus on providing social protection exclusively to citizens means that non-citizens who are not permanent residents are faced with higher user fees for most health services, and many of them rely on private insurance schemes.
- Rising life expectancy and increasing household incomes are driving the need for publicly-funded NCD care, long-term care services and income security for older women and men.

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