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The wellbeing of B40 households: A case of *MySalam* scheme from Sen's Capability Approach

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Abstract

According to the World Bank and World Health Organisation, about 100 million people in the world must pay for healthcare expenses from their own pockets, which has pushed them into extreme poverty. In light of this, the Malaysian government has launched the *MySalam* Scheme to assist the impoverished and vulnerable in overcoming financial challenges during an unforeseen critical illness. The government has introduced the *MySalam* Scheme as a new form of healthcare assistance. Thus, on the one hand, a one-time cash payout through the scheme may increase the health of B40 households and access to the facility. However, on the other hand, it may not improve the wellbeing of the B40 households unless it also expands their capability to be what they want to be. Due to that, this study aims to examine whether the Scheme improves the wellbeing of the recipients or not. This study employed qualitative research, and a total of 20 respondents were interviewed using semi-structured interviews. Findings from this study indicated that the *MySalam* Scheme improved recipients' wellbeing in terms of improving health access, providing financial health protection, and lessening the financial burden on B40 households. Even so, the government should improve the Scheme by expanding access to 65-year-olds and older people and by increasing the accessibility of healthcare centers to poor households.

Keywords: B40 households, capability approach, *MySalam* scheme, wellbeing

Introduction

The World Bank and World Health Organisation have reported that approximately half of the global population is unable to access essential health services, and approximately 100 million individuals are compelled to pay for expensive healthcare, resulting in their descent into extreme poverty (World Health Organisation, 2017). It is known that 800 million people currently spend at least 10% of their household budgets on medical costs for themselves, a sick child, or a family member. For nearly 100 million of them, these costs are so high that they force them into extreme poverty, where they must make ends meet with $1.90 or less per day (World Health Organisation, 2017). Sub-Saharan Africa and Southern Asia exhibit a significant disparity in service accessibility (Falchetta et al., 2020). In some locations, basic healthcare services such as family planning and baby vaccination are becoming increasingly available. However, there is a lack of financial

security, which has worsened the financial anguish for families as they pay for these services out of their own pocket (World Health Organisation, 2017; MacLeod et al., 2017).

As well as at the international level, healthcare provision in Malaysia has also become a major concern for the government. This was triggered by the COVID-19 pandemic, which saw high death rates around the country. Even so, the budget allocation for healthcare is currently inadequate, as only 2% of Malaysia's Gross Domestic Product (GDP) is spent on healthcare (Lum, 2022). Not only that, but it may be stressful for a low-income individual who must spend money on family members who have critical illnesses (Abd Wahab et al., 2022). For instance, the study shows that most of the families that spent a lot on healthcare were rendered insolvent, which is 35% of total healthcare expenditure (Lum, 2022). As such, there are increasing trends in which people have to finance their own healthcare in a very expensive way, especially if they want to have better health treatment. For instance, those who are richer may get better treatment at private facilities, but the poor cannot even afford to pay for the cost and withdraw from the treatment (Kelland, 2010; Lim et al., 2017). Due to the above problems, the government has introduced the *MySalam* Scheme in order to assist the poor who cannot afford to pay for healthcare services. The Scheme is one of the healthcare initiatives that provide beneficiaries with critical illness and hospitalization in the B40 household (Raj, 2019). In fact, the government, through the Scheme, provided the poor with a one-time cash payout (Malaysiakini, 2019).

Although, at present, the Scheme has been widely distributed to the B40 household, their financial health is still not enough to support their medical needs. According to Schanz, Alms & Company (2019), the current scheme of *MySalam* covers about 45 critical illnesses; thus, the current provision of the scheme may not be sufficient to cover illnesses like cancer, kidney failure, and multiple sclerosis (Ong, 2019). According to reports, several strategies for the Scheme and other forms of financial aid have been implemented in rising economies in order to reach a larger population (Malaysiakini, 2019; Rapi et al., 2022). Nevertheless, the under-penetration in low-income segments is a significant obstacle, particularly for B40 households, as these individuals are more susceptible to diseases and have minimal protection (Nurdianawati, 2021). Not only that, the Scheme information was not effectively disseminated, and many in the low-income group were not aware of the scheme. Hence, some of them did not claim even though they had received hospital claims. In addition to a lack of information dissemination, the scheme was also claimed to be too bureaucratic and had a lot of technical problems that made it difficult for people to claim its benefits (Ong, 2019).

Therefore, on the one hand, a one-time cash payout through Scheme may increase the health of society and access to the facility. Still, on the other hand, it may not improve the wellbeing of the B40 households unless it also expands the capability of the B40 households to be what they want to be, for instance, the capability to access healthcare centers, their benefits, and an easy claim process at any time. As such, this research aims to understand how the *MySalam* Scheme improves the capability and wellbeing of B40 recipients and in what ways, using Sen's Capability Approach.

Capability approach as a conceptual framework

Wellbeing and quality of life are the main aims of the economic development programs. The emphasis has mostly been on the financial impacts of the initiatives, such as income, employment, and material distress, in order to gauge wellbeing and quality of life (Kim et al., 2020). However,

this approach is not sufficient to understand wellbeing from economic factors; rather, it should be understood from the capabilities and opportunities of the people to do what they want to do. Amartya Sen has proposed this approach, which is known as the capability approach. Unlike the traditional economic framework, which measures the wellbeing of people through income, the capability approach emphasizes the ability and capacity of people to be and do (Sen, 2002). The capability approach, according to Robeyns (2005), is a comprehensive normative framework for assessing and measuring social arrangements and human flourishing, as well as for developing policies and making recommendations for social change in society.

The capability approach is widely employed in a variety of subjects, most notably development studies, welfare economics, social policy, and political philosophy. It is a theory used to assess several aspects of people's wellbeing, such as inequality, poverty, an individual's wellbeing, or the group's overall wellbeing (Sen, 2002). Furthermore, the theory serves as a framework for planning and assessing policies ranging from welfare state design in wealthy nations to development policies adopted by NGOs and governments in poor countries. According to Fukuda-Parr (2003), the capability approach provides the theoretical foundations of human development by providing a tool and a framework within which to conceptualize and assess the phenomena of poverty, inequality, and wellbeing. In his study as with the capability approach, Jacobson (2016) found that the goals of development, justice, and wellbeing should be conceived in terms of people's functional capacities, which are the most efficient means of engaging in the behaviors and pursuits that individuals choose to engage in and being who they want to be. These beings and actions, which Sen refers to as functioning, are what give life meaning (Sen, 1999). Functions include working, resting, being literate, healthy, being a member of the community, and being valued. Completion and freedoms or valued alternatives that one can choose from are the two things that separate realized and practically feasible functioning and capabilities (Robeyns, 2005). People have the freedom and opportunities to live their desired life, pursue their desired actions, and be the individuals they desire, choosing the most important ones (Alkire, 2005). For instance, everyone should be free to live a healthy life, just as other people, but they should also be able to get access to better healthcare at any time they need it. The capability approach's defining feature is its emphasis on the things that individuals are capable of doing effectively (Naz, 2020). That means the capability approach examines policies in terms of how things influence people's skills, if people are well, and whether the necessary means or resources are accessible.

Robeyns (2005) found three conversion elements that may shape the relationship between a good and the functions to attain particular beings and doings. First, a person's physical state, gender, ability to read and write, and other skills can affect how they turn a good's qualities into a function. Next are social conversion factors, including governmental policies, norms of society, discriminatory practices, and power relationships. Third, environmental conversion factors include climate and location. All of these elements may enable or disable people from being what they want to be. Robeyns (2005) asserts that understanding what resources a person possesses or can utilize is insufficient to determine which functions they can do. The most important factor is that we need to understand people's capability and their circumstances. So, the capability approach acknowledges variation among individuals by emphasizing a variety of functions and capabilities as the critical space, personal and socio-environmental conversion factors that convert things into functioning, and the entire cultural and institutional setting that significantly impacts the conversion factors and capability set (Alkire, 2005; Robeyns, 2005; Sen, 2002).

The *MySalam* Healthcare Scheme in Malaysia

Malaysia has provided several healthcare assistants to Malaysians, and the MySalam Scheme is among the healthcare assistance programs given to Malaysians. It aims to help the poor and needy overcome financial difficulties in the unexpected event of a critical illness, and it is part of the government's initiative to assist and facilitate the lower income group, which is the B40 household, to resume a normal lifestyle despite the financial challenges arising from critical illnesses. The Scheme was introduced in 2019, and the B40 household can apply for the scheme in March. This scheme is eligible upon diagnosis of one of the 45 critical illnesses, such as Alzheimer's disease or severe dementia, angioplasty and other invasive treatments for coronary artery disease, bacterial meningitis, and other critical illnesses facing the recipients (*MySalam* Portal, 2022).

The benefits of the Scheme include a one-time RM8,000 (US$1716) as well as RM50 (US$10) daily hospitalization income replacement up to 14 days or a maximum of RM700 (US$150) per calendar year at any government hospital (Ong, 2019). The Scheme also covers recipients that receive Household Living Aid or *Bantuan Sara Hidup* (BSH) that are aged between 18 and 65 and their spouses, single individuals aged between 40 and 65 and earning less than RM24,000 (US$5148) per annum. OKU individuals are those aged between 18 and 65 and earning less than RM24,000 (US$5148) per annum (*MySalam* Portal, 2022). The Scheme is a Malaysian government project for healthcare aid that focuses on low-income households in order to alleviate the burden on B40 households, as the majority of B40 households are experiencing financial difficulties, particularly in terms of health. The Scheme is related to the capability approach, which looks at whether the Scheme is capable of improving the wellbeing of the recipients, which is the B40 household. It is because most healthcare insurance seems not to contribute to the improvement of the recipient's health condition because of the high expenses that cannot be covered for certain critical illnesses for which most low-income people around the world have been pushed down by poverty when paying the medical expenses with their own pockets. Moreover, the coverage of the Scheme is related to 45 critical illnesses, for which most of the medical expenses are more costly than for other illnesses. So, it is important to examine whether the Scheme is capable of improving their health condition because most of the critical illnesses that have been listed in the Scheme are very costly for the B40 households. The Scheme is still a new form of healthcare assistance that the government has introduced, and due to that, there are very few studies that focus on the impact of the Scheme on the B40 households. Thus, this study aims to understand how and in what ways the Scheme improves the wellbeing of the B40 recipients.

Methods

This study employed qualitative research methods in order to understand whether the *MySalam* Scheme improves the wellbeing of the B40 households in Kedah. The main data collection was semi-structured in-depth interviews. The interviews were conducted in Bahasa Malaysia, considering the difficulty of B40 households in understanding English. All interviews were recorded with permission from the interviewees, and they lasted between 40 minutes and one hour. The interview started by asking for the respondent's information, such as age, gender, occupation, and information on the scheme's protection, such as the understanding of the B40 household on the scheme and the importance of the scheme for the less fortunate income group. The 20 respondents were recruited through purposive sampling and have achieved the saturation level.

The respondent must be the recipient of the scheme. The interviewees came from different parts of the Kuala Muda district, such as Sungai Petani, Merbok, and Bedong. The identified areas include residential areas in Bakar Arang, Sungai Lalang, Semeling, Sungai Layar, Sungai Muda, Lembah Bujang, Tanjung Dawai, and Bandar Laguna Merbok, which have received the scheme. These areas have a high population density, and the chances of selecting the recipients of the scheme were high. This interview took place at the respondents' houses, and the researchers also interviewed at hospitals or clinics nearby. The data was analyzed using thematic analysis and aided by the NVivo 12 software. NVivo 12 offers techniques for gaining a broad sense of what themes are present in the data as well as the ability to delve deeper into the content for further investigation (Bryman, 2012). Several themes have been identified from the analysis, and details will be discussed in the next section.

Findings

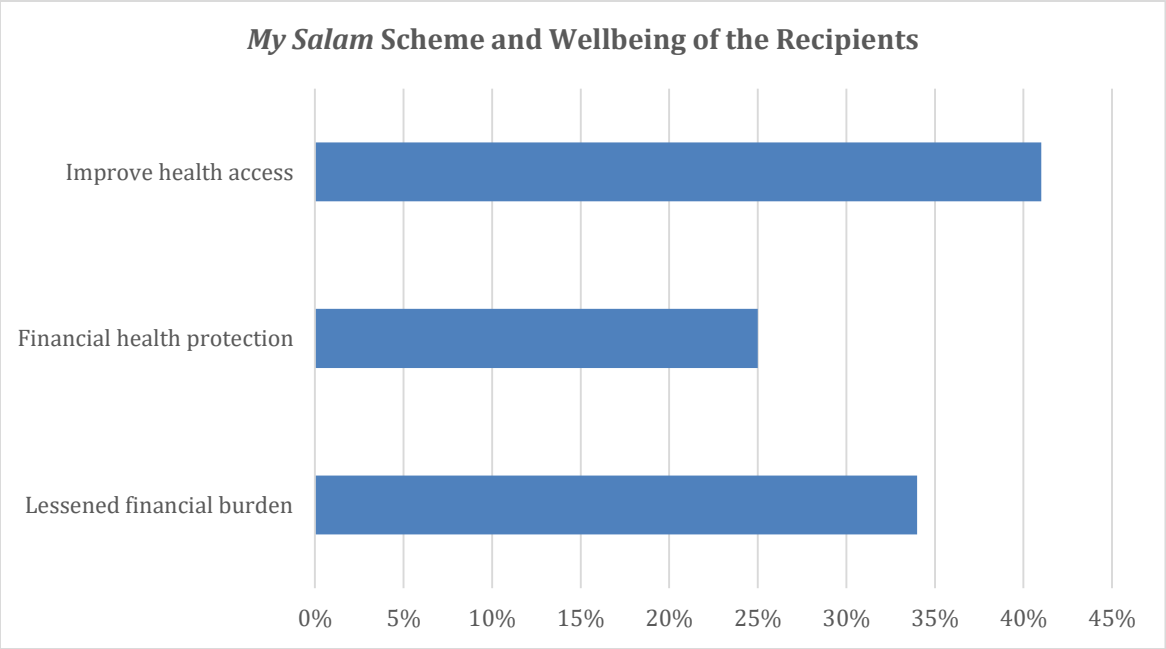
A total of 20 respondents have participated in this study (Table 1). There was a balance between males and females; each respondent was 10 males and 10 females. Each respondent was given a pseudonym to conceal their identity. The respondents were between 20 and 60 years old. In terms of occupation, six respondents were rubber tappers, five respondents were factory workers, three respondents were technicians, and three respondents were garbage collectors. Meanwhile, one respondent was unemployed. Another two respondents were full-time housewives. Both of them, despite being full-time housewives, have to take care of their sick husbands, but they still have time to bake local *'kuih'* and sell it around their housing area. In terms of monthly income, 5 respondents received below RM 1,000 (US$214), while another 12 respondents received below RM 2,000 (US$429). Another three respondents received RM3,000 (US$643). This study endeavored to ensure balanced participation from all major ethnic groups - Malay, Chinese, and Indian - through cooperation with community leaders in the *Sungai Petani* areas. However, it was not possible because many of the approached respondents refused to participate in the interviews. Of a total of twenty respondents, two were Chinese, and the rest were Malays. All 20 respondents suffered various types of diseases such as kidney failure, leukemia, stroke, heart attack, diabetes, cancer, poliomyelitis, severe dementia, ovarian cysts, and HIV infection, and one respondent was blind. Table 1 shows the profiles of the respondents who participated in the study.

Table 1. Demographic profile of the *MySalam* scheme recipients

Respondent	Gender	Age	Occupation	Income per month/Household (RM/USD)	Type of diseases
1	Male	20s	Clerk	RM 2,800 (US$600)	Blind
2	Female	40s	Factory Worker	RM 1,500 (US$321)	Diabetes
3	Male	30s	Unemployed	RM 850 (BRIM/OKU card) (US$182)	Poliomyelitis
4	Male	20s	Garbage Collector	RM 1,800 (US$385)	Kidney Failure
5	Male	30s	Rubber tapper	RM 1,300 (US$278)	HIV Infection
6	Female	40s	Housewife (baking *'kuih')*	RM 1,800 (US$385)	High blood pressure
7	Female	30s	Factory Worker	RM 1,500 (US$321)	Heart Attack

8	Female	50s	Housewife (baking *'kuih'*	RM 900 (US$192)	Stroke
9	Female	20s	Factory Worker	RM 1,500 (US$321)	Leukemia
10	Female	30s	Factory Worker	RM 1,700 (US$364)	Ovarian Cyst
11	Male	40s	Technician	RM 3,000 (US$643)	Heart Attack
12	Male	40s	Technician	RM 2,500 (US$536)	Heart Attack
13	Male	50s	Garbage Collector	RM 900 (US$192)	Kidney Failure
14	Male	50s	Garbage Collector	RM 500 (US$107)	Cancer
15	Male	60s	Rubber Tapper	RM 1,200 (US$257)	Severe Dementia
16	Male	60s	Rubber Tapper	RM 1,200 (US$257)	Severe Dementia
17	Female	20s	Factory Worker	RM 1, 200 (US$257)	Stroke
18	Female	50s	Rubber Tapper	RM 1,300 (US$278)	Stroke
19	Female	60s	Rubber Tapper	RM 1,000 (US$214)	Heart Disease
20	Female	60s	Rubber Tapper	RM 1, 200 (US$257)	Kidney Failure
Total: 20 respondents					

Source: Researchers' fieldwork, 2022



Source: Researchers' fieldwork, 2022

Figure 1. The Identified Themes from the Interviews

a. Lessening the financial burden

The first theme found was lessened financial burden, in which 34 percent of the respondents stated that the *MySalam* Scheme was able to reduce their financial burden, such as by supporting financial treatment by getting a free treatment or a treatment discount. Basically, most of the respondents interviewed felt that the Scheme was beneficial to the B40 households, for instance, "…sufficient

in reducing the financial burden faced by low-income B40 households" (Respondent 17) and "sufficient to reduce the financial burden...supporting medical cost or treatment" (Respondent 19). The Scheme was considered important, especially for low-income groups, not only because they have very limited income but also because of other severe diseases. Both respondents, 17 and 19, were categorised as B40 households. On the one hand, Respondent 17 was a single mother, and her monthly income was only RM1,200 (US$257). She has had a severe stroke, which needs frequent treatment to ensure her blood tests are at a good level. She has been receiving the Scheme for two years since its inception. On the other hand, Respondent 19 suffered from heart disease and worked as a rubber tapper with a monthly income ranging from RM 500 (US$107) to RM 1,000 (US$214). Both individuals were limited not only in financial capability but also in physical capability. As well as reducing financial problems, Respondent 13 described that the Scheme had enabled him to get "free medical check-up...RM50 (US$10) daily hospitalization income… treatment's discount," which he mentioned is important for him as a poor man and as a husband who became the sole income earner as a garbage collector.

These findings were in line with Hoffman and Paradise (2008), who claimed healthcare insurance enables access to care in public by way of protecting individuals and families against the high and often unexpected costs of medical care, as well as by connecting them to networks and systems of health care providers which help low-income groups reduce financial burden. From the above findings, the *MySalam* Scheme was able to reduce the financial burden on the recipients to get healthcare, especially for poor households.

b. Providing financial health protection

The second theme found in this study was that the *MySalam* Scheme was beneficial, for instance, in providing financial health protection to recipients. It was because it has lower cost-sharing requirements and covers services that private insurance often limits to the recipients. From the findings, 25 percent of the respondents agreed that the Scheme was beneficial in providing financial health protection to B40 households. That is, the Scheme is actually a financial health protection takaful scheme initiative that provides takaful protection to individuals who are eligible to receive the benefits of the *MySalam* community protection scheme through the *MySalam* trust fund. For instance, Respondents 13 and 6 stated that the Scheme "gives financial health protection whereby direct payment is made to obtain health services that do not expose people to financial hardship and do not threaten living standards" and "I really need this scheme because it is a crucial scheme to provide health protection and greater support to pay for my treatment cost" (Respondent 6). That means the scheme reduces the recipients' worries about direct payment when they are getting treatment.

For those who have suffered major health treatment, the cost may be one of their concerns. For instance, Respondent 5 stated that the Scheme enables him to receive "free treatment" for his HIV infection due to blood transfusion, even though the treatment could be charged to him. Another respondent also claimed that the Scheme has helped him get expansive treatment for his chronic cancer. His income was not sufficient to cover the treatment, so he applied for the Scheme, and with that, he was able to get chemotherapy treatment for free. For example,

> ...it gives financial health protection to the public through the *MySalam* Trust Fund. It provides peace of mind and protection against loss, damage, or theft that is caused by debt. *MySalam* Scheme gives protection from your home to your health…

(Respondent 14)

From the findings, the Scheme was able to not only reduce the financial burden but, most importantly, provide tranquility to the recipients because they do not worry about paying for their health treatment at a higher cost. Respondent 4, for instance, who was in his 20s and suffered from kidney failure, stated that the Scheme was effective in covering the cost of treatment because he just needed to pay RM5,000 (US$1072) for his operation rather than RM35,000 (US$7504) of the total cost of the treatment. This indicates that the scheme provides tranquil care to the recipients without worrying about paying a high cost to get treatment for their disease.

> ... It is beneficial for the public, and I think this *MySalam* Scheme needs to be continued because it gives a lot of benefits, such as reducing the burden on B40 households and improving their health conditions… (Respondent 4)

c. Improving health access

The third theme explains that the scheme enables poor people to improve their access to health care. Most of the respondents agreed that the *MySalam* Scheme provides benefits to low-income groups because it fulfills the needs for necessities, as articulated by the respondents. Most of them applied it to support their lives, as it helped them resume a normal lifestyle. This incentive provided by the Malaysian government is crucial to providing a health care protection scheme for the needy to overcome financial difficulties during critical illness. The last theme from the findings was that the scheme had a positive impact on the B40 households. For instance, Respondent 10, who was in her 30s and worked as a factory worker, earned a monthly income of RM1,700 (US$364). She suffered a severe ovarian cyst and was eligible to receive this Scheme. She stated that the scheme has had a good impact on her: "This scheme has shown a good impartial attitude towards me, especially for my health condition, and I have received early treatment for my disease." This is also supported by respondents 11 and 12, who both suffered from heart attacks. They stated that the Scheme gave them benefits:

> From my experience, *MySalam* has had a good impact on me… (Respondent 11)

> ...it shows a positive and good impact on me as it provides a free medical cost that has overcome my financial burden to pay for the expenses … (Respondent 12)

A respondent who was in his 30s lived alone and was unemployed, suffered from a chronic disease called poliomyelitis, and was unable to walk. He has been receiving the *MySalam* Scheme for one year and has used it twice. Apart from that, he has received other government assistance, such as a BRIM for RM350 (US$75) and an OKU card for RM500 (US$107). In the interview, he shared his thoughts on the benefits of *MySalam* for the public:

> It is beneficial for the public and should be continued because it has given several benefits, especially for those like me who only depend on government assistance… (Respondent 3)

Discussion

Based on the aforementioned findings, wellbeing can be defined as the state of being comfortable, healthy, or a combination of feeling good and functioning well (Robeyns, 2005). The capability approach covers all dimensions of human wellbeing analysis. Individually, the recipients' wellbeing can be assessed based on their ability to put the MySalam Scheme into action. For instance, the government's assistance through the scheme enabled the majority of the recipients, who were previously unwell, to achieve improved health at a significantly reduced cost. Thus, they were able to live like normal people. From the findings, the recipients stated that the Scheme has increased their wellbeing by giving them positive emotions. Various factors, including the provision of beneficial benefits to B40 households that alleviate their financial burden, can contribute to an increase in wellbeing. Being well can be seen as the factor that motivates B40 households to apply for the Scheme. It can assist them in improving their wellbeing and maintaining their good health because various benefits, such as free treatment, treatment discounts, or cash payouts, are provided under the Scheme. This allows them to maintain good health, which will contribute to the government's social progress. This will minimize cases of diabetes and kidney failure, thereby reducing social inequalities. The government's ability to maintain society's health by enhancing human health and ensuring access to high-quality healthcare is closely linked to its socioeconomic standing. Therefore, good health improves people's wellbeing.

From the capability approach perspective, the provision of the *MySalam* scheme to the B40 households has significantly improved their wellbeing. The Scheme was considered a resource for the B40 households, and they can use it to get access to their medical treatment at a cheap price. The Scheme's assistance enabled the B40 households, who frequently battled various diseases and faced health limitations that prevented them from full employment, to improve their health and return to a normal life. The B40's inability to work due to their health condition worsened their quality of life, leading to financial difficulties in covering their medical expenses. They faced a significantly increased risk of accruing medical bills, which could lead to debt. Therefore, the implementation of the scheme motivated them to seek treatment for their diseases, which has significantly improved the wellbeing of B40 households. Access to health services enables them to safeguard their finances from potentially high expenses. Not only that, but the majority of the respondents were able to successfully claim the scheme because they had access to transportation to the nearest clinic or hospital. They utilized various modes of transportation, including cars and motorcycles, to commute to the clinic or hospital. For them, the process of claiming the Scheme is easier because they have access to it, such as transportation. Successfully claiming the Scheme enhances an individual's wellbeing, as it allows them to reap the benefits it offers.

Furthermore, the Scheme demonstrates that the government was aware of the B40's inability to access health care. As a result, the government's support for the Scheme has improved the B40's access and wellbeing. The government refers to this approach as a social arrangement, preserving the freedom of the B40 to live their lives as normal individuals. Furthermore, the government made the Scheme available to all B40 groups without discrimination, automatically including those who were already recipients of government financial aid. The majority of the respondents reported that the process of applying for and claiming the Scheme was remarkably straightforward. When the government establishes clear and simple procedures to implement a policy, it enhances the level of satisfaction within society. This social support and provision by the government improves access to healthcare among B40 groups, thus increasing their wellbeing.

Interestingly, most clinics in urban and rural areas, as well as hospitals, offered the Scheme. The Scheme's coverage in many government facilities makes access to the B40 easier. In terms of distance, the majority of respondents believed that the distance between their residence and a clinic or hospital was not particularly large. Most of them shared that it took them only one to five kilometers to reach the nearest clinic or hospital. The scheme has significantly improved the recipients' health and wellbeing by providing affordable treatment, allowing them to lead normal lives.

Conclusion

Given the ongoing uncertainty and issues plaguing the world today, it is crucial to safeguard vulnerable groups, particularly low-income households, from their impact. The Malaysian government has developed a number of initiatives to address issues relating to poor healthcare. The aim of this paper is to examine whether the MySalam scheme improves the wellbeing of the recipients. According to the study, the provision of the Scheme to the B40 groups has improved their ability to live a normal life like other people. This specifically reflects the B40, who were suffering from various diseases such as kidney failure, heart problems, high blood pressure, leukemia, diabetes, and many others. These diseases have restricted their ability to work, thereby reducing their income and financial capacity to cover their medical expenses. So, the assistance of the Scheme enabled the poor to get free access to healthcare, and this improved their wellbeing.

However, there is much room for improvement. For instance, the Scheme is probably one of the best and most efficient ways to protect vulnerable groups, such as B40 households. Cash, however, cannot be the only bullet in the gun. One of the better options is to improve equitable access to healthcare and protect people from financial risks, as Parkinson's disease now primarily affects people in their 70s and older. The scheme, on the other hand, only covers people aged 18 to 65. As a result, the vast majority of Parkinson's patients are denied treatment due to their age. The government should do a better job of publicizing the scheme, as many people are still unaware of its existence. In Sabah, for instance, many people were still unaware of the scheme's existence. Improvements need to be made to ensure that the information on the initiative reaches target groups in rural areas of Sabah because these groups are in need of *MySalam* healthcare assistance (Malaysiakini, 2019). Moreover, organising roadshows to disseminate and propagate information on the scheme, especially in rural areas, would be beneficial in raising awareness among these people.

Besides, the government should also improve the accessibility of healthcare centers to poor households. Perhaps more centers should be built, or better transportation for the Scheme's recipients to access healthcare centers should be provided. Transportation barriers significantly impact the accessibility of the Scheme's recipients, such as their ability to make it to their medical appointments. There is a limitation for people who live in rural areas where public transportation services are limited; they need to travel far distances to receive care. Those who do not have healthcare centers in rural areas may not have the latest technology to offer the highest level of care, which means they need to travel away from their home community to get medical care. Building more healthcare centers and improving transportation services will be beneficial to helping low-income groups receive medical care services at the highest level.

Moreover, the government can improve healthcare assistance by setting up an independent committee to review the Scheme. It is crucial to ensure that all B40 households in Malaysia receive

the aid provided by the government. The government, in general, and the Ministry of Health, in particular, should take this into account by setting up an independent committee to review the scheme and make it run smoothly and in effective and efficient ways. It is to avoid any problems or issues that may arise for the public as a result of the Scheme's lack of concern for them. The public has the right to voice their opinion regarding the issues arising from the policies or programs that the government has implemented. Due to that, the government should be responsible for taking action and making this scheme one of the long-term healthcare assistance programs, especially for the poor.

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