

**IMPACTS OF LEGISLATIVE CONTROLS ON  
PRIVATE HOSPITALS IN MALAYSIA**

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**FACULTY OF ECONOMICS AND ADMINISTRATION  
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## ABSTRACT

The commercialisation of private hospitals under a loosely regulated framework has brought forth critical issues affecting cost, equitable access and quality care. The variation of care, existence of unregistered hospitals, adverse events and the prohibitive cost culminated in the historical implementation of the prescriptive Private Healthcare Facilities and Services Act 1998 [Act 586] and Regulations 2006 to regulate all private hospitals nationwide. This study aims to examine the impact of Act 586 on the private hospitals in Malaysia in relation to the government's intended objectives of accessibility, equity and quality care. It is a qualitative study utilizing the case study approach. The instruments encompass key informants interviews, focus group discussions, observations, and content analysis to elicit the impact of the legislation. Fifteen private hospitals were purposively selected in the Klang Valley. A total of 130 key informants from the private and public health sectors, professional bodies, civil society, universities and patients have contributed their perceptions to this study. The empirical findings identify several emerging themes on the impact of the Act 586 on the private hospitals. These themes are interrelated and include issues on the policy, power, governance, compliance, non-compliance, cost, inequity, quality, politics and the enforcement. The study reveals the high level of state investment in the private hospitals in Malaysia. Act 586 mandates the approval and licensing of private hospitals to ensure patients' safety and equitable access to quality care. However, there is the concern that the vast statutory powers vested in the Minister and the Director General of Health are prone to abuse and the lack of transparency. Most of the licensed private hospitals are from the developed states. The inequitable distribution of private hospitals affects the national health objectives. While the Act 586 expressed explicitly that the governance of the private hospital is to be physician-led with the person-in-charge, but in reality private hospitals are managed by corporations. There has been a mixed of outcomes in the compliance and non-compliance.

Most private hospitals faced challenges but complied with the new guidelines on mandatory licensing to continue operating their businesses. Some providers have even migrated to new purpose-built hospitals to ensure good compliance system. However, non-compliance on the controversial issue of fee-splitting between the doctors and the managed care organisations remained unresolved. Although the professional fees are regulated with a Fee Schedule, but the hospital charges remained unregulated and arbitrarily exorbitant. Notwithstanding, there is evidence of opportunistic practice of some medical specialists overcharging their patients beyond the permissible limit and often with questionable justifications. Invariably, the cost of care has escalated. Particularly, the high out-of-pocket payment in the private hospitals is an inequity issue where the majority of the population may be deprived of quality care. The private hospitals have initiated their own quality initiatives albeit with the wide variations. There is no systematic dissemination of information on treatment and outcome. While the Act 586 provides adequate enforcement capacity, Ministry of Health Malaysia appears to be constrained in regulating the influential private hospitals effectively.

## ABSTRAK

Perkhidmatan hospital swasta secara komersial tanpa kawalan rapi telah menimbulkan berbagai masalah terhadap kos, akses saksama dan penjagaan kesihatan berkualiti. Perbezaan penjagaan perubatan, kewujudan hospital tanpa pendaftaran, insiden tidak diingini berlaku serta kos rawatan yang tinggi telah mengakibatkan penggubalan Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 [Akta 586] dan Peraturan-Peraturan 2006 untuk mengawal semua hospital-hospital swasta di negara ini. Kajian ini bertujuan untuk menganalisis impak Akta 586 terhadap hospital-hospital swasta di Malaysia berhubung dengan objektif-objektif nasional iaitu akses yang saksama dan penjagaan yang berkualiti. Penyelidikan ini menggunakan pendekatan kajian kes. Kaedah kualitatif ini merangkumi temuramah dengan pemberi maklumat utama, diskusi kumpulan fokus, pemerhatian lapangan, serta penelitian dokumen untuk memperolehi maklumat mengenai impak terhadap hospital-hospital swasta. Sejumlah 15 hospital swasta telah dipilih khas di Lembah Kelang untuk kajian ini. Seramai 130 pemberi maklumat utama dari sektor kesihatan swasta dan awam, badan-badan profesional, pertubuhan sivil, universiti dan pesakit telah memberikan persepsi mereka. Hasil kajian ini telah mengenalpasti beberapa tema utama. Tema-tema ini adalah berkaitan dengan isu dasar, kuasa, urus tadbir, kepatuhan dan keingkaran peraturan, kos, ketidakseimbangan, kualiti, politik dan penguatkuasaan. Kajian ini menunjukkan Kerajaan mempunyai tahap pelaburan yang tinggi dalam sector hospital swasta. Akta 586 mewajibkan perlesenan semua hospital-hospital swasta di negara ini untuk memastikan keselamatan para pesakit serta penjagaan yang berkualiti. Namun demikian, kebimbangan terhadap kuasa-kuasa yang luas terletak di bawah Menteri dan Ketua Pengarah Kesihatan mungkin menimbulkan masalah dalam salahguna kuasa dan ketidaktelulusan. Kajian ini menunjukkan kebanyakan hospital swasta berada dinegeri-negeri maju dan keadaan ini menjejaskan hasrat dasar negara untuk akses yang saksama. Akta 586 memperuntukkan

bahawa hospital swasta diketuai oleh seorang pengamal perubatan yang bertanggungjawab, tetapi pada hakikatnya, kebanyakan hospital-hospital adalah dikuasai oleh syarikat-syarikat korporat. Kajian ini juga menunjukkan terdapat pematuhan dan keingkaran kepada peraturan-peraturan di kalangan hospital-hospital swasta. Walaupun kebanyakan hospital swasta menghadapi berbagai masalah untuk mematuhi peraturan baru, namun majoriti hospital-hospital telah mematuhi garis panduan untuk meneruskan perniagaan mereka. Terdapat beberapa hospital swasta telah berpindah ke premis hospital baru untuk mematuhi peraturan serta mencapai sistem amalan baik di hospital. Sungguhpun demikian, terdapat keingkaran peraturan mengenai isu kontroversi tentang pecahan fi di antara para doktor dengan syarikat-syarikat insuran yang masih belum diselesaikan. Walaupun fi professional doktor dikawal, tetapi caj bahagian hospital swasta adalah tidak dikawalkan dan didapati tinggi. Kajian ini juga telah mendedahkan bahawa terdapat di kalangan doktor pakar mengambil kesempatan untuk membuat caj rawatan yang tinggi serta melepasi had maksimum yang ditetapkan dengan justifikasi yang boleh menimbulkan keraguan. Amalan sedemikian telah meningkatkan kos penjagaan di hospital swasta. Kajian ini juga menunjukkan sebilangan besar para pesakit di hospital terpaksa menanggung kos secara persendirian. Fenomena ini telah menunjukkan isu ketaksaksamaan di mana segolongan besar penduduk mungkin tidak mempunyai peluang untuk menikmati penjagaan berkualiti di hospital swasta. Walaupun setiap hospital swasta mempunyai inisiatif penjagaan kualiti secara berasingan, namun terdapat banyak perbezaan dari segi piawaian serta tiada satu sistem penyebaran maklumat tentang rawatan dan akibat episod rawatan berkenaan. Akta 586 telah memperuntukkan bidang penguatkuasaan yang mencukupi, tetapi Kementerian Kesihatan Malaysia dilihat sukar untuk mengawal hospital-hospital swasta yang berpengaruh ini secara berkesan.

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## ACRONYMS AND ABBREVIATIONS

Act 586	Private Healthcare Facilities & Services Act 1998
APHM	Association of Private Hospitals of Malaysia
ASPMP	Association of Medical Specialists in Private Practice Malaysia
CABG	Coronary artery bypass graft surgery
CAHP	Coalition Against Healthcare Privatisation
CAP	Consumers Association of Penang
CEO	Chief Executive Officer
CHI	Citizens' Health Initiatives
DG	Director General of Health
CSO	Civil Society Organisation
EPU	Economic Planning Unit
FPMPAM	Federation of the Private Medical Practitioners' Associations, Malaysia
FPPS	Full Patient-paying Scheme
GDP	Gross Domestic Product
GLC	Government Linked Corporation
ICU	Intensive Care Unit
IHH	Integrated Health Holdings
JIHC	Joint Inter Hospital Committee
KPJ	Kumpulan Perubatan Johor Sendirian Berhad
MCO	Managed Care Organisation
MD	Medical Director
MDA	Malaysian Dental Association
MDAC	Medical and Dental Advisory Committee
MMA	Malaysian Medical Association
MOH	Ministry of Health Malaysia
MSQH	Malaysian Society for Quality in Health
NEP	New Economic Policy

NHS	National Health Service
OPP	Out-of-Pocket Payment
OSA	Official Secrets Act 1972
PIC	Person-in-charge
PPACA	Patient Protection and Affordable Care Act 2010
Regulations 2006	Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 [P.U. (A) 138/2006]
UMNO	United Malay National Organisation
WHO	World Health Organisation

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## CHAPTER 1: INTRODUCTION

### 1.1 An Overview

Public policy on health care reforms initiated by the global financial institutions in the 1980s had generated immense international debates (World Bank, 1987; 1993; Mackintosh, 2008; Bloom et al. 2014a). The ideological shift advocating for the reduction of the state's role in the health care provision to the promotion of the private sector has social-economic implications (World Bank, 1987; 1993; WHO, 2000; 2010a; Kickbush & Gleicher, 2012; Basu et al. 2012). Nevertheless, many developing countries have been influenced and shifted their role from direct provision of health care service delivery to the regulation of private providers (World Bank, 1987; WHO, 2000; Kickbush & Gleicher, 2012). Faced with fiscal crisis, these developing countries adopted privatisation as part of their economic liberalisation policies. Invariably this development has resulted in restricting welfare and social expenditures (Jomo, 1995; Tan, 2008; Jomo & Wee, 2014).

Consequently, the private sector played a major role in the financing and provision of health care services in these developing economies (Berendes et al. 2011; Forsberg et al. 2011). In the midst of this rapid market development, support for regulatory institutions has lagged behind (Bloom et al. 2014a). Critical issues affecting the health care system such as inequitable access, spiralling cost and sub-optimal care confronted these emerging economies. These health care complexities remained problematic to policy makers (Mackintosh, 2008; Berendes et al. 2011; Abdullahi et al. 2012; Barnett & Hort, 2013). On the contrary, there had been extensive debates on privatisation and parallel development of regulations in the developed countries. Despite adopting market-oriented

reforms within the public sector, the role of government in the financing and provision of equitable access and quality health care delivery remained intact especially in the United Kingdom and Scandinavian countries (Walshe, 2003; Chee & Barraclough, 2007). Even in European countries with social insurance schemes such as Austria, Belgium, France, and Germany, the market reforms have led to greater state regulatory intervention to control cost escalation (Saltman, 2002; Walshe, 2003). Across the Atlantic, the United States of America (US) has a predominant market-led health care system with an equivalent growth of health care regulations which stretches back over two decades (Brennan & Berwick, 1996; Walshe, 2003; Folland et al. 2013; Straube, 2013).

Most of the literatures on regulation are from developed countries with history of strong institutions, professional bodies, consumerism, and civil societies actively engaging and shaping the health care sector (Walshe, 2003; Santerre & Neun, 2013). However, most developing countries do not experience such identical historical background. Relatively little is known about how governments in the developing countries perform their regulatory functions in relation to safety, equitable access and quality care (Hongoro & Kumaranayake, 2000; Bloom & Standing, 2001; Bloom et al. 2014a). Furthermore, there is little empirical research explored into the impact of the regulatory enforcement in health sector in these developing countries (Walshe, 2003; WHO, 2010a; 2010b; Abdullahi et al. 2012). State institutions in regulating the markets in these emerging economies are perceived to be weak and have limited capacity of regulatory enforcement (Peters & Muraleedharan, 2008; Bennett et al. 2014; Bloom et al. 2014a). In this context, Malaysia as a developing country is of no exception. There is also the research gap on regulation in health care segment. Not surprisingly, Nik Rosnah (2002) argues that very little has been written about private health sector regulation. Hence this thesis intends to bridge the gap through the analysis of the new regulations which has been promulgated in 2006.

Malaysia adopted the privatisation policy including the health sector in the mid 1980's (Chan, 2011; Lee et al. 2011; Jomo & Wee, 2014). Prior to this era since post independence, health policy has been a major priority in national socio-economic development plans. In this context, Malaysia has been a welfare-oriented state in terms of providing financing through centralised taxation and provision of accessible public health care to all its citizens (Roemer, 1991; Chee & Barraclough 2007; Chan, 2007; 2011; Chee & Por, 2015). Nevertheless, the shift towards economic liberalisation policy has been instrumental to the burgeoning development of private healthcare facilities and services in the urban areas. The expectations of the affluent society, rising disposal income, demographic and epidemiological changes, advancement in medical technology, and entrepreneurial medical practice were contributing factors to the establishment of numerous for profit-private hospitals. Subsequently, the emergence of medical insurance and health tourism provided incentives for the rapid expansion of private hospitals (Chee, 2008; Chan, 2011; Malaysia Productivity Corporation (MPC), 2014; Ng et al. 2014). The mushrooming of these commercialised private hospitals under a loosely regulated environment has resulted in unintended consequences (Chee & Barraclough 2007; Chan, 2007). This unprecedented phenomenon has brought forth numerous complex issues affecting public's accessibility in terms of affordability, equity and quality care in the private health sector. All of which posed major health care concerns to policy makers (Nik Rosnah, 2002; 2005; 2007; Sirajoon & Yazad, 2008; Nik Rosnah & Lee, 2011; Ng et al. 2014).

While Malaysia's Second Outline Perspective Plan 1991-2000 (Malaysia, 1994) envisaged the government's intention to promote the growth of the private sector, it had simultaneously acknowledged the urgency to address the critical health issues of "accessibility, affordability, equity and quality health care" as stipulated in the Mid-Term

Review of the Sixth Malaysia Plan 1991-1995 (Malaysia, 1993, p. 244). In addition, the government has expressed explicitly its intention “to reduce its health care provision gradually and increase its regulatory control together with enforcement functions” under the Seventh Malaysia Plan 1996-2000 (Malaysia, 1996, p. 544). Consequently, this has culminated in the implementation and enforcement of a new legislation gazetted as the “Private Healthcare Facilities and Services Act 1998 (Act 586)”, and its Regulations in 2006 cited as the “Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 [P.U. (A) 138/2006]” (Malaysia, 2006).

The enactment of this prescriptive health care legislation in 1998 coincided with the aftermath of the Asian Financial Crisis 1997/1998 where medical tourism was promoted by the government as an important growth strategy (Chee, 2008; Lee et al. 2011). The new Act 586 heralds a historical landmark in the regulatory reform initiatives of the private health care sector ever had in Malaysia. This highly prescriptive Act 586 with its regulations is the first comprehensive private health care legislation regulating all private hospitals, and all other private healthcare facilities and services nationwide except cosmetology after a span of 35 years. It replaced the previous basic Private Hospitals Act 1971 which was found to be grossly inadequate in coping with the complexities of the fast changing private health care landscape (Nik Rosnah, 2002; 2005; 2007; Sirajoon & Yazad, 2008; Nik Rosnah & Lee, 2011).

This thesis aims to examine the impact of the Private Healthcare Facilities and Services Act 1998 [Act 586] and its Regulations 2006 on the private hospitals in Malaysia in achieving the intended “national objectives of accessibility, equity, and quality in health care” (Malaysia, 1993, p. 244). On the same note, the objective of the study is also to assess whether the enforcement of the new regulatory reform initiatives have been

successful in influencing the intended behaviours of the private health care providers in terms of compliance to meet the government's health care priorities. The study also hopes to contribute further academic debates to intellectual discourses on the future of private healthcare delivery. Further, this study intends to provide feedback to the policy makers for better health care for its citizens.

## **1.2 Background**

The initial health care system in Malaysia since independence in 1957 has been seen as a welfare-orientated state until the 1980s (Roemer, 1991; Chan, 2003; 2007; 2011). This state's predominant role is evident in the principal funding through taxation and in the provision of accessible public health care delivery to all strata of its population (Roemer, 1991; Chee & Barraclough, 2007). The Ministry of Health Malaysia (MOH) is the largest healthcare provider together with other ministries and organisations (Sirajoon & Yadaz, 2008). Under MOH, the public has the accessibility to universal primary health care in both the urban and rural areas. The "extensive network of integrated primary health care clinics in the rural areas nationwide was exemplary" (Meerman, 1979, p.142). Similarly, the public hospitals providing secondary and tertiary care were heavily subsidised and widely accessible to the society (Sirajoon & Yadaz, 2008; Ng et al. 2014). Hospitalisation user fees were nominal and even exemptions were granted to those who could not afford to pay. These public hospitals served as social safety net to the population at large especially the poor and marginalised groups (Malaysia, 1994; Hanafiah, 1996; Chan, 2011; Jomo & Wee, 2014). There was no significant barrier to public healthcare accessibility. The public health care system encompasses a wide range of promotive, preventive, curative and rehabilitative services. On the same note, the nation's public health care system was described as egalitarian and gained international recognitions

(Muhamad Hanafiah, 1996; Meerman, 1979; Sirajoon & Yadaz, 2008; Jomo & Wee, 2014; Malaysia Productivity Corporation (MPC), 2014; Ng et al. 2014).

However, the state's liberalisation policy under the privatisation policy in the 1980s, witnessed a major transformation of the health care system in the country (Chan, 2003; 2007; Lee et al. 2011; Jomo & Wee, 2014). With the promotion of the private sector, there was a dramatic upsurge in the number of investor-owned corporate private hospitals providing mostly curative and specialist services in the affluent urban sectors. These profit oriented corporate private hospitals were originally initiated by local enterprising doctors and subsequently with both local and foreign corporate investors (Chee & Barraclough, 2007; Nik Rosnah & Lee, 2011a; 2011b).

The concurrent significant increase in private capital investments and the entrepreneurial initiatives have not only resulted in the burgeoning of fee for service in private hospitals but also other private healthcare facilities and services in the urban areas throughout the country (Chee & Barraclough, 2007; Sirajoon & Yazad, 2008; MPC, 2014). These private healthcare facilities and services among others include primarily the medical practitioners' clinics, dental clinics, pharmacies, maternity homes, nursing homes and the existence of a few charitable private hospitals. Subsequently, new types of private healthcare facilities and services such as ambulatory care centres offering diagnostic and day care services, haemodialysis centres and hospices emerged mostly in the affluent townships. Traditional and complementary medicine added plurality to the private health sector. Over the decades the nation had undergone the process of metamorphosis with the gradual evolution and the eventual transformation of the Malaysian healthcare system. This phenomenon had resulted in the emergence of the current two-tiered public and

private health sectors (Chee & Barraclough, 2007; Ramesh, 2007; Sirajoon & Yazad, 2008; Nik Rosnah & Lee, 2011a; 2011b; MPC, 2014; Ng et al. 2014).

This unprecedented development had far reaching as well as unintended consequences. These commercialised private hospitals and other healthcare facilities posed some concerns such as patient's safety hazards and unconstrained prohibitive private healthcare cost which had prompted the urgent attention of national policy makers. In parallel, the Private Hospitals Act 1971 which had been the governing legislation on the private healthcare sector was found to be grossly inadequate to cope with the unbridled development of the private hospitals and other healthcare facilities and services. The former basic legislation did not have the provision for the enforcement capacity to regulate these private hospitals nationwide.

This loosely regulated private healthcare landscape had resulted in much unintended socio-economic implications (Sirajoon & Yazad, 2008; Nik Rosnah & Lee, 2011a; 2011b). This phenomenon culminated in the enactment of a comprehensive private healthcare legislation entitled the Private Healthcare Facilities and Services Act 1998 [Act 586] and its Regulations 2006 to achieve the national objectives among others, "to improve access to healthcare, correct the imbalances in standards and quality of care as well as rationalize medical charges in the private health sector to more affordable levels" (Malaysia, 2001, p. 486).

### **1.3 Statement of Problem**

The state's public policy of economic liberalisation in 1980s especially in the promotion of corporate private hospitals sector without an adequate prerequisite regulatory framework had resulted in less positive effects and unintended consequences. There was

no evidence of an effective regulatory mechanism to control exponential growth of these corporate private hospitals with unconstrained entrepreneurial initiatives nationwide (Chee & Barraclough, 2007; Nik Rosnah & Lee, 2011a; 2011b). This unprecedented growth had wide social economic implications. It was reported to have affected public's accessibility to these private hospitals and other private healthcare facilities and services, inequitable distribution of medical and health resources and in some cases resulted in poorer quality of care (EPU, 1996; Nik Rosnah, 2002; 2005; 2007; MOH, 2011; Nik Rosnah & Lee, 2011a; 2011b). Some of these crucial issues that will be the focus of this study are highlighted below:

### **1.3.1 Accessibility, Patient's Safety and Quality Care**

Notwithstanding the regulatory lacuna, there is also the potential danger for more dysfunctional outcomes in the private health care sector in Malaysia. These implications resulted in major critical issues affecting public accessibility to private hospitals in terms of patient's safety, affordability, equity and quality care. In addition, the fragmentation of private providers and the wide variation of medical care posed threatening national health issues. The existence of numerous unlicensed private hospitals with unregistered medical professionals and other illegal private healthcare facilities and services further exacerbates the health care complexities (MOH, 2011; Nik Rosnah & Lee, 2011a; 2011b).

The accessibility to these unlicensed private hospitals and other private facilities with unqualified healthcare professionals including bogus doctors posed high potential patient's safety risks and major concerns to policy makers (Nik Rosnah, 2002; Sirajoon & Yazad, 2008; MOH, 2011). On the same note, a local pioneer exploratory research study done previously indicated that there were at least 13 private hospitals operating without licences for various reasons since 1992 (Nik Rosnah, 2002). Furthermore, many

of these commercialised private hospitals were operating on non-purpose built premises or on commercial shop lots premises whereby patient's safety and quality care measures may have been compromised (Nik Rosnah & Lee, 2011).

### **1.3.2 Inadequate Provision of Emergency Services**

It is noted that the provision of emergency facilities and services were often minimal and not a priority in most private hospitals. Many private medical establishments did not provide an adequate pre-admission critical care facility and services. Public accessibility to the emergency department in many of these private hospitals often encountered several problems. Further, there were incidents where medical emergencies had been denied due to economic reasons (Nik Rosnah 2002; 2005; 2007; Abu Bakar Sulaiman, 2006; mSirajoon & Yadav, 2008; Nik Rosnah & Lee, 2011a; 2011b).

Although some private hospitals seemed to provide emergency services, there was no evidence of a proper triage system in place in the emergency department where the most critical cases could be identified and attended to immediately. The inadequate trained healthcare professionals and often poorly equipped resuscitation facilities in the emergency department further exacerbated the problem of an equitable access and quality care. In reality, many of these private facilities did not have emergency blood bank supply system and were highly dependent on public hospitals and the National Blood Bank. Critical patients were often redirected and sent to the nearest public hospitals (Nik Rosnah, 2002; 2005; 2007; Sirajoon & Yadav, 2008; Nik Rosnah & Lee, 2011a; 2011b).

### **1.3.3 Rise in Adverse Events, Medical Errors and Negligence**

There is also the concern that professional indemnity and incident reports are on the rise as a result of adverse events, medical errors and negligence in private hospitals (Medico

Legal Report, 2007). In this context, the Medical Defence Malaysia Berhad reported a negotiated court settlement in a medico-legal case involving a brain damage child for RM 3.25 million. The last bench mark for negotiated case settlement was RM 2.50 million in year 2005 (Medico Legal Report, 2008). This phenomenon invariably would result in the overall escalating private healthcare costs.

#### **1.3.4 Exorbitant Medical Bills**

Sirajoon & Yazad (2008, p. 280) argue that “crass commercialism” has embedded in the private hospitals sector with outrageous charges over the decades. The spiralling costs of medical bills raised public anxiety and scrutiny (Rasiah et al. 2009; MOH, 2011). The prohibitive hospitalisation charges has affected public’s accessibility to these private hospitals in terms of affordability, equitable access and quality care (Nik Rosnah, 2002; 2005; 2007; Chan, 2007; Sirajoon & Yazad, 2008; MOH, 2011; Nik Rosnah & Lee, 2011a; Ng et al. 2014).

Furthermore, crass commercialism is evident in the private hospitals with the widespread complaints of opportunistic practices of some private hospitals using arbitrary and exorbitant charges with questionable padded bills (Chan, 2007; Sirajoon & Yazad, 2008; Ng, 2010; Lum, 2010). This phenomenon had been a major source of grievances especially among private patients paying out of pockets and those with medical health insurance coverage at private hospitals (*The Star*, 4 December 2007; *The Star*, 12 January, 2011; *The Star*, 6 December, 2011; *The Star*, 6 April, 2012). The provision of services in private hospitals is based on the affordability and upfront monetary deposits which serves the selected rich and deprive the majority of the population (Chan, 2007; Lum, 2010; *The Star*, 28 April, 2010).

### **1.3.5 Weak Enforcement Capacity**

The ineffective monitoring and law enforcement capacity further exacerbate the problems of accessibility to private hospitals (Nik Rosnah & Lee, 2011a; 2011b). As mentioned above, the regulatory authority under MOH is aware of the complexities confronting the private hospital sector. The numerous complaints of over-servicing such as the alleged over-diagnosis and over-treatments, unsatisfactory services, and compromised quality care, yet MOH is perceived to have done little to curb these problems (Chan, 2007; Ng, 2010; Lum, 2010).

Besides, there are also the perennial complaints of overcharging by some specialist doctors who stretched their professional fee to the maximum limit and sometimes beyond the permissible limit under the Malaysian Medical Association Fee Schedule guidelines (MMA, 2002). This practice appears rampant and often with questionable justifications. These medical specialists claimed that their professional charges were within the guidelines under the Malaysian Medical Association Fee Schedule (MMA, 2002) and instead alleged that hospital ancillary charges were exorbitant (Jalleh, 2006; Ng, 2010; Lum, 2010). This phenomenon had caused anxieties and confusions among the patients and the public. In spite of heavy public criticisms, private hospitals continued operating with an ambivalent attitude and had not even responded to these allegations publicly (Chan, 2007; Ng, 2010; Lum, 2010).

Ironically, the slender Private Hospitals Act 1971 did not have the enforcement capacity to empower MOH to enter or close these unlicensed private hospital premises. The regulatory body could only circumvent this weakness by invoking the Poison Act 1952 under the pretext of drug inspection by the pharmacists. For licensed premises, the Private

Hospitals Act 1971 gave the power of inspection but not enforcement (Abu Bakar, 2006; Khairi, 2006; Sirajoon & Yazad, 2008).

### **1.3.6 Information Asymmetry**

One of the problems faced by patients in the private hospitals is the asymmetric information. Patients are often less informed and vulnerable in encountering with the well informed private health care providers. Invariably, patients have to depend on the medical providers in making decisions on what medical and services to be purchased. Most patients are not only unaware of their rights and the professional fee charges but also less informed of the billing system in the private hospitals.

In reality, there is no advance full disclosure of private hospital charges other than some common published room rates, normal delivery and health screening packages (Chan, 2007; Lum, 2010; Ng, 2010). Often there is no mechanism in the private hospitals where public compliants about standards, cost and performance are attended to appropriately. The lack of avenue to voice their grievances has led to negative media exposures and adverse publicity to the medical providers in general (Sirajoon & Yazad, 2008). However, all these outstanding issues of accessibility, equity and quality care have remained highly contentious and controversial before the historical implementation of new private healthcare legislation in 2006 (Chee & Barraclough, 2007; Sirajoon & Yazad, 2008; MOH, 2011; Nik Rosnah & Lee 2011a; 2011b). It is against this background that provides the researcher the motivation and justification to embark on this study.

#### **1.4 Research Questions**

This doctoral study is guided by three research questions as follows:

- i). What is the impact of the Private Healthcare Facilities and Services Act 1998 [Act 586] & its Regulations 2006 on the private hospitals in Malaysia in terms of achieving the intended national objectives of improving accessibility, correct the imbalances in standards and quality of care, and rationalising the medical charges to more affordable levels?
- ii). What are the factors that influence the impact of the Act 586 on the private hospitals?
- iii) How is the enforcement capacity of the MOH with the enforcement of Act 586 on the private hospitals?

#### **1.5 Objectives of the Study**

- i) To examine the impact of the Private Healthcare Facilities and Services Act 1998 [Act 586] and Regulations 2006 on the private hospitals in Malaysia.
- ii) To identify the factors that influence the impact of Act 586 on the private hospitals.
- iii) To investigate the enforcement capacity of the regulatory body at MOH in improving the performance of the private hospitals.

#### **1.6 Significance of the Study**

This study aims to contribute to new empirical findings on the impact of historical regulatory reform initiative under the Private Healthcare Facilities and Services Act 1998 [Act 586] & Regulations 2006 on the private hospitals in Malaysia. There has been no known academic research ever been explored after the landmark private health care regulatory intervention in 2006. Hence, this study is the first of its kind to explore as to whether the new regulatory intervention achieves the government's desired national objectives of accessibility, equity and quality care in the healthcare sector. While there

has been a pioneer exploratory study conducted between 1996 and 1999 by Nik Rosnah Wan Abdullah (2002) on the assessment of government regulations on the private health care sector before the implementation of the Act 586, but there was no further study done after its enforcement. The rhetoric expectations of the new Act 586 were discussed at length with the hope that those shortcomings in the private hospitals sector could be overcome after the enforcement of the Act 586. Nik Rosnah's (2002) study recommended that a further research study should be undertaken after the implementation and the enforcement of this comprehensive Act 586. Hence, this study is a follow-up to revisit and fill the research gap with the current findings to compare whether the situations have changed after the enforcement of this historical legislation in 2006. Putting the outcomes of the two studies together would contribute to new knowledge and provide an insight to the government for better health care delivery.

Furthermore, the study is of great significance as much of the major outstanding issues relating to concerns of consumers and patients over the three decades could be addressed in Act 586 and its regulations. The priority of patients' rights has been explicitly stipulated under the new prescriptive legislation Act 586 in terms of patients' safety and the accountability of the health care provider. The private hospital is responsible for the policy statement of its obligations toward patients' rights using the facilities and services. The patient's rights among others, encompass the accessibility to professional care, emergency services, consent, billing charges, grievance mechanism and patient's access to its own medical report. More significantly, the professional fees have been regulated for the first time and this study will reveal whether rationalising the medical costs at affordable can be achieved. Besides, the new legislation addresses the weaknesses of the previous Private Hospitals Act 1971 in the enforcement capacity in the private health sector (Abu Bakar Sulaiman, 2006; Khairi, 2006; Nagara 2006; Sirajoon & Yazad 2008).

As Malaysia aspires to be a progressive and high-income nation in 2020, as envisioned in Vision 2020, ensuring health and well being of its multi-racial population is crucial to achieving its economic and societal development objectives (Malaysia, 2011). There is a need to transform the delivery of the health care system both in the public and private health sectors to ensure effective delivery, greater efficiency and affordable cost (Malaysia, 2011; Ng et al. 2014). Among the initiatives to be undertaken under the Tenth Malaysia Plan (2011-2015) is the streaming of the regulatory and provision roles. The MOH is entrusted on the governance, stewardship, enforcement including reviewing of existing legislations to enhance quality care and ensure patient safety. Hence, this study is of significance as examining the impact of Act 596 and its regulations on the private hospitals is in line with the government's development objectives in the health sector (Nik Rosnah, 2002; Nik Rosnah & Lee, 2011; Malaysia, 2011; MPC, 2014).

### **1.7 Methodology**

This study is based on an exploratory qualitative research methodology using case studies to address the research questions and objectives. The case study approach provides an in-depth insight into the issues and problems investigated. The Malaysian health system is complex and regulations involved many government and non-governmental actors in this sector further exemplified the justification for using case studies. Hence, to understand the phenomenon on the impact of the regulatory intervention in 2006, fifteen private hospitals were purposively selected in the Klang Valley for case studies.

The approach is principally designed using key informants' interviews, focus group discussions, and observations. Key informants were also purposively selected based on their rich experience and expertise (Stake, 1995; Yin, 2012; 2009; Creswell, 2014; Gilson, 2014). Interviews were conducted on 130 key informants who are also key stakeholders

in both the public and private health sectors. These key informants include members from the professional bodies, non-governmental organisations, patients and their relatives to obtain the primary data. Focus group discussions were also held including officials from the MOH. In addition, researcher's personal experience as the Chief Executive Officer in managing private hospitals before and after the regulatory reform initiatives contributed to the overall collection of primary data for this research. In compliance with research ethics protocols, the confidentiality of all informants and the private hospitals had been maintained in this study.

Besides, secondary data were gathered from official publications and press statements from the relevant stakeholders such as the MOH, government agencies and the professional bodies. For the purpose of triangulation (Denzin & Lincoln, 2011), data were also extracted from the various documentation, archival records, academic books and journals, conference papers, private hospitals' websites, patients' medical bills, media reports and data bases. Multiple sources of data are collected with the hope that they will all converge to provide an answer to the research questions (Yin, 2012; Creswell, 2014; Gilson, 2014). The methodology of this study shall be discussed in depth in Chapter 3 of this thesis.

## **1.8 Scope of Study**

The study intends to investigate the impact of the regulation at work on both the behaviours of the regulated private hospitals in Malaysia and the regulatory authority under the MOH in relation to the intended national objectives. Henceforth the scope of study has been designed at two levels; one at the MOH and the other at the private hospitals. The scope of the study at the MOH among others, examines the enforcement of mandatory approval and licensing of private hospital establishments, the compliance

and the concern in addressing the inequitable distribution of private hospitals nationwide. In addition, this scope of investigation is extended to examine the enforcement capacity of regulatory body under the Ministry of Health Malaysia as to whether it has the adequate resources in terms of financial and manpower, and the information to regulate the private hospitals in Malaysia. However, the scope of study excludes the clinical governance and audit in the private hospitals as it is currently not under the purview of Act 586.

### **1.8.1 Purposively Selected Private Hospitals**

The scope of study encompasses the closer examination of the regulation at work in fifteen purposively selected private hospitals in terms of compliance, non-compliance and performance improvement under the regulations. These compliances among others include the mandatory approval and licensing of private hospitals to ensure patient's safety, and the equitable access to quality care. The scope of study also extends to the examination of the performance and the responsibility of person-in-charge, fees schedule and the outcome in rationalising the medical charges to more affordable levels with the regulated professional fee schedule. Similarly, the quality care initiatives undertaken in the private hospitals including accreditations, patient grievances mechanism, and the establishment of Medical and Dental Advisory Committee are areas covered under the study.

### **1.8.2 Study Area**

The study area encompasses the densely populated Klang Valley which comprised the highly developed states of the metropolitan Federal Territory of Kuala Lumpur and the affluent state of Selangor (Malaysia, 2006). As this area "account for almost one-third of Malaysia's total Gross Domestic Product" (MPC, 2014), the government has identified it as one of the major drivers of high economic growth under the National Key Economic

Areas to achieve high income status in 2020 (Malaysia, 2011). Furthermore these two most developed states have the largest number of 91 private hospital establishments which represents 43.54 percent of the total number of licensed private hospitals nationwide in 2008 (MOH, 2008).

Nevertheless, the scope of this study has its limitations in view of the high confidentiality, non-disclosure and sensitivity of data to be disclosed at the private hospitals and the MOH.

## **1.9 Outline of the Thesis**

This thesis encompasses nine chapters. Chapter 1 is the general introduction to the thesis which preludes to the research and motivation of the study. The chapter begins with a brief background discussion on the influence of global health care market reforms, the Malaysian health care system, the statement of problem to be investigated, the research question and the objectives of the study, the significance and the scope of the study. Chapter 2 is the Literature Review. The chapter discusses the concept of public policy, and theoretical literature on regulation in general and in particular the government's role in the health sector to achieve the national priorities. Central to the discussions among others, include the health policy, impact of regulations, theoretical underpinnings and the comparison made between regulatory experiences in the developing countries and the developed countries.

Chapter 3 provides the research methodology in the study. It discusses the options of the available research methodologies. Specifically to answer the research questions, an exploratory qualitative approach was the choice in this study. Utilising key informant stakeholders' interviews, focus group discussions, and observations are sources of

principal data collection to examine the impact of the regulatory intervention on the private hospitals. Chapter 4 discusses the Malaysian Healthcare System. This chapter provides an overview of the healthcare system in the country pre and post independence era. Central to the discussions include a range of complex issues and the predominant intervention role of the state in shaping the current national health care system.

Chapter 5 revisits the healthcare privatisation policy in Malaysia. This section discusses mainly on two highly controversial healthcare privatisations projects, and the attempted privatisation of the National Heart Institute. Discussions also focus on the incremental policy of privatisation in the public hospital sector leading to the formation of coalition of civil societies and non-governmental organisations against privatisation in healthcare, and the objection on the move to privatise the National Heart Institute (Institut Jantung Negara). The proposed National Health Financing Scheme under 1CARE for 1Malaysia is also discussed.

Chapter 6 and Chapter 7 provide the answers to the research questions and objectives with the results of the study. These empirical chapters present the analytical findings on the impact of the enforcement of the regulatory intervention in the private hospitals to achieve the government national health objectives. The findings among others take a closer look on the policy, governance, performance of the private hospitals in terms of compliance, and non compliance of the regulations, particularly the mandatory approval and licensing of private hospitals for patients' safety and quality care. Further, the responsibility of the person-in-charge and its obligations to patients' rights, grievance mechanism, the regulated professional fee schedule, the issue of fee-splitting, the expected billing charges and quality initiatives undertaken including accreditation are examined. The study also provides the findings of the outcome of the implementation and

the enforcement capacity of the MOH as the regulatory principal in addressing the concern of the inequitable distribution of the private hospitals under the agency theoretical framework.

Chapter 8 provides the discussion section. This chapter deliberates on the outcome of the findings as to whether the research questions and objectives of this study are achieved. The thematic issues of health policy, power, governance, compliance, costs, inequity, quality, politics and the performance of enforcement capacity are discussed in-depth in the chapter. A comparison of the empirical findings is also made with the previous pioneer study done by Nik Rosnah (2002) and other relevant local studies. In this context, a comparison and contrast of the similar studies on health care regulatory policy and experiences in both the developing and developed countries such as Germany, Netherlands, United Kingdom, Canada and United States are also discussed.

Chapter 9 is the conclusion of the thesis. This chapter concludes with the summary of this thesis including the thematic findings pertaining to the regulations of the private hospitals, and recommendations for the future. Further, discussions on the limitation of this study as well as the implications for further study draw to the conclusion of this thesis.

#### **1.10 Concluding Remarks**

This qualitative research study examines the impact of the highly prescriptive Act 586 and its regulations on the private hospitals in Malaysia. It provides the answers to the research questions and objectives of the study on the impact of the regulatory enforcement of Act 586 in achieving the government's intended objectives of accessibility, equity, and quality care. This study in particular scrutinises the policy, compliance, accountability and the performance of the private hospitals looking from the public choice, interest

groups, and principal-agent theoretical perspectives. Although the mandatory approval and licensing of private medical hospitals for patient's safety and provision of quality care has been implemented since 2006, the expectation and outcome have been seen to be a mixed phenomenon of compliance under this study. In view of the divergence objectives, there are evidence of compliance and non-compliance to the regulations. Further, this study examines the enforcement capacity of the MOH as a regulatory authority in monitoring the private hospitals nationwide. Despite the enforcement of Act 586, the regulatory body has encountered unprecedented challenges in its role to regulate the private hospitals albeit the limited resources and political constraint encountered. This study hopes to contribute to the field of knowledge, and provide some insight to the policy makers in its regulatory functions to provide better future health care delivery. The following Chapter 2 provides in depth discussions on the health policy and regulations in the literature review relevant to this study.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

This chapter discusses the general concept of public policy and theoretical aspect of regulation with specific reference to the health care sector with two objectives: Firstly, to provide a concise synthesis of the multidisciplinary literature aimed for the better understanding of the context of policy, regulation, mechanisms and the justification for state intervention in regulatory reforms. Secondly, to develop a framework for analyzing and examining of the impact of the regulatory intervention which is relevant to this research study. This literature review also draws attention from the studies of various authors on the extent of health regulation at work and its impact in the developed countries as compared with the limited evidence from developing countries.

### **2.2 Definition of Public Policy**

Despite the variations in the definition, a general consensus has derived that public policies are the results from decisions made by the governments. This includes decisions by government to remained status quo or decisions to make changes (Birkland, 2001; Howlett & Ramesh, 2003). Policy theorist such as Dye (1972, p.2) provides a concise definition with the argument that public policy as “anything a government choose to do or not to do”. While the argument may appear to be too straight forward but it is not without merits. Further, Dye (1972) asserts that the government is responsible for making public policy. In fact the government has the legitimate authority to make decisions that are binding and carried out for the nation as a whole (Blank & Burau, 2007). Invariably, whenever there is a discourse about public policy the focus is on the action of the government.

Dye (1972) emphasizes that public policies encompass an important choice on the part of the governments to perform something or do nothing and these decisions are made by the state bureaucrats and its agencies. The course of action among others may include such decision as to increase taxations or decline to make additional funds available for health care or some policy area. However, Jenkin (1978) provides a more explicit concept of public policy than the one suggested by Dye (1972), albeit threading on the similar themes. Likewise, Jenkin (1978) views that public policy-making involves a set of decisions taken by political actors to achieve societal objectives within a specified situation. Precisely, a government addresses a problem with a series of decisions culminating in what constitute a public policy. Hence, a health policy for example may encompass a series of decisions in relation to “the establishment of health facilities, certification of healthcare professionals and medicines, and the provision and the financing of healthcare” (Howlett & Ramesh, 2003, p.6).

Further, Jenkin (1971) observes that to have a deeper understanding of government’s health policy, it is crucial to consider all the decisions made by government actors involved in the financing and the management of its health-related activities. Nevertheless, “a government’s choice of a policy may be limited, for example, by the lack of financial, personnel, or informational resources, by international treaty obligations, or by domestic resistance to certain options” (Howlett & Ramesh, 2003, p.6). Hence, health policy in many countries may not be fully understood without taking into consideration the powerful, self-serving opposition that the medical profession is able to initiate against any government’s effort to cut healthcare costs by reducing the professional income (Alford, 1972; Howlett & Ramesh, 2003).

Another public policy theorist Anderson (1984, p.3) defines a policy as “a purposive course of action followed by an actor or a set of actors in dealing with a problem or matter of concern”. While this definition has similarities with that of Dye (1972) and Jenkin (1978), Anderson (1984) provides an additional important feature, which emphasizes the connection between the action of the government and the existence of a problem which require action. Occasionally the government may make announcement for the reasons for making such a decision. “However, a government often does not give reason for making a decision; or when it does the publicly avowed reason may not be the actual reason” (Howlett & Ramesh, 2003, p.7). Under such circumstances it is pertinent for research analysts to examine why a certain policy was adopted and, frequently, why another seemingly better alternative was excluded. It is indeed a complex task for analysts to explain why a policy was not enforced as intended, and examining the outcome of a policy is a challenge (Howlett & Ramesh, 2003).

### **2.3 Health Policy**

Invariably, health care has been perceived as a controversial policy issue (Blank & Burau, 2007). In fact, it is pertinent to differentiate the terminology used between health policy, health care policy and health politics. Health policy has been broadly defined as those directions of action proposed or taken by the states, which have implications on the health of their population (Blank & Burau, 2007). While health care policy has a much narrow definition that refers to those directions of action taken by the states which involve in the provisions and financing of health services. Lastly, health politics comprises the interactions of political actors and institutions in the health care sector. No doubt politics is a critical dimension of all attempts to initiate health policy but politics is seen to be very complex and country specific (Blank & Burau, 2007).

Invariably, the concept of health policy can be differentiated from other sectors of public policy, but in fact it is closely interrelated with the wide range of social economic public policies. Ideally, health policy aims to provide an efficient and high quality services to its population on an equitable basis. In addition to universal access and cost containment, other objectives might be included such as the priority of patients' choice, ensuring the high accountability of healthcare providers and guaranteeing the safety on the utilisation of the latest medical technologies (Blank & Burau, 2007). Nevertheless, there are many goals in health care. Blank & Burau (2007, p.93) argue the three central competing goals of health policy are “equity/access, quality, and cost containment (efficiency)” as shown in Figure 2.1.

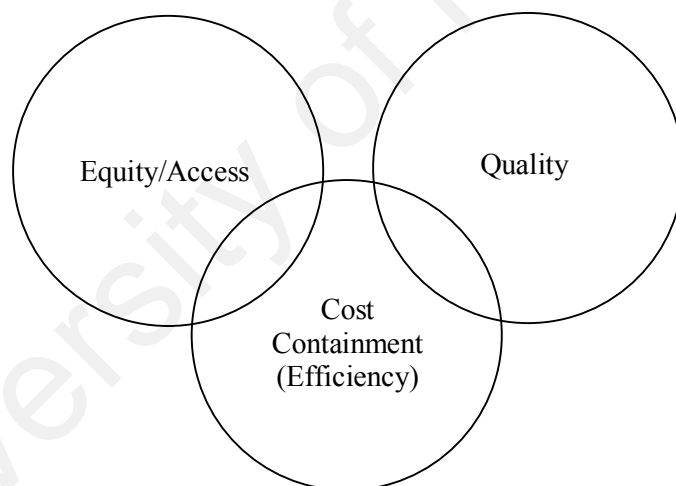


Figure 2.1 Competing goals of health care (Blank & Burau 2007, p.93)

Health care consists of the regulatory, distributive and redistributive policies (Blank & Burau, 2007). Regulatory policies among others include the imposing of fee schedules, mandatory licensing, approval of drugs for use and other controls on the medical practice. The distributive policies are more evident in national health services, but also occur in some countries through the provision of public health services and health promotion activities. Lastly, the redistributive health policies are based on the concept of needs and

entitlements of the population. This policy is where the government focus its effort and resources from the healthy to the non-healthy citizens (Blank & Burau, 2007). In fact, Blank & Burau (2007) argue that “health care is one of the most regulated sectors in all developed countries in spite of their divergent types of health systems” (p.3). Nevertheless, “official records of government decision-making are found in such forms as laws, acts, regulations and promulgations” (Howlett & Ramesh, 2003, p.7). Hence it is pertinent to discuss further on the conceptual framework of regulation which is relevant to this study.

## **2.4 Concept of Regulation**

Regulation has been said to be one of the most extensively debated issues over the decades especially in the health sector (Saltman & Busse, 2002; Walshe, 2003; Ensor & Weinzierl, 2007; Morris et al. 2012; Santerres & Neun, 2013; Bloom et al. 2014a; Mauro, 2015). Public discourses more often than not have generated more controversies than providing solutions. In view of its complexity and multidisciplinary perception, it has been acknowledged that there is no one generally accepted standard form of definition for regulation (Chinitz, 2002; Walshe, 2003; DeBakey, 2006; Makintosh, 2008; Mauro, 2015). Notwithstanding there are numerous, diverse and often conflicting definitions. Each definition is not only based on the different academic backgrounds, and different political affiliations but the different set of intrinsic values that underpinned these perspectives (Saltman & Busse, 2002).

As Chinitz (2002) posits, regulation is seen rather differently when grounded from different conceptual lens of economics, management, law, and politics respectively. From the economists’ perspective, they are more concerned not only on the controlling of prices, the aspect on volume capacity, and market structure but more importantly the

behavior of economic actors as well. While the management theorists on the other hand are more interested in mutual compromises, types of control, and effective decision-making through decentralisation. From the public management's perspective, the concern is not only on the implementation but the importance of enforcement capacity of the regulatory initiatives. Further the legal theorists tend to focus on issues related to law and statute. The political scientists on the other hand are more concern on the need to negotiate the complexity of the diverse interests and the securing of the desired consequences through political process. It focuses on the importance of transparency and accountability. Regulation in reality is said to be an evolving mix of these often highly complex and diverse disciplinary perspectives (Chinitz, 2002).

## **2.5 Approaches to Regulation**

Writers like Baldwin et al. (1998) categorise the numerous concepts on regulation derived from literatures into three core classifications. The first classification defines regulation explicitly as mandatory rules which are implemented by the government enforcement authority. Under this classification, the legislation may either be for economic or social objectives. However, it excludes the criminal justice system unless there is a relevant cited court decision as a precedent set. The next classification is what is commonly seen in political economic literature, which encompasses a wider scope of all state intervention to steer the overall economy among others including state ownership and contracting. In addition, this classification includes policy on taxation and public disclosure. The final classification in its wider perspective encompasses all dimensions of desired and undesired social control. Among others, this includes societal norms and values in the desired policy initiatives to build a holistic approach regulation.

Likewise, Saltman and Busse (2002) state that these findings concurred with a similar study initiated by Altman et al. (1999) on the approaches toward state regulatory intervention. Threading the work of Wallack et al. (1991), the study describes the regulatory approaches under four models namely; the elective, directive, restrictive and prescriptive model. From the standard theory of economics perspective, regulation is seen as the state control over the unconstrained activity of the private market. As such, under the elective model, which is said to be the least interventionist, regulation is imposed by the state specifically to tackle market failure. The directive model on the other hand is where the state uses its authority to regulate certain types or standards of service as a purchaser or regulator. However, the restrictive model is where the state regulatory intervention aims to constraint the prevailing market environment. Lastly, the prescriptive model is where the state mandates the prerequisites for the provision of services in the market place. It is considered the most interventionist model (Saltman & Busse, 2002).

Contrary to the above, there is also another diverse viewpoint on regulation whereby social goods and normative values are taken into consideration. While the normative values are the initial and primary concerns, but over the passage of time, issues of economic efficiency have been given secondary priority. Consequently this has resulted in the emergence of the stewardship approach on regulation as the top priority (Walshe 2003; Walshe & Boyd, 2007). Thus regulation is seen as “the sustained and focused control exercised by a public agency over activities that are socially valued” (Selznick, 1985, p.363). He asserts a concept that limits regulation as a phenomenon. Regulation is seen as a valued activity which is crucial for the authority to have an oversight and jurisdiction over the regulatees. It is seen as a state centre view of regulation with much emphasis on intervention (Selznick, 1985).

Subsequently, on a similar ideological perspective, Colton et al. (1997) posit the existence of two tiers of government regulations for economic stakeholders namely the general tier, and the restrictive tier. The general tier is said to be the least restrictive. It involves ensuring that corporations meet state statutory requirements pertaining to the protection of the consumer's rights, and also the protection of the environment for sustainable development. In the restrictive tier, a much more oversight and enforcement is seen. Hence, the different perspectives on regulations with their different intrinsic values that form the basis of these perspectives are summarized in Table 2.1.

Table 2.1: Different Perspectives on Regulation (Saltman & Busse, 2002)

Authors	Concept	Main findings
Chinitz (2002)	Good and bad health sector Regulation: An overview of public policy dilemmas.	Conceptual framework & regulation in health sector such as regulating on capacity, prices, quality care & the accessibility. Regulation in practice is an evolution of the mixed multidisciplinary approaches.
Saltman & Busse (2002)	Balancing regulation and entrepreneurialism in Europe's health sector: Theory & practice.	The entrepreneurialism in Europe in the 1990s was a powerful catalyst to healthcare reforms. Entrepreneurialism can lead to unintended effects, when there is no effective state regulation. As entrepreneurial activity grew, there was parallel growth of state related regulations.
Baldwin, Scott, & Hood (1998)	A Reader on Regulation.	Provided three broadly different & contradictory rationales for regulations: 1. Public interest 2. Interest group perspective 3. Self interest
Altman, Reinhardt, & Shactman (1999)	Regulating Managed Care.	Regulation is seen as the government's regulatory intervention in the market sector. This approach describes a continuum of four models of regulation: 1. Elective, 2. Directive, 3. Restrictive, 4. Prescriptive.
Selznick (1985)	Focusing organizational research on regulation.	The emergence of the stewardship approach on regulation. Regulation is crucial in exercising authority over the regulatees. Emphasis on state regulatory intervention.
Colton, Frisof, & King (1997)	Lessons for the health care industry from America's experience with public utilities.	Two tiers of state regulations for economic actors. General tier: least restrictive ensuring corporations meet state statutory requirements to protect the consumer's rights and safety. Restrictive tier: tighter level of regulation applied. Public accountability, universal access & quality of service

## 2.6 Features of Regulation

Regulation is seen to encompass three primary features, which include firstly, the public interest purpose, secondly, the regulatory agency, and lastly the formal regulatory powers and processes (Baldwin et al.1998; Kumaranayake et al. 2000; Walshe & Boyd, 2007;

Abdullahi et al. 2012; Morris et al. 2012; Santerre & Neun, 2013). Under the purpose of public interest, regulation is usually aimed primarily to safeguard the public or society at large. However, this concept in practice can be contentious at times, but it usually involves public policy priorities. These public interest objectives can either be or both social and economics in nature such as protecting consumer's rights, assuring accessibility or supply, improvement performance, restraining escalating costs, and making the influential powerful producer organisations more accountable and responsible (Walshe, 2003; Walshe & Boyd, 2007; Morris et al. 2012; Santerre & Neun, 2013; Folland et al. 2013). In this respect it encompasses governance, transparency and the disclosure of information by the regulated organizations to the government and other stakeholders. This is also to promote regulatory compliance (Walshe & Boyd, 2007; Abdullahi et al. 2012; Santerre & Neun, 2013; Folland et al. 2013).

The second feature is the regulatory agency entrusted with the task and responsibility to exercise authority over regulated organisations on behalf of society. Its existence is based on legislations. In this instance, it could be a government regulatory authority mandated with legal power, authority, funding and governance arrangements. Alternatively, it can also be provided by independent, non-governmental organizations. The regulatory body may have a wide range of regulatory power to control and influence the regulated organizations. Invariably, the greater the authority is empowered to the regulatory agency it is more likely to secure the intended regulatory compliance (Walshe, 2003; Walshe & Boyd, 2007).

Lastly, powers and process are entrusted to the regulatory agency to execute its enforcement functions which is usually based on the legislation (Leatherman & Sutherland, 2007; Walshe & Boyd, 2007). Enforcement “refers to the methods that

regulators use to persuade, influence or make the organisations they regulate to change” for better performance improvement (Walshe 2003, p. 35). Traditionally, the basic tools of regulation seems rudimentary using formal persuasion and informal influence but mandate compliance. Over the years various regulatory strategies have been complex and deterrence approach has been adopted. These strategies among others, include the “imposition of financial penalties, placing restrictions on the organisation’s activities, requiring certain actions to be taken and, ultimately, organizational delicensing or closure. Regulators often use the disclosure or publication of their findings as an enforcement strategy” (Walshe 2003, p.35).

However, a new approach to regulation has emerged among regulatory theorists calling for the provision of “responsive” or “smart” regulation instead of the regulatory model of deterrence versus compliance. It is seen as a pragmatic attempt to move away from the established dichotomies, and replaced with a new approach which is highly flexible and adaptable to influence certain desired behaviour without using legal force. “Advocates of responsive regulation argue that it is important for regulators to have a complete hierarchy of regulatory interventions available to them, and are able and willing to use them” (Walshe 2003, p. 43). The hierarchy of regulatory intervention is frequently presented as a pyramid as in Figure 2.2.

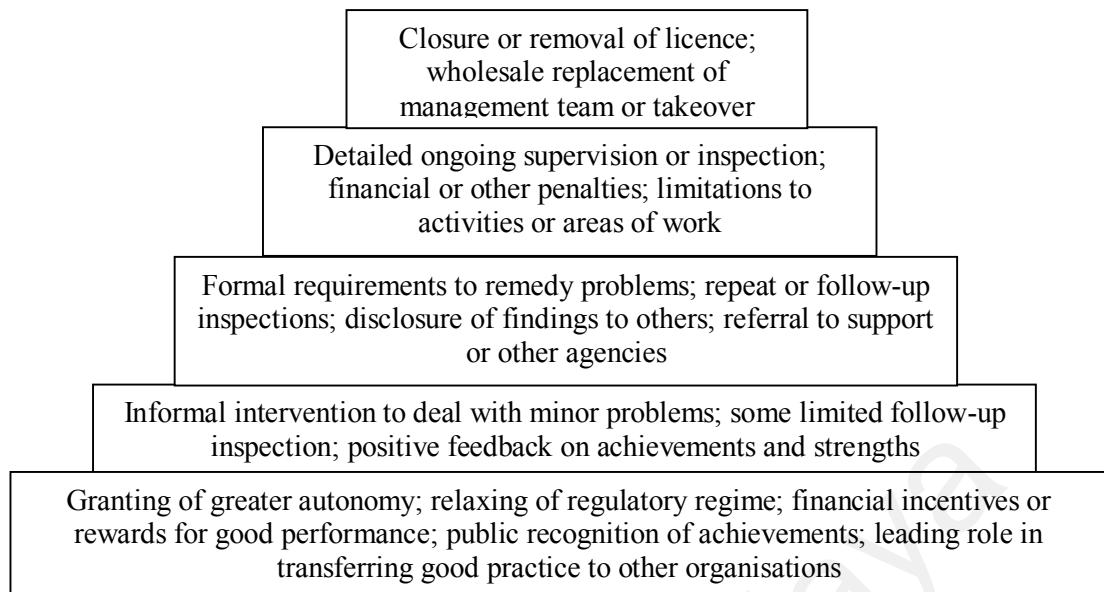


Figure 2.2: A hierarchy of regulatory enforcement (Walshe 2003, p. 43)

The objective of this hierarchy of regulatory enforcement is to give the regulator a wide range of interventions that can be used responsively to meet the needs and behaviour of the regulated institutions. The interventions at the bottom of the pyramid are usually the most often used for granting greater autonomy and the least intervention. Moving up the pyramid, the interventions become more serious as it involves much time and resources to the regulatory body and the regulated institution. At the apex of the pyramid are the “nuclear interventions” that involve in the closure or removal of licence in the most serious cases of poor performance (Walshe, 2003, p. 43). With responsive regulation, it is argued the better is the enforcement capacity in achieving regulatory compliance (Walshe, 2003; Washe & Boyd, 2007; Braithwaite, 2011).

Indeed, beyond these regulatory mechanisms, regulators also anticipate the challenges in the implementation process. Designing a good regulating regime on paper is one thing but the implementation and enforcement capacity is another matter. Regulatory implementation not only involves a complex set of assessment strategies but equally

important is the political will (Walt, 1998; Saltman & Busse, 2002; Walshe, 2003). There is a tendency for politicians to interfere in the regulatory process and may reassert their control over the regulators. Although in theory some autonomy and freedom from political interference are necessary, in reality, the implementation and enforcement capacity remains a huge challenge especially when faced with the regulatory agents, which are not only influential but equally powerful regulated organisations (Walshe, 2003; Laffont & Martimort, 2009).

## **2.7 State Regulatory Intervention**

The rationale for state regulatory intervention has often drawn controversy and little consensus have been derived among researchers worldwide. Although some proponents supported state regulatory intervention, others have criticized any active role of the state “as self-serving and unacceptable” (Saltman & Busse, 2002, p.10). The state is expected to play a lesser dominant role capacity and provides steering responsibility in regulating the health care sector (Saltman & Ferrousier-Davis, 2000; WHO, 2000). DeBakey (2006) argues that the crucial matter, which appears contentious is the government’s role, especially in the provision and funding, and regulating the health care services. Critics of government regulatory control and advocates for healthcare market reform assert that extensive involvement of the state in healthcare will result in more undesired consequences among other complex bureaucracies, gross inefficiencies and inferior unsatisfactory services (Hamowy, 2001; DeBakey, 2006). Whilst advocates for state intervention assert that regulatory control is seen as necessary in view of market failure. Government control is seen as the best alternative to improve not only cost-effectiveness but equitable access to quality health care services (Baldwin et al.1998; Saltman et al. 1998; Mongan & Lee, 2005; Morris et al. 2012; Santerre & Neun, 2013; Folland et al. 2013; Mauro, 2015).

Nevertheless, the application of the general approach of regulation on the healthcare system is indeed a complex process (Saltman & Busse, 2002). Health care with its specific characteristics as a social good, externalities, asymmetric information and uncertainty require special attention (Morris et al. 2012; Folland et al. 2013; Santerre & Neun, 2013). Many of the conditions of market failure are prevalent in health care sector. For instance there are often monopolistic suppliers with large hospital networks or medical groups, and monopsonistic purchasers of big health plans and health insurers. Invariably both groups will attempt to use their market power to gain competitive advantage at the expense of the society (Walshe 2003, p.22-23). Hence the state regulatory role in the health sector is to achieve the specific objectives such as accessibility, equity and quality care in the health systems (Walshe, 2003; Leatherman & Sutherland, 2007; Braithwaite, 2011; Morris et al. 2012; Folland et al. 2013).

Likewise, Braithwaite (2011) argues that regulation of quality care is complex as it requires an inclusive strategies involving all stakeholders' commitments and participations to ensure regulatory compliance. These mechanisms of regulation encompass a wider scope of activities of tools and strategies, which are complex and multifaceted. Similarly, the health sector is equally complex with its multidisciplinary services. The constantly evolving modern medical technology and the multidisciplinary nature of health services to the society are evidence. Therefore, any attempt to integrate these two complex entities of specific tools and strategies into a distinctive regulatory package in health care is a huge challenge (Leatherman & Sutherland, 2007; Braithwaite, 2011; Folland et al. 2013).

In the health sector, just like other service sectors, the state would normally "settle for reasonable approximations and imperfect solutions, knowing that even these will be hard

to implement and sustain over time” (Saltman & Brusse, 2002, p.13). However, health sector regulations can be seen from two perspectives, which can be expressed as “policy objectives” and “managerial mechanisms” (Saltman & Brusse, 2002, p.13). Each perspective has its own specific functions but each need to complement the other to achieve the overall health objectives. Invariably, state regulatory intervention is to achieve the core social and economic policy objectives as illustrated in Table 2.2. This among others includes “equity and justice, social cohesion, economic efficiency, health safety, informed citizen, and individual choice” (Saltman & Busse, 2002, p.14).

Table 2.2: Social and Economic Policy Objectives (Saltman & Busse 2002, p.14)

Equity and justice: to provide equitable and need based access to health care for the whole population, including the poor, rural, elderly, disabled and other vulnerable groups.
Social cohesion: to provide health care through a national health care service or to install a social health insurance system.
Economic efficiency: to contain aggregate health expenditures within financially sustainable boundaries.
Health and safety: to protect workers, to ensure water safety and to monitor food hygiene.
Informed and educated citizens: to educate citizens about clinical services, pharmaceuticals, and healthy behavior.
Individual choice: to ensure choice of provider, and in some cases insurer, as much as possible within the limits of the other objectives.

Whereas, the aspect of health sector managerial mechanism is primarily focused on precise regulatory mechanisms, which policy makers intend to achieve as illustrated in Table 2.3.

Table 2.3: Health Sector Management Mechanism (Saltman & Busse, 2002, p.15)

Regulating quality and effectiveness: assessing cost-effectiveness of clinical interventions; training health professionals; accrediting providers.
Regulating patient access: gate-keeping; co-payments; general practitioner lists; rules for subscriber choice among third-party payers; tax policy; tax subsidies for subscriber choice among third-party payers; tax policy; tax subsidies.
Regulating provider behavior: transforming hospitals into public firms; regulating capital borrowing by hospitals; rationalizing hospital and primary care/home care interactions.
Regulating payers: setting rules for contracting; constructing planned market for hospital services; introducing case-based provider payment systems (eg. diagnostic-related groups); companies; retrospective risk based adjustment of sickness fund revenues.
Regulating pharmaceuticals: generic substitution; reference prices; profit controls; basket based pricing; positives and negative lists.
Regulating physicians: setting salary and reimbursement levels; licensing requirements; setting malpractice insurance coverage.

The objective of this mechanism is on the management of both human and material resources efficiently and effectively. This encompasses regulating equitable access to quality care, providers' behaviour, doctors' professional fees, pharmaceuticals products and services. The management dimension of regulation normally comes under the jurisdiction of the Health Ministry and other Social Committees in Parliament, including matters listed in Table 2.2 (Saltman & Busse, 2002, p.14). Even though the objectives of policy and management mechanism may appear different conceptually, the two dimensions are crucial for an effective and sustainable regulatory framework in the health sector (Saltman & Busse, 2002).

With the rapid growth of regulations, policymakers are also increasingly concerned over the effectiveness, or the impact of the regulatory reform initiatives as to whether the intended or desired objectives have been achieved (Hampton, 2005; Sparredoom, 2009; Mauro, 2015). However, empirical research on how these regulatory approaches work

and the impact of regulation on organizational performance has remained scarce (Walshe & Shortell, 2004; Walshe & Boyd, 2007; Sparredoom, 2009; Mauro, 2015).

## **2.8 The Impact of Regulation**

Most of the studies done on the impact of regulatory intervention focused on the prospective evaluation of the proposed regulatory changes (Kirkpatrick & Parker, 2004; Walshe & Boyd, 2007). While regulatory impact assessments based primarily on quantitative methodologies have been carried in terms of costs and benefits analysis, its findings are subject to challenges. These critics are skeptical on the methodologies deployed and the assumptions about regulated organisations' behavior are founded on economic theory. Further, prospective regulatory impact studies are seldom followed after regulatory implementation (Walshe & Boyd, 2007; Sparredoom, 2009).

Invariably, the assessment of the impact of regulation often encounter the difficulties in terms of methodology used as regulatory compliance are generally implemented across the board to all regulated organisations (Sparredoom, 2009). However, there are many other factors influencing the behaviour of these regulated organisations. Likewise, Walshe and Boyd (2007) argue that impact evaluations are invariably conducted pre and post regulatory implementation, or evaluation of chosen characteristics of compliance with regulations, undertaken as regulations are introduced. In this context, when the intended effects and desired objectives to be achieved in the regulatory intervention are identified explicitly, it is possible to assess the assumptions to particular changes in the behavior and compliance of regulated organisations.

The impact of regulation is often seen as the outcome of the bilateral interactions of the regulatory authority and the each regulated organization. Regulators are empowered with

authority and influence over regulated organization, however, such bilateral interactions with most regulated organisations are often limited. Their effect on regulatees is seen as a result of direction, detection or measurement, and enforcement capacity as illustrated in Table 2.4 (Walshe & Boyd, 2007, p. 29).

Table 2.4: The Potential Impact of Regulatory Regimes (Walshe & Boyd 2007, p. 29)

Direction	Regulated organisations make changes in response to system-level regulatory interventions, such as the setting of standards, or the publication by the regulator of reports on particular issues or themes. They do so without directly anticipating any immediate action by the regulator to assess their performance or seek compliance.
Detection or measurement	Regulated organisations make changes in response to the measurement of their performance. They may do so prospectively, aiming to improve their performance before it is measured, through data collection/monitoring or through an inspection or visit. They may also do so retrospectively, responding to the results of measurement interventions.
Enforcement	Regulated organisations make changes in response to specific enforcement actions by the regulator, such as the publication of reports, the imposition of fines or penalties, or the prospect of further regulatory intervention such as a follow-up visit or inspection.

In this context, regulatory directives such as the issuing of minimum standards of compliance and publishing regulator's report on inspections may be effective through self compliance by regulated organisations (Walshe & Boyd, 2007; Braithwaite, 2011). In addition, Walshe and Boyd (2007, p. 30) argue that the "effectiveness of regulation" can be examined in terms of the nature of the changes brought about after the regulatory intervention. One such dimension is to categorise the impact into three specific areas;

- structure,
- process,
- outcome.

Under the structure, the organisation as a whole is examined as to whether structural changes have occurred. Organisational structural changes, for instance new

transformation of leadership, or new organisational management takeover arrangements may be the easiest to evaluate. However, their contributions to organisational performance may not be easy to assess. Process changes in organisations such as implementation of better service delivery, and monitoring processes may not be difficult to evaluate. However changes in organisational outcomes, meeting clientele expectation and satisfaction, improved quality service performance and cost containment may be most closely connected to the desired objectives of the regulation. But in reality, measurement may be more challenging (Walshe & Boyd, 2007; Sparredoom, 2009).

Alternatively, another important dimension to analyse the impact of regulatory intervention is to examine the intended and unintended effects of regulation in terms of “their likely positive and negative effects on organization performance or behaviour” as illustrated in Table 2.5 (Walshe & Boyd, 2007, p. 30).

Table 2.5: Positive and Negative Impacts of Regulation (Walshe & Boyd, 2007, p.30)

Positive effects	Negative effects
<ul style="list-style-type: none"> <li>• Specific changes and improvements in services resulting from regulatory attention;</li> <li>• Causing organisational reflection and comparison with regulatory standards and with the performance of others;</li> <li>• Giving important or longer term issues great organisational priority than they would otherwise receive;</li> <li>• Providing leverage for change for groups or individuals within regulated organisations;</li> <li>• Driving continuing improvement as regulatory standards are continually updated and improved.</li> </ul>	<ul style="list-style-type: none"> <li>• Temporary rather than sustained performance improvement, which disappears after regulatory intervention;</li> <li>• Pointless conformance behaviors in which things are done solely to satisfy regulators which have little or no value for service users or the organization;</li> <li>• Defensive or minimal compliance, in which standards effectively act as a limit on rather than a stimulus for improvement.</li> <li>• Creative compliance, in which organisations appear to comply with regulatory requirements by making superficial changes;</li> <li>• Prevention of innovation or improvement, in which regulatory standards discourage or prevent change;</li> <li>• Distortion of organisational priorities, as organisations respond to issues raised by regulators instead of dealing with internally identified issues;</li> <li>• Opportunity costs, as organisations invest considerable resources, particularly managerial time, in interacting with the regulator</li> </ul>

The manifestation of positive effects are observed when distinct changes and performance improvements in service delivery resulted from the implementation of regulations. Besides, this effectiveness is evident resulting in organisational change and comparison with minimum standards mandated under the regulation, and also comparing with the performance of other regulated organisations. Similarly, giving importance to regulatory compliance on a long term basis and driving continuous improvement initiatives in regulated organisations have positive impacts (Walshe 2003; Walshe & Boyd 2007).

While on the other hand, negative effects can be seen in regulatees' resistance as changes are temporarily, rather than sustained performance improvement which tend to disappear

after regulatory inspection (Walshe & Boyd, 2007, p. 30). This is evident with the non conformance behaviors of the regulatees, which actions are seen to be done minimally merely to satisfy the requirements of the regulators, which ultimately have least added value for healthcare consumers (Walshe, 2003; Walshe & Boyd, 2007). Unintended effects can also be seen in defensive or minimal compliance in which standards effectively act as a limit rather than an impetus for improvement. Further negative effects can be manifested in “creative compliance” (Walshe & Boyd, 2007, p. 30) in which regulatees seem to conform with regulatory requirements by making superficial mock up and changes. Invariably, there is distortion of organisational priorities. These regulatees have a tendency to respond to issues raised by regulators during inspections instead of being pro-active dealing with outstanding issues within the organisations such as equitable access to quality care.

## **2.9 Review of Regulatory Experiences**

Based on the preceding in depth discussions on the conceptual and theoretical perspectives of regulation, it would be pertinent to review some of the regulatory experiences in both the developing and developed countries. Comparison of studies done on how regulation at work in these countries provides a further insight into the impact of regulatory reform initiatives in the health sector which is relevant to this study.

### **2.9.1 Regulatory Experiences in Developing Countries**

There has been limited evidence from developing countries of research done on regulation in the private health sector in comparison with industrialised and developed countries, where a substantial amount of research had been done (Bloom & Standing, 2001; Mills et al. 2002; Kirkpatrick & Parker, 2004; WHO, 2010a; 2010b; Bennett et al. 2014). As discussed earlier in Chapter 1, most of the literatures on regulations are from developed

countries with history of strong institutions, judicial systems, professional bodies and civil societies playing significant roles in the regulating the health care sector (Peters & Muraleedharan, 2008; Akhtar, 2011; Bloom et al. 2014a). In contrast, many developing countries do not have such similar historical background but attempt to pursue universal healthcare coverage. Despite the rapid evolution of private health care markets in the developing countries over the last two to three decades, support for regulatory institutions has lagged behind (Bennett et al. 2014; Bloom et al. 2014a). State institutions are perceived to be weak with limited capacity of regulatory enforcement. The lack of resources and information to the state further accentuate the problems of regulating the complex health sector effectively with potential risk of regulatory capture and rent seeking. This phenomenon is prevalent in most developing countries across Asia, Asia-Pacific, Africa, Latin American and Caribbean communities (Zeribi & Marquez, 2005; Abdullahi et al. 2012; Barnett & Hort, 2013; Bennett et al. 2014; Bloom et al. 2014a).

Evidence gathered so far indicated that unregulated health markets can lead to unintended outcomes. The unconstrained spiralling cost, inequitable access, and suboptimal care have affected the vast majority of the population consisting of the poor and marginalized groups in these countries (Peters & Muraleedharan, 2008; Tung & Bennett, 2014; Bennett et al. 2014; Bloom et al. 2014a). The private out-of-pocket payment (OPP) is significantly high and has poverty impact (Meyer et al. 2013). In this context, Van Doorslaer et al. (2007) cited the huge catastrophic private expenditure for health care in Asia undermining equitable access and quality care. Likewise, Abdullahi et al. (2012, p.1) argue that “the growing concern that health care provided in the private sector is not always of high technical quality”.

Hongoro and Kumaranayake (2000) argue that regulations in the developing countries is strikingly different to that of the developed countries. Although the study in 2000 seems outdated with the present moment, it is relevant as it suggests that the regulatory control to influence compliance in the private health sector has not been effective. Utilising stakeholders' perception interviews from health providers in Zimbabwe, the study concluded that there were several factors hampering the effectiveness of the regulations. There were agency problems and asymmetric information especially on basic regulations between the public institutions and private health care providers. The implementation and enforcement of regulations had been weak. The regulators did not have the resources in terms of manpower and financial capability to monitor and enforce the regulations (Hongoro & Kumaranayake, 2000; Akhtar, 2011; Bennett et al. 2014). Besides, there were evidence of opportunistic practices among private providers including self referral practices, and incidents of fraud in health insurance claims. The employment of unregistered healthcare professionals further exacerbates the problems in private health sector. The low public awareness of their rights and the lack of grievance mechanism had affected the effectiveness of the regulations (Hongoro & Kumaranayake, 2000; Akhtar, 2011; Bennett et al. 2014).

In concurrence, Nik Rosnah (2002) cited the findings of Soderlund and Tangcharoensatien (2000) whereby in most developing countries there are merely "paper" regulations in the form of legislative efforts made to regulate the private health sector, but unfortunately do not have the political will to implement these regulations (Soderlund & Tangcharoensatien, 2000, p.347). Often the form of regulation is similar between countries notwithstanding having widely diverged social, economic, and health sectors. This suggests that these regulations come from a common legislative template of "copy and paste" into the local environment without understanding the background of the

health sector concerned. Further, it lacked the contextual fit and much of this regulation failed to be enforced. For instance, for most sub-Saharan Africa States, the regulation failed to address the fundamental issue of what public need that is for greater accessibility to health care, and not better quality care by less accessible limited group of health professionals (Wireko & Beland, 2013).

There were several other factors affecting the effectiveness of regulations. Major asymmetric information was evident between the regulatory agencies and the private health providers. These authors (Hongoro & Kumaranayake, 2000; Soderlund & Tangcharoensatien, 2000) contend that most developing countries are in the pre-regulatory stage for half of a century ago, and some health ministries do not even have the capacity to enforce health sector regulation. In this context, in poorer developing countries “regulatory capture” is said to be prevalent where state institutions’ enforcement capacity are found to be weak (Soderlund & Tangcharoensatien, 2000; Hongoro & Kumaranayake, 2000; Bloom et al. 2008; Bloom et al. 2014a). For instance, in the state of Andra Pradesh, India, majority of abortions are done in the private sector under the national legislation, yet the regulatory authority is found to be weak in its monitoring and enforcement capacity (Ensor & Dey, 2003). The problem of illegal early termination of pregnancies is a prevalent phenomenon in developing countries and a major health concern to policy makers. In Argentina, a study has called for the enforcement of the legal abortion public policy in the Province of Santa Fe in view of the rampant illegal termination of pregnancies (Ramos et al. 2014).

Elsewhere, studies in the Latin American and Caribbean countries (LAC) which include Argentina, Brazil, Chile, Colombia, Costa Rica, the Caribbean Community, the Dominican Republic, and Honduras revealed that efforts to regulate quality care in the

regional health sector encountered major challenges. Although regulatory framework had been established in LAC, the weak regulatory institutions and inadequate resources have hampered the monitoring and enforcement capacity to achieve equitable access and quality care (Zeribi & Marquez, 2005).

In the same note, Ensor and Weinzierl (2007) argue that many developing countries had limited capacity in regulatory intervention to ensure equitable access, affordability and quality healthcare. Numerous studies have indicated that the state has unrealistic goal and capacity to regulate using command and control strategies (Ensor & Weinzierl, 2007; Bloom et al. 2008; Bloom et al. 2014a). In China, the state regulates the prices of most medical services provided to patients through quasi-public institutions. As a result, the regulated pricings are often below their average cost. Subsequently, these medical providers compensate this with inflated billings, and excessive sales of medications (Liu et al. 2000). Further, a study by Xiao et al. (2013) examined how the introduction of regulation aim to contain excessive pharmaceutical costs in rural health facilities had different impacts on health systems performance between districts in China.

In the case of Lao People's Democratic Republic for instance, the state's public policy aims to encourage the supply and demand of essential drugs. While the objective seems feasible in the public sector but encountered challenges in enforcing compliance in the private health sector unless financial incentives are provided (Stenson et al. 1997; Ensor & Weinzierl, 2007). Similarly, a study in Indonesia found that it is impossible to regulate private pharmacies solely through regulations but require a much informal approach through financial incentives and consumers' participations (Ensor & Weinzierl, 2007). Birungi et al. (2001) highlight similar concerns in Uganda in relation to the lack of policy discourse between the state and private providers. A study in Pakistan indicates that even

after five years of the ban on the usage of the drug Imodium (for treatment of diarrhoea) for children aged five years and below, the majority of private medical practitioners continued prescribing it to young patients despite the illegality (Bhutta & Balchin, 1996; Ensor & Weinzierl, 2007). A more recent study by Zaidi et al. (2013) found major gaps in the accessibility to essential medicines in Pakistan driven by the weaknesses of the pharmaceutical regulation and the health care system.

In many countries, the regulation of medical staff has been entrusted to the professional bodies to ensure standards and professional integrity. However, there have been much criticisms targeted on self regulation of professional bodies which have self-vested interests. These professional bodies only attempt to discipline members of gross contravention when there is an official report lodged or through negative media reports. Besides, professional bodies have failed to monitor proactively the practice of these providers in developing countries (Affii, 2005; Ensor & Weinzierl, 2007). In comparison, the medical professional bodies in the European and Northern American countries are well established. Medical councils in most developing countries are unable to exert control over their members who are financially influential and politically well connected (WHO, 2006).

In Thailand, a study reveals that the medical council only investigated on its members who had transgressed the code on kidney transplantation when it was highlighted in the mass media (Teerawattananon et al. 2003). The result of the situation would inadvertently affect public confidence as the case reported in India where public's trust in the regulatory authority is at the lowest level (Ensor & Weinzierl, 2007). In the case of Malaysia, a study concluded in 2002 indicates that the Malaysian Medical Council (MMC) comprising solely of medical practitioners "has not established an inspectorate to carry out its

responsibilities by ensuring, for example, that those registered with the MMC are practicing in accordance with the conditions on their licensing certificates and that they practice competently” (Nik Rosnah, 2007, p. 50).

Likewise, Hort and Bloom (2013) argue that there are wide variations in government regulating the burgeoning private health sector in Asia-Pacific region. Both researchers assert that “current policies range from neglect or ‘laissez-faire’ to specific measures that encourage private sector engagement” (Hort & Bloom, 2013, p.5). They cite the case in Indonesia where 50 percent of the hospitals are owned by the private sector and yet the Health Ministry has not implemented any specific policy to regulate these private medical institutions (Hort & Bloom, 2013). Even though there is a public policy on dual practice for medical professionals from public institutions restricting to two locations for private practice, this regulation has been grossly violated (Hort et al. 2011).

A systematic review of comparative performance of private and public healthcare system in developing countries undertaken by Basu et al. (2012, p.1) suggest that private providers “more frequently violated medical standards of practice and had poorer patient outcomes, but had greater reported timeliness and hospitality to patients”. In addition, this systematic review “do not support the claim that the private sector is usually more efficient, accountable or medically effective than the public sector; however the public sector appears frequently to lack timeliness and hospitality towards patients” (Basu et al. 2012, p.1).

In 2014, Bloom, Henson and Peters argue that many developing countries encounter difficulties in creating new institutional arrangements for their health systems in view of the rising change and high public expectations. Efforts to replicate models from

developed countries have not been seen to be effective. It is acknowledged that there is little evidence for seeking effective institutional solutions to overcome the issue of asymmetric problems in the developing countries (Leonard et al. 2013). The process of building new regulatory arrangements will inevitably encounter huge challenges in view of the degree of the market structure and behavior in these countries (Bloom et al. 2014a).

Hence, the need for complementary measures have been advocated among others such as decentralisation of regulatory approaches, responsive regulation, accreditation, and advocating greater consumer awareness and institutions in assisting the regulatory control in the private health sector (Lagomarsino et al. 2009; Abdullahi et al. 2012; Bloom et al. 2014a). Besides, public-private collaboration in partnership has also been recommended (Lagomarsino et al. 2009; Roehrich et al. 2014).

In spite of the limited capacity in developing countries, the state has significant responsibility in the strategic management, and the governance of the national health system through regulatory approaches. This concurred with WHO and some researchers using the term “stewardship” to reflect the government’s responsibility in achieving its overall social and economic objectives (Saltman & Ferroussier-Davis, 2000; WHO, 2010a; 2010b; Abdullahi et al. 2012; Barnett & Hort, 2013).

### **2.9.2 Regulatory Experience in the Developed Countries**

In contrast to developing countries, the developed countries especially the European health systems are said to be undergoing major transformations to ensure equitable access and quality care together with the parallel development of regulations. Most European Union countries provide universal access to health care and continuously strived to meet to economic, political and social demands (O’Donnell, 2011; Jacobson, 2012; Roscam-

Abbing, 2012; 2015; Wiig et al. 2014; Saltman, 2015; Yaya & Danhouno, 2015). Due to the demographic and epidemiological trends, health inequalities and advancement in medical technology have triggered high escalating cost in developed countries (Yaya & Danhouno, 2015). The demand for health reforms have been evolving significantly to contain the escalating costs and at the same time providing high quality health care and services to the communities. Reforms have inevitably transformed the role of the government in health provision, financing and regulation. Recently most developed countries adopted several reforms to enhance the role of markets in their health systems (OECD, 2011; Yaya & Danhouno, 2015). Hence, discussions on the comparison and contrast of the different health systems in the following sub-sections include Germany, Netherlands, United Kingdom, Canada and the United States will provide a better insight to this study.

### **Germany**

Historically, state regulatory interventions in health care sector began in Europe with Germany establishing the first social insurance for healthcare (DeBakey, 2006). In fact it was the world's first national healthcare insurance program with the German state regulatory intervention in 1883 led by Chancellor Otto Edward von Bismarck. Subsequently, other European nations followed suit in establishing their respective national health insurance with some major configurations and variations in the healthcare sector (DeBakey, 2006; Quigley et al. 2008; O'Donnell, 2011; Jacobson, 2012; Roscam-Abbing, 2012; 2014; 2015; Wiig et al. 2014; Saltman, 2015).

### **The Netherlands**

Almost all northwest European countries such as Netherlands, Scandinavia and United Kingdom have traditionally adopted patients' choice of providers. Governments in these

countries responded to this development with legislations for patients' rights to influence accessibility to health care. For example in 2006 Netherlands enacted the Health Insurance Act, and the Act on Market Regulation in Health Care to provide a comprehensive health insurance coverage for the whole population. The main feature under the new health insurance system reform is the regulated competition between insurers and providers. The Dutch government placed greater focus on patients' choice in selecting the health insurers and medical providers for equitable access and quality care (Victoor et al. 2012; Roscam-Abbing, 2012; 2014; 2015; Wiig et al. 2014; Saltman, 2015).

### **United Kingdom**

In the United Kingdom (UK), the state regulatory intervention was seen with the passing of the National Insurance Act 1911, which provided health care accessibility to the British working classes against illness and unemployment (Walshe, 2003; Walshe & Boyd, 2007; Atun, 2015). It was the first contributing system of insurance and seen as an initial step towards universal health care until the enactment of the National Health Service Act of 1946. Subsequently, the National Health Service (NHS) was established as the country's public run healthcare system for all its citizens and legal migrants (WHO, 2010a; 2010b). NHS provides universal coverage to all its citizens (Walshe, 2003; Walshe & Boyd, 2007; Morris et al. 2012; Rea & Griffiths, 2015). Henceforth, there was a rapid development in the use of regulations in both the private and public sectors since the 1980s despite calls for deregulation. Notably, the Health Advisory Service (HAS) was established in 1996 as the first regulator of NHS following public inquiry into major adverse events and compromised care at Ely Hospital in Cardiff (Walshe, 2003; Perotin et al. 2013).

However the rapid growth of private health care in the 1980s and 1990s, and the fragmentation of providers with outdated regulations posed concerns to the policy makers. There was an urgent need for crucial regulatory reforms (Walshe, 2003; Perotin et al. 2013). Consequently, the private health and social care sector was reformed in 2000 following numerous adverse reports and problems highlighted (Health Select Committee 1999). With the enactment of the Care Standards Act 2000, a new national regulatory, the National Care Standards Commission (NSC) was established to regulate a wide range of health and social care providers (Walshe 2003). In the midst of a major regulatory reform in April 2002, the Department of Health announced the creation of two new “super-regulators”. A Commission for Healthcare Audit and Inspection to regulate all health provisions and a Commission for Social Care Inspection to regulate all social care (Department of Health, 2002). Subsequently, the focus on patients’ safety, incident reporting in primary care and significant event reviews are crucial in the current British medical practice (Rea & Griffiths, 2015). However, with the enactment of the “Health and Social Care Act 2012”, it is seen as a controversial attempt to promote privatisation through marketisation in the NHS (Kracher & Greer, 2015).

In spite of the controversial legislation in 2012, Atun (2015, p. 917) argues that “NHS is one of the proudest achievements in UK”. Further, the author asserts that the “NHS has not only played an important part in improving the health of the nation, but has provided to citizens and residents of UK financial protection during illness and sickness. The NHS provides value for money and value for many” (Atun 2015, p. 917).

## **Canada**

In Canada, the state played a remarkable role in the financing and provision of universal health coverage under the national public health insurance. In 1947, Saskatchewan

became the first province in Canada to implement hospital insurance program (Folland et al. 2013; Santerres & Neun, 2013; Marchildon, 2014). Subsequently, in 1956, the federal government proposed an open-ended equal cost sharing plan with the Canadian provinces, and in 1958, all provinces had implemented cost-sharing hospital coverage. Notwithstanding the unprecedented medical practitioners' protest and strikes, Saskatchewan implemented comprehensive universal medical coverage. On the same note, the federal government in 1965 offered another equal cost bearing arrangement with other provinces for comprehensive universal medical coverage. The Medical Care Act 1996 was implemented which provided cost-sharing for physician care (Folland et al. 2013; Santerres & Neun, 2013; Marchildon, 2014).

Since 1972, all Canadians were granted universal access to quality medical care and services irrespective of employment, health and financial status. In response to the spiraling healthcare cost and the calls to eradicate overcharging together with user fees, the Canadian Health Act of 1984 was subsequently enacted (Folland et al. 2013; Santerres & Neun, 2013). The major requirement of the Act is that hospital and medical practitioners' services be totally publicly financed. In addition, the Act explicitly forbids any of its citizens from purchasing from the private health sector a medical service which is available under the public health system. The state intervention aims to provide universal accessibility, equity and quality care to Canadians based on the model of public funding (Folland et al. 2013; Santerres & Neun, 2013; Marchildon, 2014).

### **United States of America**

However, state regulatory intervention in healthcare in the United States of America (US) is more complex and lagged far behind European countries for various factors. Historically, the development of medical professional and clinical training were not

regulated until the end of the 19<sup>th</sup> and early 20<sup>th</sup> centuries. State licensing examination boards for American physicians started in the 1870s and it was in 1898 when all states were regulated (DeBakery, 2006). In the beginning of the 20<sup>th</sup> century, it was reported that only 10% of practicing medical practitioners graduated from established medical faculties. It took another two decades before all new medical practitioners were from formal medical faculties arising from determined attempt from the American Medical Association and the Flexner Report in 1910 (Debakey, 2006).

Another significant factor cited for the much delayed state regulatory intervention in American healthcare system is the profit motivation, which is culturally embedded with commercialisation and entrepreneurship in the private sector (DeBakey, 2006; Folland et al 2013; Santerres & Neun, 2013). Perhaps the most important factor is “a lack of sense of community” in the United States (Hollingsworth, 1986, p.86), as compared with the European cultural concept of “social solidarity” (Shonick, 1995, p. 285-91).

In European countries, the health systems have been reported to be evolving and departing from control of professionals, to different types of command-and-control, and efforts to standardise performance and measurement of outcomes (Saltman et al. 1998; Øvretveit, 2012). Traditionally, the medical professionals had predominant role in the health system in the most developed countries since the early era of the last century (Aune, 1999; Saltman & Busse, 2002). This control scenario changed significantly post World War II where the states began putting great emphasis in the accessibility and the provision of better health services to the population. Consequently, this led to the struggle for controlling the health system between the medical practitioners, businessmen, insurers and the government (Saltman & Busse, 2002).

Similarly, the battle for control of the health care system was also evident in the United States over the decades. The doctors and the insurance corporations had vehemently opposed any proposed compulsory health insurance legislation as the case in Canada (Santerre & Neun, 2013; Folland et al. 2013). It was not until 1965 when President Lyndon B. Johnson signed a historical legislation creating Medicare, which paved way for state regulatory intervention in healthcare activities for the first time in the United States (Debakey, 2006). In addition, it also paved way for the extended role of the state in the medical practice (Santerres & Neun, 2013; Shaw et al. 2014). Government insurance programs like Medicare and Medicaid provided coverage for the elderly, chronically ill, and the very poor groups.

However, the rapid rising cost of care has led to the enactment of the Health Maintenance Organization (HMO) Act 1973 as a cost containment measure (Walshe, 2003; Folland et al. 2013). The US has the largest and most expensive healthcare system in the world (Walshe, 2003). Prior to the enactment of the “Patient Protection and Affordable Care Act 2010” (PPACA), in 2009 approximately 17 percent of the population or 50 million Americans had no insurance protection for health care accessibility and had to depend on charity of healthcare providers. The exorbitant rising costs and inequitable access to quality care have been one of the major political issues confronting the US. Eventually, the U.S. Congress passed PPACA in March 2010 to focus on the uninsured for accessibility to health care services (Walshe, 2003; Folland et al. 2013; Santerres & Neun, 2013; Shaw et al. 2014).

Invariably, the governments in many developed countries played significant role and took control of many health insurance funds to achieve national health priorities. In spite of this state intervention, the medical professionals played an equally crucial role in limiting

the government's dominance over the health sector. Subsequently, the importance of equity in health care as well as economy emerged particularly in the 1980s, following the global ideological trend of privatisation (Saltman & Busse, 2002). Many states initiated a number of regulatory and financial initiatives under privatisation policy which aimed at improving equitable access to health services and cost containment. Subsequently, the health systems in the late 1980s were seen in the midst of trade off between the issues of accessibility and efficiency, and the states were seen to asserting dominance over their health systems (Shonick, 1995; Marmor, 2000).

This phenomenon was probably in line with the emergence of civil society and the challenging role of public administration at that time. Various forms of planned or regulated market mechanisms were considered as options by the health policy makers. Consequently, this led to the new health system with the objective of seeking a neutral platform between the strict command-and-control systems and the powerful competitive market on other hand (Saltman & Busse, 2002).

In spite of efforts diverting away from the command and control system, the important role of regulation remains intact. In fact, where these states reduced their provision role, they gave significant resources to contractual relation between purchasers and providers. In cases where medical practitioners had been granted financial inducement to be more efficient, in return the states seek better key performance indicators of health care outcome. This regulatory intervention was done to safeguard the emphasis on financial constraints where patient's safety may be compromised (Simchen et al. 1998; Roehr, 2012). The regulatory control was said to have implications on the medical profession too. For example, a dichotomy could be seen among the medical practitioners, i.e. those

who preferred managerial roles in the dynamic health care systems and those who preferred to retain as professional clinicians (Saltman & Busse, 2002).

Notwithstanding the regulatory intervention, the objectives of pursuing the best outcome and quality initiatives remained to a large extent unfulfilled (Mauro, 2015). Besides, it does not appear to have the capacity of coping with the uncertainty arising from the health care system. More so, every quality measurement is prone to criticisms over the reliability and validity. Subsequently, many medical institutions in Europe for example, countered with the dissemination of information including mortality data when challenged. Further, criticisms were also extended over to the appropriate measurement of customer satisfaction survey in accessing the delivery of healthcare services (Morris et al. 2012; Øvretveit, 2012; Rodney & Hill, 2014).

As discussed in the preceding sub-sections in this chapter, the development of health sector regulation can be seen as not a simple straight forward progression “but rather a constant mix and remixing of regulatory tools that have accumulated throughout the years of a country health system’s development” (Chinitz, 2002, p.62). The regulatory intervention is a continuing process of reacting to the development of new challenges in the regulated sector. For instance, in spite of the impact of the unprecedented European financial crisis in 2008, the health care systems remained strong and intact (Saltman, 2015).

Saltman (2015) further reiterates that while the diversity of the European health systems are not seen to be converging towards a common regulatory model, but have been seen to be sharing new innovations in regulatory initiatives while preserving their own cultural embeddedness and solidarity within the European Union. In contrast, the case of US

insurance-based health system has resulted in escalating and exorbitant cost of care, inadequate access to health insurance and health services for Americans, which led to the unprecedented enactment of the “Patient Protection and Affordable Care Act 2010” (Keegan, 2013; Shaw et al. 2014). This controversial legislation aims to address the critical and fundamental complexities within the US health policy since the 1960s (Bagley & Levy, 2014; Shaw et al. 2014; Rao & Hellander, 2014).

Having discussed on the impact of the regulation and review of the regulatory experiences in the developing and developed countries, the following sub-sections will focus on fundamental issues of accessibility, equity and quality care in the health sector.

## **2.10 Accessibility in Health Care**

Accessibility to health care facilities and services has been a complex and major concern to policy makers (Morgan & Lee, 2005; Abdullahi et al. 2012; Karamitri et al. 2013; Bloom et al. 2014a; Neutens, 2015). Although there are extensive debates on the issue of accessibility to health care, there appears little consensus on the definition (Oliver & Mossialos, 2004; WHO 2000; 2010a; 2010b). Likewise, World Health Organisation (WHO) defines accessibility to health care services from four broad perspectives such as availability, accessibility, affordability and acceptability (WHO, 2001a). The availability of services indicates the current range of facilities and services offered, in relation to the demand and needs of the community. Meanwhile, accessibility is defined where effective care can be delivered to each individual person in the society (WHO, 2001b). Affordability denotes the financial capacity of an individual as to whether he is able to pay for his financial needs, whereas acceptability concerns matters involving social, and discrimination of gender in the community (WHO, 2001b).

Despite the extensive debates by health care advocates on the definition, the measurement of health care accessibility is equally challenging and complex (Chee & Wong, 2007). Both authors argue that “even though morbidity indicators are used to reflect the health needs of the population, it is difficult to ascertain whether the utilisation of services is adequate to meet morbidity levels. Utilisation rates are therefore used as indicators of demand rather than need or access” (Chee & Wong, 2007, p. 137).

Further, Chee and Wong (2007) argue that the accessibility to health care is based on the four broad perspectives propounded by the WHO (2001a; 2001b). Accessibility involves not only the awareness of health care needs, facilities and services provided, but also the obstacles in seeking such services. A crucial prerequisite to accessibility is the availability of healthcare facilities and services provided. The financial capacity of the individuals utilising the health care establishment and services determines the affordability. More often than not this involves an out-of-pocket payment to obtain such services. The poor and marginalised groups may be denied the accessibility to health care (Patouillard et al. 2007; Berendes et al. 2011; Tung & Bennett, 2014). Even though some services are at times provided free of charge, there is an opportunity cost involved. This is in relation to cost for travelling to the health institutions and may even suffer financial loss of income due to the absence from work (Chee & Wong, 2007).

The expectations of the health consumer are high. The acceptability of services provided must be able to satisfy their expectations. In addition, acceptability also “implies to the extent to which they are perceived as to be of good quality, convenient and amenable to use, effective in alleviating pain, or in preventing and treating disease, illness, and injury as well as being culturally appropriate” (Chee & Wong, 2007, p. 137). Accessibility has often been associated with the equity concept. Invariably, state intervention in health

sector is justified on the ground for equity. In practice, the poor and marginalised groups are often deprived of accessibility to quality health care services. The beneficiaries of the health care services provided are seen mainly to a selective rich segment of the population. Further, this rich-poor disparity is markedly evident for tertiary and secondary care compared to primary care (Chee & Wong, 2007; Meyer et al. 2013; Tung & Bennett, 2014).

A more recent study by Neutens (2015) asserts that the concept of accessibility “involves five dimensions including affordability (i.e. cost of health care utilization), acceptability (i.e. health service compliance and satisfaction), availability (i.e. adequacy of health service provision), geographic accessibility (i.e. travel impedance between patients and providers) and accommodation (i.e. appropriateness and suitability of health services)” (Neutens, 2015, p. 14).

## **2.11 Equity in Health Care**

The World Health Organization (WHO) posits that one fundamental prerequisites to the approach of primary health care is the concept of equity. From the WHO’s perspective, equity is defined as equal access to available care for equal need, equal utilisation for equal need and equal quality of care for all (WHO, 2010a; 2010b). It not only denotes fairness but justice as well (Durairaj, 2007; Rodney & Hill, 2014). Equity in health suggests that equal opportunity is provided for individuals to seek the best prospect for quality care. In practice, no one should be deprived from attaining this prospect (Whitehead et al. 2001; Karamitri et al. 2013; Rodney & Hill, 2014). Hence, equity can be seen from two dimensions in the provision of health services i.e. horizontal and vertical equity. For instance, an individual seeking equal treatment for equal need is based on the perspective of horizontal equity. On the other hand, vertical equity suggests that

individuals with unequal needs should be given treatment based on their differential diagnosis needs (Zere et al. 2007; Morris et al. 2012; Santerres & Neun, 2013; Terraneo, 2015).

While there are several definitions on equity, all of which suggest that accessibility to health services is need based. Thus the emphasis for regulatory intervention is to enable the community to have an equitable access to basic health services according to the need and not based on the financial capacity. Hence, equity in access to health services may be argued as equitable access for equal needs (Meyer et al. 2013; Rodney & Hill, 2014; Terraneo, 2015). In this respect, the disadvantaged communities may invariably experience multiple inequities and may not benefit the desired outcomes (Durairaj, 2007; Karamitri et al. 2013; Rodney & Hill, 2014; Terraneo, 2015).

## **2.12 Quality in Health Care**

The concept of quality care has posed many different interpretations. Although, there seems to be an understanding of the concept, there is no consensus on how the definition of quality of care would be accepted by all health care providers (Quigley et al. 2008; Roscam Abbing, 2012; Wiig et al. 2014; Renedo & Marston, 2015). The quality of care may be defined in the light of the provider's technical standards and the patients' expectations (Roscam Abbing, 2012; Wiig et al. 2014; Renedo & Marston, 2015).

Quality care refers to “the quality of technical care consists of the application of medical science and technology in a way that maximises its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favourable balance of risks and benefits” (Donabedian, 1980, p.5). Nonetheless, from the physicians' perspective, the

concept of quality in patient care is synonym to the best clinical outcome practice. This optimum clinical outcome means lower mortality and better neurological function for the patients (Teasdale, 2008; Barnett & Hort, 2013; Renedo & Marston, 2015).

From the patients' perspective, it is their wish for the best clinical outcome, experiencing the delivery of services, and meeting their expectations are equally significant (Bakar et al. 2008; Teasdale, 2008; Wiig et al. 2014; Renedo & Marston, 2015). Besides, the quality of performance of the underlying systems, structures and processes that support the provision of care to individuals has clear relevance to organisations and communities (Teasdale, 2008). In this respect, there are six main aspects or dimensions within the overall concept of quality (Lohr & Schroeder, 1990). These aspects are patient's safety, effectiveness, patient centre, timeliness, efficiency and equity. These dimensions have become widely accepted and influential (Teasdale, 2008; Barnett & Hort 2013; Wiig et al. 2014; Rea & Griffiths, 2015; Renedo & Marston, 2015).

In regulating quality care, the government has a significant role in the collection and dissemination of information on performance of the health providers (Saltman & Brusse, 2002; WHO, 2010a; Straube, 2013). In view of the major problem of asymmetric information, the dissemination of information on performance is crucial to guide the health consumers and medical insurers to secure services from reputable medical institutions offering better quality of care and services. However, for the regulatory strategy to be successful, it has to rely largely on the availability of data provided (Gravelle & Sivey, 2010; Barnett & Hort, 2013).

In addition, there is also the issue of collaboration between the health facilities and the staff in the exercise of collection and data dissemination. In this context, acquiring

comparative data on hospitals and physicians' performance have not only been problematic, but equally controversial in which they failed to account for the medical bills especially in case mix (Edwards et al. 1998; Quigley et al. 2008; Roehr, 2012). Case mix often describes the billing system of the hospitals in treating the various patients categorised by diagnosis-related groups. On the other hand, the providers may feel intimidated to assist and may compromise in quality monitoring. As such this can undermine the efforts of regulators in monitoring quality care initiatives and patients' rights (Quigley et al. 2008; Roscam Abbing, 2012; Renedo & Marston, 2015).

The implementation of patients' rights in the legislation is to ensure safety, equitable access and quality of care (Saltman & Brusse, 2002; Abdullahi et al. 2012; Roscam Abbing, 2012; Rodney & Hill, 2014). While such provisions for patients' rights may create awareness, it may also encountered early skepticism. Patients' rights may be implemented more effectively if sanctions can be applied to healthcare facilities that do not meet up to the minimum standards (Roscam Abbing, 2012; 2014). These rights among others encompass the accessibility to professional care, emergency services, to be informed and consent, and to receive a copy of billing rates. Besides, patient grievance mechanism may increase the compliance with patients' right bills (Wiig et al. 2014). Implementation of patients' right bills may not be effective if they are "neither enforced by statute, externally regulated, nor, as yet, monitored in an official way" (Silver, 1997, p.213). In reality, the sanctions and the social cultural environment may to some extent have effects on the patients' rights to be implemented.

### **2.13 Theoretical Underpinnings**

The extensive literature from economics, political science, law and management have culminated in several theoretical perspectives on regulation for academic debates and

discourses. Some of these critical thoughts have explicitly or implicitly influenced the perception about the concept, purpose and theoretical perspective of regulation (Walshe & Boyd, 2007). Hence drawing from preceding literature review, further discussions on the theoretical underpinnings which incorporate theories such as the principal-agent theory, public choice theory, and the public interest theory are of relevant to this study. The application of these theories provides further insight on the impact of Act 586 on the private hospitals in Malaysia in achieving the intended national health objectives.

#### **2.13.1 Public Choice Theory**

This theory applies its rudimentary understanding on rationality and self interest to institutions and organizations based on neoclassical economics (Morris et al. 2012; Folland et al. 2013). It posits in the most simplistic manner that the relevant stakeholders in a particular sector would trade off in power, influence, and control. Regulation is often designed in a particular market environment eventually serving the interests of the regulated institutions. This idealist view has often drawn deep skepticism on the concept and the rationale for regulatory reforms. It argues that the stakeholder's group with the most influential interest in any regulatory reform is the regulated producers and providers or the institutions. This group tends to dominate the regulatory intervention for their own benefits over a period of time (Morris et al. 2012; Santerre & Neun, 2013).

In summary, these public choice theorists advocate for open market competition and usually is the choice over any regulatory controls. Further it asserts that problems of market failure will inevitably respond immediately rather than regulatory intervention. Besides, regulation would more likely lead to the hazard of regulatory capture and anti-competitive behaviors. This phenomenon is where the regulatory authority is unable to perform its function because of the political power of the influential providers (Laffont &

Martimort, 2009; Folland et al. 2013). Similarly, there is a hazard of the regulatory authority becoming an advocate for the regulated organisation's interests instead of asserting control of the regulatory authority. For instance, this may be seen in the form of market entry barrier and suppression of competition through the formation of cartels. Invariably these theorists are skeptical of regulation. They belong to the school of thought of regulatory capture and regulatory cycle. This theory has drawn severe criticisms that it is simplistic in assumptions pertaining to motivation and behavior without empirical evidence (Walshe & Boyd, 2007; Santerre & Neun, 2013).

### **2.13.2 Public Interest or Interest Group theory**

The public interest theory on the other hand posits a more neutral approach to regulatory reforms and takes into consideration the diverse interests groups' expectations with mutual adjustments and reconciliations. This ultimately shapes the regulatory system with the inclusiveness of the diverse interests groups such as the providers, organizations, consumers, payers and funders, professional organizations and others. Invariably, this theory assumes that in the interaction with the state, these diverse interests groups shall pursue their self-interests if decision of the state affect their well-being (Laffont & Martimort, 2009; Morris et al. 2012; Santerre & Neun, 2013).

In addition, these interest groups have the means to influence the public decision makers through various channels. One of which is through discreet monetary gratifications or corruptions. Besides, more pervasive are the hope for future employments for public officials and regulatory staff with the regulated organizations. Nevertheless, the development of personal relationships provides incentives for public officials to treat their industry stakeholders cordially. Finally, the industry can also operate discreetly through

key elected officials over the regulatory agency with political contributions and donations (Laffont & Martimort, 2009; Morris et al. 2012; Santerre & Neun, 2013).

Public interest theorists postulate that in spite the fact that regulation can be captured by powerful and influential groups, there is a mechanism for making regulation accountable to stakeholders in wider society. Invariably, it is through these regulatory processes that complex matters like standards, compliance and enforcement are fundamentally negotiated between these interest groups (Laffont & & Martimort, 2009; Walshe & Boyd, 2007 Morris et al. 2012; Santerre & Neun, 2013).

### **2.13.3 Principal Agent Theory**

This theory is concerned with the asymmetric and contractual relationship between one individual or party which is often referred to as the principal and the other commonly known as the agent. It is a situation whereby one party has to rely on the act of another in view of the asymmetric information. The agent is the party which is taking the action and the principal is the affected party (Walshe & Boyd, 2007; Poth & Selck, 2009; Morris et al. 2012; Santerre & Neun, 2013). Generally, the principal-agent relationship is about a situation in which the principal has full knowledge of his agent's motivations which may lead to actions that are contrary to the objectives of the principal especially in the health sector. The agent is often well informed and enjoyed informational advantage over the principal.

The concern is how the principals can protect themselves against opportunistic behaviour of the agents (Walshe & Boyd, 2007 Morris et al. 2012; Santerre & Neun, 2013). Under these circumstances the principal can design an incentive plan to induce the agent to act in favor of the principal (Walshe & Boyd, 2007; Poth & Selck, 2009; Morris et al. 2012;

Santerre & Neun, 2013). Hence the principal directs the agent's activities in some way either through a contractual relationship, or a legislative instrument (Arrow, 1963; 1985; Schneider & Mathios, 2006; Walshe & Boyd, 2007; Poth & Selck, 2009; Santerre & Neun, 2013)

A classical example of this principal-agent problem is the relationship between the doctor and patient (Schneider & Mathios, 2006; Poth & Selck, 2009; Nguyen, 2011; Morris et al. 2012; Folland et al. 2013). The well-informed doctor is perceived to be an agent acting on behalf of the patient who is the principal, in making decisions on what medical treatment and services to be purchased. In the event that the doctors made decisions pursuant to the preferences of the patients and unaffected by self-interests, then they would be considered as perfect agents. However, the extensive theoretical and empirical studies have indicated that doctors do not act as perfect agents (Evans, 1974; McGuire, 2001; Morris et al. 2012; Folland et al. 2013; Santerre & Neun, 2013).

Precisely, a previous study done by Evans (1974) hypothesizes the theory of supplier-induced demand in the doctor and patient relationship. The theory is sometimes referred to as provider-induced demand whereby the doctors engaged in some form of persuasive activity to influence the patients' demand according to the doctors' self-interests (McGuire, 2001; Morris et al. 2012). In 2012, Morris and colleagues cited a comprehensive review of evidence by McGuire (2001) that doctors do response to financial incentives, and they appear to influence demand partly in response to self interests.

This relationship is sometimes known as the agency theory and is also used to describe and analyze the relationship between the regulatory agency authorities and the regulated organizations (Schneider & Mathios, 2006; Morris et al. 2012; Folland et al. 2013;

Santerre & Neun, 2013). The main concern under this theory is how to tackle the asymmetry of relationship. While the regulator as the principal has certain power, the regulated organization as agent usually is well informed, has more information and the resources to invest in the efforts to secure advantage in the relationship. Generally, the principal and agent have divergent objectives and conflict of interests is inevitable. Hence, the agency theory helps to illustrate the relationship despite the regulators limited resources, are able to draft systems of regulation to overcome the principal-agent problem (Walshe & Boyd, 2007; Poth & Selck, 2009; Morris et al. 2012; Folland et al. 2013; Santerre & Neun, 2013).

In the health sector, Arrow (1963) cites the relationship between the state regulatory authority and the medical care providers, which further exemplifies the principal agent theory almost perfectly. The state as a principal has a responsibility to ensure the accessibility of healthcare services to all segments of its population (Straube, 2013; Roscam Abbing, 2015). Nevertheless, a divergent of objectives between the state and the private sector with entrepreneurial healthcare providers can be anticipated (Schneider & Mathios, 2006; Morris et al. 2012; Folland et al. 2013; Bloom et al. 2014b). In this context, the state desired objectives are toward affordability, equitable access and quality healthcare service provisions, while the private entrepreneurial healthcare providers' objectives are "inevitably seek to segment markets so as to exploit the profitable niches" (Saltman & Busse, 2002, p.5).

Against this aforementioned background, this research study will be using the three theories as the framework to examine the impact of the government regulatory instrument on the private hospitals in Malaysia as to whether the intended national health priorities

can be achieved. These three theories have their inherent strength and weaknesses as shown in Table 2.6.

Table 2.6: Strength & Weaknesses of Theories (Walshe & Boyd, 2007)

Theory	Strength	Weaknesses
Public Choice Theory	Advocates for open market competition and usually is the choice over any regulatory controls.	The idealist view has drawn severe criticisms. It is simplistic assumptions of behaviour without evidence.
Public Interest or Interest Group Theory	Take into consideration the diverse interests groups' demand and expectation with mutual adjustments in the regulatory policy making process.	Risk of Regulatory capture. Powerful and influential interest groups have the means to influence the regulators through discreet monetary gratifications or corruptions.
Principal Agency Theory	The theory helps to illustrate the relationship between the regulator as the principal and the regulated organization as agent. The principal despite limited resources, is able to design system of regulation to overcome the agency problem.	An unrealistic assumption that conflicting objectives between principal and agent could be resolved through incentives and measurement of outcome. Involved high transaction cost. Problem of adverse selection and moral hazard arising from information asymmetries.

#### 2.14 Conceptual Framework of the Study

Jabareen (2009) defines conceptual framework as a network that provide a comprehensive understanding of a phenomenon. The framework provides not only a causal or analytical setting but, rather, an interpretative approach to social reality. Nonetheless, the conceptual framework analysis has its limitations such as the fact that different researchers may have different perspectives of the same phenomenon. This may create different conceptual frameworks, and possible difficulties finding suitable texts and data. However, it offers some important advantages such as flexibility, capacity for modification, and understand phenomena rather than to predict them (Jabareen 2009).

Private health care is complex and several actors are involved in the health policy and regulatory enforcement process such as government agencies, managers and interest groups. In addition, it also includes professional bodies and health institutions such as hospitals (Walt, 1994; Walt et al. 2008; Gilson, 2014). Using the theoretical underpinnings, this study aims to examine the impact of the new legislation, the “Private Healthcare Facilities & Services Act 1998 (Act 586) and Regulations 2006” on the private hospitals in the Malaysia in achieving the national health objectives among others, the accessibility, equity, and quality care (Malaysia, 1993; 1996; 2001).

In addition, the other issues to be investigated in this research are how and why the regulatory authority under MOH (principal) employs regulation as an instrument to influence the compliance of the private hospitals (agents) in relation to its intended priorities in the private health sector as illustrated in Figure 2.3.

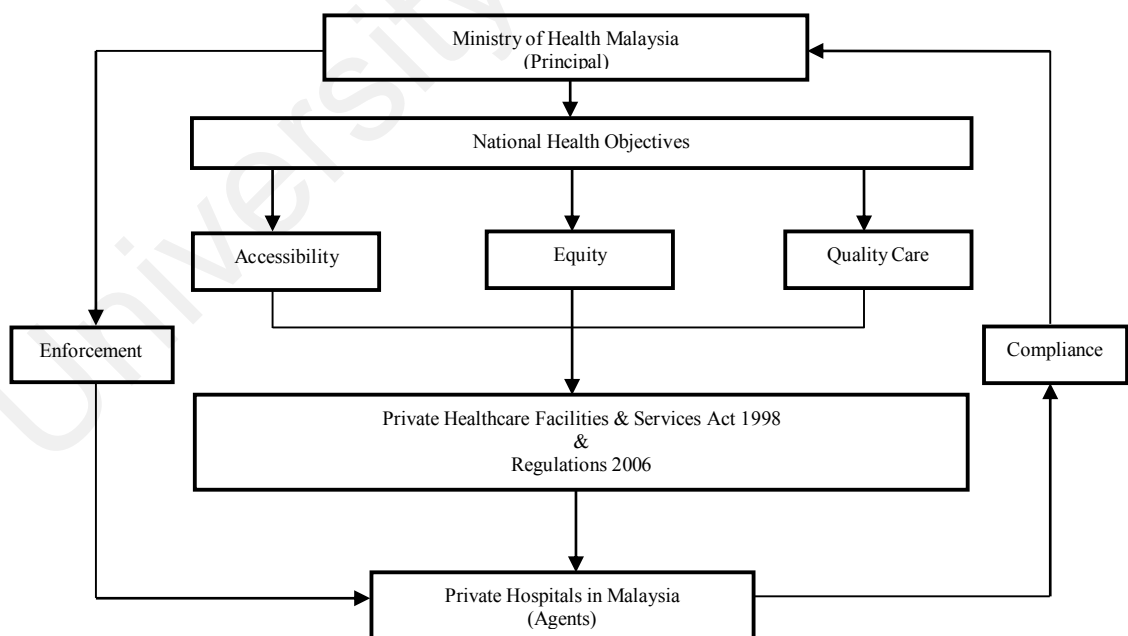


Figure 2.3 Conceptual Framework of the Study

At the same time, the study also examines the performance of the enforcement capacity under the MOH in regulating the private hospitals in terms of the mandatory licensing of facilities, compliance, approval and distribution of private medical hospitals nationwide. However, this study excludes the clinical governance and audit in the private hospitals as currently there is no provision under Act 586.

## **2.15 Concluding Remarks**

This chapter examines some crucial concepts and theories of regulation with specific reference to the health care sector which provides the foundation for analysis of this research study. In addition, the chapter aims for a better understanding of the context of policy, regulation, mechanisms and the justification for state intervention in regulatory reforms. The literature review provides the framework for analysing and examining the impact of the regulatory intervention on institutions which is relevant to this research study. In addition, the literature review also draws observations from some comparative studies of the regulatory experiences in both the developed and developing countries, which are of significant relevance to this research. Although there has been a rapid evolution of the private health sector in developing countries, support for the development of regulatory institutions has lagged behind, resulting in critical health care complexities of accessibility, equity and quality care. Whereas, in the developed countries especially the European countries, Canada and even the United States which have undergone major healthcare reforms, there is also a parallel development of regulations to ensure equitable access and quality care. In fact, many countries which have traditionally relied on the market in health care are making greater use of regulation and planning in the future health services. Having presented the literature review, the following Chapter 3 provides an overview of the research methodology used in the collection and analysis of data for this study.

## **CHAPTER 3 : RESEARCH METHODOLOGY**

### **3.1 Introduction**

This chapter discusses the research methodology employed in this study which encompasses the general design to the research process, from the theoretical framework to the collection and the analysis of data. The chapter commences with the discussion of the methodological approaches as to whether a positivist or naturalistic framework or a combination of mixed method approach is most appropriate to be utilised in this study. This methodological decision making process led to the choice of a qualitative study. It then describes the methods for data collection and the analysis process in particular the key stakeholders' interviews and discourses, which formed the core of the research methodology.

### **3.2 Methodology**

Research methodology is seen as a systematic approach to solve the research problem. While there are various methods and approaches available in social science studies, the nature of most researches need more than a single approach. Hence researchers should have the choice of methods to be used as it may provide better answer than a single method (Leedy & Ormrod, 2005; Silverman, 2010; Bryan, 2012; Braun & Clarke, 2013).

In seeking the understanding of process and outcome of a public policy, an important decision has to be made by a researcher prior to the onset of the study as to whether to use the naturalistic or positivist methodological framework. Each of these approaches has its origin and understanding from a different epistemology or knowledge based. Research analysts such as Lincoln and Guba (1985) posit that naturalistic studies are conducted in natural settings or entities because naturalistic ontology suggests that realities are wholes

and inseparable from their context. These researchers are of the opinion that knowledge is subjective and unique (Silverman, 2010; Bryan, 2012; Yin, 2012; Braun & Clarke, 2013).

On the other hand, from the positivist's perspectives, the process of inquiry is deductive and following established rules, and rigorous in providing explanations objectively. Data gathered are usually defined by a priori that will confirm or reject what has been deduced from the theory. This approach is closely associated with quantitative research methods, which commonly involves experimental or quasi-experimental research design (Lincoln & Guba, 1985; Leedy & Ormrod, 2005; Silverman, 2010; Bryan, 2012; Braun & Clarke, 2013).

On the contrary, naturalistic researcher tends to be inductive and does not utilise either a priori theory or variables. In fact theory and variables are expected to appear from the inquiry. Furthermore, naturalistic investigation is closely associated with qualitative methods which permit the study of relationships and their consequences (Lincoln & Guba, 1985; Leedy & Ormrod, 2005; Silverman, 2010; Bryan, 2012; Yin, 2012). According to Sofaer (2002), "health care is delivered in naturalistic settings and in a wide range of professional, organisational and community context. There has been, of course, very rapid change in health care" and qualitative method is the preferred choice (Sofaer, 2002, p.329).

Creswell (2014, p.183) argues that "qualitative methods demonstrate a different approach to scholarly inquiry than methods of quantitative research. Although the processes are similar, qualitative methods rely on text and image data, have unique steps in data analysis, and draw on diverse designs". On the same note, Braun and Clarke (2013, p.3)

suggests that “the most basic definition of qualitative research is it uses words as data collected and analysed them in all sorts of ways. Quantitative research, in contrast, uses numbers as data and analyses them using statistical techniques”.

Earlier on, Polkinghorne (2005) asserts that qualitative research is a generic term under which a variety of research methods that use language data are gathered. The author further asserts that “qualitative research is inquiry aimed at describing and clarifying human experience as it appears in people’s life. Qualitative data are gathered primarily in the form of spoken or written language rather than in the form of numbers” (Polkinghorne, 2005, p.137). Thus, the data obtained for study experience require the engagement of the first-person or self reports of participants’ own experiences. The choice of which methodology is most appropriate for this research was based on the aim of the study that is to examine the impact of the new legislation, “Private Healthcare Facilities & Services Act 1998 (Act 586) and Regulations 2006” on the private hospitals in the Malaysia. This objective strongly suggests the use of a methodological approach which could elicit the various key stakeholders’ experiences, and views on the public policy process and outcome of the implementation of the private health care legislation. Hence, qualitative approach was felt to be the most appropriate for this study as suggested by Gilson (2014).

“Policy analysis starts from the understanding that policy making is a process of continuing interaction among institutions (the structure and rules, which shape how decisions are made), interests (groups and individuals who stand to gain or lose from change) and ideas (including arguments and evidence). Such qualitative analysis is a legitimate area of academic inquiry and has practical importance for health system development” (Gilson, 2014, p. 3).

Nevertheless, some research analysts argue that currently the research field is less about the rigidity and dichotomies of qualitative versus quantitative methodologies, but instead the research practices have a mixed of the two methodologies (Tariq & Woodman, 2013; Creswell, 2014). Both qualitative and quantitative methodologies seem to represent the extreme ends on a continuum (Newman & Benz, 1998). Sometimes a study tends to be more qualitative than quantitative and vice versa. However, in 2014 Creswell suggests three research approaches such as (a) qualitative, (b) quantitative, and (c) mixed methods. He further reiterates that “mixed methods research resides in the middle of this continuum because it incorporates elements of both qualitative and quantitative approaches” (Creswell, 2014, p.3).

Based on this practice, a decision was also made in this study to incorporate quantitative approaches to obtain a more holistic understanding of the policy process, implementation and the impact of the new health legislation. In this context, several sources of secondary data were also extracted quantitatively to see the pattern of burgeoning development of private hospitals in Malaysia under a loosely regulated environment. These data were derived to enhance the reliability of the qualitative data collected through interviews and informal discourses.

This research study tends to be more qualitative than quantitative in the approach owing to the perspective the research is undertaking. Having decided on the qualitative approach, the next step is obviously to choose which qualitative method is most appropriate for the study. In this context, research analysts have cited several methods among others including case study, ethnography, history, ground theory, narrative and phenomenology (Stake, 1995; Yin, 1994; 2012; Silverman, 2010; Creswell, 2014). Yin (1994; 2003; 2012) states that the selection of an appropriate strategy is based on the type

of research question posed, the extent of control the investigator has over actual behaviour events, and the degree of focus on contemporary as opposed to historical events.

In addition, Creswell (2014) suggests that “a research problem is the problem or issue that lead to the need for a study. It can originate from many potential sources. It might spring from an experience researchers have had in their personal lives or workplaces. It may come from an extensive debate that has appeared in the literature. The literature may have a gap that needs to be addressed, alternative views that should be resolved, or a branch that needs to be studied. Further, the research problem might develop from policy debates in government or among top executives” (p.108).

Analyst such as Tesch (1990) advocates the use of case study approach when the objective of the research is to increase understanding. Particularly, “case studies are a designed of inquiry found in many fields, especially evaluation, in which the researcher develops an in depth analysis of a case, often a program, event, activity, process or one or more individuals. Cases are bounded by time and activity, and the researchers collect detailed information using a variety of data collection procedures over a sustained period of time” (Creswell, 2014, p.14). The advantage of qualitative survey is its ability to provide comprehensive textual descriptions of the behaviour and perception of the various actors on a research issue (Braun & Clake, 2013; Gilson, 2014). Even analyst such as Patton (2002) argues case study as “information rich and illuminative, that is, it offers useful manifestations of the phenomenon of interest” (p. 40).

On the same note, Polkinghorne (2005) asserts that “because the goal of qualitative research is enriching the understanding of an experience, it needs to select fertile exemplars of the experience for study. Such selections are purposeful and sort out; the selection should not be random or left to chance” (p. 140). He further reiterates “the purposive selection of data sources involves choosing people or documents from which the researcher can substantially learn about the experience” (Polkinghorne, 2005, p.140).

Case study is the strategic inquiry in which the researcher explores, in depth, a program, an event, an activity, a process, or one or more individuals (Stake, 1995). Based on this concept, it is felt that a case study approach was most appropriate to this research because it contributes to the understanding of the impact and implementation of health policy process.

Further, Yin (1994) argues that “case studies are the preferred strategy when ‘how’ or ‘why’ questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon with some real life context” (p.1). The use of case study will provide maximum advantage as it tries to answer the ‘what’, ‘how’ and ‘why’ questions regarding private health policy development and implementation of the regulations. Furthermore, Yin (1994) posits that “the distinctive need for case studies arises out of the desire to understand complex social phenomena” (p.1).

In this context, case study enables the investigation of the healthcare complexities and exploration of how time shapes the regulatory development in the private health care sector (Walt et al. 2008; Gilson, 2014). The unique strength of case study is its ability to deal with a full variety of evidence which includes interviews, observations, and documentation as illustrated in Table 3.1 (Yin, 1994; 2003).

Table 3.1: Strengths and Weaknesses of Five Sources of Evidence utilised in the Study  
(Yin, 2003, p. 86)

Source of Evidence	Strengths	Weakness
Documentation	stable—can be reviewed repeatedly unobtrusive—not created as a result of the case study exact—contains exact names, references, and details of an event broad coverage—long span of time, many events, and many settings	retrievability—can be low biased selectivity, if collection is incomplete reporting bias—reflects (unknown) bias of author access—may be deliberately blocked
Archival Records	<i>[Same as above for documentation]</i> precise and quantitative	<i>[Same as above documentation]</i> accessibility due to privacy reasons
Interviews	targeted—focuses directly on case study topic insightful—provides perceived causal inferences	bias due to poorly constructed questions response bias inaccuracies due to poor recall reflexivity—interviewee gives what interviewer wants to hear
Direct Observations	reality—covers events in real time contextual—covers context of event	time-consuming selectivity—unless broad coverage reflexivity—event may proceed differently because it is being observed cost—hours needed by human observers
Participant-Observation	<i>[Same as above for direct observations]</i> insightful into interpersonal behavior and motives	<i>[Same as above for direct observations]</i> bias due to investigator's manipulation of events

Furthermore, triangulation of data collection methods is crucial in ensuring credibility and reliability in research outcomes (Creswell, 2003; 2014). It was decided that a triangulation of methods be utilised in the present study to provide a comprehensive illustration of the research including validity. “Qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures, while qualitative reliability indicates that the researcher’s approach is consistent across different researchers and different projects” (Creswell, 2014, p. 201).

In this study, preliminary research questions and a conceptual framework guided the research towards data collection. The research adopted a flexibility approach to cope with any new development disclosed in the study. This research design permits initial research questions to be modified to suit the occurrence of new issues that become more apparent during the course of research. The data collection process may also change with the emergence of theory, developing broad themes and interpretations (Creswell, 2003; 2014).

Theory or themes provide theoretical perspectives, guide researchers as to what issues are important to examine and the people that need to be studied. The researcher had started gathering detailed information from key informants and synthesized this information into categories or themes. A conceptual framework is then used to guide the researcher as to what issues are important to examine based on respondents' interviews in the study area.

### **3.3 Study Area**

According to Creswell (2014), "the idea behind qualitative research is to purposefully select participants or sites (or documents or visual material) that will best help the researcher understand the problem and the research question" (p.189). The Klang Valley which is located in West Peninsular Malaysia has been purposively chosen for the study area. It covers an area of 2,826 square kilometres comprising the metropolitan Federal Territory of Kuala Lumpur and the developed state of Selangor (Malaysia, 2006).

In terms of geographical distribution of population, Selangor including the Federal Territory of Putrajaya which has the highest population of 5.07 million people. The Federal Territory of Kuala Lumpur had a population of 1.63 million people in 2008 (MOH, 2008). In addition, the Federal Territory of Kuala Lumpur has the highest

population density of 6,891 persons per square meter in the country for the year 2010 (MOH, 2011). Besides, this study area has the highest concentration of private hospitals in the country with a total of 91 private hospitals. These private medical institutions constitute 43.54 percent of the total 209 private hospitals licensed nationwide in 2008 (MOH, 2008; 2011).

### **3.4 Study Sample of Private Hospitals**

Fifteen private hospitals were purposively selected for this study. Seven of these private hospital establishments are located in Selangor while the rest of the eight private hospitals are located in the Federal Territory of Kuala Lumpur. The selection was based on two criteria. First, the utilised bed capacity and second, the type of facilities and services provided. The first category comprises of seven large sized private hospitals with bed capacity of over 200 beds and providing full tertiary care facilities and services. The second category consists of four medium sized private hospitals with bed capacity of between 100 to 200 and providing partial tertiary care facilities and services. The last category comprises of four small sized private hospitals with less than 100 beds and providing secondary care facilities and services. For the purpose of this research and ethical consideration, the identity of these fifteen private hospitals are kept confidential, and would be identified through coding as Hospital A, B, C, D, E, F, G, H, I, J, K, L, M, N, and O respectively as shown in Table 3.2.

Table 3.2: Profile of Study Hospitals

Hospital	Bed Capacity	Type of Facilities & Services	Type of Premises	Type of Ownership	Legislation under which they were licensed
A	> 200	Tertiary Care	Purpose Built	Stand Alone Corporation	Private Hospitals Act 1971
B	> 200	Tertiary Care	Purpose Built	*GLC.	Private Healthcare Facilities & Services Act 1998
C	> 200	Tertiary Care	Purpose Built	*GLC.	Private Hospitals Act 1971
D	> 200	Tertiary Care	Purpose Built	*GLC.	Private Hospitals Act 1971
E	> 200	Tertiary Care	Non Purpose Built	*GLC.	Private Hospitals Act 1971
F	> 200	Tertiary Care	Purpose Built	*GLC.	Private Hospitals Act 1971
G	>200	Partial Tertiary Care	Purpose Built	Board of Trustees	Private Hospitals Act 1971
H	100-200	Partial Tertiary Care	Purpose Built	Stand Alone Corporation	Private Hospitals Act 1971
I	100-200	Partial Tertiary Care	Non Purpose Built	*GLC.	Private Hospitals Act 1971
J	100-200	Partial Tertiary Care	Purpose Built	Stand Alone Corporation	Private Healthcare Facilities & Services Act 1998
K	100-200	Partial Tertiary Care	Purpose Built	Board of Trustees	Private Hospitals Act 1971
L	100-200	Partial Tertiary Care	Non Purpose Built	*GLC	Private Hospitals Act 1971
M	< 100	Secondary Care	Non-Purpose Built	*GLC.	Private Hospitals Act 1971
N	<100	Secondary Care	Non Purpose Built	*GLC	Private Hospitals Act 1971
O	<100	Secondary Care	Non Purpose Built	Stand Alone Corporation	Private Hospitals Act 1971

\*Government Linked Companies

Seven of these private hospitals namely, A, B, C, D, E, F and G are classified as big sized hospitals with over 200 beds capacity and providing tertiary care facilities with various

specialty and subspecialty services. These private medical institutions are well equipped with the latest state of the art medical technology and sophisticated modalities.

While the other five study private hospitals H, I, J, K and L are classified as medium sized institutions with bed capacity between 100 to 200 offering partial tertiary care facilities complement with a few specialty and subspecialty services. Finally, the remaining three private medical facilities M, N, and O are classified as small sized hospitals of less than 100 beds. These private facilities providing mostly secondary care facilities and a few “bread and butter” specialty services such as internal medicine, general surgery, obstetrics and gynaecology and paediatric medicine.

In terms of corporate ownerships, nine of these private hospitals namely B, C, D, E, F, I, L, M, and N are owned by government linked corporations (GLCs) which the state has majority vested equity interests. However, four other private hospitals, A, H, J, and O are owned by stand alone corporations. In spite of this status, public policy mandates a 30 percent of Bumiputra equity control or GLCs participation in these private hospitals. Only two other private hospitals G and K, which had their original roots as charitable and non-profit hospitals that are currently managed by the respective Board of Trustees.

From the perspective of medical care accessibility, private hospitals such as A, B, C, D, E, and F are tertiary care establishments providing a wide range of medical specialties and subspecialties services such as cardiology and cardiothoracic surgery, neurology and neurosurgery, minimal invasive spine surgery and oncology. These private hospitals are considered as large medical institutions with over 200 bed size capacity and are equipped with the latest state of the art medical technology. Whereas medium-sized private hospitals such as G, H, I, J, K, and L provide partial tertiary care facilities and services.

These institutions have bed size capacity ranging between 100 to 199 beds except for Hospital G which has slightly over 200 beds capacity. The remaining hospitals M, N, and O are small-sized private medical establishments with bed size capacity below 100 beds providing secondary care facilities and are complement with a few specialties services.

### 3.5 Data Collection

This study was conducted between 2010 and 2011 using a purposive sampling method to examine the impact of Act 586 at two levels. One study was conducted at the private hospitals to examine their performance in terms of compliance and non-compliance. Similarly, examination was also done at the MOH as the regulatory body in terms of the enforcement capacity among others, the approval and licensing of facilities, and the concern to address the inequitable distribution of private hospital establishments nationwide. Primary data were gathered utilising key informant interviews, focus group discussions, and observations as illustrated in Table 3.3.

Table 3.3: Sources and Techniques used to Collect and Analyze Data 2010/2011

1. Primary Data Sources	Techniques
a) Key informants from the private health sector: Private hospitals, managed care organisations and medical insurance companies.	Interviews, focus group discussions, and observations.
b) Key informants from public health sector: Ministry of Health Malaysia, Public Hospitals and Public Universities.	Interviews, focus group discussions, and observations.
c) Key informants from the professional bodies, corporations, political parties, non-government organizations, civil society and private paying patients	Interviews.
2. Secondary data sources	Documentation & Archival records; Attending International Healthcare Conference 2010 organised by APHM & Local Healthcare Seminars.

Information obtained has been validated from at least two different sources such as repeat interviews, and documentary evidence. Secondary data were derived among others, from official publications of government agencies such as the MOH, professional bodies, academic publications, research papers, medical bills, and as a delegate attending the International Healthcare Conference and Exhibition 2010 organised by the Association of Private Hospitals of Malaysia. Besides, researcher also attended the local healthcare seminars organized by University of Malaya and the MOH respectively.

In view of the complexity, heterogeneity of actors and the multidisciplinary nature of the facilities and services in the private hospitals, this study conducts an exploratory approach by utilising case studies to explore the impact of the new private health care legislation and how these regulations at work in the study private hospitals. The rationale for case studies is most appropriate as it will provide a greater depth understanding of such type of research. In addition, the choice of detailed case studies will help to focus on the inquiry and help to gain an insight into the impact of the different aspects of the regulation on the behaviour of the actors (Walt et al. 2008; Yin, 2012; Creswell, 2014). Although the fact that case studies may miss the macro perspective of the private health care delivery sector in the country, it permits the researcher to focus on specific issues and at the same time identifying the various regulatory processes at work in the study private hospitals (Sofaer, 2002; Walt et al. 2008; Gilson, 2014).

Studies were purposively conducted in fifteen private hospitals to have a closer look of regulations at work. This includes among others, the compliance on the mandatory licensing of facilities and services to ensure accessibility and patient's safety, the responsibility of the person-in-charge, rationalising the medical charges to more affordable levels, and quality care initiatives undertaken. These study hospitals represent

a purposive sampling frame of 7.18 percent of the total 209 private hospitals licensed in 2008. The Klang Valley has 91 private hospitals which represents 43.5 percent of the total registered private hospitals in Malaysia (MOH, 2008).

### **3.5.1 Focus Group Discussions**

Research analysts such as Morgan (2002) and Liamputtong (2011) suggest the preferred method of group discussions when the research approach is exploratory in nature. This approach of data collection is based on open discussions on predetermined matter with a variable number of participants initiated by the moderator. The objective is to obtain free flow of opinions and avoid a situation of undue influence of the moderator (Morgan, 2002; Liamputtong, 2011).

Primary data were gathered from three different focus group discussions. These focus groups discussions comprise mostly those medical and nursing professionals from the MOH, the State Medical and Health Department of the Federal Territory of Kuala Lumpur and a study hospital for the purpose of triangulation and cross reference. In each of the focus group there were about four to six participants. The focus group discussion provides an insight of regulations at work and the enforcement capacity of Act 586 on the private health care sector especially on the private hospitals. Information obtained further strengthened the reliability and validity of the findings.

### **3.5.2 Key Informant Interviews**

Interviews were conducted with the key informants who are also stakeholders to assess their rich experiences, views, and priorities on the impact of the new legislation. Perceptions of the various key stakeholders with their extensive experience reflect the reality on the ground (Yin, 2003; 2012; Creswell, 2014; Gilson, 2014). Besides, it not

only generates rich but meaningful data and information under the study (Polkinghorne, 2005; Walt et al. 2008; Braun & Clarke, 2013). Hence the identification of key informants is crucial and an important aspect in this research design. The key informants' interviews were derived from the various relevant stakeholders in the health care sector. Data were derived from three categories of relevant stakeholders of the health sector in Malaysia:

- a) Public Sector,
- b) Private Sector,
- c) Others.

The first category is the informants from the public sector. This category comprises 25 officials from the public health sector. Key informants from the public health sector comprising of current and past officials from the MOH. This list of key informants includes a former Director General of Health, Directors and Unit Heads to the medical regulators from the Enforcement Unit, Private Medical Practice Division, Engineering Division and the Nursing Board. Personal communications were conducted with officials from State Medical and Health Department including the Director, and other relevant senior officials who were involved in the implementation and enforcement of the new private healthcare legislation. Besides, information were gathered from medical specialist consultants, medical officers, pharmacists, assistant medical officers, nurses and paramedic staff from public hospitals, and academicians from public universities.

The second category is the key informants from the private health sector. A total of 80 key informants from the private healthcare sector include the past and present senior management executives of the private hospitals participated in the study. Some of these key informants have previous working experience in at least two of these private hospitals. This list of key informants includes the Executive Director, Chief Executive Officer (CEO), Chief Operating Officer, Medical Director, General Manager,

Accountant, Director of Nursing, Pharmacist and the staff of the various departments in the private hospitals. These departments encompass the emergency department, admission and discharge department, patient billing department, inpatient wards, operation theatre, central sterile supplies department, cardiac invasive laboratory, imaging, clinical laboratory, marketing and promotion, and customers' service department. Primary data were also collected from the medical and dental professionals such as the specialist consultants of the various specialties and sub-specialties across the various private hospitals. Data were also collected from the private practitioners, the medical and health insurance companies, managed care organisations, third party administrators and the pharmaceutical companies from the private healthcare sector.

The last category comprises of key informants who are classified as "others". This group of 25 key informants include two politicians who were former Health Ministers. The data obtained from this category includes members from professional bodies such as Malaysian Medical Association (MMA) who among others include three former Presidents, Federation of the Private Medical Practitioners' Associations, Malaysia (FPMPAM), Association of Medical Specialists in Private Practice (ASPMP), Association of Private Hospitals of Malaysia (APHM), Medical Defence Malaysia Berhad, and Bar Council. In addition, data were gathered from corporations, non-governmental organisations such as Malaysian Society for Quality in Health (MSQH), and civil society. Besides, data were also collected from academicians from universities, and a group of private paying patients and their relatives who have utilised the services of the private hospitals.

Thus a total of 130 key informants have contributed to the data collection exercise. The reason for the use of multiple key informants is to provide information from different

perspectives about the experience of the impact of the new legislation. In addition, multiple participants serve well the purpose of triangulation on the experience and views looking from different lens (Polkinghorne, 2005; Walt et al. 2008). While semi-structured interviews and personal communications were the preferred choice because it gave the researcher control over time, content and sequence of the interview but it has its own limitations. These among others may include the interviewer bias due to the lack of standardisation and the lack of anonymity (Yin, 1994; 2012). Besides, the interviewer must possess the prerequisite good communication skills in order to achieve the maximum benefits from the interview process (Polkinghorne, 2005; Braun & Clarke, 2013).

### **3.5.3 Observation**

Creswall (2014, p. 190) states that “qualitative observation is when the researcher takes field notes on the behavior and activities of individuals at the research site. In these field notes, the researcher records, in an unstructured or semistructured way (using some prior questions that the inquirer wants to know), activities at the research site”. Further, qualitative observers may also engage in roles varying from a non-participant to a complete participant. In this study, observations were made during the data collection exercise at the private hospitals and MOH where field notes were taken. The observations were made in which the actual activities and environment at the research sites were compared with those documented, policy objectives and the requirements under the Act 586 and its regulations.

### **3.5.4 Researcher’s Personal Experience as a CEO of Private Hospitals**

On the personal front, in 2003 the researcher was the Chief Executive Officer of a proposed 300 bedded Australian designed modern private tertiary care hospital in the

Klang Valley. This purpose-built Australian designed private hospital was almost structurally completed but unfortunately had to be temporarily abandoned due to financial constraint during the aftermath of the Asian Financial Crisis 1997/1998. However, this private hospital was eventually acquired by one of the leading GLC private healthcare provider conglomerates in the country.

Subsequently, prior to embarking on this doctoral study, the researcher was the Chief Executive Officer of a 232 bedded partial tertiary care private hospital from 2004 to 2008. This private medical institution offers a wide range of multidisciplinary facilities and services, among others encompasses subspecialties services such as cardiology and cardiothoracic surgery, and oncology in the Klang Valley. It was during this challenging period of the implementation and enforcement of the new health care legislation that the researcher had the personal experience and opportunity to be an active participant in the regulatory reform initiatives. Precisely, witnessing the historical events of the regulatory transition period just before and after the enforcement of the new private healthcare legislation on 1<sup>st</sup> May, 2006.

In this context, the researcher had attended a dialogue initiated by the Health Minister together with members of professional bodies such as MMA, ASPMP, private hospitals, Association of Private Hospitals of Malaysia (APHM) and other relevant stakeholders to discuss various issues pertaining to the implementation and enforcement of the Act 586 and Regulations 2006 at MOH, Putrajaya on 29<sup>th</sup> January, 2007. Subsequently, unofficial visits were also made by the researcher and his colleagues to the various private hospitals in the Klang Valley to gain an insight on the regulations at work in these hospitals. Feedback were also gathered through discussions and observations with the medical and nursing professions including medical specialists, and paramedical staff on the

experiences encountered in terms of the policy, compliance and non compliance of the new health care legislation. Invariably under these circumstances, the researcher was exposed to the issues of the new regulatory requirements and had to engage constantly with the regulatory authority under the MOH in terms of policy, compliance, licensing, annual inspection and the enforcement under the new legislation.

This rich experience and exposure provided the researcher an opportunity to interact and to establish a close networking relationships with officials of the regulatory body under the MOH, the management and staff of the various private hospitals, healthcare professionals, pharmaceuticals, insurers and managed care organisations, private corporations, non-governmental organisations, patients and relatives, and other stakeholders in the private health sector. Networking with the various categories of relevant people and stakeholders had coincidentally provided the researcher the motivation to gain a further insight of the regulatory intervention. Some of these stakeholders had eventually become researcher's key informants and sources of personal communication in providing the relevant primary data collection under this research study conducted between 2010 and 2011.

During the data collection process, the researcher was also engaged as a Chief Executive Officer of a corporation in the health care industry from March 2010 to September 2010. The researcher was involved in the setting-up, licensing and commissioning of a boutique private medical centre in Kuala Lumpur in terms of compliance under the new healthcare legislation Act 586. The researcher had the hands-on experience as an actor in dealing with the various stakeholders in the health sector including the regulatory body of MOH for mandatory approval and licensing.

### **3.5.5 Documentation**

One of the main sources of data collection under this study was from published historical data. It does not only provide valuable sources of information and references but also for the purpose of triangulation (Denzin & Lincoln, 2011; Yin, 2012). The use of document is justified in this study due to the highly political nature of the public policy process as suggested by several authors (Sofaer, 2002; Walt et al. 2008; Yin, 2012; Gilson, 2014).

News reports from various media were also used as a source of evidence to strengthen the creditability of the research. The rationale for using news reports held by several policy analysts is that media reportage may also be included as other channels by which a problem may be brought to the attention of policy-makers and put on the policy agenda (Sofaer, 2002; Walt et al. 2008; Yin, 2012; Gilson, 2014).

Although secondary data may be timely and relevant to the researchers' needs, the disadvantage is the inaccuracy of such information (Yin, 2003). Such published data may be biased in support of vested interests (Yin, 1994; 2012). These bias reports from mainstream media such as newspapers is due to the nature of affiliation and ownership which need cautious verification and treatment. Hence, each documentary information has to be evaluated in terms of creditability and authenticity (Denzin & Lincoln, 2011).

The secondary data under this study were obtained from various official publications such as Malaysia Development Plans, Economic Reports, Annual Reports and publications from Ministry of Health Malaysia, Department of Statistics Malaysia, Professional Bodies, academic books, international refereed academic journals, medical bills, the various private hospitals' websites and the internet. Data were also gathered from mainstream media reports, press statements from the Health Minister and Director

General of Ministry of Health, Malaysia.

Data and information were also gathered from the attendance of the various international healthcare conferences organised annually by the Association of Private Hospitals of Malaysia (APHM) from 2006 to 2010, Conference on the Private Hospital & Private Healthcare Institution Administration in Malaysia with special emphasis on the Private Healthcare Facilities & Services Act 1998 (Act 586) and Regulations 2006, 15<sup>th</sup> & 16<sup>th</sup> November, 2006, Kuala Lumpur. Further, data were collected while attending the healthcare seminars organised by the Faculty of Economics and Administration, University of Malaya in 2010, and MOH on 11<sup>th</sup> December, 2011.

### **3.6. Approval from National Medical Research and Ethics Committee (NMRR)**

Although this study is non-clinical in nature, it has sought the approval from the National Medical Research and Ethics Committee, MOH (NMRR) as a matter of courtesy before embarking on the collection of data. In compliance to NMRR's requirement, the researcher had to submit the research proposal together with detailed documentation including an Investigator's Agreement and the Faculty of Economics and Administration's consent to the NMRR for their approval. It took a lengthy period before an approval was given subject to the various stringent terms and conditions among others the data confidentiality is to be adhered. The submission with a registered identification ID: NMRR-10-301-5561 has been given approval and noted that the study has no clinical intervention on patients in hospitals.

### **3.7 Fieldwork**

The fieldwork of this study was conducted between mid 2010 and late 2011. Purposive sampling was utilised as a method of selection of key informants for interviews based on

their information rich experiences and official capacities in the various fields in the health care sector. It is crucial to select information rich participants for in depth understanding of issues which are of central importance to this study (Polkinghorne, 2005; Yin, 2012; Braun & Clarke, 2013).

Hence, during the initial stage, ten official invitation letters were sent to the various purposive selected key informants for an interview in this study. These letters were sent out with the endorsement from the Deputy Dean for Post-Graduate Studies of the Faculty. This was subsequently followed by numerous telephone calls and electronic mails to request for their participations. In addition, researcher had also sought a letter of support from the Faculty of Economics and Administration for the purpose of undertaking research field work. The letter of support from the Faculty was deemed necessary as the historical regulatory intervention in 2006 was controversial and eventful. There was an unprecedented resistance in the implementation of the Act 586 and the professional bodies deemed the Act 586 as criminalising their professions. In a separate incident, there was nationwide protests calling for the deferment of the implementation and enforcement of the Act 586.

In view of the sensitivity arising from the enforcement of Act 586, there were scepticisms on the motive on this research study and assurance had to be given that it was an academic study. The researcher adopted a cautious and less structured approach in the interviews and personal communications with the various key informants during the initial stage of field work. In spite of the less structured approach, many of the key informants were apprehensive and equally concerned about their confidentiality. There were mixed responses for the interviews despite the assurance given on the confidentiality. The key informants from the public sector were governed by the Official Secret Act 1972 that

disallowed them to divulge government information, which may be classified as a secret information while the key informants from the private health sector were equally concerned about their corporate confidentiality.

Some key informants had even responded requesting for more details on the semi-structured questions to be posed to them during the interviews. The key informants were informed that data gathered from the interviews would be used for the purpose of this study. A few key informants wanted the request for interview to be referred to the top management for approval or approval from their research and ethics committee. Obviously, the protocols caused considerable delays for getting interviews. Despite the researcher's background and experience in the private hospitals as an actor previously, there were key informants who had declined the request for an interview. In this context, new key informants were sought to replace those who had declined earlier.

In spite of the official restrictions of information imposed, there were also many genuine respondents who were willing to share their experiences and views on the impact of the Act 586 on the private hospitals. In this respect, snowball technique was used to interview the key informants and personal communications to gather the data. However, none of the informants wanted their interviews to be recorded on a tape recorder and requested to remain anonymous but allowed hand written notes to be taken.. Hence from the onset of research, total confidentiality of the key informants had to be assured to encourage honest and meaningful insight to this research.

While the anonymity and confidentiality are maintained in the dissemination of the findings for this study, the key informants have been identified by a coding system. It is felt that at times it is necessary to know the status and category of the key informants so

that their statements can be quoted and put into context. The identification codes used were based on the three categories of key informants classified and discussed earlier under sub-section 3.5.2. For instance, Code PUB was for key informants from the public health sector, Code PRI was for key informants from the private health sector, and the last category of key informants was coded as OTR as illustrated in Table 3.4. A detailed list of 130 key informants with their coding status and position is enclosed in Appendix A for reference in this study.

Table 3.4: Identification Codes for Key Informants

Category	Key Informants	Code
Public Sector	25 officials from the MOH including a former Director General of Health; Private Medical Practice Division; Engineering Division, State Medical and Health Department, medical & nursing professionals, pharmacists, assistant medical officers from public hospitals, & academicians from public universities.	PUB 1 to PUB 25
Private Sector	80 key stakeholders including past and present senior management of the various private hospitals including Executive Director, Chief Executive Officer, Chief Operating Officer, Medical Director, General Manager, Accountant, Director of Nursing, Pharmacist and the staff of the various departments in the private hospitals; medical & dental specialists, private practitioners, & medical insurance companies.	PRI 1 to PRI 80
Others	Two former Health Ministers. Key informants from Malaysian Medical Association including three former Presidents, Federation of the Private Medical Practitioners' Associations, Malaysia, Association of Medical Specialists in Private Practice, Association of Private Hospitals of Malaysia (APHM), corporations and non-governmental organisations such as Malaysian Society for Quality in Health, private paying patients and their relatives.	OTR 1 to OTR 25

The key informants were given the freedom to express their experience about what was central to them but at the same time ensured that issues which were crucial to study were covered based on some prepared semi-structured guidelines. Face to face interviews,

telephone interviews, emails and personal communication were conducted. Each interview ranges between one to three hours. Further, each exploration results in languaged data. These languaged data are “interrelated words combined to sentences which subsequently results in discourses” (Polkinghorne, 2005, p. 137). Notes on crucial issues were taken down immediately after each interview with the key informants.

During the field work, the researcher was also engaged as a Chief Executive Officer with responsibility in the setting-up, licensing and commissioning of a boutique private medical establishment in Kuala Lumpur. In this context, the researcher had an opportunity to gain further insight and personal experience on the impact of the regulatory intervention. Henceforth, the data collection process continued with key informant interviews, focus group discussions, and personal communication with the relevant stakeholders during this period until late 2011 when it is felt that data collection had reached the saturation level. According to Creswell (2014) the idea of “saturation is when, in qualitative data collection, the researcher stops collecting data because fresh data no longer sparks new insights or reveals new properties” (p. 248).

It was during this fieldwork period the researcher had the hands-on experience as an actor and participant observer in dealing with the various stakeholders in the health sector including the regulatory body of MOH in the data collection exercise. In addition, the researcher had the privilege of attending and meeting other key informants at the “International Conference on Healthcare 2010” which was organised annually by the Association of Private Hospitals of Malaysia (APHM), and healthcare seminars organised by the Faculty of Economics and Administration, University of Malaya in 2010, and MOH in 2011 where primary and secondary data were also collected.

### **3.8 Data Analysis**

After the completion of the data collection exercise, the information gathered need to be analysed in order to interpret what data were relevant to the issues being investigated. There are various perspectives available to analyse data depending on the type, aim, and the design of research (Silverman, 2010; Denzin & Lincoln, 2011; Yin, 2012; Creswell, 2014). The data was organised and managed before the analysis process. While there are several different qualitative approaches to the analysis of data from interviews, but the design flexibility remains top priority than following one system of analysis (Reynold et al. 2011; Braun & Clarke, 2013; Creswell, 2014).

Precisely, the public policy process is a complex phenomenon and influenced among others, the social, cultural and political settings. In order to understand the complex phenomenon of policy process in the private health sector, it is paramount to study the political power and the influence of a phenomenon, individuals or organisations in its natural setting. Walt et al. (2008) assert that “health policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests, and ideas in the policy process” (p. 308). Such discourses on health policy analysis are of significant importance. In general, discourse has been defined “as a specific ensemble of ideas, concepts, and categorizations that is produced, reproduced, and transformed in a particular set of practices and through which meaning is given to physical and social realities” (Hajer, 1995, p. 44).

In this study, discourse analysis was of assistance as it placed the emphasis on words as spoken in interviews and discourses gave a better understanding on the impact of the public policy. This understanding may also vary according to the perceptions of the key informants on the impact of Act 586 on the private hospitals in Malaysia in terms of

achieving the national health objectives of accessibility, equity and quality care. Besides, discourses helped in analysing interview data where contradictions and divergent views were encountered, and provide understanding of the interpretations. As the key informants are from diverse backgrounds, discourse analysis is able to determine the ways power and influence are configured and transformed in the private hospitals sector in Malaysia with the enforcement of Act 586.

### **3.9 Codes and Themes**

Braun and Clarke (2013) argue that “coding is a process of identifying aspects of the data that relate to your research question”. In this respect there are two main techniques to coding in pattern-based forms of qualitative analysis namely, (a) selective coding and (b) complete coding. Selective coding is a process which a researcher is able to recognise a corpus of ‘instances’ of the phenomenon which he is interested in, and selecting those out. It requires a process of more reading and familiarisation over a period of time” (p.206). On the other hand, in complete coding, “codes identify and provide a label for a feature of the data that is potentially relevant for answering your research question” (Braun & Clarke, 2013, p.207). Furthermore, Braun & Clarke (2013) gave an analogy of codes in relation to the building blocks of analysis. Citing the example on the analysis of a brick-built, tile-roofed house, the themes are the wall and the roof; the codes are the individual bricks and tiles. In general terms, “codes can be either reflect the semantic content of the data (we call these data derived or semantic codes) or more conceptual or theoretical interpretations of data (we called these researcher-derived or latent codes)” (Braun & Clarke 2013, p. 207).

Similarly, analyst like Creswell (2014) assets the “use of coding process to generate a description of the setting or people as well as categories or themes for analysis. These

themes are the ones that appear as major findings in qualitative studies and are often used as headings in the findings sections (or in the findings section of a dissertation or thesis) of studies” (p.199). This analysis is “useful in designing detailed descriptions for case studies, ethnographies, and narrative research projects” (Creswell, 2014, p. 200).

In this study, the researcher utilised the coding protocols suggested by Braun and Clarke (2013) and Creswell (2014). The initial set of codes was created after having read the hand written notes taken during the interviews while paying attention to the vital sections, phrases or words and allotting them with a code. This process of coding was done simultaneously, keeping in mind of the research questions which had been established earlier in the research study.

Subsequently, manual coding was chosen as the preference over the use of qualitative computer data analysis program such as MAXqda, Atlas.ti, or QSR NVivo software package for some obvious reasons. Although the use of qualitative computer data analysis programs have become quite popular recently and they can help researchers organise, sort and search for information in text or image data, however, it needs time and skill to learn to employ effectively (Creswell, 2014). In view of the data derived from the study are complex and rich, manual coding provides the researcher the advantage of being able to conceptualise and integrate the information albeit the laborious and time-consuming process. The meticulous and slow process of manual coding makes it less likely that significant concepts will be missed. Finally having each category or theme written out on a separate sheet of paper will make it easier to identify the variations within each category or theme. This process assisted in the subsequent process of write ups in the thesis as illustrated in Figure 3.1.

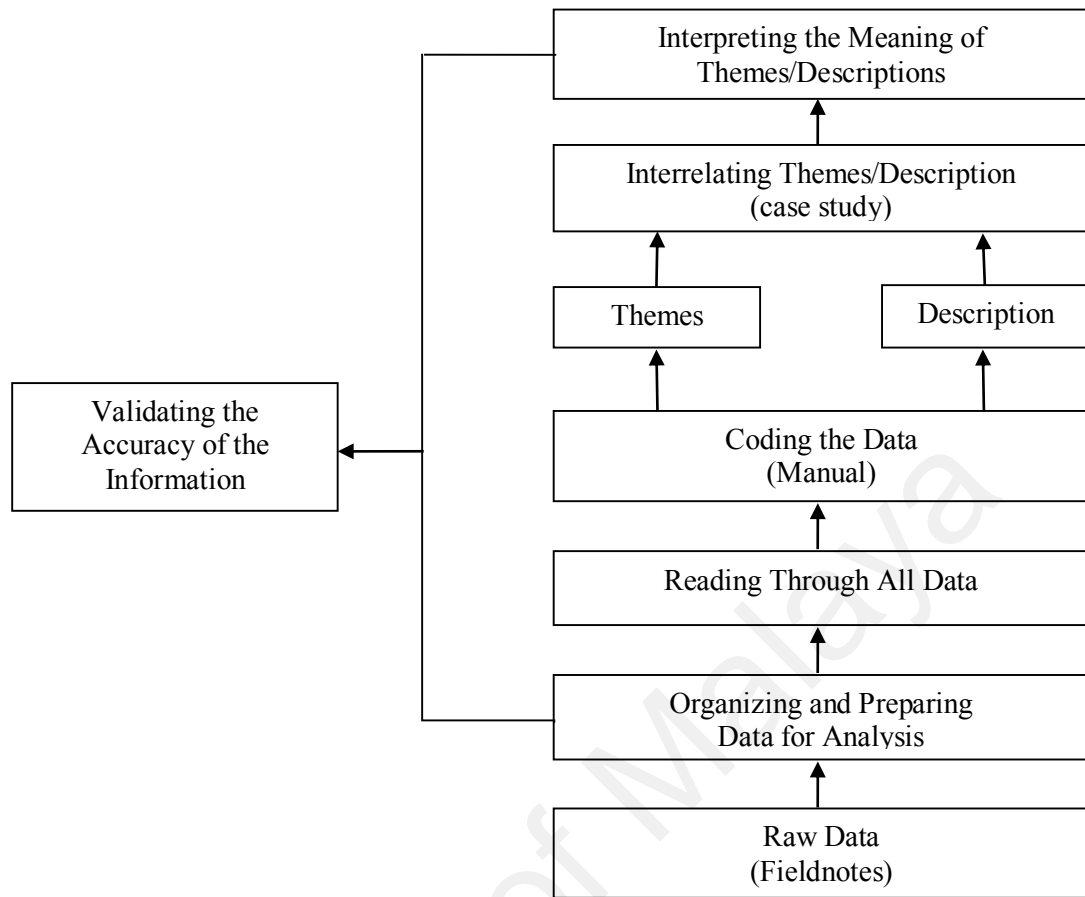


Figure 3.1: Data Analysis Process in the Research Study 2010/2011

Finally when the coding process had been completed, the list of categories generated was studied and summarised into smaller group of themes. Vigorous re-examinations of the coded data had been undertaken so as to identify emergent themes. The following core themes became evident during this process such as policy, power, governance, compliance, non-compliance, cost, inequity, quality, politics, and enforcement.

Subsequently after having identified and developed these themes, the analytic methodology becomes more apparent as a form of discourse analysis. Each theme is then examined so as to distinguish, compare and contrast the various approaches in which the key informants had chosen to express themselves over an issue. Consequently, these themes led to the development of the thesis in examining the impact of the new

legislation, the Private Healthcare Facilities & Services Act 1998 (Act 586) and Regulations 2006 on the private hospitals in the Malaysia.

### **3.10 Concluding Remarks**

Having presented the different methods utilised for the data collection and analysis in this chapter, the empirical findings of the impact of the regulatory intervention will appear in Chapter 6, and Chapter 7 of this thesis. The following Chapter 4 will provide an overview of the Malaysian Healthcare System in an era before and after the privatisation policy in the 1980s together with a critical discourse on some of the major complexities prevailing in the health sector. These complexities are of major concerns to the public and policymakers leading to the historical regulatory intervention of the Private Healthcare Facilities and Services Act 1998 [Act 586] and Regulations 2006 on the private health sector nationwide.

## **CHAPTER 4 : HEALTH CARE SYSTEM IN MALAYSIA**

### **4.1 Introduction**

This chapter provides an overview of the development and transformation of the health care system in Malaysia. The overview presents some in-depth discussions focusing on a range of complex issues in shaping the health care system. This includes policies and reform initiatives in pursuit of the universal health coverage objectives. In the post independence era, the government played a predominant role as a “welfare-oriented state” in terms of the provision of accessible universal primary healthcare and principal funding through general taxation. This welfare-oriented role has positive impact and tremendous improvement in the public healthcare system throughout the country. However, following the influence of global ideology calling for the increase role of the private sector and the reduce role of the state, Malaysia similarly embarked on massive privatisation policy in the 1980s (Jomo, 1995; Chan, 2014; Jomo & Wee, 2014). This period of economic liberalisation policy had among others resulted in the significant development of the private healthcare sector in particular the private hospitals. Consequently, this phenomenon over the decades had led to the transformation of the healthcare system with the emergence of a dichotomous of public and private healthcare sectors (Barraclough, 1999; Chee & Barraclough, 2007; Nik Rosnah & Lee, 2011; Chan, 2014; Ng et al. 2014).

This chapter also provides some critical assessments on the unprecedented growth of these corporate private hospitals and its socio-economic implications which have been of major concerns to policymakers. The issues of rising public expectations, inequitable distribution of resources, the wide variation of care and the escalating medical care costs are discussed. Discussions in this chapter also highlight on the conflicting role of the government as a welfare-oriented provider on one hand, and the promotion of capitalist

expansion role on the other. This is evidence with the emergence and extensive network of government linked corporate private hospitals nationwide. In the midst of these challenges, this chapter also provides an insight into the dilemma facing the public hospital sector with the massive brain drain of human resources into the private hospital sector. The depleted human resources had affected the equitable access and quality care in this sector leading to dissatisfactory services, negligence and the rise in medico-litigations (Nik Rosnah, 2002; 2007; Nik Rosnah & Lee, 2011a). The remedial effort of the government in focusing human capital development to overcome the massive brain drain, and the comparison made between the private and public health sectors are some areas featured in the discourse.

Subsequent discussions in this overview among others encompass the controversial privatisation with the aim to provide a better understanding to the background of this study especially on the outcome of the regulatory landscape. However, an in-depth critical examination in particular on two major healthcare privatisation projects such as the Government Medical Store (GMS) and the major privatization of five hospital support services will be discussed separately in the following Chapter 5 in view of its complexities.

Deliberations in this chapter also centred on the some critical issues and challenges confronting the Malaysian healthcare system despite the impressive selected health indicators. The current healthcare system with the government shouldering the major burden of the cost appears to be unsustainable in the near future (Ramesh, 2007; Phua, 2007; MOH, 2011). The spiralling total healthcare costs, the high out-of-pocket payment in the private health sector, the responsiveness, accessibility and inequitable distribution of facilities and services, and variations in quality care are discussed at length toward the

closing of this chapter. The following sub-section provides the background looking on the healthcare systems from the global perspectives in general and in particular the Malaysian perspective.

## **4.2 Background**

### **4.2.1 Healthcare Systems: Global Perspective**

World Health Organisation (WHO) had identified three phases of healthcare reform initiatives which were seen to be overlapping in its report on health systems (WHO, 2000). Under the first phase, countries adopted universal national healthcare systems especially those newly independent countries. Many of these developing countries extended the healthcare systems beyond the ones established mainly to cater for the benefits of the colonial government and the discriminated suboptimal healthcare provision for the general local population. A few charitable healthcare facilities were seen servicing for the poor and marginalised groups. This was followed by the second phase, in which accessible primary healthcare was promoted and extended to the larger population. In this context, the primary healthcare was focusing on the majority rural population where poverty is prevalent. Finally, the third phase of healthcare reforms was derived from the global ideological thinking in the 1980s calling for market mechanisms with the emphasis on the role of the private sector as the engine of growth and discarding the welfare orientation with the reduction role of the state (WHO, 2000).

This global ideological approach arising from the aftermath of the global economic crisis in the late 1970s with the escalating spiralling oil prices together with the depressing prices of raw commodities had consequently led to severe debt and fiscal crisis in developing countries. In response, the World Bank provided the prescription of mandated structural adjustment policies resulting in fiscal austerity drive in social and welfare

expenditures (Blooms et al. 2008). Similarly, in the health sector, there was a call for a reduction in the direct provision of healthcare by the states and the emphasis in the promotion of healthcare privatisation. However, there were major concerns about the financing of such a pluralistic system. In view of its complexity, the general trend then was looking forward to a mechanism for contributory social insurance financing scheme. The proponents for privatisation emphasised the benefits of greater individual choice and the accountability in market mechanism (World Bank, 1987; World Bank, 1993; WHO, 2000).

#### **4.2.2 Malaysian Perspective**

Notwithstanding some variations, the Malaysian healthcare system was seen to have undergone similar patterns of development. The first and second phases of development of the healthcare system seem to be typically fit into the development described albeit some local variations. Invariably this among others include the universal primary healthcare accessibility with the development of a network of integrated rural public healthcare system and an urban primary healthcare mostly provided by private medical practitioners. Further, the universal accessibility to public hospitals for secondary and tertiary care was funded through general taxation. However, after the privatisation policy in the 1980s and the decades thereafter, the principle of universal healthcare accessibility had been subjected to the third phase of healthcare system development. This led to the emergence of a mixed of public and private health systems running concurrently in the provision and financing of healthcare delivery in the country (Chee & Barraclough, 2007; Ramesh, 2007; Chee, 2008; Chan, 2007; 2010; 2011; 2013; 2014; Ng et al. 2014; Chee & Por, 2015).

### **4.3 Welfare-Oriented State**

Upon independence from the British colonial administration in 1957, Malaysia had been a welfare-oriented state in terms of providing financing through taxation and provision of accessible public health care to all its citizens until the 1980s, in line with the Alma Ata Declaration in 1970s (Roemer, 1991; Chee & Barraclough, 2007; Nik Rosnah & Lee, 2011a; 2011b; Chan, 2007; 2010; 2011; 2013; 2014). Like many newly independent developing African and Asian countries, Malaysia was committed to the provision of universal access to primary healthcare in response to the expectations raised before independence (Blooms et al. 2008). The healthcare system in Malaysia is complex and multifaceted. The Ministry of Health (MOH) is the largest provider of healthcare in conjunction with other ministries and organisations. Hence, healthcare policy under the MOH was central and integral to the subsequent national development plans in Malaysia (Ramesh, 2007; Sirajoon & Yazad, 2008; MOH, 2011; Chan, 2013; 2014; MPC, 2014; Ng et al. 2014; Chee & Por, 2015).

Further, during this period the health policy was of non controversial and without any political contention unlike policies on economy, culture and education. Health policies adopted were often in consultation with the various stakeholders including the Malaysian Medical Association (MMA) (Chee & Barraclough, 2007). Policy on accessibility in terms of affordability, equity and quality healthcare services had been the main concerns of the government (Muhamad Hanafiah, 1996; Sirajoon & Yazad, 2008; MOH, 2011; Chan, 2013). The state remained committed to the provision of universal primary healthcare coverage. This is evident with the rapid expansion of accessible network of rural health clinics providing free of charge primary health care services where the majority of the population was in the rural areas (Malaysia, 1996; Ramesh, 2007; Sirajoon & Yazad, 2008; Ng et al. 2014).

In the post independence era under the Rural Health Services, each rural public health clinic unit provide healthcare service to a population of 50,000 people with a three tiered organisational hierarchy consisting of a district main health centre, four sub-district health centres, with each having four midwife clinics cum quarters (Sirajoon & Yazad, 2008). The district main health centre was under the charge of a medical and health officer and assisted by a trained medical assistant (currently designated as assistant medical officer), public health nurses, a pharmacy assistant, midwives and other ancillary staff providing static as well as mobile primary healthcare services including maternal and child healthcare. Each sub-main health centre is manned by a medical assistant, a public health staff nurse, assistant nurses, midwives and support staff. The medical and health officer would provide coverage visits to the other four sub-health centres on a weekly basis and attend to cases referred by the respective trained medical assistants and public health staff nurses. In addition, patients requiring further investigations and treatments were referred to the nearest public hospital (Sirajoon & Yazad, 2008).

Later, the three tiered rural public health system was converted to a two-tier system after an Operational Research Study done in collaboration with WHO in 1969 to improve better accessibility and quality of healthcare services (Sirajoon & Yazad, 2008). Under the two-tier health system, each rural health unit covered a population of between 15,000 to 20,000 people. In addition, each rural health unit consists of a health centre which is upgraded with the services of a medical doctor and dentist and four rural clinics known as “klinik desa” managed by community nurses. A rural clinic was planned to cover a population of between 2,000 to 4,000 of rural folks (Muhamad Hanafiah, 1996; Sirajoon & Yazad, 2008).

In terms of accessibility, the First National Health and Morbidity Survey in 1986-1987 revealed that 74 percent of the population of Peninsular Malaysia lived within 3 kilometres of a static health facility and that 89 percent lived within 5 kilometres of such facility. The majority of 83 percent of the Malaysian population resides in Peninsula Malaysia. A decade later in 1996, the Second National Health and Morbidity Survey found improved healthcare accessibility, with 81 percent of the population lived within 3 kilometres and 93 percent lived within 5 kilometres of public facilities. In the same year there were 897 public health centres and 1,987 rural clinics available nationwide ((MOH 1997; Sirajoon & Yazad 2008). Currently, there are 1,039 health clinics and 1,821 community clinics providing healthcare services nationwide. In addition, there are 254 1Malaysia Clinics in selected urban areas providing basic medical care since 2010 (MOH, 2014a; Chee & Por, 2015).

Even for remote areas, which are difficult to reach, there are 212 mobile health teams (land and riverine), and the eight teams of “Flying Doctor Services” using helicopters which are currently been used especially in the states of Sabah and Sarawak (MOH, 2014a). In general, the rural population had the accessibility to comprehensive health services encompassing from outpatient curative care to preventive and promotive services under the rural health unit (Muhamad Hanafiah, 1996; Sirajoon & Yazad, 2008). The extensive rural health development later formed the main infrastructure of the current integrated and accessible rural public primary health care system in the country. It was reported and indeed an overwhelming success with 93 percent of the rural population provided with accessible universal primary healthcare coverage (Roemer, 1991; Ramesh, 2007; MOH, 2011; Chan, 2014).

Furthermore, Malaysia's health care system has also gained international recognition as one of the more successful systems among developing countries (WHO, 2006). This is evident with the progressive positive health indicators over the decades. Life expectancy at birth has increased from 56 years for males and 58 years for females in the 1957 to 66 years and 70 years in 1980, and subsequently to 72.56 years for male and 77.18 years for females respectively in 2013 (MOH, 2014). Table 4.1 shows some selected health indicators for Malaysia from 1957 until 2013.

Table 4.1: Selected Health Indicators for Malaysia 1957-2013 ( Health in Malaysia Achievements and Challenges, MOH, 2000; Health Facts 2000; 2012; 2014, MOH)

Year	1957	1970	1980	1990	2000	2010	2011	2012 <sup>p</sup>	2013 <sup>e</sup>
Population (million)	6.30	10.30	13.80	18.00	23.27	28.59	28.96	29.34	29.71
Annual Growth Rate (%)	NA	2.70	2.40	2.30	2.40	1.80	1.30	1.30	1.30
Life Expectancy At Birth (in years)									
• Male	56.00	64.00	66.00	69.00	70.30	71.90	72.16 <sup>p</sup>	70.37 <sup>e</sup>	72.56 <sup>e</sup>
• Female	58.00	68.00	70.00	73.00	75.20	77.00	76.80 <sup>p</sup>	77.03 <sup>e</sup>	77.18 <sup>e</sup>
Crude Birth Rate	46.20	32.50	31.20	28.40	24.50	17.50	17.60	17.20	17.20
Crude Death Rate	12.40	7.00	5.80	4.70	4.40	4.80	4.70	4.60	4.70
Infant Mortality Rate	75.50	40.80	23.90	12.10	8.10	6.80	6.50	6.30	6.6
Maternal Mortality Rate	3.20	1.50	0.60	0.20	0.30	0.28	0.26	0.26	NA

Note: <sup>e</sup> estimated data. <sup>p</sup> provisional/preliminary data. NA: Not available

The infant mortality rate has decreased significantly over the years from 75.5 per 1,000 live births in 1957 to a figure of 23.9 in 1980, 12.1 in 1990, 6.3 in 2001 and 6.6 per 1,000 live births in 2013. Further the maternal mortality rate has also decreased progressively from 3.2 per 1000 live births to 0.25 per 1,000 live births reported in 2013. Similarly, crude birth rate and crude death rate were markedly reduced over the decades (MOH, 2014a).

Besides inheriting a public hospital referral system initiated by the British colonial administration after independence, new public hospitals were rapidly developed in the 1960s. These public hospitals were heavily subsidised under the MOH to cater for the accessibility of the local population in the urban and sub urban areas. In addition, these public hospitals provided general out-patient care, inpatient care, accident and emergency services and all other related medical specialities. The range of medical services varied depending on the size and locality of the hospital. All public hospitals were linked to enable patients to be referred from one level to the next level of care based on the complexity of the medical problem encountered (Sirajoon & Yadav, 2008).

Even in rural areas, there was the development of non-specialist basic speciality community hospital in every district to meet the norm of at least two beds per 1,000 population. Overall there were 118 public hospitals in 1996 (Sirajoon & Yadav, 2008) and by 2013 there are 149 public hospitals with 43,437 official beds (MOH, 2014a). These public hospitals are classified as district hospitals, district hospitals with specialist services, general hospitals, national referral institutions and teaching hospitals. Besides, there are also non-MOH public hospitals such as teaching hospitals at the institutions of higher learning under the Ministry of Education, and military hospitals for armed forces personnel are under the Ministry of Defence. In addition, an exclusive hospital for the indigenous people which was initially under the jurisdiction of Ministry of Home Affairs, has been taken over by the MOH, complemented the public healthcare delivery system (Sirajoon & Yadav, 2008; MOH, 2014a).

Subsequently, more urban public polyclinics centres providing comprehensive services were established to relieve the burden of congestion and workload in the outpatient departments in government hospitals. The public hospitals in the districts provide mostly

secondary care services while the General Hospital in each state provides secondary and tertiary care services respectively (Muhamad Hanafiah, 1996; Sirajoon & Yazad, 2008). In addition, these public hospitals levy modest charges according to the class of ward chosen. Approximately 85 percent of all public hospitals are in third class wards category where inpatient treatments are provided either free of charge or paying only a nominal sum.

Under the Fees (Medical) Order 1982 (Amendment) of the Fees Act 1951, the cost of outpatient treatment in the MOH hospitals was set at RM 1.00 (one Malaysian Ringgit is worth approximately USD 0.30) while a specialist consultation cost RM 5.00. In addition, inpatient daily ward charges ranged from a mere RM 3.00 in a third class shared ward to RM 80.00 in the first class single air-conditioned room (Malaysia, 1994; Nik Rosnah, 2002; Chan, 2014). Further in terms of accessibility and affordability, 93 percent of users of health clinics provided by the government and 66 percent of the users of public hospitals did not pay for the services rendered (MOH, 1996). Fees collected as revenues from public hospitals constituted about 3 percent of the total MOH expenditure (Chua, 1998; Safurah et al. 2013). In fact, the government subsidises almost 95 percent of the patients' cost of treatment and the majority or close to 90 percent of the population has access to healthcare services. Invariably, the public health system provides a safety net against catastrophic expenditure especially for chronic illnesses (MOH, 2011; Chan, 2014; Ng et al. 2014).

Adding plurality to the public health care sector was the existence of a few non-profit charitable private hospitals in the urban areas. These private facilities were established by the early Chinese philanthropists and religious private hospitals by the Christian missionaries which were seen originally to provide care for the poor and the marginalised

groups. However, over the span of years and facing stiff competitions from the corporate owned for profit private hospitals, these charitable institutions subsequently began catering for the affluent society to cross-subsidize the cost for treatment of the poor (Chee & Barraclough, 2007; Rasiah et al. 2009; 2011). In the course of events, some of these private charitable facilities are seen to have diverted from their original benevolent mission of a non profit organisation. They began operating like the corporate private hospitals for business sustainability except for a few non- profit charitable hospitals struggling for survival. Notwithstanding, some of these charitable private hospitals have embraced the corporate business culture of running the organisations for profits but at the same time soliciting financial contributions and received much donations from the public as well as the government (Chee & Barraclough, 2007).

The era prior to the 1980s, there were a handful of corporate owned for profit private hospitals which were first initiated by a few enterprising group of doctors and subsequently in joint venture business with private corporate investors. There were also a few scattered small private maternity and nursing homes with entrepreneurial initiatives established mainly in the affluent urban areas. Besides, the private primary health care in the urban sector was predominantly provided by solo or group practice of general practitioners for fee of service, together with some private medical specialists, private dental practitioners and private pharmacists (Chee & Barraclough, 2007).

On the other hand, in the rural private plantation and mining sectors owned by the multinational conglomerates, there were a few static and mobile dispensaries providing primary health care under the labour laws (Barraclough, 1999; Chee & Barraclough, 2007). In addition, there were a few small and poorly equipped estate hospitals catering mostly for the menial workers. In cases of acute emergency and serious illness, patients

were despatched to the nearest public hospitals. In this context, the MMA had been highly vocal on the estate hospital services which were found to be of poor standard of care (MMA, 1988). Subsequently, in late 1996 the government announced the closure of estate hospitals and convert them to clinics status (Barracough, 1999). Besides the practice of western medicine, traditional medicine and complementary medicine were also seen to complement the private health care sector (Nik Rosnah, 2002; 2005; Chee & Barracough, 2007).

Overall the public health care system has been described as egalitarian in character with its focus on primary care with greater accessibility assured in terms of geographical and financial perspectives. Further public health system under the stewardship of MOH encompasses a comprehensive range of preventive, curative and rehabilitative healthcare services. The standard of healthcare provision is said to be high and almost comparable with those of developed countries (Meerman, 1979; Chee & Barracough, 2007; Chee, 2008).

Malaysia's health care system had achieved remarkable advances in comparison with many developing countries especially Asian countries in spite of its low expenditure to the Gross Domestic Product (GDP). For instance, Malaysia spent about 3.0 percent GDP in the provision of health services in 1997 (World Bank, 1999), 3.26 percent GDP in 2000, 3.85 percent GDP in 2005, and 4.4 percent GDP in 2011 as illustrated in Table 4.2 (MOH, 2014b).

Table 4.2: Total Expenditure on Health and Percentage to GDP, 1997 – 2012 (RM Million)  
(MOH, 2014b)

Year	Total Health Expenditure (RM million)	Total % to GDP
1997	8.05	2.85
1998	8.75	3.09
1999	9.71	3.23
2000	11.64	3.26
2001	13.18	3.74
2002	14.59	3.81
2003	18.40	4.39
2004	19.91	4.20
2005	20.13	3.85
2006	24.23	4.22
2007	26.39	4.11
2008	29.09	4.12
2009	31.39	4.96
2010	35.58	4.58
2011	38.55	4.40
2012	42.26	4.50

Currently the total expenditure on health as a percentage to GDP (current prices) is still low at 4.50 percent compared with other developing and developed countries (MOH, 2014b; WHO, 2014). Surprisingly, it was reported that Malaysia ranked second best in the world after Cuba in terms of geographical universal access to primary care for its citizens (Chan, 2013; 2014).

Based on these impressive health indicators and the low public expenditure to GDP, Malaysia can proclaim to have achieved universal health coverage (UHC) (Chan, 2014; Ng et al. 2014). Threading the work of Gilson et al. (2007), UHC is said to be achieved “when the whole population of a country has access to good quality services according to needs and preferences, regardless of income levels, social status, or residency” and when policies adopted among others include “objectives of equity in payments (where the rich pay more than the poor), financial protection (where people should not become poor as a

result of using health care) and equity in access or utilisation (where care received is according to need rather than ability to pay)” (Ng et al. 2014, p.2).

However, this remarkable achievement in the healthcare system is under critical scrutiny after Malaysia embarked on the privatisation policy in the 1980s. The promotion of private hospitals under a loosely regulatory framework had brought forth major health complexities such as the escalating exorbitant cost, inequitable access and variations in quality care (Chan, 2007; 2011; 2013; 2014; Chee & Barraclough, 2007; Rasiah et al. 2009; Nik Rosnah & Lee, 2011a; Ng et al. 2014). Hence, discussions on privatisation policy in the subsequent sections are crucial to have a better understanding of its impact and repercussions on the health care system in Malaysia which is relevant to this study.

#### **4.4 Privatisation Policy in Malaysia**

The global economic and structural crises in the early 1980s have exposed several weaknesses of institutional capacity of the public sector in many countries including Malaysia. The growing demands and structural reform policies have resulted in inefficiency and overburden costs of many public sectors including the health care. This phenomenon had resulted in the shift in the global ideology as reflected in the so called “Washington consensus” policies of international institutions, which had encouraged the reduction in the size of state participation and the promotion of the private sector (Jomo, 1995; Tan, 2008; Jomo & Wee, 2014). Privatisation was highly advocated since the 1980s by many countries especially where major sectors of the economy had been dominated by state controlled enterprises (Jomo, 1995; Tan, 2008; Lee et al. 2011; Chan, 2013; 2014; Jomo & Wee, 2014).

Malaysia was among the early developing countries to embark on this privatisation programme, which has been advocated as a prescription and endorsed by the international financial institutions particularly the World Bank, Asian Development Bank, and International Monetary Fund as part of the structural adjustment programmes (Jomo, 1995; Chan, 2014; Jomo & Wee, 2014). In fact, privatisation programme launched in Malaysia between the mid 1980s and mid 1990s was the most extensive in the developing countries. This period coincides with the era of the Thatcher's administration in United Kingdom and the Reagan's presidency in the United States where the rhetoric privatisation was strongly entrenched. Based on the many of the decisions made on privatisation in Malaysia, the modus operandi seemed to resemble the privatisation initiatives in United Kingdom (Jomo et al. 1995; Tan, 2008; Chan, 2013; 2014; Jomo & Wee, 2014).

Similarly, the earliest references to privatisation in Malaysia were made known sometime in 1983 by the then Prime Minister Mahathir Mohammad under the "Malaysia Incorporated" concept. Following this concept the government would provide an enabling economic environment in terms of infrastructure, deregulation and liberalisation, and the overall macroeconomic management where the private sector would assume the role as the engine of growth (EPU, 1985; Malaysia, 1986; Jomo, 1995; Tan, 2008; Jomo & Wee, 2014).

#### **4.4.1 Rationale for Privatisation**

Several factors were cited for Malaysia's interest in public reform initiatives during the 1980s. Both economic and political factors have often been cited. However, political motivation was said to be the predominant factor in the case of Malaysia as this affected the character and outcome of privatisation policy (Jomo, 1995; Tan, 2008; Jomo & Wee,

2014). Political economists such as Tan (2008), Gomez and Saravanamuttu (2013), Chan (2013; 2014), and Jomo and Wee (2014) argue that privatisation was partly in response to the inefficiencies of the New Economic Policy (NEP) in achieving its affirmative objectives. While inefficiencies were tolerated during high period of economic growth in the 1970s, but the economic recession in 1982 was untenable. Tan (2007) asserts that privatisation was ultimately motivated by political considerations reflecting a new shift in the balance of power as well as the increasing competition for resources within the dominant United Malays National Organisation (UMNO), partner in the ruling coalition front government. Several authors such as Yusoff (1990); Jomo (1995); Gomez (2002); Gomez and Saravanamuttu (2013); Chan 2013; 2014; and Jomo and Wee (2014) argue that privatisation policy became an important means for supporting and providing opportunities to reward the emergence of new, politically well-connected, predominantly, but not exclusively, Bumiputra Malay rentiers.

Besides, the privatisation policy among others coincided with the move to curb public capital expenditures and public enterprises deficits (Dass & Abbott, 2008). The poor performance of the many public enterprises comprising both federal and state levels brought forth strong criticisms. These state-owned enterprises (SOEs) were notoriously associated with wastage, inefficiency, and corruption (Rugayah, 1995; Ismail, 1995). It is claimed that these SOEs in Malaysia not only increased public debt, but also inefficient and accumulate losses. This further led to the wastage of investment resources, which increased the government's fiscal burden and slowed down economic growth (Rugayah, 1995; Ismail, 1995).

#### **4.4.2 Guidelines on Privatisation**

In pursuant to the policy of economic liberalisation, the government issued the Guidelines on Privatisation in 1985, which outlined the broad objectives, the key sectors to be privatised and the implementation of privatisation (EPU, 1985). The official objectives among others; first to relieve the financial and administrative burden of the government; second, to promote competition, efficiency, and productivity of services; third, to accelerate the growth rate of the economy; fourth, to reduce the size of the public sector; and fifth, to meet the objectives of the New Economic Policy (EPU, 1985). In this context, Jomo (1995) argues that in Malaysia, the definition of privatisation has been extremely broad which encompasses “partial and full divestures, contracting-out, leasing, build-operate transfer arrangements and corporatizations” (p. 43). In spite of the official broad guidelines, the issue of prerequisite regulatory framework was not seen to be given emphasis until much later years in the era of privatisation programmes (Adam & Cavandish, 1995; Naidu, 1995; Nik Rosnah, 2002).

Nevertheless, the basic approach to regulation is clarified under the “Rules and Regulations Regarding Acquisitions, Mergers and Takeovers” which stipulates that the guidelines may be viewed as a means of restructuring the pattern of ownership and control of the corporate sector. Besides, the guidelines encourage those forms of private investment which contribute to the development of the country, consistent with the objectives of NEP (Ministry of Finance, 1989). NEP was announced by the government in 1970 after the events of ethnic conflicts in May 1969. The objectives of NEP among others was to create the socio-economic environments for national unity through massive economic redistribution programmes to achieve its twin prong of poverty eradication and the restructuring of society. Efforts to restructure society sought to reduce inter-ethnic economic disparity, and to create a Bumiputra entrepreneurial community (Jomo & Wee,

2014). Likewise, Adam and Cavendish (1995) assert that “this approach has resulted in heavy emphasis on the form of corporate ownership, rather than on corporate performance per se, but whilst there is concern that over-regulation of the economy in pursuit of NEP objectives has constrained growth and accentuated private-sector risk-aversion, the experience of recent decades suggests that regulation has been managed relatively judiciously” (p. 40). Both authors argue that while there is substantial capacity for regulation, whether initiatives already taken so far point to the development of appropriate regulatory structure is still uncertain (Adam & Cavendish, 1995).

#### **4.4.3 Absence of Prerequisite Regulatory Framework**

Notwithstanding the absence of a prerequisite regulatory framework on privatisation, Malaysia embarked on massive privatisation programmes from the mid 1980s to the mid 1990s encompassing the transport, communication, construction, public utilities and the health sector. During this period, Malaysia has been frequently portrayed as one of the successful stories of privatisation amongst developing countries (Jomo, 1995; Tan, 2008; Jomo & Wee, 2014).

The extensive privatisations during the first seven years period were based on an ad hoc policy on “the first come, first served basis” which drew heavy criticisms due to the lack of transparency and public accountability (Jomo, 1995; Gomez, 2002; Tan, 2008; Jomo & Wee, 2014). There were controversies in the manner of awarding privatisation projects without an open tendering system. In fact, there were general concerns over the costs, accessibility, and quality of the services provided. The evidence of substantial increase in user price prior to privatisation implies that these official guidelines do not motivate public confidence (Jomo, 1995; Jomo et al. 1995; Rogayah, 1995; Jomo & Wee, 2014).

In addition, with the state controlled mainstream media and amendment of the Official Secret Act in 1986 among others, to include the government tender documents and the mandatory jail sentence upon conviction further exacerbated the limited public democratic space and governmental transparency (Jomo, 1995; Rogayah, 1995; Jomo & Wee, 2014). While government gave assurance of a regulatory framework, there was little evidence of such regulation on privatisation (Jomo, 1995; Adam & Cavendish, 1995; Nik Rosnah, 2002; Jomo & Wee, 2014).

#### **4.4.4 Traditional Regulatory System**

On a similar note, the traditional regulatory system in Malaysia was seen to be in the nascent stage and independent regulatory role was a relative new concept (Burr, 1995; Jomo, 1995; Adam & Cavendish, 1995). The types of regulations available then were merely to control over market entry through licensing, supervision of tariffs and the maintenance of service standards. The regulatory system was seen to be ad hoc, evolving over the years and scope of regulatory intervention was rather basic. Adam and Cavendish (1995) argue that “generally regulation has been internalised within the government agencies, or department with inherent legislative powers of control and regulation” (p.40).

#### **4.4.5 Privatisation Master Plan 1991**

Acknowledging criticisms of the arbitrary ad hoc policy, it was not until 1991 that the government commissioned a Privatisation Master Plan (PMP) which among others stipulated the policy framework, action plan and the time line of privatisation projects (EPU, 1991; Jomo & Wee, 2014). It identified the public enterprises to be privatised in various phases and a total of 149 potential agencies for divestment including the health sector (EPU, 1991). Although the PMP 1991 has proposed a single uniform regulatory structure for all privatised enterprises under a Privatisation Act, the issue of post-

privatisation regulation received scant attention (Jomo, 1995). Further Jomo argues that “events on the ground have preceded it, however, and there already exists a separate regulatory structure in the Telecommunications Act of 1989” (Jomo, 1995, p.87). Coincidentally this particular Act has much resemblance with the Telecommunication Act of 1984 in United Kingdom. Malaysia has implemented an almost identical regulation and competition structures (Jomo, 1995).

#### **4.4.6 Regulatory Landscape**

Similarly, several issues have been raised as there is an absence of a timely structure and capacities of the regulatory agencies for the private sector monopolies. Besides, there is the lack of clarity surrounding the exact structure of the regulation. Critics have asserted that by following the United Kingdom model of privatisation, the Malaysian government may have underestimated the cost of resources required (Jomo, 1995).

Subsequently under the Seventh Malaysia Plan 1996-2000 (Malaysia, 1996), several regulatory authorities were established to maintain standards and protect public interests in terms of pricing, availability and quality of services provided, and to ensure healthy development of the privatised sectors. Thus, between the period 1991-1995, a total of 11 regulatory authorities were established to regulate the privatised sectors such as “electricity and gas supply, ports, airports, highways, post, telecommunications, railway and sewage” (Malaysia, 1996, p. 215). These regulatory agencies are monitored by the Economic Planning Unit (EPU).

Nonetheless, there is no explicit link between the functions of regulatory agencies and the creation of incentives to ensure that the privatised entities provide efficient services (Jomo, 1995; Naidu, 1995). Further, another key feature in the regulation is the respective

ministers seem to have considerable influence over the policies of the privatised providers. Authors like Burr (1995), and Naidu and Lee (1997) argue that there is ambiguity with regard to the autonomous power of the relevant regulatory agency as these regulatory agencies appear to require ministerial endorsement or even political interference. Regulators are not seen as independent from their respective ministries (Burr, 1995; Naidu & Lee, 1997). Further, Naidu (1995) suggests there is “a distinct possibility, in some cases, of capture of the regulatory agency by industry” (p. 217).

Despite, Malaysia has been seen to be making good progress in the early era of privatisation especially in meeting the government’s explicit stated objectives. Privatisation has been instrumental in enhancing economic growth (EPU, 1991). This growth is said to have been attributed by permitting private entrepreneurship in sectors which were previously held by the government. In addition, privatisation has been credited for reducing government’s administrative and financial commitments. Based on the PMP, revenue from sale of government equity in the various privatised entities has generated RM 1.18 billion, and the government had purportedly saved an excess of RM 8.2 billion in capital expenditure for the development of infrastructures through privatised build-operate-transfer projects (EPU, 1991; Jomo, 1995).

However, most of these declared theoretical gains were rebutted. Critics argue that there were trade-offs and the privatisation policy has extremely compromised most of the explicit official objectives (Adam & Cavendish, 1995; Jomo, 1995; Naidu, 1995; Gomez, 2002; Gomez & Saravanamuttu, 2013; Chan, 2014; Jomo & Wee, 2014). Over the decades and the subsequent state’s intervention of bail-outs, and the financial failures as evidenced especially in the eventual renationalization of four of its largest privatization projects namely, Indah Water Konsortium (IWK), the operator of the national sewage

system; Kuala Lumpur's Light Rail Transit (LRT), Malaysia Airlines (MAS), the national airline, and Proton, the national car company by 2000, proved that the claim was premature (Tan, 2008). The privatisation initiatives have been seen as not a panacea to the economical problems in developing countries particularly Malaysia. It is argued that the failure in the Malaysian case has been generally blamed on the problems of political patronage, rent-seeking, corruption and ineffective regulatory framework linking to the weak institutions. (Jomo, 1995; Jomo et al. 1995; Gomez, 1995; Tan, 2008; Gomez & Saravanamuttu, 2013; Chan, 2013, 2014; Jomo & Wee, 2014).

#### **4.5 Healthcare Privatisation**

Similarly, the privatisation of health care sector was however an equally controversial and highly political sensitive issue in Malaysia as the state had been the principal financier and welfare provider of health to its citizen since independence in 1957 until the 1980s (Chee & Barraclough, 2007; Lee et al. 2011; Chan, 1997; 2013; 2014; Chee & Por, 2015). The ruling National Front Government, which comprised of a coalition of political parties dominated by the United Malays National Organisation (UMNO) found extreme difficulty in extricating its obligations and responsibilities towards the majority of the rural Malay Bumiputra community who had given their political support then (Chee & Barraclough, 2007; Lee et al. 2011; Chan, 2013; 2014; Chee & Por, 2015).

The 1991 Privatisation Master Plan had included little about the healthcare sector which was not seen as a priority compared with the other privatisation projects. Nevertheless, the Government Medical Store (GMS) was identified as the first to be privatised. In addition, the public general hospitals had also been identified potentially to be privatised. These public hospitals were scheduled to be privatised 5 years later (EPU, 1991).

In reality, privatisation in healthcare sector was however much delayed after over a decade (Chee & Barraclough, 2007). Analysts such as Barraclough (2000), Chan (2007; 2010; 2013), and Chee and Barraclough (2007) argue that the delay has been due to not only political factor but the insurmountable challenges facing the populist UMNO led coalition front government in abandoning its principal role as a welfare-oriented state. This controversial topic on healthcare privatisation will be discussed further in the following Chapter 5. Nevertheless, the subsequent section on this chapter discusses the promotion of the corporate private hospitals under the context of ‘passive’ privatisation policy (Chee & Barraclough, 2007).

#### **4.6 Development of Corporate Private Hospitals**

Faced with this dilemma of political sensitivity and feared of the electoral backlash in the 1980s, as an alternative policy, the encouragement of the development of private hospitals and other private healthcare facilities and services was seen as less contentious (Chee & Barraclough, 2007). The state’s policy of passive privatization is evident with the encouragement of the development of private healthcare facilities and services especially the corporate private hospitals. This phenomenon was seen to be in line with the Malaysia’s Incorporated Concept providing a conducive environment in terms of infrastructure, deregulation, liberalisation, and the overall macroeconomic management, but the private sector is to assume the role as the main engine of growth (EPU, 1985; Jomo, 1995; Chee & Barraclough, 2007; Jomo & Wee, 2014).

Strong encouragement is explicit in the economic policies in the form of granting numerous tax incentives to the private health sector. These attractive incentives among others include the industrial building allowance for setting up and commissioning of private hospital premises. In addition exemptions were given from service tax for

expenses on medical project consultancy and the utilisation of medical equipment in the hospitals. Tax deduction for expenses on pre-employment training was also given to support the growth of private hospitals nationwide (MOH, 2002; Chee & Barraclough, 2007; Chan, 2014).

In spite of the strong support and influence, private investment grew rather slowly at 2.3 percent per annum amidst the global recession during the period between 1981 to 1985 (Malaysia, 1986). However, the total private investment grew rapidly at an average rate of 16 percent between 1991 to 1995, in response to better economic performance (Malaysia, 1996). Meanwhile, under the Seventh Malaysia Plan (1996-2000), the government has expressed its intention “to gradually reduce its role in the provision of health services and increase its regulatory and enforcement functions” (Malaysia, 1996, p.544) further underscore the proliferation of private hospitals. Besides, the sustained economic growth and the emergence of the enlarged middle class with higher disposable income, demographic and epidemiological changes, advancement in medical technology, emergence of health insurance, commercialised medical practice and medical tourism have contributed to a financially lucrative environment for investment (Chee & Barraclough, 2007; MOH, 2011; Nik Rosnah & Lee, 2011; Chan, 2014; Chee & Por, 2015). Furthermore, with the endorsement of the privatisation policy, huge corporate financing could be obtained rather easily and conglomerates ventured into the private health sector business (Jomo, 1995; Jomo et al. 1995). Between 1980 to 2000, the per capita gross national product grew more than two folds from RM 3,221.00 to RM 7,523.00 (Chee & Barraclough, 2007).

Consequently, the number of corporate private hospitals with unconstrained entrepreneurial initiatives mushroomed tremendously throughout the country especially

in the urban areas from the mid 1980s. Ironically, there was no regulatory control over “the rapid growth in the numbers, or even to modulate the distribution and consequences of the growth” (Chee & Barraclough, 2007, p. 21). The prevailing legislation available then was the Private Hospitals Act 1971 which was rather rudimentary. In view of the regulatory vacuum, the other fee-for-service private healthcare facilities and services such as the maternity, nursing homes, general practitioners and medical specialists’ clinics, dental clinics and pharmacies continued to flourish and expand unabated. Prior to this era, however, there were a few for profit private hospitals together with a handful of scattered charitable and missionary private hospitals in the private health sector along side with the informal market of complementary and traditional medicine. Since 1980s the Malaysian healthcare system has gradually evolved and transformed significantly into a two-tier dichotomous public and private healthcare sectors nationwide (Nik Rosnah, 2002; 2005; 2007; Chee & Barraclough, 2007; Chee, 2008; Rasiah et al. 2011; MOH, 2011; Nik Rosnah & Lee, 2011a; 2011b; Chan, 2007, 2013, 2014; MPC, 2014; Ng et al. 2014; Chee & Por, 2015).

Based on official statistical reports available in 1980 for instance, there were 50 private healthcare facilities and services of which 10 were private hospitals. The total private healthcare facilities and services including private hospitals, acute ambulatory centres, maternity homes, nursing homes haemodialysis centres in Malaysia grew rapidly from 50 in 1980 to 174 in 1990, 224 in 2000, and 296 in 2010. By 2013 there were a total of 656 private healthcare facilities including 343 haemodialysis centres as illustrated in Figure 4.1.

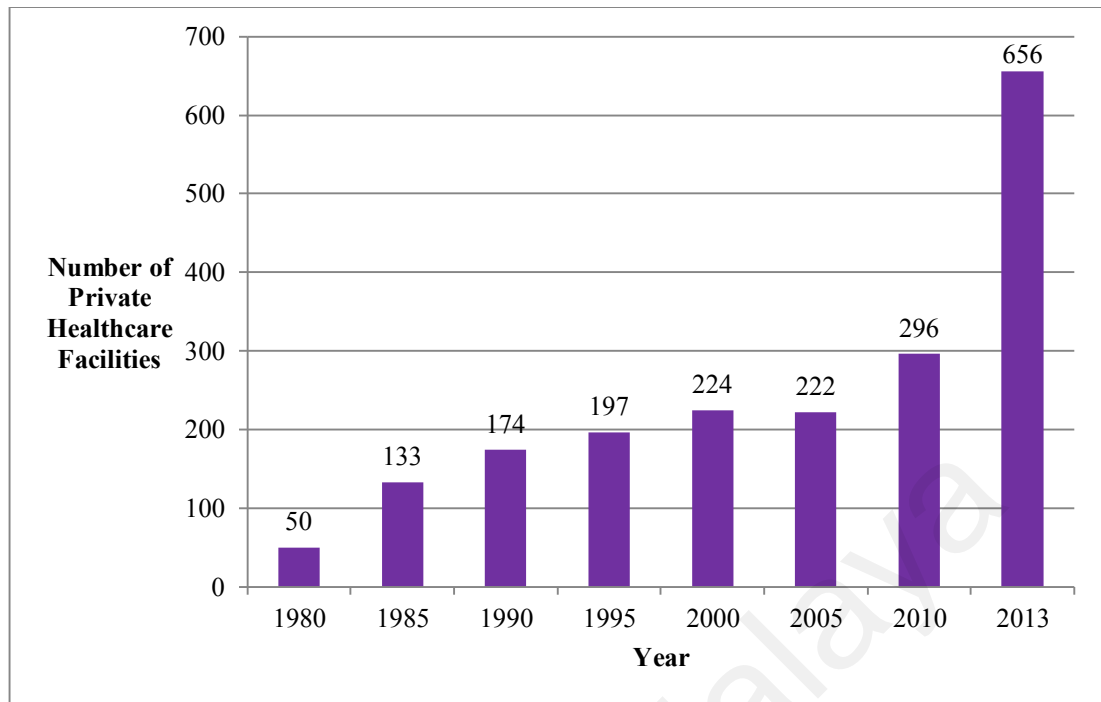


Figure 4.1: Total Number of Registered Private Healthcare Facilities in Malaysia 1980 – 2013  
(Annual Report MOH, various years; Health Facts MOH, 2000; 2005; 2010; 2014)

Significantly this unprecedented rapid growth was mainly seen in the development of corporate private hospitals which increased from 10 in 1980, to 32 in 1983, and 128 private hospitals in 2003 in tandem with rapid rise in private investment and the national income. These fees-for-service private hospitals were initially owned by groups of enterprising private medical practitioners and later on in joint-venture with corporate investors (Chee & Barraclough, 2007).

#### 4.6.1 Emergence of Government-Linked Corporate Private Hospitals

Subsequently, with the implementation of affirmative public policies, government-linked companies (GLC) owned and controlled most of the tertiary care private hospitals through mergers and acquisitions (Lee et al. 2011; Chan, 2013; 2014). In fact the GLC owned private hospitals account for more than 40 percent of the total private hospital beds in Malaysia (Chan, 2014). GLC are defined “as companies that have primary commercial objective and in which the Malaysian government has a direct controlling stake, not just

percentage ownership” (Chan, 2014, p.13). For instance at the federal level, Khazanah Nasional Berhad, the government’s sovereign wealth fund has controlling stake in Pantai Holdings, a local healthcare provider and Singapore healthcare provider Parkway Group, with nine corporate private hospitals in Malaysia through Integrated Healthcare Holding (IHH) (Lee et al. 2011; Chan, 2013; 2014).

In recent years, Khazanah is seen as a transnational investor with a new strategic shareholder Mitsui & Company Limited, a Japanese trading corporation owning 30 percent of the IHH with multiple geographical exposure via acquisitions. It is now the biggest private healthcare provider in Asia and has acquired Turkey’s largest private hospital group Acibadem (Chan, 2014). Currently, IHH is reported to be the second largest public listed private healthcare provider in the world (Chan, 2014).

At the state level, the Johor state government’s public listed conglomerate KPJ Healthcare Berhad (KPJ) has the largest chain of 26 private hospitals in the country and two in Indonesia (Chan, 2014). In Melaka, the state government had also entered into joint ventures healthcare business with stakes in Southern Medical Centre in Melaka and another in Batu Pahat, Johor. While, the Penang state government played supporting role with KPJ in the management of Bukit Mertajam Specialist Medical Centre and Bayan Baru Medical Medical Centre (Chee & Barraclough, 2007).

In addition, the Trengganu state government through its State Economic Development Corporation, which owned Kumpulan Mediiman Sdn. Berhad has three private secondary care hospitals under the group which include Kuantan Medical Centre, Darul Iman Medical, and Kelana Jaya Medical Centre (Nik Rosnah, 2002; 2005). In 2010, the state government acquired majority share holding in IHeal Medical Centre located at a popular shopping mall in Kuala Lumpur.

Besides, Sime Darby, another government linked corporation owns the flagship of 3 tertiary care corporate private hospitals namely, Ramsay Sime Darby Medical Centre, Subang Jaya, Sime Darby Ara Damansara Medical Centre in Subang and the latest ParkCity Medical Centre in the affluent Desa Park City, Kepong, Kuala Lumpur (personal communication).

In addition, Malaysia's national petroleum corporation, Petronas owns the prestigious Prince Court Medical Centre in the heart of metropolitan city of Kuala Lumpur. This luxurious purpose-built 300 bedded international showpiece with multi disciplinary facility was commissioned in 2007 at an exorbitant cost of over RM 1.0 billion. It was initially managed by VAMED of Austria, an international healthcare management corporation in collaboration with the Medical University of Vienna. Its vision is to be the leading healthcare provider in Asia offering comprehensive medical care to the highest standards through world class facilities, innovative technology and excellent customer services (Nik Rosnah & Lee, 2011a).

It is argued that the active role of the government as a corporate investor in the provision of private health care is in direct contradiction of its original policy in ensuring the welfare and social safety net for the lower income and marginalised groups (Barracough, 1999; Chee & Barracough, 2007; Rasiah et. al. 2009; 2011; Chan, 2013; 2014; Chee & Por, 2015). Further, it is also been seen to be in direct contradiction with its stated objectives under its Seventh Malaysia Plan that it would gradually reducing its role in the provision of healthcare services and instead increase its role in the regulatory provisions and enforcement functions (Malaysia, 1996; Chee & Barracough, 2007). Evidence of explicit regulatory and enforcement functions came only after the implementation of Act 586 in

2006 to regulate the private hospitals and all other private healthcare facilities and services (Nik Rosnah & Lee, 2011a).

#### 4.7 Regulatory Control of Private Hospitals under Act 586

A year after the historical mandatory registration and licensing under the new private healthcare regulations in 2006, a total of 195 private hospitals were registered and licensed in 2007. In spite of the regulatory intervention, the number of private hospital establishments continued to increase significantly to 214 by the end of 2013 as illustrated in Figure 4.2.

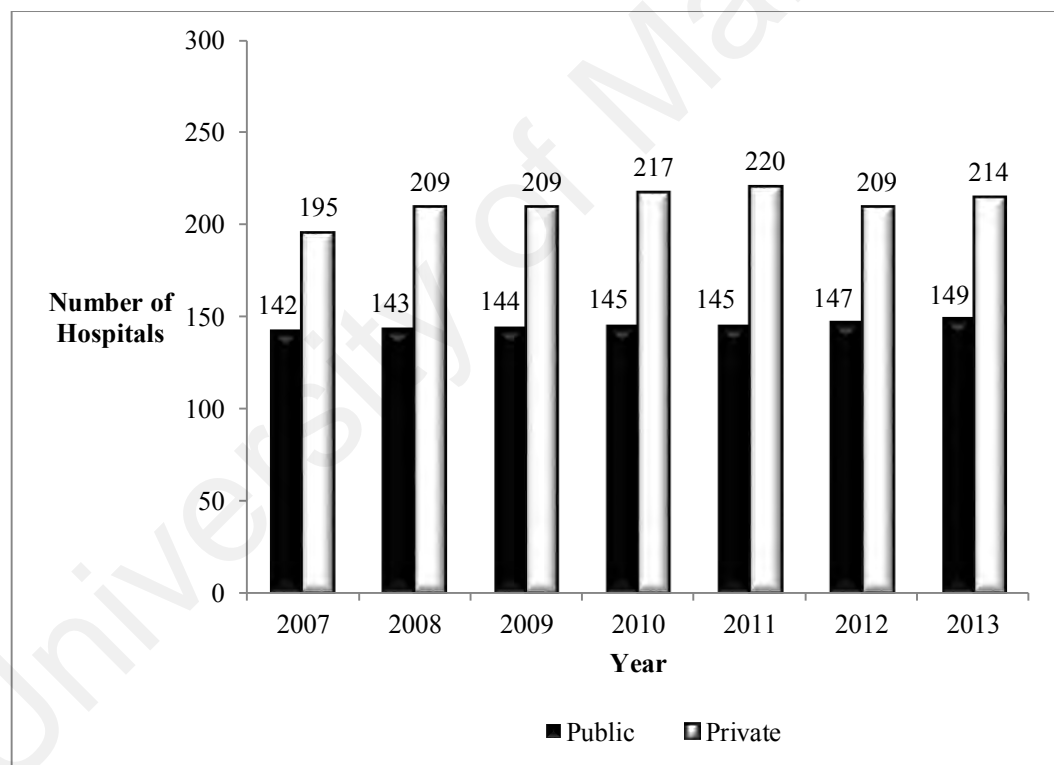


Figure 4.2: Total Public & Licensed Private Hospitals 2007-2013  
( Health Facts 2007-2014, MOH)

Correspondingly, the private hospital beds increased exponentially from 1,171 beds which formed 5.8 percent of the total hospital beds in the country in 1980 to 10,348 beds forming 28.4 percent of the total beds in 2001 (Chee & Barraclough, 2007). By 2013, there were a total of 214 licensed private hospitals providing a total capacity of 14,033

official beds or 24.42 percent of the total beds in the country (MOH, 2014a). In comparison with the public sector in 2013, there were a total of 149 public hospitals providing 43,437 official beds capacity (MOH, 2014a). The MOH formed the bulk of 141 public hospitals contributing to a total of 39,728 beds which include nine other Special Medical Institutions. On the other hand, there are also eight non-MOH public hospitals providing another 3,709 beds. Overall, the public hospitals provide 75.58% of the total 57,470 official beds available nationwide as illustrated in Table 4.3.

Table 4.3: Total Health Facilities 2013 ( MOH, 2014)

Health Facilities	NO.	BEDS
MOH Hospitals	132	34,576
Special Medical Institutions (MOH)	9	5,152
Non-MOH Government Hospitals	8	3,709
Private Hospitals	214	14,033
Private Maternity Homes	20	87
Private Nursing Homes	14	444
Private Hospice	4	38
Ambulatory Care Centre	54	125

#### 4.8 Impact of the Private Sector on the Public Health Sector

The unrelenting promotion of the commercialised private hospitals together with other private healthcare facilities and services had resulted in the massive brain drain of medical staff from the public sector over the decades (Nik Rosnah, 2002; 2005; Chee & Barraclough, 2007; Sirajoon & Yazad, 2008). This huge manpower exodus among others includes the experienced medical specialists, medical officers, dentists, pharmacists, nurses and other allied healthcare personnel into the lucrative private health sector. It affected the accessibility and delivery of equitable quality care in the public sector. As a result, public hospitals experienced depleted manpower and resources, and shouldering the burden of daily heavy workloads. Hence, there are severe congestions in public

hospitals, both in-patients and out-patients departments, with long waiting list for elective surgeries and deteriorating standard of medical care (MOH, 2011).

Disgruntled medical professionals and staff cited low wages, lack of incentives for promotions, low motivation and the heavy workload environment as factors contributing to the exodus into the private sector (Nik Rosnah, 2002; 2005; MOH, 2011; Chan, 2014). It was a major concern to the government and the medical profession itself since 1980s. For instance in 1972, it was reported that 59 percent of the total doctors were in the government public sector while 41 percent of the doctors were in the private sector mostly medical general practitioners in the urban areas. In the late 1970s, the survey found 44.4 percent of the doctors were found to be in the private health sector (MMA, 1980). Subsequently in 1986 the percentage of doctors practicing in the private sector increased significantly to 58 percent. In 1995 official statistics reported that 60 percent of the medical specialists, 51 percent of the dentists and 74 percent of the pharmacists were practicing in the private sector (Malaysia, 1996). By 1996 the percentage of doctors practicing the private sector was at 54.7 percent (MOH, 1996). However, between 1990 and 1998, an average of 324 doctors and specialists left the public sector each year.

In spite of the government's concerted efforts to increase the supply of the medical professionals and other allied healthcare staff, the public health sector continues to face the acute shortage of manpower. There was a dire shortage of specialists especially in the field of surgery, paediatrics, radiology, orthopaedics and anaesthesiology (Malaysia, 1996). Foreign doctors from developing countries were recruited as an interim measure but they were not familiar with the local clinical environment. The public sector is seen to be "the main training ground for doctors, nurses and other allied health staff who would eventually join the lucrative private healthcare sector" (Jomo & Chee, 1985, p.78).

On the other hand, there is evident of gross underutilisation of scarce technical expertise in the private health sector. A study by Abu Bakar Sulaiman et al. (1993) revealed that although more than 75 percent of the private specialists had at least 10 years clinical experience, only 25 percent of the cases handled by these specialists could be classified as “complex cases” which truly requiring the expertise of specialists. This is due to the system then whereby private specialists managed mainly unscreened and walk-in patients, unlike the referral system practiced in the public sector (Abu Bakar Sulaiman et al. 1993).

In terms of the distribution of the doctors and other allied health professionals in both the health sectors, the percentage of public to private health human resources have fluctuated over the years. This was due to social-economic factors as well as the government’s introduction of mandatory service in the public health sector. Meantime in 1999, the government proposed plans to corporatize the public hospitals in an attempt to encourage the retention of medical professionals, and partly due to the growing trend in the global practice (Chan, 2014). Hence, over the years in spite of the government providing much better financial incentives and the compulsory service in the public sector for doctors, nurses and other health professionals, brain drain into the greener pasture of the private sector is inevitable and continues albeit at a much slower pace (MOH, 2008).

Simultaneously, the government continued to invest in human capital development, which is an important resource and success factor for better performance of the future healthcare delivery (MOH, 2011). Under the Ninth Malaysia Plan (2006-2010) the major focus had been the enhancement of human capital as adequate manpower in number and skill remain elusive (Malaysia, 2006; MOH, 2011). In this context, the private sector has been encouraged to establish more medical colleges with twining programmes to

complement the supply of doctors and other paramedical staff such as nurses to overcome the acute shortage of manpower in the health sector. Over the years the number of Malaysian health professionals such as doctors, dentists, pharmacists, state registered nurses and paramedical staff trained both locally and abroad have been increased significantly to serve the needs of the health sector. A breakdown and comparison of the human resources capacity between the public and private health sectors from 2010 to 2013 is illustrated in Table 4.4.

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Table 4.4: Breakdown of Healthcare Professionals in the Public and Private Health Sectors 2010-2013 (Health Facts 2010-2013 MOH)

	2010			2011			2012			2013			
Profession	Public	Private	Total	Public	Private	Total	Public	Private	Total	Public	Private	Total	Profession: Population
Doctors <sup>1+2</sup>	22,429 <sup>a</sup>	10,550	32,979	25,845 <sup>a</sup>	10,762	36,607	27,478 <sup>a</sup>	11,240	38,718	35,219 <sup>a</sup>	11,697	46,916	1 : 633
Dentists <sup>1+3+8</sup>	2,055	1,755	3,810	2,452	1,801	4,253	2,664	1,894	4,558	3,256	1,979	5,235	1 : 5,676
Pharmacists <sup>1+4</sup>	4,610	3,149	7,759	5,288	3,344	8,632	5,908	3,744	9,652	6,752	3,325	10,077	1 : 2,949
Nurses <sup>1+7</sup>	47,992	21,118	69,110	50,063	24,725	74,788	56,089	28,879	84,968	62,514	26,653	89,167	1 : 333
Community Nurses <sup>1+7+c</sup>	20,922	167	21,089	21,928	338	22,266	22,917	301	23,218	24,152	267	24,419	-
Dental Nurses <sup>1+8</sup>	2,486 <sup>b</sup>	-	2,486 <sup>b</sup>	2,528 <sup>b</sup>	-	2,528 <sup>b</sup>	2,684	-	2,684	2,793	-	2,793	-
Radiographers <sup>1</sup>	2,039 <sup>b</sup>	n.a	2,039 <sup>b</sup>	2,167 <sup>b</sup>	n.a	2,167 <sup>b</sup>	2,883	1,451	4,334	2,699	n.a	2,699	-
Physiotherapists <sup>1</sup>	807 <sup>b</sup>	n.a	807 <sup>b</sup>	818 <sup>b</sup>	n.a	818 <sup>b</sup>	1,041	n.a	1,041	1,178	n.a	1,178	-
Asst. Medical Officer <sup>1+6</sup>	9,556	794	10,350	10,289	873	11,162	10,902	944	11,846	11,089	1,428	12,517	1 : 2,374
Pharmacy Assistant	3,318 <sup>b</sup>	n.a	3,318 <sup>b</sup>	3,534 <sup>b</sup>	n.a	3,534 <sup>b</sup>	4,068	482	4,550	4,294	552	4,846	-
Opticians <sup>5</sup>	-	2,827	2,827	-	2,512	2,512	-	2,940	2,940	-	3,060	3,060	1 : 9,711
Medical Lab. Technologists <sup>1</sup>	4,980 <sup>b</sup>	n.a	4,980 <sup>b</sup>	5,310 <sup>b</sup>	n.a	5,310 <sup>b</sup>	6,161	n.a	6,161	6,108	n.a	6,108	-

Note:

n.a: not available

<sup>a</sup>: Includes Houseman (House Officers)

<sup>b</sup>: MoH only

<sup>c</sup>: Includes Midwives (Division II)

<sup>1</sup>Human Resources Division, MoH

<sup>2</sup>Malaysian Medical Council

<sup>3</sup>Malaysian Dental Council

<sup>4</sup>Pharmacy Board Malaysia

<sup>5</sup>Malaysia Optical Council

<sup>6</sup>Medical Assistant Board

<sup>7</sup>Malaysia Nursing Board

<sup>8</sup>Oral Health Division, MoH

<sup>9</sup>Malaysian Dental Technologists Association

The intake of medical professionals into the public health system has also been significant over the last decades. In 2007 for instance, there were 14,298 doctors in the public sector and 9,440 doctors in the private sector and in 2010 the number of doctors in the public sector double to 22,429 doctors against 10,550 doctors in the private sector. By 2013, number of doctors in the public sector has tripled to 35,219 doctors (including house officers) and private sector attracted 11,697 doctors as shown in Figure 4.3. The total medical profession to population ratio is currently at 1: 633 (MOH, 2014a). As Malaysia aspired to be a developed state by 2020, the targeted doctor to population ratio has been set at 1:400 (Malaysia, 2011).

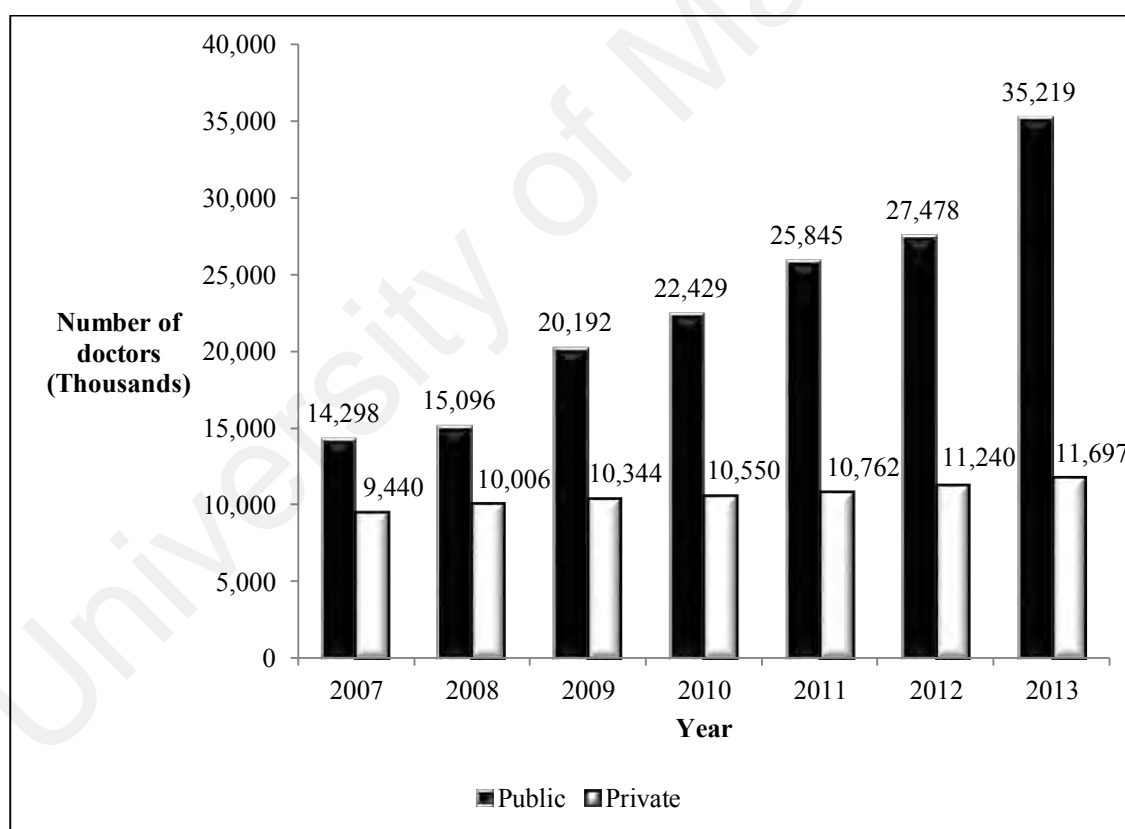


Figure 4.3: Distribution of Doctors in the Public and Private Sector 2007-2013  
(Health Facts 2007-2014, MOH)

#### 4.9 Dissatisfactory Services in Public Hospitals

The brain drain push factors had lead to the gross public dissatisfaction over the accessibility to public hospital facilities and services. Generally these public hospitals are plagued with perennial problems of severe overcrowding of patients, long queues and waiting time, and poorer delivery of service. These overcrowded public hospitals not only had to cope with the acute shortage of doctors, nurses and other allied health staff but also had to cope with the inadequate facilities and medical equipment. The public health sector seems neglected and leaving the lower income groups especially the poor grossly affected (Nik Rosnah, 2002; 2005; Lum, 2010; Ng, 2010; Rasiah et al. 2011; Chan, 2013; 2014).

This is evidence with MOH receiving an increasing number of official complaints yearly from both the public and private sector. In 2005 for instance, there were 142 complaints involving different categories among others, the unsatisfactory quality of services, misconduct of staff, failure to adhere to standard procedure, delay/ no action taken, and those classified as “others” in the public sector compared with 39 complaints against the private sector as illustrated in Table 4.5.

Table 4.5: Total Number of Complaints Involving the Different Categories, 2005-2008  
(Complaints, Enforcement and Medico- Legal Section, MOH, 2008)

No.	Categories	2005		2006		2007		2008	
		Pub	Pri	Pub	Pri	Pub	Pri	Pub	Pri
1	Unsatisfactory Quality of Services	69	14	105	32	127	49	128	34
2	Fee	0	4	0	6	0	3	0	35
3	Misconduct of Staffs	17	3	20	9	12	4	48	7
4	Failure to Adhere to Standard Procedure	12	3	2	2	5	5	5	4
5	Delay/ No Action Taken	4	0	3	1	17	5	41	2
6	Others	40	15	41	30	56	77	13	51
	Total	142	39	171	80	217	143	235	133

Note: Pub- Public ; Pri- Private

Similarly, in 2006, there were 171 complaints of various categories against the public sector and 80 complaints against the private facilities. Subsequently in 2007 there were 217 complaints of various categories against the public hospitals and 143 complaints against the private hospitals. In 2008, 63.86 percent or 235 of the total complaints lodged were from the public health facilities with 54.46 percent or 128 of them were due to unsatisfactory quality of services. Besides, there were 133 official complaints against the private hospitals of which 26.32 percent or 35 grievances against the controversial exorbitant fee charges and 25.56 percent of them were due to unsatisfactory quality of services. However there were no complaints over the fees in the public sector as it is heavily subsidized (MOH, 2008). Besides complaints of unsatisfactory services, there are concerns of the increasing number of litigations of medico-legal cases seen in both the public and private health sectors over the decades.

#### **4.10 Rise in Negligence and Medico-Legal Cases**

The development of private hospitals under the privatisation policy had lead to both intended and unintended consequences. Among the unintended consequences manifested is not only the critical issue of escalating cost, depleted manpower resources in the public hospitals but also the responsiveness and equitable access to quality medical care had been seen to be compromised. This resulted in the escalating number of negligence and medico-legal cases including summons in the public hospitals (Ranjan, 1998). From 1993 to 2002, there were 102 medico-legal cases involving compensation of some RM 6,490,649.00 (Nik Rosnah, 2002; 2005; 2007).

Subsequently official statistics from 2000 to 2008 revealed that there were a total of 98 medico legal cases settled of which 39 cases or 39.8 percent of the cases were from the obstetrics and gynaecology discipline and followed by 16 cases or 16.3 percent from the

surgical discipline in the public hospitals sector. This include cases settled in court, settled out of out including ex gratia, and also cases which had been withdrawn or annulled by the court. A total compensation of RM 5,919,896 had been paid to 98 cases from 2000 to 2008 as illustrated in Table 4.6.

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Table 4.6: Compensation Paid For Medico- Legal Cases by Discipline, 2000-2008 (Complaints, Enforcement and Medico- Legal Section, MOH 2008)

No.	Discipline	2000 (RM)	2001 (RM)	2002 (RM)	2003 (RM)	2004 (RM)	2005 (RM)	2006 (RM)	2007 (RM)	2008 (RM)	Total (RM)
1	O & G	152,974	55,000	22,500	179,853	55,000	257,994	315,224	328,775	114,000	1,481,320
2	Surgery	20,000	326,002	303,000	66,000	50,000	25,779	121,809	28,265	132,362	1,073,217
3	Orthopedics	46,534	-	5,112	-	66,000	15,000	-	10,000	70,034	212,680
4	Paediatrics	-	-	-	-	-	30,000	32,907	293,819	189,867	546,593
5	Anaesthesia	-	-	512,827	-	-	-	-	-	12,000	524,827
6	Medical	-	-	65,000	-	30,250	-	613,057	423,353	659,096	1,790,756
7	Psychiatry	-	-	-	-	-	-	141,993	-	-	141,993
8	Ophthalmology	-	49,500	13,200	-	-	-	-	-	-	62,700
9	ENT	-	-	-	-	55,560	-	-	-	-	55,560
10	Urology	-	-	30,250	-	-	-	-	-	-	30,250
	Total (RM)	219,508	430,502	951,889	245,853	256,810	328,773	1,224,990	1,084,212	1,177,359	5,919,896

Some 30.3 percent of the total payments or RM 1,790,756 were made to 14 cases in the medical discipline, followed by 25 percent or RM 1,481,320 in the obstetrics and gynaecology discipline (MOH, 2008). In 2014, there were 18 obstetric medico litigation cases filed against the MOH, as compared to 8 recorded cases in 2013 according to the Director General of Health (Noor Hisham Abdullah, 2015).

Invariably, private hospitals do not revealed the number of negligent and medico-legal cases in view of its sensitivities (Nik Rosnah, 2002; 2005; 2007; Rasiah et al. 2009; 2011). Nonetheless, a few high profile medico litigation cases in private hospitals have been heightened in the mainstream media. Despite, professional medical indemnity and incident reports as a result of adverse events, medical errors and negligence in private hospitals were on the rise (Medical Defence Malaysia Berhad, 2007). Further, the amount of damages awarded in cases of medical negligence are also on the rise. In 2015, a medico litigation involving obstetric case was awarded RM 6.9 million (Sukumaran, 2015).

#### **4.11 Issues and Challenges in Malaysian Health System**

Although the public health system has been impressive in achieving universal health coverage for primary care, and having a good hospital referral system against the background of rising healthcare expenditure, MOH faces various challenges. There is a lack of evidence in the allocation of health resources equitably, effectively and efficiently. While the government is committed to achieve equitable access, affordability and comprehensive quality care, the proliferation of private hospitals has brought forth many areas of concerns that need to be addressed urgently with the implementation of Act 586 and Regulations 2006 (MOH, 2011).

#### **4.11.1 Accessibility and Inequitable Distribution of Resources**

In spite of the greater number of 214 private hospitals in the urban area as compared to 149 public hospitals, there is evident of gross inequity in the distribution of resources and workload. The public sector has been burdened with greater workload in terms of complexity and number of in-patient admissions and out-patients visits (MOH, 2014a).

In fact, the public hospitals provided 75.58 percent of the total beds available and attended to 69.29 percent of the total 3.32 million in-patient admissions in the country. Currently, public hospitals have the manpower strength of 75 percent of the total doctors (MOH, 2014a), but 60 percent of the medical specialists remained practising in the private sector (Malaysia, 2011).

In 2011, the private hospitals were better equipped in terms of medical diagnostic technology. Out of 75 (71.43 percent) of the total 105 magnetic resonance imaging machines (MRI) and 91 (63.64 percent) out of total 143 computerised tomography (CT) scan machines are available in the private hospitals (Sivasampu et al. 2013). Obviously, the perception derived is that the private healthcare expenditure will be much more higher than the public sector (Nik Rosnah & Lee, 2011a; MOH, 2011; Chan, 2014; Ng et al. 2014).

#### **4.11.2 Escalating Cost of Care**

The spiralling cost of healthcare expenditure is inevitable due to the demographic and epidemiological changes and the advancement in medical technology. Thus the demand of the rising population is expected to increase in admission and out-patients visits. With an increase in demand for admission which is estimated at 3 percent annually, the cost of care is expected to rise in MOH hospitals (MOH, 2011). Obviously the use of modern

medical technology and interventions have improved healthcare delivery, it has incurred high cost of expenditures. These costs encompassed “training, maintenance, infrastructure redesigned and renovation, more diagnostic investigations, and perhaps new medical consumables and reagents. New modalities of care are more extensive and require more specialised facilities like operation theatres, more endoscopic suites and intensive care beds” (MOH 2011, p. 19).

In view of the current economic and financial constraints encountered by the nation, more patients are seeking medical care in the public hospitals. This has added more financial burden to the government. The primary care services are unable to provide appropriate quality contact time between doctors and patients. Thus quality care and responsiveness have been compromised, unless more resources are made available (MOH, 2011).

Besides, in 2010 there were 2.32 million non-Malaysian citizens among others, immigrants and foreign workers, which made up 8.2 percent of the population of Malaysia (Department of Statistics Malaysia, 2010). These immigrant workers depend heavily on the highly subsidised public health facilities albeit paying slightly more than normal citizens since the beginning of 2015. In spite of the financial burden, there is also the issue of huge number of undocumented and illegal immigrants estimated to be over 2 million in the country without proper health screenings and posing potential major health hazards as cited by the Director General of Health (Mohd Ismail Merican, 2015). However, these migrant workers have not only added financial burden to the government but also bringing into this country with re-emerging infectious diseases such as tuberculosis and sexual transmitted diseases which required huge cost in control and treatment management (MOH, 2011; Mohd Ismail Merican, 2015). On the other hand, the commercialisation of private healthcare facilities have also added to the unconstrained escalating total healthcare

cost. The cost of medical care in private hospitals has been cited as exorbitant and outrages (Lum, 2010; Ng, 2010; Nik Rosnah & Lee, 2011a, 2011b; Rasiah et al. 2009; 2011; Chan, 2013; 2014; Ng et al. 2014).

In this context, health analysts such as Ng et al. (2014) suggest that comparison of prices of public and private health care services can be observed by looking at the legislated fee schedule for public hospitals (Malaysia, 1994) and the regulated schedule of fees for private facilities (Malaysia, 2006) which differ markedly. While charges for public hospitals are kept low using government funding through taxation, medical bills in private hospitals can be exorbitant due to “crass commercialisation” (Sirajoon & Yazad 2008, p.280). Private medical bills are mostly paid directly using out-of-pocket payments and through private medical insurers or from employers as part of employees health benefits (Sirajoon & Yazad, 2008; Rasiah et al. 2009, 2011; Lum, 2010; Ng, 2010; MOH, 2011; Chan, 2013; 2014; Ng et al. 2014).

#### **4.11.3 High Out-of-Pocket Payments**

The rising spiralling private healthcare cost is a major concern especially as most of the private healthcare financing is through largely direct out-of-pocket payments (OPP). In fact, “OPP expenditure formed the largest single source of funding throughout the period between 1997 and 2009 accounting to about 30-40 percent of the total health expenditure or an average of 76 percent private sector expenditure” (MOH, 2012, p.5). The Malaysia National Health Account (MNHA) study revealed that OPP expenditure from 1997 to 2009 has increased from RM 2,576 million to RM 11,986 million which is an increase from 0.91 percent GDP to 1.76 percent GDP. This almost four-fold increase in per capital OPP health spending in absolute value from RM 118 in 1997 to RM 430 in 2009 (MOH, 2012).

A high OPP expenditure is a characteristic of a lower income country while Malaysia is categorised in the upper middle income group. Although Malaysia has achieved universal health coverage, the high OPP expenditure reflects the gradual shift of its profile to that of a lower income country (MOH, 2011). Notwithstanding, Malaysians are protected from financial catastrophe in health expenditure, the high OPP may among others indicate patients' choice and preference of those who could afford to pay (MOH, 2011; Chan, 2013; 2014; Ng et al. 2014).

Invariably, the high OPP payment is said to be the least equitable manner in financing healthcare. This has been a major financing concern for countries in achieving the health objective of universal health coverage (WHO, 2014a; 2014b). In addition, the high OPP has serious social-economic implications. In a study by Xu et al. (2007) indicate that higher OPP payment in the overall financing mix has resulted in negative welfare impact on the country's households and financial catastrophes. The poor and the vulnerable groups may be denied of the most needed care. In order to avoid household financial catastrophe resulting from health spending, it has been estimated that a country's overall share of OPP payment has to drop significantly below 15 to 20 percent of the total health expenditures (Xu et al. 2010).

#### **4.11.4 Concern over Rising Total Health Expenditure**

Malaysia is currently encountering major challenges in how to cope with the escalating cost and finance the rising demand for health services as the health system becomes exorbitant. The advancements in medicine and technology have contributed to the high health expenditures. The existing financing mechanism system is said to be unsustainable, unless there is a transformation in the current system. Invariably, there will always be the funding issue in view of the rapid escalating total health expenditure (MOH, 2011;

Chan, 2014; Chee & Por, 2015). Over the years rising total expenditure has been substantial seen in both public and private health sectors.

A comparison of health spending between public and private can be observed. For instance in 2012, the public and private health spending was RM 22,461 million and RM 19,795 million respectively as shown in Table 4.7.

Table 4.7: Total Expenditure on Health by Sources of Financing by Public & Private Sectors, 1997-2012  
(MNHA Health Expenditure Report 1997-2012, MOH)

Year	Public		Private		Total
	RM Million	%	RM Million	%	RM Million
1997	4,413	53.26	3,873	46.74	8,286
1998	4,800	53.65	4,147	46.35	8,947
1999	5,299	53.97	4,519	46.03	9,818
2000	6,304	53.95	5,381	46.05	11,685
2001	7,399	57.06	5,568	42.94	12,967
2002	7,954	56.17	6,206	43.83	14,160
2003	10,455	58.4	7,447	41.6	17,901
2004	10,616	55.3	8,583	44.7	19,199
2005	9,712	49.94	9,735	50.06	19,447
2006	12,625	53.59	10,933	46.41	23,558
2007	13,811	52.93	12,281	47.07	26,093
2008	15,738	54.1	13,354	45.9	29,092
2009	17,847	56.85	13,547	43.15	31,394
2010	19,614	55.13	15,965	44.87	35,579
2011	20,378	52.86	18,173	47.14	38,550
2012	22,461	53.15	19,795	46.85	42,256

These figures indicate to a public and private spending ratio of 53: 47 and this identical trend is observed during the period from 1997 to 2012. During this 16 years period, the total expenditure for both the public and private sector indicates a rising trend. However,

public share of health expenditure remained higher than the private throughout the period except in the year 2005 (MOH, 2014b).

#### **4.11.5 Quality and Standard of care**

The emphasis on quality and standards is of paramount importance in healthcare. With the rising patients' expectations in receiving responsive and timely quality care have imposed additional burden on healthcare providers. Providing sustainable quality care services require both improved practices and resources. While the public health sector under MOH has established transparent quality assurance programme, but this is not typical in the private sector. Public and civil society have complained of the high drug prices and criticised the expensive private hospital care making it beyond the reach of the majority of the population (MOH, 2011; Nik Rosnah & Lee, 2011a; Rasiah et al. 2011; Chan, 2014). In addition, Ng et al. (2014) suggest that the availability of some commonly prescribed drugs may be inadequate in public hospitals and this phenomenon has resulted in patients having to purchase them in private pharmacies. On a similar note, an empirical study by Barbar et al. (2007) concluded that the availability of essential medications in public hospital was found to be low in spite of those drugs recommended in the National Essential Drug List and MOH Drug Formulary. The shortage of essential drugs has gross impact on patients' accessibility to these medications. Patients had to purchase their medications from private pharmacies which were found to be expensive (Barbar et al. 2007).

Besides, a wide variation in the provision of care and several contributing factors have been cited. Studies have shown that outcomes are better when doctors have the experience and performed large volume of procedures in medical institutions. The fact remained that "many of the private hospitals and specialists do not achieve the necessary scale" (MOH,

2011, p.19). Although the specialty credentialing and privileging has been introduced, its implementation is weak because the doctors receive their medical licences for life in Malaysia. There is no regulatory requirement for renewal or recertification for competency except for the renewal of annual practicing certificates (Nik Rosnah, 2002; 2005; 2007; Nik Rosnah & Lee, 2011a; MOH, 2011). This criterion is seen as far less stringent in comparison to their counterparts in developed countries. Professional bodies have also reported bogus doctors and unqualified health professionals providing care in the private health facilities (MOH, 2011). This phenomenon has culminated with the implementation of the Private Healthcare and Facilities Act 1998 (Act 586) and Regulations 2006 to address the healthcare complexities (MOH, 2011; Nik Rosnah & Lee, 2011a; 2011b).

The health system is seen to be lacking in incentives to improve the quality care and productivity (MOH, 2011). Currently, the private sector does not have a systematic collection of data outcomes as compared to the National Indicator Approach in the Quality Assurance Programs in the MOH hospitals. As such, there is no motivation in implementing mechanisms promoting best practices such as pay-for-performance scheme. Hence, it is a challenge for private hospitals or doctors to compare outcomes. On the other hand, patients faced asymmetric information and agency problems (Nik Rosnah & Lee, 2011). Patients are unable to compare the providers to have a better informed decision to seek medical care. Besides, quality of care has been seen to be impinged through the delays in the introduction of new medical treatments and technology (MOH, 2011). Medical specialists are often burden with clinical workload than to participate in clinical trials and new therapies. On the other hand, Malaysia has inadequate control mechanism over hospitals requiring them to adopt improvement of care. Further, the shortage of staff in MOH sections dealing with approval of new effective drugs and

devices have hampered the introduction of these drugs and devices into the country in a timely manner. This situation is of great concern despite years after approvals and adoption for use newer drugs and devices in the US and European countries (MOH, 2011).

#### **4.12 Concluding Remarks**

Indeed, managing the dichotomous private and public health sectors has been very challenging task. Nevertheless, Malaysia healthcare system has achieved remarkable advances compared with other developing countries based on the impressive selected health indices and the low public expenditure to GDP. However, the universal health coverage seems under threat with the escalating total healthcare expenditure. Under the prevailing economic condition and financial constraint, the choices are limited for healthcare reforms. There may be a need for greater public and private collaboration and partnership to increase productivity through efficient utilisation of resources, and the performance in the delivery of quality healthcare services. Nevertheless, the country may need to consider alternative options to increase funding to the public sector for sustainable healthcare delivery. Currently the proposed 1CARE Malaysia National Healthcare Financing Scheme has drawn much criticisms and controversies over the lack of transparency and the fear of another case of massive healthcare privatisation. Hence, the following Chapter 5 provides an in-depth discussion on the healthcare privatisation policy to provide a better overview of the Malaysian health care system.

## **CHAPTER 5 : HEALTHCARE PRIVATISATION**

### **5.1 Introduction**

This chapter discusses the privatisation policy in the health care sector which was much delayed over a decade as compared to other privatisation projects embarked in the mid 1980s. The critical assessment of the dominant role of the state in shaping the healthcare privatisation initiatives against the backdrop of its official rationale have been argued and articulated. The Privatisation Master Plan 1991 (PMP) had proposed a single uniform regulatory structure for all privatised projects under a Privatisation Act to safeguard public interests, however, the post-privatisation regulations received scant attention including the health sector. The discussion in this chapter among others, include the impact of two major and equally controversial privatisation projects, firstly, the Government Medical Store, and secondly, the massive privatisation of the five support services in the public hospitals. The discussion also critically examines the incremental policy change over the years in the introducing plurality into public hospitals with the establishment of private wing, outsourcing of services, and full fee payment scheme. Besides, the proposed privatisation of public hospitals had culminated in the nationwide protest lead by the Coalition Against Healthcare Privatisation (CAHP) which had severe political implications. In addition, the highly controversial attempt to privatize the National Heart Institute and equally sensitive, the proposed National Healthcare Financing Scheme are covered in this chapter.

### **5.2 Privatisation of the Government Medical Store**

The first healthcare entity to be privatised was the Government Medical Store (GMS) in Petaling Jaya, Selangor in 1994 without an adequate regulatory framework to protect the health consumers. Ironically, the government pharmaceutical manufacturing,

procurement and distribution centre to the public health sector was not even in the red (Gomez & Jomo, 1999; Chan, 2000; 2003; 2004; 2007). The award with an annual volume of US\$100 million, or 8 percent of the MOH's budget, includes a 15 years privilege granted to manufacture, purchase and allocate pharmaceutical supplies to all public hospitals and health clinics (Gomez & Jomo, 1999; Chan, 2000; 2003; 2004; 2007).

The Government Medical Store (GMS) was initially privatised to Southern Task Sendirian Berhad (STSB), a subsidiary of conglomerate Renong which is politically linked to the current government. In addition, the hospitals under MOH were instructed by order to purchase their supplies from the new company using regular funds allocated to them annually. In exceptional cases where STSB could not supply a particular product, then a local purchasing requisite could be made with their approval (Gomez & Jomo, 1999; Chan, 2000; 2003; 2004; 2007; Chee & Barraclough, 2007).

Subsequently, in the post privatisation era, Mohamed Izham et al. (1997) cite that there had been several negative reports of arbitrarily price hiked. This includes exorbitant pricings on essential drug items which are commonly use in the hospitals such as narcotic analgesics (pain relievers) like morphine and pethidine. The unprecedented move of arbitrary price hiking has raised alarming concerns among the various stakeholders such as doctors and pharmacists.

Besides, the supply distribution network laid down by the GMS was also reported to be modified but failed to show any marked improvement in the services rendered. As a result, a number of complex issues were raised as to why STSB was not meeting the minimum standards set by GMS before privatisation (Mohamed Izham et al. 1997).

Hence the immediate question posed was why the need to privatise GMS. The overall unsatisfactory performance of STSB was a gross embarrassment to the government. In addition, the poor performance was a manifestation of the failure of the government's assertion and rationale of privatisation as a distributive policy (Mohamed Izham et al. 1997). Invariably, after two years and seems as a face saving measure resorted to change to another politically linked Bumiputra corporate entity namely, Remedi Pharmaceuticals (M) Sdn Bhd (Chan, 2000).

Remedi Pharmaceuticals (M) Sdn Bhd (RPSB), is a subsidiary company under United Engineers Malaysia (UEM), which is also politically linked to the government (Gomez & Jomo, 1999; Chan, 2000). Remedi Pharmaceuticals has been rebranded and currently known as Pharmaniaga, while the parent company is UEM World, is controlled by the national sovereign fund Khazanah Nasional Berhad (Gomez & Jomo, 1999; Chan, 2000).

### **5.2.1 Comparative Study on Drug Distribution and Pricing**

Notwithstanding some adverse reports, there has never been any formal study being taken publicly to assess the drug distribution system under the management of RPSB. Hence in 1997, researchers at the Universiti Sains Malaysia embarked on a comparative study on the drug distribution and pricing in Malaysia before and after privatisation (Mohamed Izham et al. 1997). Respondents were drawn from pharmacists in 100 government hospitals in the nationwide study. Drug pricing study was based on GMS's pricing list in 1993 before privatization against RPSB's pricing list in 1996 on common items.

The study revealed that in spite of a 3.3 fold hike in price post privatisation, the quality of products or services provided had not shown any satisfactory improvement (Mohamed Izham et al. 1997). In conclusion, the move to privatise GMS did not seem to have any

positive impact on system of drug distribution in Malaysia. However, the minor improvement in the quality service by RPSB is off-set by the lowering of the overall standards in the quality of similar drug products offered prior to privatisation. This was the similar issue with STSB. Ironically, there is a clear indication of arbitrarily price hike with the creation of a more exorbitant pricing product line as evidence on the prices of many essential drug sold by both RPSB and STSB (Mohamed Izham et al. 1997).

Overall, the empirical findings of the study concluded and concurred that the record of a reasonably cost effective drug distribution system set by GMS previously has been tampered with the move to privatize the GMS. With privatisation, there seems to be a creation of a drug distribution system which is profit motivated and since its implementation has not been very impressive in its general performance (Mohamed Izham et al. 1997; Babar & Mohamed Izham, 2009).

### **5.2.2 Challenges of Escalating Cost**

After a decade of privatisation it is evidence that the healthcare system is now facing the challenges of escalating and spiralling cost of which expenditure on medications form a significant bulk of the government's expenditure. It was reported in the mainstream media that hospital drugs were to cost more (New Straits Times, December 4, 2004; *The Star*, December 4, 2005). For instance in 1995, the cost of procurement of drugs in public hospitals under MOH was over RM 200 million, and this expenditure has been increasing exponentially to RM 800 million in 2004. The escalating cost of drug is a challenge to policy makers (New Straits Times, December 4, 2004; *The Star*, December, 4 2005). Exorbitant prices of drugs is not only a budgetary financial burden to the government but a concern to the healthcare consumers and the civil society including the Consumers

Association of Penang (CAP), which had been lobbying to reduce the high medicine prices over the decades but without much success (*The Star*, July 3 2004).

### **5.2.3 Evaluation of Drug Prices and Implications**

A joint study on the evaluating of drug prices, in terms of the availability, affordability, and price element together with its impact of accessibility to drug medication in Malaysia was conducted by WHO and Health Action International (HAI) (Babar et al. 2007). Data on prices from 48 samples of medications were gathered from 20 government facilities, 32 private retail pharmacies and 20 private medical clinics in four geographic locations in peninsula Malaysia. These data were subsequently compared with international reference price (IRP) to find a median price ratio and to examine the affordability of medicine based on the daily income of the lowest paid government employee of RM 16.03 per day (US \$4.18). The empirical findings indicated that procurement prices were excessively high for innovator brands (IBs) in the government sector. IBs are original brand-name drug products with patent protection approved by the Food and Drug Administration for safe medical consumption.

Besides, both IBs and generics were found to be extremely exorbitant in the private doctor dispensing sector, and the private sector retail pharmacies in comparison with the IRP. In the public sector procurement, the median price ratios of 14 IBs were 2.41 times higher than the IRP, while 26 most-sold generic equivalent medications were found to be 1.56 times higher than the IRP. Generally the prices of medicine in Malaysia were found to be extremely expensive in comparison with international pricing (IRP). For example, the prices of IB were 16 times higher in private pharmacies than the IRP, while generics were 6.6 times higher. In the private practitioners' clinics, the prices were 15 times higher for IBs and 7.5 for generics (Babar et al. 2007).

Further, private medical practitioners' markups were found to be high with 50-76 percent for IBs, and over 316 percent for generics. In addition, these medical practitioners had the advantage of lower price generics and accrued large profit from the high mark up in the medications prescribed for their patients. On the other hand, markups were also high in retail pharmacy accounting for 25 percent to 38 percent for IB, and 100 percent to 140 percent for generics respectively. The Malaysian price markups were found to be higher in comparison with the data of those nations studied by WHO-HAI. In terms of accessibility and affordability for instance, patients had to face the financial burden of spending about a week's income for the cost of medications for a month treatment of ailments such as gastric ulcer and high blood pressure (Babar et al. 2007; Babar & Mohamed Izham, 2009).

#### **5.2.4 Revoking the Manufacturing Licence**

It is not surprising to hear after almost 15 years, that the Ministry of Health's Pharmaceutical Services Division has decided to revoke the manufacturing license of Pharmaniaga Berhad with effect from 1<sup>st</sup> March, 2010 after routine medical audit for non-compliance as reported in the mainstream media (*The Star*, 4 March 2010). Under normal circumstances, manufacturing licence is only revoked based on non-compliance of Good Manufacturing Practice (GMP), which is the gold standard in pharmaceutical drug manufacturing (personal communication). The action to revoke the manufacturing license is taken as a last resort after several passive soft reminders especially on such a powerful and politically sensitive government linked corporation (GLC). However later upon appeal, the manufacturing license was granted. This phenomenon concurred with the voluminous theoretical and empirical literatures associated with the market failure in health care, and the agency theory of "regulatory capture", and the political constraint

faced as discussed earlier in the Literature Review (Laffont & Tirole, 1991; Rees & Vickers, 1995; Bloom et al. 2014a).

It can be deduced that GMP has been grossly compromised and patient's safety is at stake especially on drug adverse reactions. In short, privatisation of GMS did not achieve the objective in relieving the financial and administrative burden of the government. The fact that GMS was never in financial distress or in the red and had a proven track record in the pharmaceutical drug manufacturing, procurement and distribution system and to be the first health care entity to be privatised is a gross contradiction to the government's own public policy. Besides, it violates the public trust and confidence, and reinforces the overall general public's perception of the state promoting cronyism and rent seeking in privatisation (Jomo, 1995; Tan, 2008; Gomez, 2009; Jomo & Wee, 2014) This assertion is further exemplified in the subsequent privatisation of five public hospital support services.

### **5.3 Privatisation of Five Hospital Support Services**

Subsequently, two years later in 1996 after the privatisation of GMS, there was another controversial healthcare privatisation in Malaysia. The massive privatisation of five hospital support services costing US\$ 2.8 billion was granted to three different local private providers without much evidence of competitive tendering and adequate regulatory framework. The concession is perceived to be the largest health care privatisation project ever undertaken in the world (Chan, 2000; 2007; 2013; 2014; Nik Rosnah, 2002; 2005; Noorul Ainun, 2003; Chee, 2008; Chee & Barraclough, 2007; Barraclough & Phua, 2007; Lee et al. 2011). Similarly, this privatisation granted a 15-years lease for "cleansing, linen and laundry, clinical waste management, biomedical

engineering maintenance and facility engineering maintenance for all MOH hospital and facilities” (Nik Rosnah 2002, p. 119).

As in the case of privatisation of the Government Medical Store, the three politically linked beneficiaries were Tongkah Medivest, Faber Mediserve and Radicare responsible for the three distinct geographical zones respectively (Gomez & Jomo, 1999; Chan, 2000; Nik Rosnah, 2002; Noorul Ainun, 2003; Barraclough & Phua, 2007; Chee & Barraclough, 2007; Chee, 2008; Lee et al. 2011).

### **5.3.1 Political Linked Corporations**

Tongkah Medivest was a corporation owned by Mokhzani Mahathir, the son of former Prime Minister (Chan, 2000). The company was later known as Pantai Medivest. Faber Mediserve is a corporation under the Faber Group, which is also politically linked to the UMNO interests. The third successful beneficiary was also owned by Bumiputra entrepreneurs with strong political cables to the dominant party in the National Coalition Front government (Gomez & Jomo, 1999; Barraclough, 2000; Chan et al. 2000; Chee & Barraclough, 2007).

Pantai Medivest’s sister company, Fomema has been granted the exclusive contract for monitoring the medical examinations of foreign workers in Malaysia. Both Pantai Medivest and Fomema are subsidiary companies of Pantai Holdings Limited, which owns the tertiary care corporate private hospital, Kuala Lumpur Pantai Medical Centre at Bangsar, and six other corporate private hospitals then. Besides, Pantai Holdings has been granted a 51 percent controlling stake in another concession from the Ministry of Transport for managing a monitoring system for vocational license holders (Chan et al. 2000; *The Star*, 4 March 2010).

### **5.3.2 Government as a Transnational Investor**

After the 1997/98 Asian Financial Crisis, Mokhzani Mahathir sold his controlling stake of 32.9 percent to one close associate Lim Tong Yong in April, 2001 who subsequently disposed off the stake to Parkway, a Singapore premier healthcare chain provider (Chee & Barraclough, 2007). Sometime in September 2005, the media reported that Parkway Holdings, Singapore had bought a 31 per cent in Pantai Holdings and became the single majority share holder (The Straits Times, 14 September, 2005; The Edge Malaysia, 21 August 2006). With the acquisition, it not only gave them effectively control but also became the largest private healthcare provider in Southeast Asia (Chee, 2008). Following the acquisition, five of the seven board of directors of Pantai Holdings were replaced with corporate representatives from Parkway and its majority share holder, Newbridge Capital Incorporated, a US fund manager which had acquired a 26 percent stake in Parkway on 25 May, 2005 (The Straits Times, 14 September, 2005). However, Chee (2008) argues “lucrative government concessions meant for Bumiputra rentiers thus ended up in the stables of a foreign company” (p. 2150).

This move resulted in much political uproar and dissatisfaction especially among members of the dominant party in the ruling national coalition front government and questioning the Government's decision to approve the sales of such a national strategic asset to Singapore. In response, Khazanah Nasional Holdings, the national sovereign fund had to engineer a scheme seems as though a “take-over” to secure control of Pantai Holdings (The Edge Malaysia, 21 August 2006). Subsequently, Khazanah Nasional renegotiated and bought back the controversial majority ownership stake of 51 percent with a hefty price at RM 2.65 per share then through a joint venture company Pantai Irama Ventures Sdn Bhd with Parkway owning the stake at 49 percent. Even with this acquisition exercise, Parkway continues to manage the Pantai group (The Edge Malaysia,

21 August, 2006; Chee, 2008). Nevertheless, it was seen as an unnecessary expensive corporate exercise borne by Khazanah. In a media statement dated 28<sup>th</sup> August, 2006, Khazanah announced that it has identified the health sector as one of the key new strategic sectors to invest in as part of its broader investment strategy (Khazanah Media Statement, 28 August, 2006). The undisclosed part of the transaction was the local bourse rules were breached and that Pantai Holdings remained under the control of Singapore's Parkway. Ironically, the local bourse rule did not impose a Mandatory General Offer, which reflected to some extent the weak the regulatory enforcement and institution in the country (Lee et al. 2011).

Malaysian were said to have been deceived by the fancy corporate restructuring designed by Khazanah Holdings. In fact, Khazanah's move was highly political motivated and unexpected. The unprecedented move incurred a hefty corporate loss of RM 200 million as a save face measure and national pride at the expense of taxpayers (Lee et al. 2011). Until then Khazanah Holdings has only an investment stake in the Apollo Group of hospitals in India (Khazanah, 2006). However, in 2010 Khazanah Holdings made several international headlines in connection with its triumph over India's Fortis Healthcare in a hostile takeover battle for Singapore's Parkway, Asia's largest public listed hospital provider at a massive cost of US \$3.3 billion. With this unprecedented acquisition, Khazanah owned a group of 16 hospitals with over 3,400 beds capacity in Asia (The Wall Street Journal, 27 July, 2010; The Telegraph, 27 July, 2010; *StarBiz*, 11 June, 2010).

#### **5.4 Financial Burden**

Many commentators have deduced that healthcare privatisation did not achieve the government's official rationales and objectives among others to reduce of financial burden of the state nor economic efficiency but instead privatisation had incurred

inefficiencies and financial burden to the state and the tax payers (Barraclough, 2000; Chan et al. 2000, Chan, 2007; Wee & Jomo, 2007; Phua, 2007).

Based on reports from the Finance Division, MOH, the expenditures on hospital support services escalated from RM 143 million (US\$ 54 million) in 1996 to RM 468.5 million (US\$ 174 million) in 1997. There was a 3.2 fold hike in expenditure with no evidence of better coverage and improvements in quality of services rendered. The spiralling cost has escalated to RM 507.9 million (US\$ 188 million) in 1999 (Chan et al. 2000; Chan, 2007; Wee & Jomo, 2007; Phua, 2007).

Significantly, there is evidence of a dramatic increased in the operating expenditure arising from health care privatisation of GMS in 1994 and the subsequent privatisation of the hospital support services from 1996. The expenditure for the privatisation of the hospital support services formed one of the biggest items under MOH budget which caused the overall MOH expenditure to be extremely high. Invariably, the expenditure for support services escalated over six folds from RM 263 million in the Sixth Malaysia Plan period (1991-1995) to RM 1,956 million in the Seventh Malaysia Plan period (1996-2000) as illustrated in Table 5.1.

Table 5.1: Ministry of Health, Malaysia: Operating Expenditure, 1981-2000  
(Ministry of Health Annual Reports (various years); Wee and Jomo, 2007)

	<i>Support services</i>		<i>Total</i>	
	<i>Expenditure (RM million)</i>	<i>Change (%)</i>	<i>Expenditure (RM million)</i>	<i>Change (%)</i>
Fourth Malaysia Plan, 1981-1985	135	—	4,442	—
Fifth Malaysia Plan, 1986-1990	164	21.5	5,789	30.3
Sixth Malaysia Plan, 1991-1995	263	60.4	9,548	64.9
Seventh Malaysia Plan, 1996-2000	1,956	643.7	16,784	75.8

Wee & Jomo (2007, p.105) assert that “an increase in cost resulting from privatisation means that the increase in allocation to health largely went to the private companies that received the contract for the privatisation services rather than to an improvement in service quality or coverage”.

## 5.5 Corporatisation of General Hospitals

The proposal to corporatise public general hospitals received huge public outcry and protests from the civil society organisations. In 1995 the government embarked a feasibility study on corporatizing 14 of general hospitals in the state capitals with the aim of changing the public service culture, which was historically associated with inefficiency. Besides, these hospitals could operate along commercial lines, including recruitment of their own staff at competitive remuneration packages (Nik Rosnah, 2002; Barraclough & Phua, 2007). The rationale for corporatising these facilities was to encourage competition like the corporate private hospitals and adopt a more realistic cost recovery mechanism, but they would still be government owned and would operate on a not-for-profit basis. Likewise, Chan (2007) argues that corporatising public hospitals is perceived as the best option by the policy makers.

The Seventh Malaysia Plan (1996-2000) laid out its objectives to undertake corporatisation and privatisation of hospitals together with the medical services as strategies to upgrade the efficiency of services, and retained experienced manpower. In addition, the government intends to reduce its provision role in the of health services and increase its regulatory and enforcement functions (Malaysia, 1996).

In a related matter, Barraclough and Phua (2007) argue that the generic of privatisation policy to be applied to the health sector had caused confusion among Malaysians. The distinction between corporatisation and privatisation has been blurred. A clear example was the initial announcement made by the Health Minister in 1994 that the Kuala Lumpur Hospital would be corporatised, and subsequently that it would be privatised (Barraclough & Phua, 2007).

However, in 1996 while embarking on the Seventh Malaysia Plan, the Prime Minister Mahathir Mohammad made an official announcement that the government intended to privatise many of the public health facilities, including hospitals (Mahathir, 1996). In this context, the National Heart Institute (Institut Jantung Negara) was corporatized soon after it was opened (Chan, 2014). The university teaching hospitals such as University Malaya Medical Centre and Hospital Universiti Kebangsaan Malaysia had also instituted corporatisation exercise (Barraclough & Phua, 2007).

This announcement caused immediate nationwide public outcry, protests by the civil society organizations and political parties in the country (Chan, 2007; Chee & Barraclough, 2007; Lee et al. 2011). Their main objections and concerns were apart from the general pronouncements that the government would assist the poor, there were no concrete plans to offset the impact of the healthcare privatisation especially on the poor

and marginalised groups. However, with the continuous massive protests, by the time of the 1999 General Election, this policy was shelved and the government assured that more financial allocations would be channeled to the public health system (*The Star*, 14 August, 1999; Nik Rosnah, 2002; Chan, 2007; Chee & Barraclough, 2007).

## **5.6 Protest Against Privatisation & Corporatisation**

The issue of privatisation of health sector has been intensively debated within the civil society organizations and protested by various interest groups (Chee & Barraclough, 2007; Rasiah et al. 2009; Lee et al. 2011). These interest groups comprised the Consumers' Association of Penang (CAP), Federation of Malaysian Consumers Associations (FORMCA), Malaysian Medical Association (MMA), Malaysian Trades Union Congress (MTUC) and Suara Rakyat Malaysia (SUARAM), leading to the formation of the Citizens' Health Initiative (CHI) in 1997. This broad based coalitions attempt to seek greater public participation in policy making on matters affecting the public health system. Besides, this was an immediate response primarily to the government policy that has introduced privatisation in health care and the intention for public hospitals to be corporatized. Furthermore, privatisation would significantly decreased the welfare based scheme with minimum payment, "to a residualist scheme whereby only certain categories of patients would be exempted from payment" (Chee & Barraclough, 2007, p. 212).

### **5.6.1 Citizens' Health Manifesto**

In 1998, CHI launched the "Citizens' Health Manifesto" and received huge endorsement and support from the various segments of the population. The healthcare privatisation became a major sensitive political issue during the run up to the 1999 General Election. Four major opposition political parties [Parti Islam Se Malaysia, Parti Keadilan Rakyat,

Democratic Action Party and Parti Sosialis Malaysia] issued a joint manifesto that health care privatisation is to be abolished, the healthcare system is to be reexamined and to explore a mechanism for a national health insurance coverage scheme (Towards a Just Malaysia, 1999). Fearing political electoral backlash, the government made a decision that public health facilities would not be corporatised prior to the 1999 General Election (Chee & Barraclough, 2007). Notwithstanding, the government's assurance of not corporatising the public hospitals, there were evidence of other discreet incremental policies and practices such as outsourcing services to private hospitals among others like radiology, radiotherapy and haemodialysis; private practice approval for public hospitals and a proposed mandatory national health insurance scheme have in fact incited a more consolidated protest from Civil Society Organisations (Chee & Barraclough, 2007; MOH, 2008).

The fight against health care privatisation associated with political patronage is a huge daunting task in light of the powerful interest groups which were aggressively asserting to maintain their status quo in Malaysia. Awareness of this challenge subsequently led to the formation of the "Coalition Against Health Care Privatisation" (CAHCP), which is made up of 81 NGOs, trade unions and political parties in Malaysia (Chee & Barraclough, 2007; Lee et al. 2011). The Coalition was initiated strictly against any further privatisation of the health care system and demanded transparency and accountability from the government on any future plans to be introduced in the health care system (Aliran, 2006). In addition, the coalition has devised several strategies to slow down healthcare privatisation in the country and had the growing support from a wide spectrum of the population. It has carried out several public awareness and demonstrations, whistle blowing on alleged government plans to privatise or corporatise healthcare services and

it had confrontational debates with the policy makers on healthcare privatisation (Chee & Barraclough, 2007; Lee et al. 2011).

Awareness and efforts by CAHP against healthcare privatisation has been well received and respected by the society. Among others, it includes the demonstration staged by some 400 protesters outside the MOH, Putrajaya in 2004 demanding a halt to the privatisation of government hospitals and clinics. It was a turning point and a mark of solidarity for CAHP's delegation to meet the Health Minister to express their strong opposition to healthcare privatisation in Malaysia (Aliran, 2006). Subsequently on the 13<sup>th</sup> February, 2006, similarly CAHP embarked on a massive campaign in which over 20,000 pamphlets were distributed to patients, hospital staff, and visitors in nine government hospitals with the inscription "do not destroy government hospitals". The campaign was to create greater public awareness and an attempt to deter any healthcare privatisation in the future (Chee & Barraclough, 2007; Lee et al. 2011).

### **5.6.2 Protest against Full Patient-paying Scheme (FPPS)**

In March, 2010, CAHP criticised and attacked the full patient-paying scheme (FPPS) which was introduced in 2007 as a private wing of selected public hospitals. The scheme is to attract affordable private patients paying extra for direct access to specialists in government hospitals. The policy of FPPS is aim to enhance the specialists' income and to retain them in the public sector. CAHP also carried out simultaneous pickets in four public hospitals nationwide demanding the halt of the FPPS which they alleged to be detrimental to both patients and doctors. CAHP asserts that the government specialists are too keen to do private practice treating full paying private patients and neglect their primary duty to other less paying patients in the hospitals (Chee & Barraclough, 2007; Lee et al. 2011).

The continued agitations and protests against privatisation have been seen as a nuisance and politically motivated which may jeopardise government's future privatisation plans. As such healthcare privatisation initiatives as far as possible were discussed discreetly within the senior inner circle at the ministerial level or the technical working committees at the MOH (Chee & Baraclough, 2007; Lee et al. 2011). Whatever confidential matters discussed are classified under the Official Secret Act 1972 (OSA) which provides the government the platform to stream roll on whatever policy without the knowledge of the general public. Amongst the Civil Society Organisations, the MMA has been privileged to be invited to technical working committees to provide health care policy inputs and often seen to take moderate stance against healthcare privatisation while the CAHP has been sidelined (Chee & Baraclough, 2007; Lee et al. 2011).

Notwithstanding, the controlled mainstream media and suppressive laws such as the OSA 1972, the Printing Presses and Publication Act 1984, the Sedition Act 1948, and the Universities and Colleges Act 1971, and the Societies (Amendment) Act 1984, the CAHP have often been successful in uncovering healthcare privatisation initiatives for instance the proposal on the National Health Financing Scheme through the internet which has been an effective means of disseminating information (Chee & Baraclough, 2007; Lee et al. 2011).

### **5.6.3 Impact of Civil Society**

The growing recognition of the importance of Civil Society Organisations' (CSOs) role in the country cannot be denied. Though Malaysians are seen to lack the democratic awareness for political change a decade ago (Loh & Saravanamutu, 1999), the advent of information technology seen a rising consumer health awareness. The dismal failures of privatisations, the blatant disregard for a just society, and the urgent call for an equitable

access to quality the health care system by the discerning public have significant impact on the socio-economic and political landscape (Chee & Barraclough, 2007; Rasiah et al. 2009; Lee et al. 2011; Chee & Por, 2015). In 2008 General Election witnessed the unexpected election of six parliamentarians from the CSOs on the opposition platforms to seek and redress the social inequities and justices for the people. In addition, this unprecedented election witnessed the historical “political tsunami” which afflicted adversely on the ruling national coalition-front government, Barisan Nasional for the first time losing five state governments to the loosely formed united opposition front parties known as “Pakatan” (United Front) in Penang, Kedah, Kelantan, Perak and Selangor respectively. Although the Barisan Nasional had won the general election, it lacked the traditional two third majority, which is of vital importance for the passing of new legislations or amendments to current legislations for any future privatisations at the Federal legislature. It is indeed the beginning for the CSOs inclined parliamentarians to legitimately check and question the government especially on the future direction of healthcare privatisation policy so that the public and lower income group especially the poor are not adversely affected (Lee et al. 2011).

### **5.7 Private Wings in Public Hospitals**

Barraclough and Phua (2007), and Chee and Barraclough (2007) argue that even in the public government hospitals there is evidence of incremental policy change in introducing plurality into these public hospitals with the establishment of private wings. The rationale for the policy change according to the Health Minister, Chua Soi Lek in 2004 was to retain specialists in the public sector. Private wings would be permitted in non-corporatised government hospitals on trial basis (*The Star*, 7 May 2004). Subsequently, the Minister announced in 2005 that a pilot project would be launched in Putrajaya and Selayang Hospitals to treat full fee-paying patients who have private medical insurance

coverage or those who are part of an employee medical benefit scheme (Barraclough & Phua, 2007).

In 2007 the Full Fee-Paying Patient Services Scheme was implemented at Putrajaya Hospital and Selayang Hospital. It was reported that both hospitals during the implementation period of the pilot project indicated that the number of out-patients visits was the highest at 72.9 percent, followed by inpatients visits at 24.2 percent, and daycare visits at 2.9 percent. A total of 2,573 patients including new and follow-ups cases had utilized the facilities and services in 2008 of which 70.9 percent were Malaysians (MOH 2008). Similarly, the local patients formed the majority of new patients at 84.5 percent compared to 15.5 percent of foreigners. The number of new patients including both locals and foreigners under the scheme ranges from 8 to 74 patients per month. The Full Fee-Paying Patient Services Scheme will be introduced in stages to several specialist hospitals in 2009. Steps have been taken to review related guidelines to improve the scheme prior to the implementation at other hospitals (MOH, 2008).

### **5.8 Moves to Privatisise National Heart Institute / Institut Jantung Negara (IJN)**

Sometime in late 2008, there was a national outcry when Sime Darby, a government linked corporation made an unprecedented public announcement that it has offered to the government to buy a stake in IJN and gave assurance that fees structure would not rise. Further, the statement made by Prime Minister Najib Razak that the government has no objection to sell IJN as long as the need of the poor is taken care. He also hinted that there was a demand from IJN medical staff for salary hike and cited the possibility of brain drain if their demand was not met. In an immediate response, 33 of the 35 medical consultants in IJN issued a joint press statement refuting the argument and denied any link with proposed privatisation (*The Star* 19 December 2008; Lee et al. 2011; Chan,

2014). There was an overwhelming nationwide objections and protests from the general public and CSOs. Fearing another political backlash after hardly recovering from the political tsunami in 2008 General Election, the Government finally made a public announcement that it was not selling IJN and Sime Darby simultaneously withdrew from the bid (Lee et al. 2011; Chan, 2014).

While IJN had succeeded in fencing off the bid from Sime Darby to acquire it in late 2008, it appears to be facing another challenge internally. The threat of another tempt of privatisation seemed to emerge within the Board of directors of IJN. There were allegations that the Board was finalizing plan to privatise the 17 year old prestigious National Heart Institute discreetly (Malay Mail, 22 October 2009).

The alleged second attempt to privatise IJN was initiated after obtaining the prior approval from the Economic Planning Unit (EPU) and Ministry of Finance to conduct a Widespread Asset Unbundling scheme or the “divide and conquer concept”. It was directed towards dividing IJN’s operational functions and creating new subsidiary companies as what had happened to the privatisation of Malaysia Airline System (MAS) before (Tan, 2008). It is alleged that the new subsidiaries among others, include joint-venture company for hospital support services, IJN Assets management company for the maintenance of the building and equipment, and IJN Pharmacy company to deal with pharmaceutical supplies and medical devices. With this discreet corporate exercise, it is alleged IJN would emerged as a new business corporation focusing on generating profitable returns. This grossly contradict the government’s original policy of the establishment of IJN of its corporate social responsibility of providing welfare services to the lower income group, the poor, the government servants and retirees (Lee et al. 2011).

This contradictory policy concurred with the increasing number of concerned discerning public and civil society who are opposed to such proposed privatisation exercise. This among others include the former pioneer and renowned Chief Cardiothoracic Surgeon of IJN, Dr Yahaya Awang who was instrumental in the setting up and commissioning IJN as the cardiothoracic centre of excellence. Dr. Yahya Awang was quoted in the media, “It (IJN) was never meant to be commercial institute. It was meant to be a centre of research, a premier academic institute. Therefore, I am rather suspicious of the privatisation idea. It is not as if the hospital is not doing well. Ideally, a health institution such as IJN should be physician-led” (*The Star*, 21 December 2008).

Generally, the public perception is that the exercise would deviate from the original spirit and sole intention of IJN inception, which was to provide Malaysians with better and affordable healthcare (Lee et al. 2011). The rationale for IJN to go privatisation is questionable as MOH has plans to build another 5 new cardiac thoracic institutions in Malaysia (MOH, 2000). The Ministry would definitely need the support of IJN in terms of medical expertise training, personnel, management and operations. Besides, Hospital Serdang has also been planned to be a cardiac thoracic centre after IJN albeit objection from the later. In fact, IJN has never been in the red (Lee et al. 2011). The manner it is proposed to be privatised appears to be almost similar to the case of the privatisation of Port Klang Container Terminal in 1983 which was not in the red (Adam & Cavendish, 1995; Kuppusamy, 1995).

So far no official announcement has been made because of its political sensitivity. It seems the charted path of modus operandi is being implemented discreetly and without any transparency just like any other previous highly controversial privatisation projects in Malaysia. The fact that most mainstream media are owned by interest groups

sympathetic to the ruling dominating coalition government and the press is closely regulated, comparatively little has been written about health policy in Malaysia (Barracough & Phua, 2007; Lee et al. 2011; Jomo & Wee, 2014; Chan, 2014).

### **5.9 Proposed National Health Financing Scheme (NHFS)**

The government's concern with the escalating health care cost, which was a financial burden was reflected in the 1980s with the embarking of National Health Financing study in 1984/85 (Chua, 1996; Kananatu, 2002; Ramesh, 2007; Chan, 2007; Phua, 2007; Chee & Barracough, 2007; Lee et al. 2011; Chee & Por, 2015). Following the study, it was recommended that for Malaysia to be sustainable in the management of health care cost, it should establish a national health insurance scheme which is contributed by all for its in-patients and out-patients services to overcome the spiralling cost. Subsequently, the government commissioned another study sponsored by the Asian Development Bank in 1988. Among others, the study recommended a mandatory contribution scheme funded from both the employers and employees, with the government subscribing the premium for the poor. The recommendation received the support of the government, however there was no action until the mid 1990s (Chua, 1996; Kananatu, 2002; Ramesh, 2007; Chan, 2007; Phua, 2007; Chee & Barracough, 2007; Lee et al. 2011).

The government's search for alternative health care financing scheme led to the establishment of the Employees Provident Fund Account III in 1994. There were objections and reservations by the public and the civil society organizations In view of adverse political sensitivity and implications of any such proposal to increase private spending from this account, the plan was not implemented (Barracough, 1999; Chan, 2007; Ramesh, 2007). Subsequently, there were numerous consultancy studies carried out over the past twenty years to gather more feedback on the proposal for NHFS. However,

the outcomes of these studies were never released to the public. The latest known study was conducted by Karl Karol from Australia, which started the project in 2002 (Ramesh, 2007; Chan, 2007; Phua, 2007; Chee & Barraclough, 2007; Lee et al. 2011; Chan, 2014; Chee & Por, 2015).

Consequently in the Eighth Malaysia Plan (2001-2005), the government expressed explicitly that a NHFS is to be implemented for the whole nation (Malaysia, 2001). Despite, no new details were mentioned explicitly except the poor and the government servants and the retirees would be taken care of under the scheme. There were gross anxieties and concerns on the proposed scheme over the lack of transparency. The proposed scheme is seen to be shrouded with secrecy (Ramesh, 2007; Chan, 2007; Phua, 2007; Chee & Barraclough, 2007; Lee et al. 2011; Chee & Por, 2015). There is a scarcity of information about the proposed scheme except for occasional announcements made by the succession of Health Ministers over the media that the scheme would not be privatised (Ramesh, 2007; Chan, 2007; Phua, 2007; Chee & Barraclough, 2007; Lee et al. 2011). There appear to have little consultations with interest groups such as the public and Civil Society Organisations. The fact that it has substantial impact of financing strategies on households, it is desirable and important for a clear understanding of the equity implications.

The proposed scheme was particularly timely as Malaysia had already embarked on the Ninth Malaysia Plan (2006-2010) and the government's assurance of equitable access in health care through the implementation of NHFS (Malaysia, 2006). In 2009, towards the tail end of the Ninth Malaysia Plan, the 1Care for 1Malaysia NHFS was proposed to restructure the Malaysian Health System, which will be responsive to health needs and better care for its population. The restructured NHFS is to be contributed by individuals,

corporations and government into a non-profit public funded social health insurance, which will provide health coverage including the poor and vulnerable groups (Chee & Por, 2015).

In theory, the proposed NHFS will ensure the integrity of the system, cost containment and equitable financing, and the delivery of quality health services (MOH, 2009). Upon approval from the Government, MOH will undertake the development of a full blueprint for the 1Care National Health System within a two year time frame period. Since then no further detailed announcement were made. The only tangible outcome seen is the setting up of 254 1Malaysia Clinics, 5 1Malaysia Mobile Clinics using buses and 3 1Malaysia Mobile Clinics using boats (MOH, 2014a). However, the proposal has drawn objections and severe criticisms from the various stakeholders for the lack of transparency and public discourses (Chee & Por, 2015). Likewise, Muhamad Hanafiah (2014) argues whether Malaysia has learned anything after over three decades of NHFS study.

Critics point out that the health care expenditure in Malaysia has traditionally hover around 3 percent to 4 percent of GDP of which the public sector's portion of healthcare expenditure accounting on an average of slightly over 2 percent which is well short of the World Health Organization's (WHO) minimum recommendation of 5 percent to 6 percent (WHO, 2014). Upon scrutinising the private health care expenditure in Malaysia as a share of the GDP for the period between 1997 and 2009, rose from 1.24 percent in 1997 to 2.25 percent in 2009 (MOH, 2012). The public health care expenditure also rose from 1.61 percent in 1997 to its peak of 2.59 percent in 2003 before dipping to 2.34 percent in 2004 and 1.96 percent in 2005, and rose back to 2.71 percent in 2009 as shown in Table 5.2.

Table 5.2: Public and Private Share of Total Health Expenditure and Percent GDP, 1997-2009  
(Malaysia National Health Accounts, MOH, 2012)

Year	Public Sector Expenditure (RM Million)	Private Sector Expenditure (RM Million)	Total GDP (RM Million)	Public Expenditure as % GDP	Private Expenditure as % GDP
1997	4,540	3,504	281,795	1.61	1.24
1998	4,879	3,873	283,243	1.72	1.37
1999	5,424	4,288	300,764	1.80	1.43
2000	6,479	5,156	356,401	1.82	1.45
2001	7,669	5,513	352,579	2.18	1.56
2002	8,310	6,278	383,213	2.17	1.64
2003	10,856	7,543	418,769	2.59	1.80
2004	11,092	8,820	474,048	2.34	1.86
2005	10,227	9,904	522,445	1.96	1.90
2006	13,216	11,012	574,441	2.30	1.92
2007	14,098	12,291	642,049	2.20	1.91
2008	16,524	14,077	742,470	2.23	1.90
2009	18,401	15,291	679,938	2.71	2.25

Total healthcare expenditure to GDP in 2009 was at its peak at 4.96 percent amounting to RM 33.69 billion with the private healthcare expenditure at 43.15 percent and the public healthcare expenditure at 56.85 percent (MOH, 2012). Hereafter, the total percentage of health expenditure to GDP has declined gradually from 4.45 percent in 2010 to 4.30 percent in 2011 (MOH, 2012).

Comparatively, the phenomenon of this trend in Malaysia is alarming as the public health care expenditure in most developed countries remained very much higher exceeding 70 percent than the private health sector (WHO, 2014). For instance in 2011, Denmark's government expenditure on health as a percentage of the total expenditure was at 85.3 percent, Finland 75.4 percent, France 76.8 percent, Germany 76.5 percent, Netherland 79.5 percent, Norway 85.1 percent, Sweden 81.6 percent and Canada 70.4 percent. The United Kingdom's public expenditure was at 82.8 percent of the total public health care

expenditures while Malaysia, Thailand and Singapore were at 55.2 percent, 77.7 percent and 33.3 percent respectively (WHO, 2014).

Further, the World Health Statistics (WHO, 2014) revealed the concern that the total Malaysian public healthcare expenditure at 3.8 percent to the GDP in 2011 is far much lower than most developed countries and the developing countries such as Argentina, Brazil, China, Columbia, Cuba, Vietnam and our neighbors Thailand and Singapore. The healthcare expenditure to the GDP of developed countries such as Belgium is 10.5 percent, Canada 10.9 percent, Denmark 10.9 percent, France 11.6 percent, Germany 11.3 percent, Japan 10.0 percent, Netherlands 11.9 percent, Norway 9.9 percent, Sweden 9.5 percent, United Kingdom 9.4 percent and the United States 13. respectively as illustrated in Table 5.3 (WHO, 2014).

Table 5.3: Selected Health Expenditure Ratios of Member State WHO 2011  
(World Health Statistics WHO, 2014)

Member State	Total expenditure on health as % of GDP 2011.	General Government expenditure on health as % of total expenditure on health	Private expenditure on health as % of total expenditure on health.	General Government expenditure on health as % total government expenditure 2011.
Belgium	10.5	75.9	24.1	15
Canada	10.9	70.4	29.6	17.4
Denmark	10.9	83.3	14.7	16.1
Finland	9.0	75.4	24.6	12.3
Germany	11.3	76.5	23.5	19.1
France	11.6	76.8	23.2	15.9
Netherland	11.9	79.5	20.5	19.1
Norway	9.9	85.1	14.9	19.3
Sweden	9.5	81.6	18.4	15.1
United Kingdom	9.4	82.8	17.2	16
United States	13.6	43	57	20.3
Japan	10.0	82.1	17.9	19.4
Malaysia	3.8	55.2	44.8	6.2
Singapore	4.2	33.3	66.7	8.9
Thailand	4.1	77.7	22.3	15.3
Vietnam	6.8	45.2	54.8	10.1
China	5.1	55.9	44.1	12.5
Argentina	7.9	66.5	33.5	21.7
Brazil	8.2	45.7	54.3	8.7
Colombia	6.5	75.2	24.8	20.2
Cuba	10.0	94.7	5.3	14
Malawi	8.3	72.4	27.6	9.3

Comparatively, the Malaysian total expenditure on health to the GDP is at 3.8% which is significantly much lower than other developing countries such as Argentina 7.9 percent, Brazil 8.2 percent, Columbia 6.5 percent, Cuba 10.0 percent, Malawi 8.3 percent and Vietnam 6.8 percent (WHO, 2014).

Even in the developing countries the general government expenditure on health as percentage of the total expenditure on health is much higher than Malaysia at 55.2 percent as shown in Table 5.3. For instance in Cuba the public expenditure is at 94.7 percent, Colombia 75.2 percent, Malawi 72.4 percent and Thailand at 77.7 percent. In terms of general government expenditure on health as a percentage of the total government expenditure, Malaysia's figure at 6.2 percent in 2011 was much lower than Cuba at 14.0 percent, Colombia 20.2 percent, Argentina 21.7 percent, China 12.5 percent, Thailand 15.3 percent, Vietnam 10.1 percent and Malawi 9.3 percent. On the contrary, government in developed countries health expenditure is very much higher with Canada 17.4 percent, Denmark 16.1 percent, Germany 19.1 percent, Netherlands 19.1 percent, Norway 19.3 percent, Japan 19.4 percent, United Kingdom 16.0 percent and United States at 20.3 percent (WHO, 2014). In spite of modest low health expenditure to GDP, it is surprising that Malaysia ranked second behind Cuba in terms of the best geographical universal health coverage in the world (Chan, 2014).

The government is seen to be gradually reducing its provision in the public health sector through cost-containment of its expenditure budget over the years, which led to the relative fall of its GDP during the recent years. This move could be seen through both reducing relative support for public hospitals in terms of restrictive resources and human capital constraints. On the other hand, the government is explicitly committed and seen to be supporting healthcare privatisation by market intervention through incentives structures such as subsidies and taxation. This phenomenon appear to follow the similar trend set by most developing countries, which is against the trend in most of the developed countries where the government still play a more significant role in the provision and financing of the public health sector which have remained and unquestioned (Chee & Barraclough, 2007; Chee & Por 2015).

### **5.10 Concluding Remarks**

Discussion in this chapter revealed that healthcare privatisation policy did not achieve the government's official rationales and objectives among others to reduce of financial burden of the state nor economic efficiency. Instead privatisation had incurred inefficiencies and financial burden to nation and the tax payers. Despite the Privatisation Master Plan 1991 proposes a regulatory framework for all privatised entities to protect consumers' interests, such regulations had not even been drafted. Invariably, the government's objective was to provide a conducive economic environment for the expansion of private sector without regulatory control but this has resulted towards intended and unintended social-economic consequences. This phenomenon is of relevant to this research study as the following Chapter 6, and Chapter 7 present the empirical findings of the impact of the Private Healthcare Facilities and Services Act 1998 (Act 586) and Regulation 2006 on the private hospitals in Malaysia.

## **CHAPTER 6 : RESULTS**

### **6.1 Introduction**

This chapter examines the impact of the Act 586 and its Regulations 2006 on the private hospitals in Malaysia in achieving the intended national health goals, among others, the accessibility to health care, to correct the imbalances in standards and quality of care, as well as rationalise the medical charges in the private hospitals sector to more affordable levels. Besides, the study examines what are the factors that influence the impact of the Act on the private hospitals. In addition, the study also investigate the enforcement capacity of the MOH in regulating the private medical institutions. The chapter presents the empirical findings based on the research methodology described in Chapter 3. This study was conducted at two levels, one at the regulatory body of MOH and the other at the purposively selected 15 private hospitals. Utilising the qualitative study approach, the main method of data collection involves in-depth interviews, focus group discussions, and observations with 130 key informants who are also key stakeholders mostly from the public and private health sectors. Twenty five of the key informants are from public health sector, which include a former Director General of Health, Directors, senior officials from the MOH, State Medical and Health Office, Federal Territory of Kuala Lumpur and the public hospitals.

The majority of 80 key informants are from the private health sector among others include the senior management executives of private hospitals such as Executive Director, Chief Executive Officer, Chief Operating Officer, Medical Director, and Director of Nursing; the medical specialists from the private hospitals, and the senior executives from the the managed care organisations and insurance corporations. The last category of 25 key informants are from members of professional bodies such as MMA including three past

presidents, Federation of the Private Medical Practitioners' Associations, Malaysia (FPMPAM), Association of Medical Specialists in Private Practice (ASPMP), Association of Private Hospitals of Malaysia (APHM), and Bar Council. In addition, data were gathered from non-governmental organisations such as Malaysian Society for Quality in Health (MSQH), and civil society. Besides, data were also collected from politicians, academicians from universities, and private paying patients who have utilised the services of the private hospitals. The data collection includes document analysis and observations as part of the triangulation process to support the findings of the the interviews. The primary and secondary data collected provide answers to the research questions and objectives of this study. The analysis of interview data was based on the core themes that have emerged from the study such as policy, power, governance, compliance, non-compliance, cost, inequity, quality care, politics, and enforcement.

## **6.2 Policy Issues**

The interview data gathered from key informants reveals that the government's policy of regulating all private hospitals and other private healthcare facilities and services under the new Act 586 is primarily to address the national and societal interests. According to eight key informants, the implementation of Act 586 and its regulations mandates the approval and licencing of all private healthcare facilities and services to ensure patient's safety, equitable access to quality care and rationalising the medical cost of care to more affordable levels, in view of the rapid commercialisation in the private health sector.

Similarly, the Director General of Health in his speech at the Private Practitioner Section, Malaysian Medical Association on the 20<sup>th</sup> April, 2008 reveals that "what is even more disturbing is the evolution of doctors behaving like businessmen and like all other businessman, profits often supersede ethics, medical professionalism, and patients' rights.

We now have over 200 private hospitals and over 7,000 private clinics. If the private health sector is not properly regulated, the quality of healthcare services will be affected. Thus, Act 586, in the eyes of the government and the public, is the best thing that has ever happened to our healthcare system” (Mohd Ismail Merican, 2008, p.20).

On the same note, the information gathered from the eight senior key informants disclose that the provisions under Section 3 of the Act 586 stipulates that no person shall establish or maintain a private hospital without approval being granted or operate without a license being granted by Ministry of Health Malaysia (Malaysia, 1998). Based on the interpretation of the provisions of the Act 586 by key informant PRI 9 who is a legal practitioner, and key informant PUB 1 who is a medical regulator reveal that any person operating an unlicensed and unregistered private hospital contravenes Section 3 of the Act 586 commits an offence. The offender upon conviction under Section 5 is liable to a punishment of RM 300,000 , or to a jail sentence up to six years, or to both in the case of an individual person. In the case of a corporate body committing an offence, the penalty is a fine to a limit of RM 500,000 (Malaysia, 1998).

This study notes that the penalty of hefty fine and imprisonment upon conviction serve as a serious deterrence to private health care providers of operating unlicensed private hospitals where accessibility, patient’s rights and safety may be compromised. The result of research findings also reveals that the health policy aims to improve access and eradicate all illegal private healthcare establishments with unregistered healthcare professionals including bogus doctors, which may affect public health safety. The previous Private Hospitals Act 1971 which was a basic legislation did not have provisions for the mandatory licencing and control leading to the unconstrained proliferation and inequitable distribution of private hospitals in the country.

### **6.2.1 Policy on the Distribution of Private and Public hospitals**

One of the major concerns of policy makers in the formulation of Act 586 is to address the societal interests of ensuring equitable access to private hospitals with quality care. The findings indicate that out of the total 209 private hospitals licensed in Malaysia, the most developed states of Selangor and WP Kuala Lumpur have the highest number of private hospitals. The classification of most developed states and less developed states is based on the Development Composite Index 2005 as an indicator of level of development of each state under the Ninth Malaysia Plan 2006-2010 (Malaysia, 2006). Selangor state has 51 licensed private hospitals followed by WP Kuala Lumpur with 40 hospitals. These 91 private hospitals constitute a significant 43.5 % of the total licensed private hospitals in Malaysia as illustrated in Table 6.1.

Table 6.1: Total Number of Approved Applications for License to Operate of Private Hospitals in Malaysia as at 31st December 2008  
(Private Medical Control Section, MOH, 2008)

State		Private Hospitals		Region	Private Hospitals	
		Count	%		Count	%
Most Developed	Selangor	51	24.4	Peninsular Malaysia	193	92.34
	WP* Kuala Lumpur	40	19.14			
	P. Pinang	23	11			
	Kedah	11	5.26			
	Perak	15	7.18			
	Melaka	4	1.91			
	N. Sembilan	7	3.35			
	Johor	30	14.35			
	<b>Sub-total</b>	<b>181</b>	<b>86.6</b>			
Less Developed	Kelantan	3	1.44	Sabah & Sarawak	16	7.66
	Pahang	8	3.83			
	Terengganu	1	0.48			
	Sabah	7	3.35			
	Sarawak	9	4.31			
	<b>Sub-total</b>	<b>28</b>	<b>13.4</b>			
<b>Total</b>		<b>209</b>	<b>100</b>		<b>209</b>	<b>100</b>

Note: WP\*- Wilayah Persekutuan (Federal Territory).

In addition, there are also 15 public hospitals under the MOH and two teaching public hospitals under the Ministry of Education serving a population of 6,700,500 residents which represents 24.17 percent of the total nationwide population of 27,728,700 people in 2008. Furthermore, there are 181 private hospitals in the most developed states of west Peninsular Malaysia which include the state of Selangor, Federal Territory of Kuala Lumpur, Penang, Kedah, Perak, Melaka, Negri Sembilan and Johor. The figure of 181 private hospitals accounts for 86.6 percent of the total number of registered private hospitals in 2008. Every state in Malaysia has a private hospital except for the smaller states of Perlis and WP Labuan. The west coast states in Peninsular Malaysia have a

population of 17,854,400 people or 64.4 percent of the total population of the nation. Besides, there are 65 public hospitals representing 48.9 percent of the total 133 public hospitals under the MOH, and two teaching public hospitals providing medical care and services in the developed states as illustrated in Table 6.2.

Table 6.2: Total Distribution of Public Hospitals under Ministry of Health and Population according to the various states in Malaysia as at 31st December 2008 (Health Facts, 2008. MOH; Department of Statistics, Malaysia; Malaysia Development Plan, 2006)

State		Public Hospitals		Region	Population (Thousand)	
		Count	%		Count	%
Most Developed States	Selangor	11	8.27	Peninsular Malaysia	5,071.10	18.29
	WP <sup>#</sup> Kuala Lumpur	4	3.01		1,629.40	5.88
	Penang	6	4.51		1,546.80	5.58
	Kedah	9	6.77		1,958.10	7.06
	Perak	14	10.53		2,351.30	8.48
	Perlis	2	1.5		236.2	0.85
	Melaka	3	2.26		753.5	2.72
	N. Sembilan	6	4.51		995.6	3.59
	Johor	10	7.52		3,312.40	11.95
	<b>Sub-total</b>	<b>65</b>	<b>48.87</b>		<b>17,854.40</b>	<b>64.39</b>
Less Developed States	Kelantan	9	6.77	Sabah & Sarawak	1,595.00	5.75
	Pahang	10	7.52		1,513.10	5.46
	Terengganu	6	4.51		1,094.30	3.95
	Sabah	22	16.54		3,131.60	11.29
	Sarawak	20	15.04		2,452.80	8.85
	WP <sup>#</sup> Labuan	1	0.75		87.6	0.32
	<b>Sub-total</b>	<b>68</b>	<b>51.13</b>		<b>9874.4</b>	<b>35.61</b>
<b>Total</b>		<b>133</b>	<b>100</b>		<b>27,728.70</b>	<b>100</b>

Note: WP<sup>#</sup> - Wilayah Persekutuan (Federal Territory).

In contrast, the less developed states in Malaysia consisting of the east coast states of Peninsular Malaysia, and Sabah and Sarawak have a total of 28 private hospitals (13.4 percent), serve a population of 9,874,400 people or 35.6 percent of the nation's population (MOH, 2008). In comparison, there are 68 public hospitals under MOH and two teaching public hospital under Ministry of Education providing medical care and services. Further breakdown of the above figures indicates that the east coast states of Peninsular Malaysia (Kelantan, Trengganu and Pahang) have a total of 12 private hospitals (5.7 percent) with 25 public hospitals and 1 teaching public hospital serving a local population of 4,202,400 or 15.2 percent of the national population.

Data of the findings discloses that the less developed states of Sabah, Sarawak and Federal Territory of Labuan in east Malaysia have a total of 16 private hospitals forming 7.7 percent of the total private hospitals licensed in the country (MOH, 2008). Despite the vast total land area of East Malaysia with its rich natural resources covering over 200,565 square kilometres [61 percent of the total land area of Malaysia]; with more than half of poor households resides mostly in rural areas in Sabah and Sarawak (Sander et al. 2014), there are only 43 public hospitals serving a population of 5.67 million mostly indigenous people. Besides, out of these 43 public hospitals available, 29 hospitals are categorised as non-specialist hospitals. Conversely, 92.3 percent of the total licensed private hospitals providing specialist care have been established in urban areas catering mostly for the affluent segment of the population in peninsular Malaysia.

The findings reveal that the private sector has more hospitals, but in reality 78 percent of the hospital beds are in the public health sector and attending to 74 percent of the total 2.95 million admissions. Government continuous efforts over the decades have successfully retained 60 percent of the doctors out of the total 25,102 registered doctors

in 2008. These statistics clearly indicate that there is gross disparity and inequitable geographical distribution of not only licensed private hospitals but also public hospitals as illustrated in Table 6.1 and Table 6.2. This gross disparity affects the national health objectives of accessibility, equity and quality care in Malaysia.

### **6.2.2 Policy for the Approval of New Private Hospitals under Act 586**

This study indicates that the policy for the approval of new private hospital establishments under Section 9 of Act 586 among others, is to ensure the national interests in the development of specific types of private facilities and any other matter which the Director General of Health's opinion is relevant. In this context, there is the concern over the vast statutory power vested with Director General (DG) in the approval which may be prone to abuse and lack of transparency. There is limited safeguards to ensure that the DG acted in accordance with provisions of Act 586. Examination of the 46 approvals for new private hospital establishments in 2008 reveals that the most developed states account for 38 approvals (82.6 percent) as illustrated in Table 6.3.

Table 6.3: Geographical Distribution of Approved Applications For Private Hospital Establishment as at 31 December 2007 (MOH 2008)

Region	Number	Percentage
<u>Peninsular Malaysia:</u>		
West Coast States	38	82.6
East Coast States	4	8.7
<u>East Malaysia:</u>		
Sabah & Sarawak States	4	8.7
Total	46	100

The findings show that the study area of Klang Valley has 22 approvals which constitutes 47.8 percent of the total approvals for new private hospital establishments. The rest of the

eight approvals which form 17.4 percent of the total approvals are from the less developed states. These findings reflect that the intended national objectives have yet to be realised. The impact of this broadly defined regulatory intervention exponentially exacerbates the existing perennial problems among others, inequity in access to quality care and services in the private hospitals in Malaysia.

### **6.2.3 Controversies in the Enforcement of Act 586**

Analysis on the feedback gathered from the interviews and observations discloses that the historical policy in the enforcement of the Act 586 and its Regulations in May 2006 has been seen to be controversial and eventful. Examination of the interview data indicates that the prescriptive regulatory instrument has generated considerable amount of public interests and awareness. The findings disclose that there were strong protests and intense debates especially among the private medical practitioners over some of the provisions deemed too exacting under the regulations, which may affect adversely on their medical practice.

In addition, the findings reveal that the regulatory body has encountered an unprecedented resistance and challenges in the mandatory registration and licencing of all private healthcare facilities and services nationwide. According to key informant [PUB 1], “despite the resistance, the protracted enforcement of the legislation has received support from the various stakeholders including the Association of Private Hospitals of Malaysia (APHM), Malaysian Medical Association (MMA), and Malaysian Dental Association (MDA)”. However, key informant [PRI 2], who is a senior medical specialist asserts that “although both professional bodies welcome the enforcement of the Act 586, but they have also expressed reservations over certain stipulations in both the Act 586 and Regulations, which are found to be too stringent and often ambiguous”.

Based on the finding of the interview data from the key informants who are medical specialists indicates that these provisions may adversely affect particularly the delivery of health care and the practice of medicine. According to private medical specialist [PRI 3], “one serious implication of the Act and Regulations is the possibility of medical practitioners practising in good faith and on the slightest failure of non-compliance be penalised with hefty fine, jail imprisonment, or both”. Further, key informant PRI 3 reiterates that “this policy may lead to defensive medicine and the fear for future doctors to practice in the private health sector. In addition, the Act is deemed to be criminalising the medical and dental professions”. Subsequently, both professional bodies submitted a joint memorandum dated 13<sup>th</sup> July, 2006 to the Honourable Minister to seriously review the severe penalties for offences committed under the Act and to defer the enforcement of the Act to a much later date (MMA & MDA, 2006).

The analysis of interview data also reveals that there has been an incremental dissatisfaction of the policy leading to nationwide protests especially during the enforcement of the Act 586 and its regulations in 2006. This study discloses that the representatives of professional bodies such as MMA and MDA who were sitting in the Technical Working Committee on the drafting of the legislation Act 586 found a wide gap between what was deliberated and the eventual gazettment of Act 586 in 1998. There was much anxiety and concern leading to the subsequent implementation of the regulations. These MMA and MDA representatives have alleged that a number of radical changes were made, a number of undiscussed additions were inserted, and a number of omissions occurred without their knowledge. Examples of some of these contentious provisions are the power of the minister, social welfare contribution, grievance mechanism, board of visitors, professional fees schedules, and criminalising of the profession.

In addition, these representatives of the professional bodies argue that all the deliberations in the Drafting Committee were under the cloak of Official Secrets Act 1972 (OSA), which prohibits the disclosure of any classified information. Any disclosure of classified information during the deliberations contravenes the OSA, and upon conviction is a mandatory one year imprisonment which is intimidating to the professionals. However, medical specialist [PRI 4] disclosed, “this policy has hindered free and open discussions between representatives of professional bodies and their members at the grass roots level on issues raised”.

Besides, these senior medical specialists also assert that there was a duration of complete silence between the time the last meeting, which was held with the professional bodies at the MOH, and the final presentation of the proposed bill to Parliament. Further, these representatives argue that there was another period of silence from the time of the gazettelement of the Act 586 in 1998 to the publication of the Regulations in 2006. The findings show that this controversial policy has inevitably led to widespread disenchantment and protests especially among the private medical practitioners’ fraternity nationwide.

The enforcement of the Act 586 has been heavily criticised as micro-managing the practice of medicine. Key informant PUB 2 concedes “the MOH is also accused of not consulting the professional bodies adequately in such a major policy decision making, as well as rushing into the enforcement of the law”. In view of the protests by the private medical and dental professionals nationwide, the MOH has finally agreed to defer the enforcement of Act 586 and its Regulations to a further six months period. The MOH has acknowledged the fact that the noble intent of the policy has not been well deliberated and informed causing nationwide protests. The findings also disclose that numerous

roadshows were conducted by MOH throughout the country to provide better information and guidelines on the enforcement of Act 586.

#### **6.2.4 Guidelines on Mandatory Approval and Licensing of Private Hospitals**

This study reveals that all new applications for private hospitals establishment are to undergo a compulsory two-tier process of application based on the specific guidelines stipulated under the Act 586 and its regulations. The first tier protocol is for the approval “to establish or maintain” mandated under Section 8 and 9 of the legislation, while the second tier protocol is for license “to provide and operate” a private hospital as stipulated under Section 15 of the Act 586. Under the new legislation, application for a license to provide and operate a private hospital must be completed not exceeding three years from the date of the approval to establish such facility as provided for under Section 14 of the Act 586 (Malaysia, 1998).

Key informant PUB 1 indicates that “all new applications amongst others require the rigorous submission of the statutory details and declarations of the applicant, licensee, and person in charge (PIC)”. This detailed submission includes the architectural building facility plans, and the justification of the need for a new facility or service at the proposed location. The human resource capacity plan with supporting evidence of qualified healthcare professionals’ valid annual practicing certificates, financial investment capacity and the description of any high technology medical equipment intended to be used are required in the application.

The information gathered from the key informants discloses that it is only upon the MOH’s mandatory approval to establish a private hospital that permits the commencement of the construction. The setup of the new facility is based on the detailed

submission of architectural building plan approved. In some cases, additional recommendations are required based on the provisions under the Act 586. Furthermore, the findings also confirm that it is only after the completion of the new building facility that the application for license to “provide and operate” of the private hospital is considered. Under the second tier protocol as mandated under Section 16 of the new legislation, a pre-licensing inspection shall be conducted by a team headed by a medical practitioner from the MOH and the State Medical and Health Office at each of the proposed private hospital. The inspection will be based on the compliance and requirements under the Act 586 to ensure patient’s safety and the provision of quality care.

#### **6.2.5 Approval or Rejection of Licence**

The result of findings reveals that it is upon receiving the site inspection report under Section 16 that the Director General of Health (DG) is empowered as to whether to approve a license to establish a private hospital. He may grant a license that is subject to some terms or conditions, and the payment of a prescribed fee. Alternatively, he may also decline the application with or without giving any reason as stipulated under Section 19 of the new private healthcare legislation (Malaysia, 1998). Any aggrieved party may appeal in writing to the Minister under Section 101 of Act 586. This policy has caused great concerns and anxieties among the medical and dental professionals. Their contention is that the reason for the decline should be disclosed and any shortcomings arising could be rectified without having to file an appeal to the Minister. According to these key informants a mechanism should be in place for a resubmission of application for approval. This study shows that two new private hospitals B and J have been approved and licensed under Act 586.

### **6.3 Power Issues**

An important theme which emerged from the analysis of interview data is on the issues of authority. The study indicates that there is the overwhelming concern over the vast statutory power vested on the Minister and to a lesser extent on the Director General of Health under the provisions of the Act 586. Invariably, there is a constant fear of the abuse of statutory power and the lack of transparency under the new Act 586 which may hamper the enforcement capacity. According to these key informants whose fear is that by granting the wide statutory power to the Minister and the Director General is perceived to be akin to a “double edge sword” which depends heavily on the personality and temperament of the individual. Particularly, key informant PRI 4 who is a past president of MMA and APHM criticises the vast statutory power vested upon these two personalities quoting, “Ministers and Director Generals come and go. Some may be more understanding than others. There is obviously a valid concern on the vast statutory power”.

#### **6.3.1 Suspension and Revocation of Approval and Licence**

Examination of the provisions under Section 43 to Section 51 of the Act 586 reveals the immense statutory power accorded to the DG who may issue a show cause notification of his intent to suspend or revoke the approval or licence or decline to approve or renew a licence. Among the grounds for suspension is the failure to comply with any direction, or guidelines given by him or the Minister. Likewise, the study discloses that the DG may also refuse to approve or renew a licence if he is dissatisfied as “to the character and fitness of the applicant be it a natural person, a body corporate, partnership or society without providing any reason” (Malaysia, 1998). Besides, the DG is empowered the refusal if in his opinion the hospital “premises in respect of which the application is made are not safe, not clean or unsanitary, or not adequately equipped and the staffing is not

adequate or not competent” for the establishment of a private hospital (Malaysia, 1998). This study shows that there are limited safeguards to ensure that the DG had exercise his powers in accordance with Act 586 and its regulations.

### **6.3.2 Temporary Closure**

In addition, key informant [PUB 2] discloses that the Director General of Health is vested with vast statutory power on the temporary closure of any private hospital if in his opinion that the existence of such facility would endanger the public health in terms of patient’s safety under Section 52 to Section 53 of the Act 586 (Malaysia, 1998). An analysis of the information gathered from key informants reveals the unprecedented enforcement capacity of regulatory sanction for the temporary closure of any private hospital for non-compliance under the new Act 586 has a significant impact on the private hospitals. The findings indicates that the power of temporary closure is a departure from the old private healthcare legislation which the standards were basic and mainly emphasised on the adequacy of practitioners in these facilities. Besides, the Private Hospitals Act 1971 did not have the provisions for enforcement capacity even to the extent of entering and inspecting any private hospital premises. The new enforcement statutory power under the new legislation serves to overcome the gap of perennial inadequacy of enforcement. In addition, the statutory power also serves as a serious deterrence to private hospital providers to ensure public accessibility towards patient safety and quality care.

Furthermore, the failure to comply to this order of temporarily facility closure under the Act 586 commits an offence, and if found guilty shall be punishable to a penalty up to RM 50,000 or to a jail sentence of not more than a year, or both for sole proprietor. For a corporation or society, the punishment is to a fine up to the limit of RM 100,000 or a jail sentence of one year, or both (Malaysia, 1998). This study reveals that two private

hospitals M and O were ordered temporary closure after adverse events of assessable death. Under Section 64 of Act 586, assessable death is defined as “a death that in the opinion of any medical practitioner or dental practitioner, may be related to anesthesia or any anesthetic procedure, or medical technology or any medical procedure, or surgery or any surgical procedure”(Malaysia, 1998).

### **6.3.3 Power of Minister**

Analysing the data gathered reveals that the vast statutory power granted to the Minister is stipulated under Section 101 to Section 107 of the Act 586, is a major concern as it is prone to potential abuse of power and lack of transparency. Invariably, the Minister is a politician who represents the various influential interest groups, and may interfere in the decision making of the DG and the enforcement capacity of the MOH. Further, key informant PRI 8 argues that the Minister “may exempt any or any part of a private healthcare facility or service licenced or registered under this Act 586 from the operation of any provisions of this Act after in consultation with the Director General under Section 103 of Act 586” (Malaysia, 1998). The decision of the Minister shall be final and there is no judicial review. This provision has immense impact of the Act 586 on the private hospitals in terms of the compliance and non-compliance in achieving the intended national health priorities.

In addition, the Minister is vested with the wide statutory power to issue general directives, among others, the power to appoint Board of Visitors in private hospitals, the power to prescribe the types of social welfare contributions, prescribes fee schedule, and the power to make regulations for the governance of private hospitals. Failure to comply constitutes an offence and upon conviction is a punishable fine, jail sentence or both. The issue is whether these final and conclusive provisions under Act 586 appear to oust the

jurisdiction of the courts. In this context, key informant OTR 19 who is a legal professional asserts that “we may have to wait for some test cases in courts to know the outcome which may affect the governance in the private hospitals”.

#### **6.4 Governance Issues**

This study also reveals that one of the important themes arising from the interviews, focus group discussions and observations is on the issue on the governance in the private hospitals in terms of the authority, decision-making and accountability. Analysis of the findings indicates that most private hospital institutions are owned and controlled by the conglomerate of government linked companies (GLCs), which have close political connection with the ruling government to have the intended positive regulatory impact. Although the post-expectation of Act 586 is a physician led private hospital, the findings disclose that the medical professionals do not seem to have the authority, and decision-making over the governance issues. By virtue of their specialised knowledge the medical professionals are employed or engaged mostly as independent contractors under a service contract agreement to practice medicine in private hospitals. This symbiotic relationship further illustrates the agency theory where the private hospital is seen acting as the principal has to depend on the well informed medical professionals as the agents to provide the delivery of medical care for the business operation of the hospital. Invariably, the principal and the agent have divergent objectives and conflict of interests is often inevitable. Similarly, the bilateral relationship between the state as the principal and the private hospitals as the agents further exemplified the principal-agency theory in this study.

The analysis of data denotes that main objective of a corporate private hospital is a profitable business in the funding and provision of medical facilities and services. This

among others include the authority in the decision-making on the financing and the provision of sophisticated ambience and facilities such as the latest state-of-art medical technology in the private hospitals. For business sustainability in private hospitals, the hospital management charges an administrative fees between 10 percent to 15 percent of the medical specialist's gross professional income for the facilities and services provided in the study hospitals.

Invariably, the commercialisation of private hospitals has adversely affected the symbiotic relationships between the doctors and the private hospitals especially with the emergence of the managed care organisations (MCOs). One contentious issue arising from this tripartite relationship is the issue of fee-splitting on the medical bills, which includes the specialist doctors' professional income. The private hospital management has entered into a Hospital Service Agreement with the MCOs unilaterally despite the objections from the specialist clinicians. Fee-splitting violates Act 586. An analytical findings on this controversial issue will be discussed in detail under sub-section 6.6 on another thematic issue of non-compliance in respect of fee-splitting in this chapter. This analysis will provide further insight into this complex matter of non-compliance of fee-splitting in the private hospitals.

Personal communication with a senior bureaucrat PUB 1 who is a Director discloses that MOH is aware of the undercurrent between the private medical specialists and the hospitals on several issues over the governance. According to this key informant PUB 1, the provisions under Act 586 serves to address the major issues of governance through the mandatory licencing and the responsibility of the person-in-charge (PIC).

#### **6.4.1 Responsibility of Person-in-Charge (PIC)**

The result of the interviews, focus group discussions and observations indicates that the licensee under Section 31 of Act 586 is highly accountable to ensure that the private hospital “is maintained or operated by a person in charge who shall be a registered medical practitioner under the law” (Malaysia, 1998). Further the new legislation mandates that the PIC “shall be responsible for the management and control of the private health facility or service to which a licence or registration relates” (Malaysia, 1998). In addition, analysing the data collected shows that the PIC is also “accountable that persons employed or engaged by the licensed private hospital are registered under any law regulating their registration, or in the absence of any such law, holds such qualification and experience as are recognised by the Director General of Health” (Malaysia, 1998). Furthermore, the PIC is also responsible for the policy statement of its obligations toward patients’ rights using the facilities and services in the private hospital. Data from the study denotes that these are some of the major post-licensing expectations of MOH to ensure good governance in private hospitals in terms of the patient’s safety and accessibility to quality care.

Notwithstanding the high responsibility sanctioned under the Act 586, in reality it is a challenge for the PIC of corporate private hospital to make independent decision-making on governance issues such as patients’ equitable access to quality care which may be in conflict with the current corporate policies and business decisions. In practice, the PIC is not in control of the management of a corporate private hospital to have the intended positive impact of Act 586.

Data from the study discloses that the PIC is normally designated to the position of the Medical Director who reports to the Chief Executive officer (CEO) in a tertiary care

private hospital. The CEO who is the head of the private hospital reports directly to the Board of Directors under the organisation chart as illustrated in Figure 6.1. The CEO and the Medical Director are also ex-officio members of the Medical and Dental Advisory Committee (MADC) by virtue of their positions. The Act 586 mandates the formation of MADC to represent all medical and dental practitioners in the private hospital and advice the management on clinical matters such as issues pertaining to patient's safety and the provisions of quality care. However, the function of MADC has not been expressed explicitly under the Act 586 to have the intended effects on the private hospitals. This topic on MADC will be discussed further under another theme on quality care issues in the following Chapter 7. However, the cost issue remains an important factor in the governance and management of a private hospital.

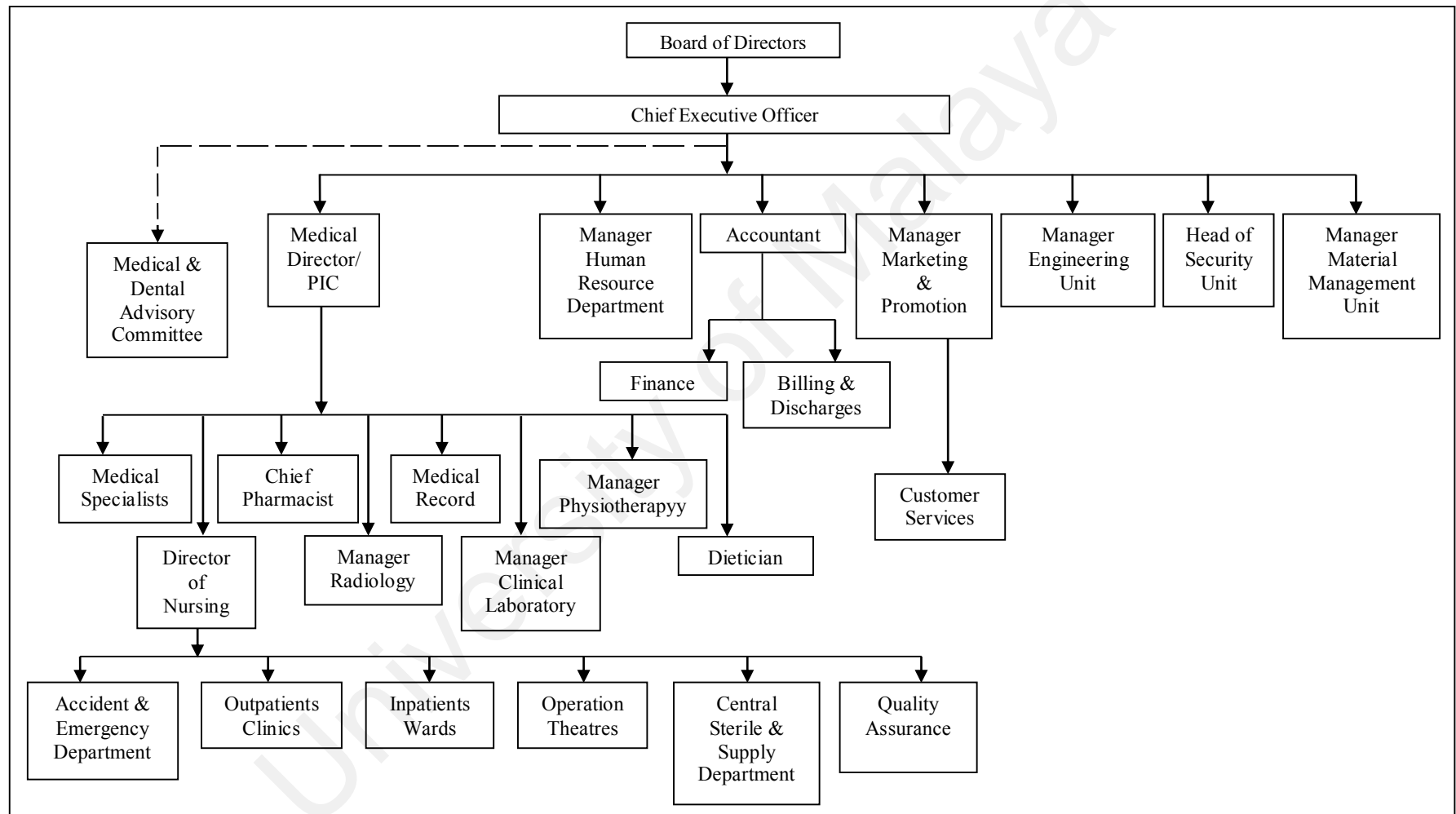


Figure 6.1 Organisation Chart of a Corporate Tertiary Care Private Hospital

#### **6.4.2 Shortage of Manpower**

The findings reveal that cost containment is a crucial factor in the management of private hospitals in view of the high operating expenditures particularly the cost of human resources. The provision of adequate staffing is crucial in ensuring the efficiency and effectiveness in the delivery of quality care in a private hospital. However, the recruitment of adequate staff may be at times compromised especially the perennial problem of shortage of medical officers in the Accident and Emergency Department in many private hospitals. For instance in Hospital I, and the management resorting to employ part-time locum doctors to save cost. This action had caused the PIC to be charged with neglecting and disregarding his professional responsibilities by employing and permitting an unregistered person to practise medicine at the corporate private hospital. The locum doctor was found treating patients without a valid Annual Practising Certificate to practice at Hospital I under the Code of Professional Conduct.

In 2010, the PIC was subsequently found guilty of infamous conduct in a professional respect under Section 29(2)(b) of the Medical Act 1971. This decision was made on the ground that he was responsible for the management of the private hospital which among others include the employment of doctors [key informant PRI 78]. According to key informants PUB 4 and PUB 5 from the regulatory body, the PIC was initially recommended to be charged under Act 586 instead of the Medical Act 1971. In addition, these informants also note the role of PIC is crucial in the management of good compliance system in a private hospital.

#### **6.5 Compliance Issues**

Another central theme that has emerged from the analysis of data from key informants and observations is on the the compliance issues. Key informants PUB 1 emphasised, “it

is important to have a good compliance system in the private hospitals to ensure the provision of quality care”. With the implementation of the new Act 586, all existing private hospitals which have been registered under the previous Private Hospitals Act 1971 are deemed to be licensed under Section 120 of the new legislation (Malaysia, 1998). In spite of the licensing granted, six key informants reveal that many of the private hospitals have encountered various degrees of challenges in terms of compliance for the provision of quality care. This phenomenon has occurred because the specific guidelines on the establishment of private hospitals were non-existent under the previous Private Hospitals Act 1971 according to these key informants.

This study reveals that Act 586 stipulates explicitly the new guidelines and specifications for the establishment of a private hospital. Amongst the major requirements imposed are the adequate fresh air ventilation system in critical areas and the additional special requirements for instituting emergency services in the private hospitals. The result of study indicates that these are some major challenges faced by the private hospitals in terms of compliance. Key informant PUB 2 disclosed, “despite the major challenges, private hospitals have been urged and given encouragement to comply with the regulations before the next license renewal inspection”.

On the question posed as to what actions have been taken by the regulatory body if a private hospital fails to comply in spite of reminders. Key informants [PUB 1, PUB 2, PUB 3, PRI 1 and OTR 2] explain that the regulatory body could either issue show cause notification to suspend or order a temporary closure of the private facility pending compliance. Alternatively, those private hospitals which had their original root as maternity facilities, and failing to comply as the facilities and services of a private hospital would result in reverting to their original status as maternity hospitals where the

requirements are less stringent under Act 586. The result indicates that one of the crucial factors cited as to why many private hospitals do not have the full compliance is because of the loosely regulated framework previously. The Private Hospitals Act 1971 was a basic legislation for the registration and licensing of private hospitals without stringent guidelines. In addition, MOH encounters the dilemma in the enforcement capacity as the slender legislation did not empower them to enter or close unlicensed private hospital premises. The regulatory body could only circumvent this weakness by invoking the Poison Act 1952 under the pretext of drug inspection by the pharmacists.

The findings also reveal that for licensed premises, the Private Hospitals Act 1971 gave MOH the power of inspection but not enforcement capacity. Arising from this regulatory weakness in the form of control has led to the proliferation of private hospitals with wide variations in design and building structures. Observation made discloses that the private hospitals are found to be operating on either purpose-built or non purpose built premises. Non-purpose built premises were originally either shophouses or commercial buildings which have been reconfigured and renovated for the purpose of a private hospital where patient's safety measures may be compromised. This study reveals that six private hospitals were originally operating on non-purpose built premises while the rest of the study hospitals operating on purpose-built premises.

Furthermore, the analysis of findings indicates that some of these private hospitals have been operating business for years even before licences are granted. Subsequently these private hospitals have applied for a licence which the MOH has no alternative but to grant approval under the old legislation. In addition, key informant PUB 18 argues that "the emergence of unlicensed private hospitals with unqualified healthcare staff further exacerbates the complexities in the private healthcare sector. The provision of mandatory

approval and licensing for private hospital establishment was non-existent under the Private Hospitals Act 1971 and its regulations”.

Similarly, the empirical findings reveal that 13 out of the 15 study private hospitals [Hospital A, C, D, E, F, G, H, I, K, L, M, N and O] have encountered various forms of challenges in terms of regulatory compliance. These 13 private facilities have been registered under the previous Private Hospitals Act 1971 which was without specific guidelines for hospital establishments. Only two newly established corporate private hospitals [Hospital B and J] have complied with the minimum regulatory requirements under the new Act 586 and its Regulations 2006 according to four key informants [PUB 4, PUB 5, PRI 20, and PRI 55]. Most of the study private hospitals faced major issues especially in the building infrastructural compliance with the new regulations for patient's safety and the provision of quality care. Among the major requirements imposed on these private medical institutions are the need for installation of 100 percent fresh air ventilation system in critical areas such as the operation theatres and intensive care units, and the additional requirements for emergency services.

#### **6.5.1 Compliance on the Adequate Ventilation System**

This study reveals that all rooms and critical areas in a private hospital are mandated to be adequately ventilated for patients' safety and quality care as stipulated under the Regulations. Information gathered from two key informants [PRI 50 and PRI 51] who are hospital project managers indicate that Act 586 has positive impact on the private hospitals. For instance, the regulations mandate explicitly that an operation theatre and its ancillary facility shall be mechanically ventilated to provide one hundred percent fresh air without recirculation. Furthermore, the regulations mandate “all ventilation or air conditioning systems serving the operation theatres shall have a minimum of three filter

beds of High Efficiency Particle Air Filter (HEPA)” (Malaysia, 2006). These are some of the major challenges and requirements pertaining to the air ventilation system to be complied by private hospitals.

This intended regulatory impact is evident in one of the study tertiary care private hospitals renowned for its international patient clientele base and medical tourism. Two key informants [PRI 7 and PRI 16] who are senior management executives disclose that Hospital C undertook an unprecedented major renovation and refurbishment works especially on the installation of the 100 percent fresh air ventilation system. This major work costs the management a hefty RM 2.0 million expenditure for compliance. This justification for the major work was because the hospital’s old air ventilation system comprised of a mixture of fresh and recirculation air which did not comply with the stringent provisions under the new regulations.

### **6.5.2 Compliance on the Emergency Services**

The findings reveal that one of the most significant impacts of Act 586 on the private hospitals is the availability of emergency services providing better access to the public, regardless of the patient’s socio-economic status and the affordability. This is the departure from the Private Hospitals Act 1971 where the provision of emergency services was not mandated and emergency services were not seen as a priority. Despite the major challenges faced by 13 private hospitals under the study in terms of compliance, efforts had been made to comply to the additional requirements on emergency services albeit the variations in intensity of care provided. All private hospitals are capable of instituting and making available essential life saving measures at all times. Another impact of Act 586 on the private hospitals providing emergency services or surgical services is the compliance to maintain a minimum blood supply in its premises at all times for its daily

use, or in a position to obtain blood quickly from other licensed blood banks or Government facilities for its daily needs. The findings also reveal that resuscitation facilities which include equipment, drugs and material are available in the private hospitals to achieve a good compliance system under Act 586.

### **6.5.3 Good Compliance System**

The result reveals that the new additional requirements pose major challenges to many private hospitals due to the lack of specific guidelines, pre-establishment issues and building structural constraints. Many of these big corporate private hospitals took this opportunity to embark on various major refurbishment works, new building expansion projects and even migration to new purpose built hospital premises. The upgrading of these facilities has been seen as meeting good compliance system as well the business expansion strategies to cater for medical tourism particularly seen in nine private hospitals.

This study also reveals that nine private hospitals have been commissioned with purpose-built hospital premises, while the other six private medical facilities [Hospital E, I, L, M, N, and O] are non-purpose-built hospital premises which have been operating on converted commercial or shophouse. These non-purpose built hospital premises have been reconfigured cosmetically and renovated extensively to serve the purpose of a private hospital based on the rudimentary Private Hospitals Act 1971. Besides the building structural constraint, the fact remained that there were compromises and trade-offs as there was no regulatory enforcement according to the key informants. However, the information gathered reveals that with the enforcement of the new legislation, most of these hospitals face major challenges in terms of compliance for patient's safety and provision of quality care. Findings also reveal that private hospitals facing financial

difficulties in terms of compliance have been acquired by the conglomerate of the GLC group of hospitals through mergers and acquisitions. For instance Hospital N has been acquired by a leading GLC healthcare provider. The study indicates that the only option available for compliance in some hospitals is to migrate to new purpose built premises in accordance with the new regulations.

In this context, two non-purpose-built hospital premises such as Hospital L and Hospital M have vacated and moved to new purpose-built hospital premises in compliance with the regulations. Similarly, three other older purpose-built hospital premises [Hospital D, G, and K] built over the decades face similar dilemma on compliance. Realising their shortcomings and the impact of the Act 586, the managements of these private hospitals have shifted their business operations to new purpose-built hospital premises to comply with the new regulations. Moreover, the findings also reveals that migration to new purpose-built hospital involved high capital expenditure and private hospitals owned by GLCs have the financial capacity. Besides, the chain of private hospitals under the flagship of the GLCs have the economy of scale and the synergies for future business expansions such as Intergrated Healthcare Holding (IHH) and KPJ Healthcare Berhad (KPJ) as discussed under sub-section 4.6.1 on the emergence of government linked corporate hospitals in Chapter 4 pertaining to the Malaysian Healthcare System in Malaysia.

#### **6.5.4 Creative compliance**

Based on the result of interviews and observations made with six key informants indicates that four medium and small sized private hospitals such as H, I, N, and O which are extremely cost-conscious have preferred to adopt a cautious “wait and see” approach. In addition, these key informants [PUB 1, PUB 2, PUB 3 and PUB 4] disclose that despite

several reminders from the regulatory body, these private hospitals appear to do some “creative or cosmetic refurbishment” works at minimum cost hoping to satisfy the acceptable standards of compliance for quality care. These creative refurbishment works do not appear to add any improvement in the performance of care to the patients. Analysing the information gathered and observations reveals that patient’s safety measures have been invariably compromised especially on the new mandatory requirements imposed such as on the adequate fresh air ventilation system in critical areas and the additional special requirements for emergency care services.

Result of the feedback acquired from two key informants PUB 4 and PUB 5 indicates that Hospital M and O which had been operating over the decades in double storey terrace shophouse failed to meet the minimum standard requirements in spite of reminders. The stipulated adequate fresh air ventilation system, the special requirements for emergency services and even the fire escape exits for patient’s safety have been compromised. It is not until the occurrence of an adverse event that their licenses to operate have been suspended and ordered for temporary closure. Analysis of the data information and observations reveals that in spite of the non-compliance, there has been no evidence of prosecution of the private hospital in court for contravening the Act 586. Instead an approval has been given to a new corporate management to take over the premises of Hospital O to comply with the regulations. While Hospital M which is owned by GLC has migrated to a new purpose-built hospital premises in compliance with the regulations. An important feedback gathered from the regulatory body [PUB1, PUB 2] is the responsibility of the person-in-charge (PIC) of a private hospital in ensuring regulatory compliance under the current new legislation.

## **6.6 Non-Compliance on Fee-splitting**

One controversial theme arising from this study is on the non-compliance issues on fee-splitting. Interviews with 16 key informants from the medical profession reveal that the practice of fee-splitting has been a major controversial issue between the medical specialists, the private hospitals and the medical insurers over the last two decades.

Key informant PRI 3 who is a senior medical specialist argues that “fee-splitting is defined under the regulations as any form of kickbacks or arrangements made between practitioners, healthcare facilities, organizations or individuals as an inducement to refer or receive a patient to or from another practitioner, healthcare facility, organization, or individual” (Malaysia, 2006). Furthermore, any person who contravenes these regulations “commits an offence and shall be liable on conviction to a fine not exceeding RM 10,000 or to imprisonment for a term not exceeding three months or both (Malaysia, 2006). Interviews gathered from the key informants disclose that inspite of the legal responsibility sanctioned, the PIC faces huge challenges in terms of overcoming the complex issue of fee-spitting in the private hospitals.

### **6.6.1 Emergence of Managed Care Organisations**

This study indicates that with the commercialisation of private hospitals, managed care organisations (MCOs), which comprised of medical insurance companies and third party administrators have become significant stakeholders in the private healthcare sector. The findings disclose that through the aggressive marketing strategy of assurance in cost-containment, these influential MCOs have managed to solicit kickbacks in the form of discount ranging between 10 percent and 20 percent on the patients’ medical bills from the private hospitals. This solicited discount includes the medical professional fees as an inducement before entering into a Hospital Provider Service Contract with the various

private hospitals. In this respect a senior medical specialist PRI 39 complained, “some health insurance companies have been asking doctors for discount from the Fees Schedule. We are against such a move and we are grateful to the Director General of Health for his support on this matter”. From the examination of the information and observations made reveals that inspite of the objections from the medical professionals, the private hospitals do not mind giving discounts to the managed care organizations in return for better business volume. The issue of fee-splitting has been seen as a widespread and discreet practice in the study hospitals. A close scrutiny of the information obtained indicates that it is a win-win strategy as business is extremely competitive in the corporate private hospitals sector. A senior key informant PRI 16 who has work experience in managing three corporate private hospitals [Hospital C, F, and J] reiterates “the emphasis of private hospital is on the financial key performance indicator on profitability which is crucial for the business sustainability and return on investment. We have a high accountability for the profit and loss of the private hospital like any other business corporations”.

Besides, six other senior key informants have concurred that the MCOs contributed significantly on an average about 35 percent of the private hospitals’ gross business revenue while the rest are mostly from out-of-pocket paying patients. Furthermore, as the medical practice in private hospitals remains highly competitive and lucrative in terms of remunerations, medical specialists are primarily engaged as independent contractors for their expertise and professional services. Their professional income is based on fee-for-service from the patients. While most medical consultants have expressed their deep concern over the practice of fee-splitting, which they considered as unethical, but they do not have much choice especially on management issues. The hospital management has

engaged these medical specialists on an individual contractual basis and subject to the provisions under Act 586.

The findings disclose that each specialist clinician is privileged to practice medicine based on his specialty with the respective principal hospital under an agency service agreement among others, to abide by the management's decision. Besides, there is also an exit clause in the contractual practice agreement whereby either party shall exercise the right to terminate the contract with prior notice which the clinicians feel extremely intimidating according to key informants who are medical specialists [PRI 2 and PRI 3]. Invariably, medical consultants are risk adverse of the possibility that their privileges to practice may not be renewed upon the expiry of contract. The agreement of the clinicians to disagree in silence has repercussions.

#### **6.6.2 Conflicts between Medical Specialists, Private Hospitals and MCOs**

This study reveals that the symbiotic relationship between the medical specialists and the private hospitals over the years has invariably resulted in constant conflict of interests and antagonisms, and subsequently with the MCOs. Feedback gathered from four key informants from the MCOs and medical insurers have often alleged the abuse of doctors with outrageous professional fees billed and contravened the new Fee Schedule under Act 586. Similarly, private hospital ancillary charges are at times outrageous and controversial with questionable padded lump sum items causing exorbitant medical bills. Many medical bills have been queried for justifications before payments are made and this phenomenon has caused intense frictions between the parties concerned according to these key informants.

Conversely, the perceptions gathered from 11 key informants who are senior medical specialists have alleged the MCOs of gross interference and transgression in the clinical management of patients which is unacceptable. Under the managed care protocol, whatever proposed patient medical care has to be approved by the insurers before investigations and treatments are initiated to ensure no potential abuse. However, these clinicians are of the opinion that their professional autonomy on patient care management have been curtailed and infringed. In this context, a senior specialist clinician [PRI 2] argues, “we are very much against insurance companies questioning our medical judgement to do a test when they are not qualified to do so. Even in an emergency life and death situation, where time is of essence, doctors may decide quickly to go ahead with the procedure, and explain to the patient and relatives later”.

Similarly, another medical specialist [PRI 3] asserts that “the provisions under Section 83 of the Act 586 has expressed explicitly that the healthcare provider cannot enter contract with MCOs that changes the powers of professionals on the management of patient, or contravene code of ethics”. Failing to comply is an offence, and liable to a maximum fine of RM 300,000.00 for corporate body and RM 500,000.00 for MCOs (Malaysia, 1998).

Further, information obtained from key informants reveals that health care providers must provide details regarding such contracts with the MCOs to the Director General of Health under Act 586, but this statutory provision appears to receive scant attention. Moreover, MCOs dealing with private hospitals must be registered with the MOH under the Act 586, however this compliance has not been enforced effectively. A close scrutiny of Section 86 of the Act 586 indicates that MCOs are mandatory to be registered with the Director General of Health even though these organisations are under the purview of the Central

Bank of Malaysia (Malaysia, 1998). The information gathered indicates that the PIC of the respective private hospitals do not provide details of such contracts to the MOH, and MCOs are seen to be resisting registration during the enforcement of Act 586.

### **6.6.3 MOH Reaffirmed Fee-Splitting a Contravention of Act 586**

On the same note, three key informants [PRI 2, PRI 3 and PRI 8] assert that the Director General of Health has issued a press statement on the 3<sup>rd</sup> April, 2008 reaffirming that the practice of fee-splitting is a breach of the Private Healthcare Facilities and Services Act 1998 [Act 586] and its Regulations (Malaysia, 2006). Fee-splitting is also said to be “unethical and is considered as a form of serious professional misconduct by the Malaysian Medical Council under Medical Act 1971” (Malaysia, 1971). Furthermore, any form of discount on professional fees can be construed as intention to induce that doctor to compromise his professional judgment for financial gain much to the detriment of his patient (Malaysia, 1971). This perspective concurs with the Code of Professional Conduct for medical practitioners on fee-splitting. A violation may subject the practitioner to disciplinary action under the Medical Act 1971 (Malaysia, 1971).

### **6.6.4 Controversial Flip flop Policy on Discount**

According to five key senior medical clinicians [ PRI 2, PRI 3, PRI 4, PRI 5, and PRI 8] indicate that the intense disputes relating to discounts between the private hospitals and MCOs have eventually led to the dramatic reversal of the earlier stand of the MOH, which is seen as a contradicting public policy. The MOH is reported to be reviewing the regulations subject to the agreement of all the stakeholders concerned. This is evidence in relation to the MOH’s press statement released by the DG subsequently on 2<sup>nd</sup> August 2010 reiterating that “it has no objection on direct dealing between a private hospital and any organisation that allows discount to be given for charges other than the professional

fees as long it is not seen as a kickback or an inducement to refer or receive patients” (MOH, 2010). The reality is that the objective of soliciting discount is an inducement to refer or receive patients under the Healthcare Service Provider Agreement between the MCOs and private hospitals.

Similarly, the DG stated that any private practitioner has the option to waive or reduce his professional charges. Furthermore, a practitioner is advised to adhere to the Fee Schedule under the Regulations 2006. The fees must be mutually agreed upon by the various Medical and Dental Advisory Committee (MDAC). In an unprecedented move the DG urged all private hospitals to consult with the practitioners on any arrangement made that affect their practice. On a same note, MOH also urged all practitioners and relevant stakeholders to comply with the Fee Schedule and refrain from fragmenting or unbundling the procedure fees (*The Star*, 3 August 2010). While the announcement has been seen as timely, and eventful, major developments have taken place since the implementation of the Act 586 in 2006. Amongst the significant complexities arising from the regulatory enforcement is the strong advocacy from the medical professionals for an urgent review to hike 30% of their professional fees under the Fee Schedule as cited by the key informants.

## **6.7 Concluding Remarks**

This chapter summarises the thematic issues which are inter-related on the policy, power, governance, compliance, and the non-compliance on fee-splitting. The policy issue is on the mandatory approval and licensing of private hospitals which is to be a physician-led establishment with the high responsibility of the PIC. Hence, this health policy is to control and eradicate the proliferation of of illegal private hospitals with unregistered healthcare professionals. Besides, the policy is to safeguard patient’s safety and quality

care. However, there is the concern over the vast statutory power vested on the Minister and to a lesser extent on the power of DG which may be subject to potential abuse and the lack of transparency in the enforcement capacity. This study reveals that most private hospitals are owned by conglomerate of GLC where the state has high level of investment. In the context of governance, the Board of Management is empowered with the authority and decision-making in the funding and provision of facilities and services in a corporate private hospital. The PIC is designated as a medical director in-charge of clinical matters but not in control of a private hospital. Besides, the study discloses the compliance and non-compliance in the private hospitals. Majority of the private hospitals face various challenges in terms of compliance as there were no specific guidelines under the old legislation i.e. Private Hospitals Act 1971. In addition, this study reveals that many private hospitals embarked on major development work and some even migrated to new purpose-built hospital premises in compliance to the new Act 586. Notwithstanding, the non-compliance in fee-splitting on the professional fees between the private medical specialists and the managed care organisations remained unresolved with the enforcement of Act 586. The findings on the professional fees will be presented under the cost theme in the following Chapter 7 together with other themes such as inequity, quality care, political issue and the enforcement capacity of the regulatory body.

## **CHAPTER 7 : RESULTS**

### **7.1 Introduction**

This chapter is the extension of the empirical findings from the previous Chapter 6 focusing on the remaining themes pertaining to cost, inequity, quality care, politics and the enforcement capacity. These analytical findings provide answers to the research questions and objectives of the study as to whether the the intended national health goals are achievable with the enforcement of Act 586 especially to improve equitable access to quality care, and rationalising the medical charges in the private hospitals to more affordable levels.

### **7.2 Cost of Medical Care**

Another significant theme which emerges from this study is on the unconstrained and spiralling cost of medical care in the private hospitals. The interviews with 20 key informants from the three categories reveal the major concern of the escalating cost of medical care in the private hospitals. One of the objectives in the enforcement of Act 586 and its regulations, among others, is to rationalise the medical charges to more affordable levels in the private hospitals with a Fee Schedule for medical and dental professions.

#### **7.2.1 Fee Schedule**

This study indicates that a fee schedule has been mandated under Act 586 to address the concern on the escalating cost issues. Documentary examination on the provisions under Act 586 reveals that the Health Minister is empowered to “make regulations prescribing a fee schedule for all the private hospitals” (Malaysia, 1998). Based on the information gathered from the key informants and observations made discloses that it is historical and for the first time that the doctors’ professional fees to be charged at all private hospitals

have been regulated but not the private hospitals' ancillary charges. With the enforcement of Act 586, all private hospitals have written policy on the professional fee schedule. Particularly, the Thirteenth Schedule on professional fee which includes consultation and surgical procedure fees. Key informant PRI 3 reveals that "the quantum of fees of each professional service in the schedule is based on various factors among others the complexity of the service, the level of expertise required, the time required and the location where the service is provided".

The result of the findings of interviews with six key informants who are medical specialists indicates that the coverage of procedures and treatments has not been comprehensive. According to these key informants many procedures have not been included especially the new minimally invasive surgical procedures. Key informant PUB 2 who is a regulator asserts that "the professional fees stipulated in the Fee Schedule are the maximum charges. Any doctor who contravene with the fee schedule constitutes an offence and is liable to a fine penalty or jail sentence or both".

The findings indicate that professional fees under the Fee Schedule are based on the maximum charges stipulated under the guidelines of the Fourth Edition 2002, Malaysian Medical Association's professional fees according to key informants [PRI 1, PRI 2, PRI 3, and PRI 4]. The enforcement of the regulated fee schedule has generated gross dissatisfactions especially among the private medical specialists. This has the impact on the medical practice in the private hospitals. These private medical doctors are of the opinion that their professional fees have been stagnant over the years and it should be revised higher to reflect the current economic inflationary situation.

In this context, the professional bodies have proposed a 30 percent hike in their professional fees under Act 586 and its regulations. According to key informant PRI 2, “a Task Force Committee on professional fees has been formed in March 2011 at the MOH to review the current doctors’ professional fees”. The revision of the current fees proposed an upward increase by another 30 percent across the board which is pending the approval and amendments to the regulations. Subsequently, in 2012 the Government approved a hike of 14.4 percent under the Thirteenth Fee Schedule. The MOH was of the opinion that the increase of 14.4 percent was more appropriate to form the basis for the increase in the professional fees which was gazetted in 2013. The quantum was based on the consumer price index of healthcare for the period 2002 to 2010 and after consulting with the various stakeholders (Noor Hisham Abdullah, 2013).

This study indicates that the private hospital medical bills consist of two main components of charges. The regulated doctors’ professional fees forms one component of the medical bill and the other component consists of the unregulated hospital charges as illustrated in Table 7.1 .

Table 7.1: Main Components of Private Hospital Bill ( Medical bills 2011)

Hospital Charges		Professional Fees	
1	Accommodation Charges	1	Specialist's Initial Consultation with Examination and Treatment Plan
2	Administrative Charges	2	Specialist's Emergency Visit
3	Pharmacy Charges	3	Specialist's First Admission Review with Examination and Treatment Plan
4	Imaging Charges	4	Specialist's Ward Visit with Examination and Treatment Plan
5	Laboratory Charges	5	Medical Officer's Consultation Fees
6	Centralised Sterile Supply Charges	6	Specialist's Procedure Fees
7	Operation Theatre Charges	7	Medical Officer's Procedure Fees
8	Cardiac Catheterisation Charges		
9	Intensive Care Unit Charges		
10	Medical Supplies		
11	Nursing Charges		
12	Equipment Monitoring Charges		
13	Equipment Utilisation Charges		
14	Anaesthetic Charges		

From the information gathered and observations made, this distinction is pertinent in view of the agency problem and information asymmetries in the private hospitals sector. From the general public's perceptions, the doctors are commonly blamed for exorbitant medical bills because the doctors are said to be symbolic of the healthcare system according to four medical specialists [PRI 1, PRI 2, PRI 3 and PRI 4].

The findings reveal that most clinicians are neither owners of corporate tertiary care hospitals and do not decide on the final medical bills of the patients. The information gathered from the medical specialists have asserted explicitly that their professional fees are now being regulated whereas the private hospital ancillary charges are unregulated, and exorbitant. This argument has also attracted negative publicity and debates in the mainstream media. On the contrary, private hospitals have not responded publicly regarding their charges and seemed to adopt an ambivalent attitude according to the four key informants.

In addition, this study reveals that on an average approximately 35 percent to 45 percent of the total patient medical bills are doctors' professional fees consisting of ward visitations and procedures especially those patients undergoing surgeries. This finding is testified by five key informants who are senior management executives from the private hospitals. While the study indicates that the professional fees are being regulated, there is evidence of a growing trend of opportunistic practice of some medical consultants overcharging their inpatients with multiple ward visitations as much as 15 times per day. For instance medical consultants charging patients 15 visitations a day at the Intensive Care Unit in Hospital F. The findings on the medical bills reveals that patients have been charged to the maximum permissible limit of RM 180.00 and beyond for each ward visitation and subsequent multiple visitations within a day. This evidence is based on

some of the purposive selected medical bills gathered from the patients who had given their consents for the purpose of this study at the private hospitals.

In this context, a mainstream media report has cited the former Health Minister, Dr. Chua Soi Lek's revelation that a patient was checked on 15 times a day costing RM 3,000 while hospitalised in a private hospital (Edwards, 2007). Furthermore, he publicly chastised the doctors in the private practice (Edwards, 2007). According to five key informants, in practice a specialist doctor is permitted to make two charges per day for ward visitations on each of his patients, irrespective of the more number of caring and compassionate ward visitations.

Furthermore, this study indicates that despite the regulated fees, sample of purposively selected medical bills gathered from the patients provide some evidence of opportunistic practice by specialist doctors in overcharging the surgical procedure fees. Examination on these medical bills indicates that some surgical procedures have been "fragmented" to include multiple fee charge codes in a single procedure to overcharge and increase the doctors' professional income without their patients' knowledge. Result of findings discloses that this phenomenon is more evident in Hospitals A, B, C, D, E, F, H, I, J and K respectively. Interviews with five key informants who are the management executives of the study private hospitals, and the medical insurers have confirmed that the practice of "fragmentation" with multiple fee charge codes in a single surgical procedure by some of these medical consultants is of great concern. This trend of overcharging patients seems to be quite a common feature in the patients' medical bills presented for payments according to these key informants.

Besides, these key informants disclose that some of the specialist doctors are also known not only to stretch their professional fees to the maximum permissible limit but beyond and breaching the fee schedule. This practice is done often with questionable justifications. Result of data collected from interviews with key informants and observations discloses that even their peers are equally concerned over this opportunistic practice. However, this study also reveals that there are caring and dedicated doctors whose professional charges are in compliance with the fee schedule. There are doctors giving various forms of discounts on their professional fees under the Act 586 upon requests from their patients as indicated by the medical specialists.

This research also reveals that there are also occasions where altruistic medical specialists waive their surgical professional fees totally for deserving patients especially those from the poor and marginalised group. For instance, a Consultant Orthopaedic and Spine Surgeon waived all his professional fees for a complex and major spinal surgery performed on a poor student nurse who was without medical insurance coverage at Hospital H. Unfortunately, these charitable deeds have not been highlighted in the mainstream media as it may be construed as advertisements and violation of their professional code of ethics according to seven senior medical specialists.

### **7.2.2 Hospital Charges**

The findings reveals that in spite of the unregulated hospital ancillary charges, patients and their relatives are now been given some indications of the medical charges to be incurred but not on other unanticipated charges. In addition, key informant PRI 2 asserts that “the provision under the Regulation 26 stipulates that the patient has the right to be informed by the private hospital prior to the initiation of care or treatment the estimated

charges for services based upon an average patient with a diagnosis similar to the tentative or preliminary diagnosis of the patient”.

Prior to the implementation of Act 586, there was major information asymmetry and more often than not patients after having discharged from the respective hospitals faced the dilemma of paying exorbitant medical bills. Some of the unsettled medical bills remained controversial and legal proceedings have been initiated to recover the payments from the defaulters as asserted by four key informants [PRI 11, PRI 16, PRI 24 and PRI 34]. In this context, patients are often asked by the attending doctor and the private hospital as to whether they have an insurance coverage or private out-of-pocket payment when seeking treatment because of the cost issues.

This study reveals that hospital charges vary from one private hospital to the other depending on the diagnosis, level of facilities and services provided. Furthermore, charges for a similar medical condition or diagnosis may also vary within the same discipline or specialty in a private hospital. Although private hospitals do not appear to practice price differentiation on private patients with medical insurance coverage and those paying out-of-pocket payment, but in reality, there is a difference in the final total medical bills according to the key informants from the private hospitals.

Besides, this study also reveals that the cost of medical bills paid by insurance tend to be higher than those patients paid by out-of-pockets are factors influencing on the impact of Act 586. This is partly because private hospitals have to factor in the contractual discount of 10 percent to 20 percent given to the MCOs according to eight key informants from the private hospitals. The differential in cost between patients with insurance coverage and patient paying out-of-pocket (OPP) has been as one of the contributing factors to the

escalating medical bills in private hospitals. This study also indicates that hospital ancillary charges are generally categorised on a lump sum basis and codified under the patient's medical bill such as room accommodation of choice, utilisation of clinical laboratory, diagnostic imaging facilities, pharmacy, medical equipment, medical supplies, utilisation of operation theatre facilities, nursing procedures and other miscellaneous charges. Invariably, private hospital charges are equally complex for the patients to understand despite the itemised billings in view of the asymmetric information as confirmed by the key informants who are patients seeking treatment in the hospitals.

The outcome of the findings also reveals that except for the published room rates for accommodation and a few common packages such as normal delivery with terms and conditions specified, there is no disclosure of full hospital charges. Based on the documentary findings from the purposively selected medical bills disclose that the hospital ancillary charges are unregulated, and the medical bills are often seen as exorbitant. From the hospital management's perspective, this is inevitable as operating cost for running the hospital efficiently is extremely high in view of the ambience, manpower, facilities and the quality of care provided as testified by six senior key informants. Despite the high charges, the private hospitals provide some minimal discounts on the ancillary charges as part of the corporate social responsibility requirements under Act 586. However, key informants [PRI 7, PRI 16 and PRI 22] allude that the discount on medical bills appears to be more of a business strategy to avert expected challenges from the public of the high charges. Further, the medical bills for some common surgical procedures such as appendectomy varies from RM 5,000 to RM 11,000 in the study hospitals. Major surgical procedures such as coronary arterial bypass grafting surgery (CABG), medical bills range from RM 35,000 to RM 79,500 per admission as illustrated in Table 7.2.

Table 7.2: Comparison of Charges from Selected Private Hospitals (Author, 2011)

Procedures	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G
Appendectomy	RM6,000 - RM8,000	RM8,500 - RM11,000	RM8,000 - RM10,000	RM5,000 - RM9,000	RM8,000 - RM10,000	RM9,000 - RM10,000	RM8,000
CABG	RM40,000	RM45,000 - RM60,000	RM45,00 - RM55,000	RM42,00 - RM79,500	RM45,000 - RM50,000	RM40,00 - RM50,000	RM40,00 - RM45,000
Colonoscopy	RM2,000	RM2,500 - RM3,000	RM2,500 - RM3,000	RM2,500 - RM3,500	RM2,000	RM3,000	RM1,800
Coronary Angiogram	RM5,000	RM5,500	RM5,000 - RM6,000	RM5,000	RM5,000	RM5,000	RM5,000
Total Hip Replacement	RM26,000	RM35,000	RM30,000	RM34,000	RM25,000	RM26,000	RM22,000
Total Knee Replacement	RM20,000	RM30,000	RM30,000	RM30,000	RM20,000 - RM25,000	RM25,000	RM24,000
Craniotomy	RM40,500	RM45,000 - RM60,000	RM45,000	RM45,000	RM30,000	RM40,000	RM25,000

Based on the high charges of medical bills and informations gathered from the patients [OTR 22, OTR 23, OTR 24, and OTR 25] indicate that the private hospitals appear to cater for the benefit of upper affluent society. These private hospital charges are beyond the accessibility and affordability of the majority of average income citizens. This is inspite of the average monthly income of Malaysian households reported to have risen from RM 4,025.00 in 2009 to RM 5,000.00 in 2012 (Department of Statistics Malaysia, 2012).

### 7.2.3 Efforts to Curb the Exorbitant Medical Costs

This study reveals that the contentious issue of escalating private medical care costs has prompted the Director General (DG) to hold a press statement on 26 December, 2010. According to key informants PRI 2, PRI 11 and PUB 1, this measure was taken to address the crucial matter of high cost in the private hospitals despite the enforcement of Act 586. The DG has announced that MOH held a meeting on 24 December, 2010 with the various

relevant and major healthcare stakeholders to seek solutions to contain the spiralling exorbitant health care costs in private hospitals, and without having to compromise on quality care under Act 586.

The findings disclose that the stakeholders invited among others, include the Malaysian Medical Council (MMC), Association of Private Hospitals of Malaysia (APHM), Chief Executive Officers and PIC of private hospitals, representatives from MCOs, insurance companies and health professional groups. Several pertinent factors were cited affecting the private health care costs and among others, include the doctors' professional fees, hospital charges and issues related to MCOs and insurance companies. In summary, private hospitals had been urged to be transparent and among others, ensure the following directives:

- Inform all patients upfront about the estimated costs of treatment, apart from the professional fees of the doctor. This would include, for example, the marked up of consumables, costs to institute quality initiatives, hospital infection control, and others.
- Provide itemised billing to patients and financial financiers when requested.
- Provide information on the estimated total costs for hospitalisation of common medical conditions and procedures on the private hospitals' websites.
- Ensure hospital charges undergo a peer reviewed process to eliminate non-compliance and unethical practices. Private hospitals must also screen the charges imposed by both hospitals and practitioners before submitting to the MCOs and insurance companies for reimbursement.
- The MOH will strengthen its regulatory functions by the following:

- Examine and provide solutions to the problem of the difference in charges between patients paying out-of-pocket and insured patients. This controversial issue has also caused the escalating healthcare costs;
- Reiterate that discounts are permitted only for hospital charges and must exclude professional fees;
- Monitor private hospitals and the doctors to ensure they do not abuse the medical benefits provided for in their insurance with unnecessary procedures and tests on their patients.
- It was also mentioned that some of the private hospitals are directed by their shareholders to charge certain fees to meet their key performance indicators which have caused the spiralling healthcare costs.
- The MOH will continue to have consultations with the private practitioners, hospitals, MCOs and insurers and others to ensure the charges are fair and reasonable. In addition, MOH will continue to insist that all medical bills are to be itemised and transparent. This will allow patients to finally make the choice of where to go for treatment as long as they have enough information about the charges.
- Strengthen the “grievance mechanism and procedures to address all grievances relating to health care costs. A grievance committee must be in place to address complaints so that the matters could be settled at the private hospital level. Further only unsolved dispute should be brought to the attention of the Medical Practice Division of the Ministry” (Mohd Ismail Merican, 2010).

### **7.3 Inequity Issues**

Another significant theme which emerged from this study is on the issue of inequity. Analysis of data collected from seven key informants who are senior management

executives of the private hospitals reveals that on average about 60 percent of the private patients are paying out-of pocket (OPP) for the medical bills. While approximately 35 percent of the patients are paid by MCOs and insurance companies. The rest of the five percent of the patients are paid by corporations and the government. For instance, there are selected tertiary care private hospitals which provide medical care and treatment for cancer patients from public hospitals. This oncology services have been outsourced and approved by MOH under the health care privatisation programme.

According to these key informants some the OPP patients encountered financial difficulties in paying medical bills especially for those patients with chronic illnesses requiring unanticipated long stay in private hospitals. These key informants note that it is not surprising for some medical bills to exceed over RM 100,000 in tertiary care private hospitals. These inpatients are required to top-up payments regularly by the account department of the private hospitals. Failing to fulfill the financial requirements within the specified time frame, these patients face the possibility of been transferred out to the nearest public hospitals should the outstanding medical bills exceed the desposits paid.

Based on the information gathered from key informants who are medical analysts and academicians indicates that the high OPP in the private hospitals is an inequity issue in the delivery of medical care. This issue of inequity is where the majority of the population and the poor may be deprived of the appropriate access to quality care services. In addition, the high OPP has socio-economic impact especially on the average income households which may face financial catastrophies and poverty. From the analysis of the data reveals that private hospitals provide services mostly to the selected rich segment and the upper social class of the population. The vast majority of the population may be denied of equitable access and quality care in private hospitals.

## **7.4 Quality Care**

Analysis from the interviews of key informants reveals a central theme surrounding on the issues of quality in the delivery of care in private hospitals. The fragmentation of private providers, the variation of care, and adverse events resulting in increasing medico litigations are major and complex issues confronting the policy makers according to 13 key informants. In addition, information from these key informants indicates that the enforcement of Act 586 and its Regulations 2006 is timely to address the minimum standards in provision of quality care in the private hospitals. Key informant PRI 2 argues that “the provisions under Section 74 of Act 586 mandates quality care initiatives and services in a private hospital”.

### **7.4.1 Incident Reporting**

This study reveals that each private hospital has instituted its own activities to ensure the quality and appropriateness of healthcare facilities and services including infection control, albeit with the wide variations in the delivery of care. For quality improvement, Section 37 of the Act 586 mandates incident reporting in the private hospitals (Malaysia, 1998). However, data on incident reporting of adverse events in private hospitals remains highly confidential and inaccessible. Result of the findings indicates that there is also information asymmetry even at the regulatory body. This is inspite of the legal provision which mandates “the information regarding such programmes and activities must be furnished to the Director General of Health as and when required by him” (Malaysia, 1998).

### **7.4.2 No Systematic Collection of Treatment and Outcome Data**

The feedback gathered from nine key informants reveals that there is no systematic collection of treatment and outcome data in the private hospitals for the dissemination of

public information on performance of quality care. This phenomenon is in contrast with the public health sector where the National Indicator Approach in the Quality Assurance Program is practised in the MOH hospitals. Similarly, there is no mechanism to enable private hospitals or clinicians to compare outcomes, or for the public to compare health providers when deciding where to seek treatment. According to a former Director General of Health [PRI 1], there is also an underutilisation of scarce resources in the private hospital sector. In addition, this key informant argues that although “more than 75 percent of the private specialists had at least 10 years experience, only 25 percent of the cases managed by these medical specialists could be classified as complex cases which justified the expertise of the specialists”. Most of the private patients have direct access to medical specialists care even without referrals and what is termed as “walk in” patients. The congestion and long waiting time in public hospitals have also prompted many patients to see medical specialists for treatment in the private hospitals.

Further, according to key informant PRI 1 and the examination of the provisions under Section 75 of the Act 586 “the Director General is to give directions to any private health care providers, in his opinion that any prescribed requirement or standard has been breached”. Failing to comply this order the health provider “commits an offence and shall be liable on conviction to a fine of not exceeding RM 50,000 and in the case of a continuing offence, to a fine of RM 5,000 for every day or part of the day during which the offence continues after conviction” (Malaysia, 1998). This study indicates that the private providers are seen to be influential and able to negotiate with the regulatory body for time on compliance in terms of improving quality care performance.

### **7.4.3 Quality Assurance Programme**

This study discloses that one of the impacts of the Act 586 seen on the private hospitals is the adoption of Quality Assurance Programme. There is a healthcare personnel overseeing Quality Assurance Programme especially in the tertiary care private hospitals. These medical institutions take pride to display their hospital accreditation achievements. Furthermore, most private hospitals are willing to share their positive customer's satisfaction surveys among others on the services provided such as hospitality, timeliness and the ambience. Although this study indicates that there is scarcity of public disseminated information on performance of quality care, 11 key informants assert that an appropriate yardstick available is to determine whether these private hospitals have some form of accreditation certification. According to these key informants, currently the practice of accreditation is voluntary and the Malaysian Society for Quality in Health (MSQH) in Malaysia is the accreditation body entrusted to ensure Malaysian hospitals meeting accreditation standards. Among the quality dimensions surveyed encompass the patient's safety, appropriateness of care, efficiency and competency of the healthcare provider according to key informants [PRI 1, PRI 29 and PRI 30].

### **7.4.4 Hospital Accreditation**

This study discloses that only nine of the private hospitals [A, B, C, D, E, F, G, I, and M] have been surveyed and accredited by the MSQH. The accreditation is to ensure minimum standards in the provision of quality patient care in a safe environment. Besides, four of these big government linked private hospitals such as Hospital B, C, D, and F have also been accredited with the prestigious Joint Commission International Accreditation and Certification award (JCI) for high quality assurance. However, the rest of the six study hospitals have yet to achieve any MSQH accreditations but have indicated their interest in the future. The reason may be due to either they are not ready for accreditation or due

to financial consideration as it involves a significant transaction cost of approximately RM 70,000 for the preliminary survey. Despite the variation in care, this study reveals that the medical and dental professionals play a crucial role in ensuring quality of care in corporate private hospitals according to nine key informants.

#### **7.4.5 Role of Medical and Dental Advisory Committee**

The findings disclose that the provision under Section 78 of the Act 586 mandates that all private hospitals for the establishment of a Medical and Dental Advisory Committee [MDAC] (Malaysia, 1998). According to six key informants who are medical specialists, the MDAC represents all practitioners practising in the private hospitals to advise the Board of Management, the licensee and the PIC on all matters relating to the medical and dental practices. Notwithstanding, the presence of MDAC in private hospitals is to advise on clinical matters, this study indicates that the medical and dental professionals do not seem to have strong influence in management's decision makings especially on quality assurance initiatives which will involved high cost. This is also evident in policy decision making such as contracts with MCOs, medical insurers, and the third parties providers where clinical patient management on quality of care may be compromised according to these specialist clinicians [PRI 2, PRI 3, PRI 4].

This study also indicates that MADC is seen to be a platform for the practitioners to serve their own business self interests in the private hospitals. Data of information gathered discloses the "club culture" and politics among the medical specialists where patients' referrals are made within their inner circles which may appear to affect the patient's interests at the point of delivery quality care. This phenomenon may adversely affect the impact of Act 586 on the private hospitals.

#### **7.4.6 Grievance Mechanism**

Interviews with six senior key informants reveal that one of the issues of quality care has been addressed under Section 36 of Act 586 in which all private hospitals are now mandated to provide a patient grievance mechanism plan. This plan and procedure among others, includes “the appointment of a patient relations officer to serve as liaison between the patient and the facility” where all complains are to be documented (Malaysia, 1998). This study indicates that all the private hospitals have in place a patient grievance mechanism. Prior to the enforcement of the legislation, patients have very limited options for addressing their grouses regarding the services provided by the private hospitals.

According to these six key informants, the issue of how effective this patient grievance mechanism is yet to be seen. These private hospitals were not keen to share these detailed information which are deemed sensitive and confidential. The findings indicate that the high expectation of patients for quality care services, the occurrence of adverse events, and the excessive hospital arbitrary charge have often resulted in patient grievances and negative media coverage. Despite the confidentiality, many of these private hospitals are proud to share their positive results of the patient’s satisfaction surveys of the services carried out. Based on feedback gathered from five key informants indicates that there are multiple providers in this sector with wide variations of medical care, the enforcement on the issue of quality care is of paramount importance to the discerning public.

#### **7.5 Political Issues**

Analysis of data reveals an important theme on the sensitive issue of politics which dominates and shapes the private health sector landscape. According to five senior bureaucrats from the regulatory body allude that political interference has hampered in their enforcement capacity to some extent under the new Act 586. The vast statutory

power vested in the Minister is of great concern with the enforcement of Act 586. The Minister may exempt any or any part of a private hospital licenced under this Act from the operation of any provisions under this Act. Further, the decision of the Minister is final and there is no judicial review. Invariably, the Minister is a politician and represents the various influential groups to protect their interests may hamper the enforcement capacity. Although the provisions of the legislation provide the enforcement capacity to regulate these influential private hospitals but MOH appears to be politically constrained in discharging the official duties. Most of the tertiary care private hospitals are majority owned by the influential GLCs where the state has high level of investment. Even in the stand alone corporate private hospitals, the state has a minimum 30 percent equity stake through the GLCs, or Bumiputra Malay participation as mandated by the government's policy. Besides, the key informants disclose that the private health stakeholders especially the medical professionals are equally powerful and politically linked to influence the impact of Act 586 on the private hospitals sector.

In this context, a previous study revealed that there were at least 13 private hospitals operating illegally without licence dating back to the early 1990s' (Nik Rosnah, 2002). However, with over three decades have passed, the issue of unregistered private hospitals is still very much alive. The findings reveal that inspite of the enforcement of Act 586 with the mandatory registration and licensing in 2006, 36 private hospitals were found operating business without registration and licence. These unregistered private hospitals were found mostly in the study area of Klang Valley and the rest in the state of Johore. On the same note, the Minister of Health was also quoted in the mainstream media threatening to expose these 36 private hospitals to the general public for patient safety (*The Star*, December 15, 2006). The Minister also warned that stern actions would be taken against them and they had a month to apply for the new licence to operate these

private hospitals. Failing which, actions would be taken such as the closure of the premises and prosecution of the management of these hospitals in court. The public would be advised not to seek medical treatment in these unregistered hospitals which may not meet the minimum standard of care (*The Star*, 15 December, 2006). These 36 unlicensed private hospitals represent a significant 18.1 percent of the total number of 199 registered and licensed hospitals for the first time under the new Act 586 in 2006 (MOH, 2007).

While the findings indicate that the Act 586 provides the wide statutory power to the Director General of Health, in reality the intervention of “political invisible hands” may pose huge constraint for the Director General of Health to exercise the full power vested in him. Exercising the immense statutory power in good faith is a challenging and daunting task. Key informant PUB 2 cited the case of a prominent medical specialist who owned a highly commercialised private healthcare facility which is known for its dynamic hard selling entrepreneurial initiatives violating the medical professional code of practice and frowned by the medical fraternity. The application for licence renewal was temporarily suspended for non-compliance according to the key informant. Yet, this boutique private healthcare facility continued to operate its business in the metropolitan city for almost a year without a licence inspite of its gross contraventions and violations. However, there was no evidence of charging the influential clinician for contravention the Act 586. According PUB 2 it was not until the political intervention of the “invisible hands” which has graciously provided the renewal of the licence against the spirits and objectives of the legislation.

## **7.6 Enforcement Issues**

One of the important themes that emerges from this empirical findings is the issue on the enforcement capacity of the regulatory body under MOH. According to five key

informants indicate that the policy makers' main concern of enforcement capacity has been stipulated under Section 87 to Section 100 of Act 586 which provides adequate and comprehensive provisions of enforcement capacity. These statutory provisions among others includes the power to "enter and inspect, power to search and seize, search and seizure without warrant," power to seal and mandatory information disclosure and investigation" (Malaysia, 1998). However, the findings reveal that to facilitate effective enforcement capacity the MOH needs adequate resources in terms of manpower, financial allocation and the adequate information to regulate the private hospitals under Act 586.

Based on the findings at Private Practice Division, MOH indicates the inadequate financial and manpower resources as there were 13 doctors available out of the 18 doctor posts budgeted as at 6<sup>th</sup> May, 2010. These medical officers have been designated as enforcement officers doing the multi-task job scope of processing applications, inspections, licensing and enforcement. The data shows the enforcement team is supported by another 12 senior nursing staff comprising of matrons and nursing sisters looking into compliance of the nursing staffing, manpower requirements and patient's safety measures under Act 586. Besides, there were 37 other paramedic and administrative staff supporting the enforcement capacity as shown in Table 7.3.

Table 7.3: Enforcement manpower at the Private Practice Division, MOH, as at 6 May, 2010

Category of Staff	Number of Staff
1. Doctors	13
2. Nursing Staff	12
3. Paramedic & Support Staff	37
Total	62

Interviews with five key informants from the regulatory body indicate that the processing of applications, inspections and evaluations for licensing and enforcement require meticulous, rigorous and complex work. With the current manpower resources and financial capacity available, the enforcement team has been over-stretched both physically and mentally covering the whole nation. Besides, the Private Practice Division regulates all other private healthcare facilities and services such maternity homes, nursing homes, ambulatory care centres, haemodialysis centres, hospices and the numerous private medical and dental clinics in the country.

While the data indicates that there is an enforcement team at the state level to support the main enforcement team at MOH, it is still also under capacity. For instance at the Private Practice Unit, Medical and Health, Wilayah Persekutuan Kuala Lumpur, there are a total of 12 enforcement staff of whom five are medical doctors, four Medical Assistants (currently designated as Assistant Medical Officers), one Matron and two Nursing Sisters as at 5 April, 2011 as shown in Table 7.4.

Table 7.4: Manpower at the Private Practice Unit, Medical & Health Wilayah Persekutuan, Kuala Lumpur as at 5 April, 2011

Category of Staff	Number of Staff
1. Doctors	5
2. Nursing Staff	3
3. Medical Assistant	4
Total	12

According to these key informants indicate that with the proliferation of private hospitals, maternity homes, nursing homes, haemodialysis centres, ambulatory care centres and other private healthcare facilities, the enforcement capacity is crucial in achieving the government's health priorities. This study reveals that the severely under strength human

resource capacity and the inadequate financial allocations at MOH have hampered the enforcement capacity. In addition, the enforcement team is led by a few senior medical officers, while the majority of the newly recruited medical officers are inexperienced entrusted to do the insurmountable enforcement work of regulating 209 private hospitals, 288 other licensed private healthcare facilities, 6,176 private medical clinics and 1,389 dental clinics nationwide. There is evidence of weak implementation and the enforcement capacity to achieve the intended national health objectives of accessibility, equity and quality care.

The findings reveal the asymmetric information and agency problems encountered by the MOH as the principal in the enforcement of Act 586 on the private hospitals under the principal-agent theoretical framework. Although the MOH's national objective is to ensure equitable access to quality care and affordability for all its citizens but the private hospitals are primarily profit motivated in providing medical care. In view of the divergent objectives, conflict of interests is inevitable. The findings also indicate that the influential private hospitals enjoy information advantage and complied to the regulations where their interests are well served. A classic example is the non-compliance issue on fee-splitting which affect the business interests of the private hospitals, and there is no incentive to comply with the regulations inspite it is illegal.

## **7.7 Concluding Remarks**

This chapter provides the answers to the research questions and study objectives on the impact of the Act 586 on the private hospitals in terms of achieving the intended national objectives of accessibility, equity and quality care. This study reveals some significant thematic findings on the following issues which are closely-related such as the cost of medical care, inequity, quality care, politics and the enforcement capacity. On the issues

on cost, the data discloses that despite the regulated professional fees, evidence of opportunistic practice by the medical specialists to increase their professional income and the exorbitant arbitrary hospital medical bills are of major concerns. The high out-of-pocket payment in the private hospitals is a major inequity issue in the findings which has adverse financial impact on the average and poor households. It is a manifestation of inequity in healthcare delivery. On the issues on quality of care, there are wide variations in the quality care initiatives in the private hospitals as compared with their counterpart in the public hospital sector. The findings on the hospital accreditations, role of MDAC and the provisions for patient grievance mechanism are also discussed under the theme on quality of care. Another theme which emerges from the study is the issue on politics which has shape the development of the private hospitals and the regulations. The agency problems, information asymmetry and the lack of resources have hampered the enforcement capacity of Act 586 on the private hospitals to achieve the intended national health objectives. The following Chapter 8 is the discussion on the empirical findings presented in Chapter 6 and Chapter 7 respectively.

## **CHAPTER 8 : DISCUSSION**

### **8.1 Introduction**

This chapter contains the discussion and interpretation of the empirical findings from the preceding Chapter 6 and Chapter 7. The purpose of this chapter is to discuss the major themes emerging from the analytical findings in answering the research questions posed earlier in the thesis. Precisely, what is the impact of the Private Healthcare Facilities and Services Act 1998 (Act 586) and its regulations on the private hospitals in Malaysia? What are the factors influencing the impact of Act 586 on the private hospitals? How is the enforcement capacity of MOH with the enforcement of Act 586 on the private hospitals? Although this study is the first of its kind since the enforcement of Act 586 in 2006, the discussion will make some comparisons with the previous regulatory study done on the private health sector in Malaysia conducted by Nik Rosnah Wan Abdullah (2002) before the implementation of Act 586. The comparison of the outcome of this study and the previous study would provide an insight into the performance of the enforcement of the Act 586 in achieving the intended national health objectives. This differentiation will also serve to fill the research gap prior to this study. In addition, the findings of this study will also make comparisons and contrasts with some relevant local studies and those studies done in the developing and developed countries presented in the literature review.

### **8.2 Policy**

This study reveals that the public health policy on the enforcement of Act 586 and its Regulations on the private healthcare facilities and services in 2006 heralds a significant landmark in the private health care sector reform in Malaysia. This historical statute controls and regulates all private hospitals, and all other private health facilities and

services for the first time in the country except cosmetology. The expectation of the enforcement of the comprehensive healthcare legislation has been much anticipated to address the national health concerns for better accessibility, correct the imbalances in standards and quality of care, as well as to rationalise medical charges in the private health sector to more affordable levels. In addition, Act 586 addresses the weaknesses of the previous Private Hospitals Act 1971 particularly in enforcement, for instance unable to enter licenced facilities, or close unlicensed facilities. The accountability of the providers and the concern of the patients' rights are included in the Act 586 and its regulations. In this context, the Director General of Health asserts that from the perspectives of the government and the public, the promulgation of Act 586 "is the best thing that has ever happened to our healthcare system" (Mohd Ismail Merican, 2008, p.20). In addition, this noble health policy has also received endorsement from the various stakeholders particularly the Association of Private Hospitals of Malaysia (APHM) and the professional bodies among others, Malaysian Medical Association (MMA), Malaysian Dental Association (MDA), Association of Medical Specialists in Private Medical Practice in Malaysia (ASPMP), and the Federation of Private Medical Practitioners' Associations, Malaysia (FPMPAM). However, the enforcement of Act 586 encountered unprecedented resistance and protests from the private medical and dental professionals nationwide over some provisions in the legislation which, are found to be too stringent and often ambiguous.

The professionals are concerned that these provisions may adversely affect the delivery of health care and the practice of medicine. The regulatory body has been accused of not consulting the professional bodies adequately in such major decision making policy. Although the professional bodies were privileged to be invited to participate in the Technical Working Committee on the drafting of the Act 586, but they argued that all the

deliberations were under the cloak of the Official Secrets Act 1972 (OSA), which prohibited the disclosure of any classified information. This policy has hindered free discussions between members of professional bodies on matters raised and caused gross dissatisfactions. These representatives of the professional bodies assert that a number of undiscussed additions were inserted, and a number of omissions occurred. For instance, the power of the Minister, welfare contribution, grievance mechanism, Board of Visitors, Fees Schedule, and criminalising of the profession. These grievances appear to be factors influencing the impact of Act 586 on the private hospitals in terms of compliance and non-compliance.

The interviews reveal that the policy of the enforcement of Act 586 and its regulations is a prelude to the proposed establishment of the National Health Financing Scheme (NHFS). The objective of NHFS is to restructure health care system which will be efficient, responsive to health care needs and better care for the population (Chee & Por, 2015). However, managing the dual health care delivery system has been a challenge (MOH, 2011). There are shortcomings and strengths in the health care system. The disparity between the public-private health care systems, the escalating cost of care, high out-of-pocket payments, rising total national health expenditures, quality and standard of care have put the Malaysian Healthcare system under considerable financial burden and its sustainability. These issues have been discussed under sub-section 4.11 in Chapter 4. These are crucial factors influencing the impact of Act 586 on the private hospitals in Malaysia.

There is indeed an urgent need of a policy to restructure the national health care financing and the delivery of health care system to ensure universal health coverage at an affordable cost to the Malaysian population. Hence, the historical regulatory intervention of the Act

586 and its regulations in 2006 is seen as a prerequisite to the establishment of a proposed NHFS which has been mooted since the 1980s as discussed under sub-section 5.9 in Chapter 5. However, the proposed scheme has been shrouded with secrecy and the public fear of another major health care privatisation (Ramesh, 2007; Chee & Barraclough, 2007; Lee et al. 2011; Chan, 2007; 2014). Invariably, the proposal has drawn severe criticisms from the various stakeholders for the lack of transparency and public discourses (Chee & Por, 2015). Similarly, Muhamad Hanafiah (2014) asserts whether the policy makers have learned anything significantly after three decades of undisclosed NHFS studies.

### **8.3 Power**

The findings reveal another central theme on the power which has generated considerable debates with the enforcement of Act 586 in 2006. One of the most significant impacts of the implementation of Act 586 is the power of mandatory approval and licensing of all private hospitals to ensure patient's safety, and the equitable access to quality care. This highly prescriptive legislation aims to control and eradicate the illegal establishment of private hospitals and the existence of unregistered healthcare professionals which pose public health safety concerns. The regulatory power of mandatory approval and licensing of private hospitals was non-existence under the Private Hospitals Act 1971 in the previous study conducted by Nik Rosnah (2002). In considering whether an approval is granted for the establishment of a private hospital, the DG is vested with wide statutory power based on the matters stipulated under Section 9 (a) to (e) of Act 586 as follows:

- (a) the nature of the healthcare facility or service to be provided;
- (b) the extent to which the healthcare facilities or services are already available in an area;
- (c) the need for the healthcare facility or service in an area;
- (d) the future need for the healthcare facility or service in an area; or

(e) any other matter which in his opinion is relevant (Malaysia, 1998).

In addition, the DG may also refuse to grant the approval to establish or maintain a private hospital based on the reasons stipulated in Section 11 (a) to (d) of the Act 586. Among the reasons for the refusal of the DG “if he is not satisfied that the applicant is capable of providing adequate healthcare facilities or services, adequate and efficient management, and administration of the facility or service” (Malaysia, 1998). Nevertheless, Section 12 (b) further provides that the DG “may refuse the application with or without assigning any reason for such refusal” (Malaysia, 1998). Likewise, Section 18 of the Act 586 sets out the limited reasons for which a licence may not be issued or renewed. Similarly, under Section 19 the DG shall have the discretion to grant or “refuse the application with or without the assigning any reason for such refusal” (Malaysia, 1998).

In the situation where the DG decides not to give any reasons for a particular refusal, there are limited provisions to ensure that the DG had exercised his powers in accordance with the Act 586 and Regulations 2006. The findings reveal that the vast statutory power vested in the DG is prone to potential abuse and corrupt practices. The only avenue for any aggrieved applicant is to appeal to the Minister under Section 101 of the legislation although the procedure for the appeal is not specified. The Minister may confirm, vary or rescind the decision of the DG and in the process may impose such terms or conditions as he deems just or necessary. The criteria for consideration by the Minister are also not specified in Act 586. There is a necessity to have certainty, clarity, and transparency in terms of compliance. However, the “decision of the Minister is final and conclusive” under the Act 586 (Malaysia, 1998). In this context there are obvious concerns over the power issues. Does this mean that the decision of the Minister appears to remove the jurisdiction of the courts regarding judicial review? In this context, a senior advocate and

solicitor [PRI 19] argues that “we have to wait for some test cases to know of the outcomes”. While that remains the law, in practical terms how effective is this safeguard, considering that the Minister obtains his advice from the DG. Conversely, the Minister as a politician representing the various interest groups may assert political influence to constrain the power of the DG and hamper the enforcement capacity. This is a classic example of the public interest theory (Morris et al. 2012; Santerre & Neun 2013).

In spite of the vast statutory power vested in the DG, in practice exercising his duties in good faith may face challenges. Nevertheless, the extensive regulatory power vested in the DG also provides ample opportunity for future reemployment benefits with the various interest groups upon official retirement. This phenomenon supports the interest group theory where bureaucrats treat the regulated stakeholders cordially with the hope of getting future employments. Likewise, Chan (2014) argues that two previous DGs upon official retirement from the regulatory body have been reemployed as presidents of private medical universities in Malaysia.

#### **8.4 Governance**

The interviews reveal another important theme on the governance issues in the delivery of care in the private hospitals in terms of the accountability, authority, and transparency. The provisions of the Act 586 stipulate the responsibility of the licensee to ensure that registered private hospital is maintained or operated by a person-in-charge (PIC) who shall be a registered medical practitioner. The licensee may also act in the capacity as the PIC who is normally designated as the Medical Director with responsibilities overseeing all the clinical matters in the private hospital. Despite the provisions for the PIC to be responsible in all clinical matters, “different persons may be appointed to manage and assume the duties and responsibilities relating to non-clinical matters including financial,

administration and the management of non-clinical resources” (Malaysia, 1998). Interpretation of the findings indicates a registered and licensed private hospital shall be led by a registered medical doctor. This is also the general perception of all key informants who are senior medical specialists and the medical regulators that doctors should lead the private hospital institutions instead of businessmen in terms of the governance issues such as the accountability, authority, and the transparency in decision-making.

In reality, most tertiary care private hospitals are owned by the state with high level of investment, or at least 30 percent owned by government linked corporations (GLCs). With the emergence of GLC private hospitals as discussed in sub-section 4.6.1 in Chapter 4, the doctors are found to be either employees or engaged as independent contractors to practise medicine in the hospitals under the terms and conditions of a Contract for Service. Although the post expectation of the enforcement of the Act 586 is a physician led private hospital, in practice the PIC is not in the control of the management of private hospitals. Invariably, the PIC reports to the Chief Executive of the private hospital as illustrated in the Organisation Chart Figure 6.1 in Chapter 6. In the event that the CEO is a physician who is an employee cannot make independent decisions which may be in conflict with the business decision and policy of the Board of Directors of the corporation. The CEO is responsible for financial key performance indicators for the business profitability and sustainability while providing the delivery of care in the private hospitals.

The study reveals cost management in private hospitals is crucial for the performance of business sustainability. Management of private hospital is complex in view of the high capital investment and labour intensive costs involved. In this process private hospitals may compromise on the recruitment of health professionals such as medical officers

which may affect the provision of quality care. For instance, the perennial problem of shortage of medical officers in the Accident and Emergency Department in Hospital I by employing part-time locum doctors to save cost for the management. This practice has resulted in the PIC being charged under Medical Act 1971 for neglecting and disregarding his professional responsibilities by employing an unregistered person to practice medicine in the hospital. Subsequently, the PIC was found guilty of infamous conduct in a professional respect in the Medical Act 1971 (Malaysia, 1971). Although the PIC is responsible for the maintenance and the governance of a private hospital in the delivery of quality care, in reality it is a challenge in terms of compliance.

### **8.5 Compliance**

The post-expectation of the enforcement of Act 586 is a good compliance system in the private hospitals to ensure patient's safety, and the provision of quality care. However, there have been a mixed of outcomes in terms of compliance and non-compliance in the private hospitals. This study reveals the major challenges faced by the various private hospitals in terms of compliance especially those hospitals established before the enforcement of Act 586. The provision for mandatory approval and licensing of private hospital provides stringent guidelines on maintenance and operation to ensure patient's safety and the obligation of the private providers.

The previous study done by Nik Rosnah (2002) discloses that there were no such specific guidelines for the establishment of private hospitals under the Private Hospitals Act 1971 and its regulations. This phenomenon has brought forth the wide variations in the building and structural designs of purpose built and no-purpose built private hospitals in co-existence. Non-purpose built hospitals which were originally on shop houses or commercial premises had been reconfigured and renovated for the purpose of a private

hospital where patient's safety and quality care may be compromised. The findings reveal that the enforcement of the mandatory approval and licensing of private hospitals with the stringent requirements for 100 percent fresh air ventilation system in the critical areas and the additional special requirements for emergency services are major challenges encountered by private hospitals in terms of compliance.

This study also indicates that the direct impact of the enforcement of Act 586 on the private hospitals involved major and unprecedented financial costs to ensure a good compliance system in place. Corporate private hospitals especially those GLC-owned have the financial capacity to embark on major construction and renovation work. For instance Hospital C a renowned tertiary care medical centre with international patients clientele embarked on the major restructuring work on the 100 percent fresh air ventilation system at the cost of over RM 2.0 million to implement a good compliance system. In this context, two other GLC-owned private hospitals operating on non-purpose premises such as Hospital L and M have migrated to new purpose built hospital premises at a hefty cost. On the same note, three older purpose built hospitals built over the decades encountered compliance issues especially on the ventilation system and the additional requirements for emergency services. These private hospitals D, G, and K have migrated to new purpose built private hospitals to have a good compliance system for patient's safety and the provision of quality care. Invariably, the substantial cost of new purpose built hospitals would eventually lead to higher cost of medical care.

The findings reveal the majority of big tertiary care hospitals are owned by the GLCs and they are able to comply with the regulations in view of their financial capacity. However, the small and medium size private hospitals face the financial burden in terms of compliance. Hospitals such as H, I, N, and O which are extremely cost conscious appear

to adopt some resistance with a “wait and see” approach. In spite of directives from the medical regulators on a good compliance system, these hospitals appear to do some “creative compliance” or “cosmetic refurbishing work” at minimum cost hoping to satisfy the regulators. Obviously these hospitals failed to comply especially with the special requirements of ventilation system and the emergency services. These creative compliance are “pointless conformance behaviours in which things are done solely to satisfy regulators which have little or no value for service users or organisation” (Walshe & Boyd, 2007, p.30).

Despite the vast statutory authority vested in the DG, the regulatory body appears to be passive in the enforcement capacity because the private hospitals are influential and powerful actors. These private providers seem to be able to negotiate with the regulatory body to have more time space to comply before an occurrence of an adverse event where the DG shall invoke the statutory power for a temporary disclosure. The data collected discloses that Hospital M and O have not complied with the regulations until the occurrence of an adverse event of “assessable death” that prompted the temporary closure of the hospitals. By definition under Section 64 of Act 586 assessable death “means a death that, in the opinion of any medical practitioner or dental practitioner, may be related to anaesthesia or any anaesthetic procedure, or medical technology or any medical procedure, or surgery or any surgical procedure” (Malaysia, 1998). The irony is that there is no evidence of any charge preferred against the PIC in court for non-compliance.

## **8.6 Non-Compliance on Fee-Splitting**

Another controversial theme that emerges from this study is on the non-compliance issue on fee-splitting which the private medical specialists are of great concern despite the enforcement of Act 586. The non-compliance on the issue of fee-splitting contravened

the Act 586, and yet there is no evidence of any prosecution against the PIC of the private hospital in court to date. Further, analysis of information gathered reveals the lack of enforcement capacity of the regulatory body. Under such circumstances conflicts have intensified between the medical specialists and the MCOs, and a number of medical specialists have been blatantly blacklisted on the insurers' panel for various reasons including overcharging with exorbitant professional fees. For example, two study private hospitals such as A and D have been suspended by the influential medical insurer according to eight key informants who are senior medical specialists. This situation has invariably caused gross inconvenience to patients with medical insurance coverage especially those with cashless facility for admission to private hospitals. Besides, the accessibility to quality medical care has also been adversely affected as some insured patients have either to forgo treatment or pay out-of-pocket. While affected patients with insurance coverage can submit claim for reimbursement payment subsequently but it is subjected to close scrutiny by the insurers.

This study reveals that fee-splitting is illegal under Act 586, yet the practice has gained much momentum and MCOs becoming more assertive. For instance, sometime in the third quarter of 2007, an influential MCO which is a subsidiary of a large multinational insurance corporation had attempted to solicit corruptly from some medical specialists and private hospitals in the Klang Valley as an inducement to be listed under their new proposed hospital network panel according to five medical specialists. A deadline had been set for an agreement to be endorsed under the terms and conditions which the specialist doctors felt grossly unfair and unethical. Among the contentious issues in the proposal include soliciting a 20 percent discount from the medical specialists' professional fees as an inducement for the doctors to be included on the insurer's panel and to have patients referred to such medical specialists and their respective hospitals.

### **8.6.1 Protests from the Medical Specialists**

The findings also reveal that the controversial MCO's proposal of soliciting 20 percent of discount from professional fees has raised overwhelming protest and strong objections from the private medical specialists. This contentious issue has also attracted publicity in the main stream media according to six key informants. In an immediate response, an ad hoc "Joint Inter Hospital Committee" (JIHC) was formed with the support from the Federation of Private Medical Practitioners' Association Malaysia and the Association of Specialists in Private Medical Practice. Following which the JIHC forwarded their concerns to the managed care organisation which had earlier revoked their service agreement with the two study private hospitals [A and D]. The MCO's proposal was not acceptable to the two hospitals. Subsequently, the timely intervention of Central Bank of Malaysia, the MCO restored its agreement with the two black listed private hospitals.

### **8.7 Escalating Cost of Medical Care**

Another controversial theme which has emerged from this study is the issue of escalating cost of medical care in the private hospitals. Despite the regulated fee schedule, the result of the study reveals that there is an increasing trend of opportunistic practice of medical professionals overcharging their inpatients with multiple ward visitations per day. Besides, there are evidence of the medical specialists practising unethical "creative fragmentation" or "creative unbundling" of a single surgical procedure with multiple charge code fees to justify the increase in professional income. The feedback gathered from the key informants from the various study hospitals and MCOs have concurred on the controversial issue of medical professionals not only overcharging their patients in the medical bills but also violating the fee schedule under the regulations. Not surprisingly, even the MOH is aware of this controversial problem but could only urge all private practitioners to comply with the Fee Schedule and refrain from fragmenting or

unbundling the procedure fees according to key informants [PUB 1, PRI 1 and OTR 2]. Inevitably, the outcome remains elusive and unresolved.

Further, the purposively selected patients' medical bills have shown some similar features and behaviour of the private hospitals in the billing systems. The documentary evidence of opportunistic practice and the general behaviour of the private health providers arbitrarily overcharging their patients resulting in the exorbitant medical bills cannot be rebutted. The growing trend of opportunistic behaviour of specialist doctors overcharging patients is alarming as it would tarnish the medical profession and public trust. The key informants reveal that there were instances where the specialist doctors have overcharged their patients with multiple ward visitations as much as 15 times per day to the maximum fee limit under the fee schedule. These analytical findings concurred with a mainstream media report which has cited the former Health Minister, Dr. Chua Soi Lek's revelation that a patient who was checked on 15 times a day costing RM 3,000.00 in the medical bill while in a private hospital. In addition, there was also another case highlighted where a doctor made 10 ward visitations on his patient per day and charging RM 2,000.00 as professional fees. The Minister has publicly rebuked the doctors in the private practice (Edwards, 2007).

In addition, the medical bills indicate that the surgical procedures have been "creatively fragmented or unbundled" to include multiple charge codes to increase the doctors' professional income without the knowledge of the patients. Besides, these medical specialists have often stretched their professional procedure fees to the maximum and beyond the permissible level of the Fee Schedule with questionable justifications. This is despite claims by some medical specialists that their professional fees are been regulated and account for about 15 to 20 percent of the total cost of the medical bills (Ng, 2006).

Even the past MMA president Dr. NKS Tharmaseelan was also seen to be defensive that doctors should not be blamed for high hospital bills as their fees only amounted to 20 percent of the bills (Chin, 2013).

Notwithstanding the provision on social or welfare contribution under Act 586, there are caring medical specialists giving various degrees of discount and a few of them have even gone to the extent of waiving their professional consultation and surgical fees completely for their deserving patients. However, these charitable works contributed by these doctors cannot be featured in the news media as it may be construed as advertisements and violation of their professional code of ethics. But the increasing trend of such phenomenon of fragmentation and “unbundling” with multiple fee codes in a single surgical procedure to increase professional income without the patient’s knowledge is a great concern. The humane nature of the doctors is currently under close public scrutiny. Sometimes the noble quality of a medical specialist is seriously doubted and questioned. The general public’s perception is that these private hospital doctors have evolved to be businessmen cum clinicians whose major concern in their practice is to make quick money from their unfortunate and less informed patients. Further, Dr. Ismail Merican, the present past Director General of Health, similarly echoed, “what is even more disturbing currently is the evolution of doctors now behaving like businessman and like all other businessman, profits often supersede ethics, medical professionalism, and patients’ rights” (Mohd Ismail Merican, 2008, p.20).

This study discloses that the PIC and the private hospitals are fully aware of this unethical opportunistic behaviour, yet nothing is seen to enforce the regulations as there are self interests. Further, all the private hospitals studied have a written policy on the quantum of fees to be charged and failing to comply with the regulations is now an offence. There

seems to be a lack of enforcement of the regulations to achieve the national objectives of equitable access, affordability and quality care. The public and consumers associations have often criticised the expensive cost of medical care in private hospitals making it beyond the accessibility of the majority of the population (MOH, 2011; Mohamed Azmi Ahmad Hassali, 2013; Ng et al. 2014; Yee, 2014). Surprisingly, a recent qualitative study conducted by a government statutory body, the Malaysia Productivity Corporation Review Research Report dated March 2014 citing otherwise. “However, it is known that the medical consultation and/or treatment fees are only a fraction of the total hospital costs to a patient” (MPC, 2014, p.xix) which not only appears to be grossly contradicting but highly questionable.

The findings reveal the information asymmetry and the agency problems that exist in the patient-providers relationship in the private hospitals. This classical illustration is exemplified in the principal agent theory on the relationship between the doctor and patient. The well-informed doctor is perceived to be an agent who is supposed to act ethically on behalf of his patient who is the principal in deciding what medical treatment and services are most appropriate and effective. In the event that the doctors made decisions according to the expectations and needs of the less-informed patients, then they would be deemed as perfect agents who are unaffected by self interests. However, the extensive empirical studies have revealed that doctors are unable to act as perfect agents in view of self interests (Evans, 1974; McGuire, 2001; Nguyen, 2011; Morris et al. 2012; Folland et al. 2013; Santerre & Neun, 2013).

Precisely, a study conducted by Evans (1974) argues the theory of supplier-induced demand particularly in the doctor and patient relationship. The theory is sometime known as provider-induced demand whereby the doctors invariably engaged in some subtle form of persuasive activity to influence the patients’ demand according to the doctors’ self

interests (Evans, 1974; McGuire, 2001; Nguyen, 2011; Folland et al. 2013). Likewise, Morris and colleagues (2012) cited a comprehensive review of evidence by McGuire (2001) that doctors do response to monetary incentives, and seem to influence demand due to self interests (Morris et al. 2012).

Similarly, the symbiotic relationship between private hospitals and the doctors illustrates the agency theory. The private hospitals are deemed to be the principals have to depend on the well informed medical professionals by virtue of its specialised knowledge in the delivery of medical care. The medical professionals are deemed as agents has to depend on the private hospitals for the provision of the facilities and services in the medical practice. Invariably the principal and agent have divergent objectives and self interests. The corporate private hospitals appear to have self interests and condone with the opportunistic practice by the medical specialists to generate profitable income despite violating the regulated fees schedule. The notion is that the more the medical specialists generate their professional income, it contributes additional revenue to the private hospitals' business profits. In this respect, the private hospital charges the medical specialists a controversial management fee of an average of 10 percent on their gross professional income besides the rentals and utilities in the study hospitals. Some medical specialists considered it as another subtle form of fee-splitting of their income and are unhappy with the management fees. On the contrary, the private hospitals considered it is as a fair administrative fee imposed as they provide the ambience, infrastructures and the resources. In this context, Hospital H charges the highest management fees of 15 percent to the dismay of the specialist consultants. Elsewhere private hospitals in Penang for example, the charge of management fees is much higher at 30 percent on the doctors' professional income (personal communication). There seemed to be an inherent conflict of values between business and medicine which have repercussion on the accessibility,

equity and the provision of quality care. In addition, there have been severe criticisms on the business of medical practice in corporate private hospitals of overcharging patients in the medical bills.

## **8.8 Inequity**

Another crucial theme which has emerged from this study is on the inequity issues in relation to the high private out-of-pocket payment which has significant impact on Act 586. This study reveals the majority of private patients of about 60 percent are paying out-of-pocket (OPP), 35 percent are by insurance coverage and 5 percent from corporations and government's out-sourcing services in the private hospitals as highlighted in sub-section 7.3 in Chapter 7. This phenomenon of high OPP suggests that the beneficiaries are mostly the rich and upper income segment of the society. The majority of the average population, the poor and marginalised groups may be denied of an equitable access to quality medical care as similarly illustrated in some studies done in the developing countries (Patouillard et al. 2007; Berendes et al. 2011; Tung & Bennett, 2014). Further, this phenomenon of rich-poor disparity is more distinctly seen in tertiary and secondary care as compared to primary care in the private health sector (Chee & Wong, 2007; Meyer et al. 2013; Tung & Bennett, 2014). In this context, the poor and disadvantaged segment of the population may invariably experience multiple inequities and may not benefit with the escalating health care costs (Durairaj, 2007; Karamitri et al. 2013; Rodney & Hill, 2014; Terraneo, 2015).

While the results of this study shows that most of the private health care financing are through direct out-of-pocket payments (OPP) is not something unexpected. The findings of this study concur with the result of another study conducted at the national level where the OPP expenditure formed the main source of private funding during the twelve years

period between 1997 and 2009 in Malaysia. The national OPP accounts to “about 30-40% of the total health expenditure or an average of 76 percent private sector expenditure” (MOH, 2012, p.5). It is a major concern. The Malaysia National Health Account (MNHA) study also reveals that “OPP expenditure from 1997 to 2009 has increased from RM 2,576 million to RM 11,986 million which is an increase from 0.91 % GDP to 1.76 % GDP. This almost four-fold increase in per capital OPP health spending in absolute value from RM 118 in 1997 to RM 430 in 2009” (MOH, 2012, p.5).

The phenomenon of high OPP expenditure in health sector appears to be a typical manifestation of a lower income developing country while Malaysia has been categorised in the upper middle income group. Hence, Malaysia’s achievement towards universal health coverage is currently under threat. The high OPP expenditure reflects the gradual shift of its profile to that of a lower income country (MOH, 2011). Although Malaysians are protected from financial catastrophe in health expenditure, the high OPP may among others indicate patients’ choice and preference of those who could afford to pay (MOH, 2011; Chan, 2013; 2014; Ng et al. 2014).

Invariably, the high OPP payment is said to be the least equitable manner in financing healthcare. This has been a major financing concern for countries in attempting to achieve the health objective of universal health coverage (WHO, 2014a; 2014b). The high OPP has serious social-economic implications. A study by Xu et al. (2007) indicates that higher OPP payment in the overall financing mix has resulted in negative welfare impact on the country’s households and the possibility of financial catastrophes. The poor and the vulnerable groups would be denied of the most needed care. Therefore to avoid household financial catastrophe, it has been estimated that a country’s overall share of OPP payment has to drop significantly below 15 to 20 percent of the total health expenditures (Xu et al.

2010). Invariably, the high household private OPP has a potential poverty impact (Meyer et al. 2013). Likewise, Van Doorslaer et al. (2007) cite the huge catastrophic private expenditure for health care in Asia undermining equitable access and quality care.

## **8.9 Quality Care**

This study reveals the numerous fragmented private providers, wide variations of standard of care and the lack of information disseminated to the public in making an informed choice are major concerns on quality issues in the private hospitals. Although Section 74 of the legislation mandates quality care initiatives and services in a private hospital (Malaysia, 1998), but the asymmetric information and the expected quality outcomes appear to remain elusive. In practice, each private hospital has instituted its own activities to “ensure the quality and appropriateness of healthcare facilities and services” including infection control (Malaysia, 1998), albeit the variations of care as there is no standardisation. On the examination of the performance of quality improvement, Section 37 of the Act 586 mandates incident reporting in the private hospitals (Malaysia, 1998). However, information on incident reporting of adverse events in private hospitals remains highly confidential. Surprisingly, there is also asymmetric information even at the regulatory body. This is despite the legal provisions which mandate “the information regarding such programmes and activities must be furnished to the Director General of Health as and when required by him” (Malaysia, 1998). The regulatory body seems to be weak in its enforcement capacity to acquire the material information from the regulated private providers. This phenomenon appears to support the public choice theory where the regulatory body is unable to perform its function because of the influential private providers. Besides, public choice theorists assert that problems of market failure will inevitably respond immediately rather than regulatory intervention (Laffont & Martimont, 2009; Folland et al. 2013).

### **8.9.1 No Evidence of Treatment and Outcome Data**

Information gathered from key informants [PRI 1, PUB 1 and PUB 2] reveals that there is no systematic collection of treatment and outcome data in the private hospitals sector which is crucial in the management of quality care. This phenomenon is a marked contrast with their counterpart in the public hospital sector where the National Indicator Approach in the Quality Assurance Program is practice in the hospitals under MOH (MOH, 2011). Similarly, there is no mechanism to enable private medical providers to compare outcomes or for the general public to compare providers when deciding where to seek treatment. Based on the information gathered from a senior medical specialist [PRI 1] there is also a gross underutilisation of scarce resources in the private hospital sector. No doubt more than 75 percent of the private specialists have at least 10 years experience, only 25 percent of the cases managed by these medical specialists could be classified as complex cases which justified the expertise of the specialists. Studies have shown that patients' clinical outcomes and quality care are better off in the hospitals where medical specialists responsible for the procedures undertake large number of their cases. Private hospitals and their medical specialists do not seem to have that scale and the frequency of surgical procedures as in the public hospitals (MOH, 2011).

### **8.9.2 Hospital Accreditation**

Despite the limitation of public disseminated information on performance of quality care initiatives, this study suggests that an appropriate measurement available is to determine whether these private hospitals have some form of accreditation certification. The current practice of accreditation is voluntary and the Malaysian Society of Quality in Health (MSQH) in Malaysia is the accreditation body entrusted to ensure Malaysian hospitals meeting accreditation standards. Among the quality dimensions surveyed encompass the "patient's safety, appropriateness of care, efficiency and competency of the healthcare

provider” according to senior key informants [PRI 29 and PRI 30] who are well-versed with hospital accreditation.

This study reveals that only nine out of the 15 private hospitals have been surveyed and accredited by the MSQH to ensure standards in the provision of quality patient care in a safe environment. In addition, four of these big GLC tertiary care private hospitals have also achieved accreditation with the prestigious Joint Commission International Accreditation and Certification award (JCI) for high quality assurance. As an incentive, these corporate private hospitals with accreditations are selected under the MOH’s panel list for the promotion of health tourism. However, the rest of the six study hospitals have yet to achieve any accreditation but have indicated their interest in the future. The reason may be due to either they are not ready for accreditation or due to financial constraint.

Although the accreditation exercise is voluntary but it comes with significant transaction costs approximately RM 70,000 for the preliminary survey. As at 31<sup>st</sup> December, 2009 the national accreditation body has accredited 119 hospitals of which 95 were public hospitals forming 80 percent of the total hospitals with accreditation awards. While only 24 private hospitals achieved the accreditation award forming 20 percent of the total hospitals accredited and these private hospitals are members of the Association of Private Hospitals of Malaysia (MSQH, 2009).

Based on the total number of 209 private hospitals licensed as at 31<sup>st</sup> December, 2008, it can be deduced that approximately 185 private hospitals or 88.5 percent of these private hospitals have not been accredited by the national body of MSQH. These private hospitals are either unprepared to meet with the minimum standards of quality care set by MSQH or due to financial reasons as mentioned earlier. Further a general inference can be made that except for the big tertiary care corporate private hospitals of which have the financial

capacity, the full compliance on quality care assurance for the rest of 88.5 percent of the private healthcare providers will remained a big challenge. However, the medical and dental professionals have a crucial role in ensuring quality care in the private hospitals.

### **8.9.3 Medical and Dental Advisory Committee**

The findings reveal that under Section 78 of the Act 586 mandates all private hospitals for the establishment of a Medical and Dental Advisory Committee (MDAC). This MDAC represents “all practitioners practising in the facility and service to advise the Board of Management, the licensee and the PIC on all matters relating to the medical and dental practices” (Malaysia, 1998). In reality this is an important provision in the Act 586 as these professionals are able to oversee the day to day maintenance of the standard of ethical care and safeguard patients’ rights in a private hospital (Loh, 2006). However, many a times the opinions of the professionals are not necessary similar to hospital management. Notwithstanding the presence of MDAC in private hospitals is to advise on clinical matters, but its functions have not been specific and expressed explicitly in the legislation. This is a major challenge face by the MDAC in the private hospitals. Although the MDAC is to advise the Board of Management but what if the advice is not acceptable to the management. The Act 586 does not compel the management to accept the views of the MDAC. In practice, the medical and dental professionals do not have strong influence in management’s decision makings especially on quality assurance initiatives which may hamper the business financial bottom line. This is evident in decision making such as contracts with MCOs, and medical insurers where clinical patient management on quality care may be compromised despite strong objection from the medical specialists.

The key informants indicate that it is a mere courtesy for the MDAC to be informed of whatever management’s decision made and to be endorsed. An inference drawn from this

study is that any specialist who is seen to be vocal on crucial issues such as addressing patient's rights, exorbitant hospital charges and fee-splitting under the Act 586 will not be called to serve in the MDAC. In a worst case scenario, the specialist can even expect his services to be prematurely terminated according to senior clinicians [PRI 2 and PRI 3]. It appears that corporate private hospitals practise the policy of patronage and the "divide and rule" in a subtle manner. Most of the specialist practitioners are engaged as independent contractors. As contract agents, these medical specialists have been admitted with privileges and conferred status either as resident consultants or as visiting consultants to practise in these hospitals under a contract for service agreement. Therefore admission of practice is under the expressed terms and conditions of the principal hospital such as to abide by management decision and the additional exit clause which is intimidating. Either party shall have the option to terminate the agreement prematurely with prior notice. Generally, the medical professionals are risk adverse and do not want to lose their lucrative private practice. Invariably both parties have divergent interests and at times may be conflicting.

On the other hand, MDAC is also seen as platform mainly to serve the practitioners' own self interests. The study indicates that the doctors appear to be protective of their own territorial turfs in view of the competitions and the fear of new entrants of specialists into the private hospitals. Besides, there is also the politics and "club culture" among the private specialist doctors where patients are been referred within their inner circle of specialists in a private hospital. This practice may affect the patient's choice of the private medical provider and quality care. Notwithstanding the policy and politics in the private hospitals, it is expected that MDAC plays a prominent role in ensuring compliance of the standards, improving the safety and quality of patient care under Act 586.

## 8.10 Politics

Another central theme which emerged from the information gathered from the key informants in the enforcement of Act 586 is the issue on politics. Interpretation of the data suggests the regulatory body of MOH appears to be constraint in discharging its enforcement capacity due to political interference. For instance, the vast statutory authority vested in the Minister under Section 103 of Act 586 to exempt any or or any part of a private hospital licenced from the operation of any of the provisions under the Act is a major concern and may hamper the enforcement capacity (Malaysia, 1998). This arbitrarily power of the Minister is prone to potential abuse and corrupt practices. Further, the decision is final and there is no judicial review at this juncture. It is not a new phenomenon in the private health sector in Malaysia as policy and politics are inseparable (Rasiah et al. 2009; Lee et al. 2011; Nik Rosnah & Lee, 2011a; Chee & Por, 2015). There is the tendency for politicians to interfere in the regulatory process and may reassert their control over the medical regulators. Invariably, the private providers are also powerful actors and politically well connected to influence health policies affecting their interests (Laffont & Martimort, 2009; Folland et al. 2013). Issues of politics and policies are closely intertwined in the Malaysian Healthcare System as discussed in Chapter 4 and the Health care Privatisation in Chapter 5 respectively.

While in theory some autonomy and freedom from political interference are necessary, in practice the implementation and enforcement capacity remains a huge challenge. This is especially when regulators faced with the regulatory agents which are not only influential but equally powerful. The findings of this study support the theoretical underpinnings discussed in the Literature Review in Chapter 2 (Walshe 2003; Laffont & Martimort, 2009).

### **8.11 Enforcement**

One of the central themes which emerged from this study is on the enforcement. Nonetheless, the Act 586 provides adequate and comprehensive provisions of enforcement capacity as compare with the previous Private Hospitals Act 1971. These enforcement powers among others includes the power to “enter and inspect, power to search and seize, search and seizure without warrant,” power to seal and mandatory information disclosure and investigation (Malaysia, 1998). However, to facilitate effective enforcement capacity the MOH needs not only adequate resources in terms of manpower, financial allocation and the adequate information but the most fundamental factor is the “political will” of the government in regulating the private hospitals.

This study reveals the lack of “political will” in the enforcement capacity which has led to the complexities of non-compliance in the private hospitals such as the controversial issue of fee-splitting between private specialist doctors and MCOs. Besides, the asymmetric information, severely under strength human resource capacity and the inadequate financial allocations at MOH have hampered the enforcement capacity. In addition, the enforcement team is lead by a few senior medical officers, while the majority of the newly recruited medical officers are inexperienced to face the influential medical providers. Despite these challenges, these medical regulators are entrusted to do the insurmountable enforcement work of regulating 209 private hospitals, 288 other licensed private healthcare facilities, 6,176 private medical clinics and 1,389 dental clinics nationwide in 2008. There is evidence of weak implementation and the enforcement capacity to achieve the intended national health objectives of accessibility, equity and quality care. This concurred with the previous study done by Nik Rosnah Wan Abdullah (2002) that the government had not allocated sufficient resources and expertise to enable the regulatory body to be effective in regulating the private providers adequately.

These phenomena reflect some similar characteristics such as the lack of the “political will”, weak institutions affecting the regulatory functions prevailing in the developing countries as discussed in sub-section 2.9.1 in the Literature Review. In contrast, the developed countries especially the European health systems have experienced significant transformations to ensure equitable access and quality care together with the development of regulations. Studies reveal that most European Union countries are committed to provide universal access to healthcare and continuously strived to meet to economic, political and social demands of the populations (O’Donnell, 2011; Jacobson, 2012; Roscam-Abbing, 2012; 2015; Wiig et al. 2014; Saltman, 2015; Yaya & Danhoundo, 2015). These regulatory reforms have inevitably transformed the role of the government in health provision, financing and regulation.

#### **8.12 Concluding Remarks**

The chapter concludes with the discussion on the core themes arising from the results of the findings and its significance in answering the research questions and the objectives of this study. Among the core themes which emerged from this study are the issues on the policy, power, governance, compliance, non-compliance, cost of medical care, inequity, quality care, politics, and the enforcement which are closely interrelated. The policy of mandatory registration and licensing is to eradicate the illegal establishment of private hospitals with unregistered healthcare professionals to safeguard patient’s safety and quality care. The overarching policy on the enforcement of Act 586 is seen as a prelude to the proposed establishment of a National Health Financing Scheme. Critics are concerned on the vast statutory power vested in the Minister and the Director General which are prone to abuse and the lack of transparency. On the governance issue, it is expected that the private hospital is controlled and managed by a registered medical

practitioner under Act 586 but in practice this is not the case as most private hospitals are managed by business corporations which are profit oriented. The post expectation on the enforcement of Act 586 is a good compliance system in a private hospital. The findings reveal the mixed of outcomes of compliance. Large tertiary care GLC private hospitals with financial capacity are able to have compliance while small and medium size private hospitals are still coping with compliance. Non-compliance of fee-splitting between the doctors and the MCOs remained controversial and unresolved despite it is illegal under the legislation. Although the Act 586 prescribed the Fee Schedule to regulate the doctors' professional fees but the hospital ancillary charges are not regulated and arbitrary. There is evidence of opportunistic practice and non-compliance of the regulated fee schedule. This has resulted in the rising cost of medical care and at times exorbitant. The high out-of-pocket payment in the private hospitals is major concern on the issue of inequity which has financial impact on the average household income and poverty. The majority of the population and the poor are deprived of the equitable access to quality care in the private hospitals.

On the issue of quality of care, there is a lack of disseminated information for the public to compare the performance of providers when seeking medical care. Currently, there is no systematic collection of clinical outcome data in the private hospitals as compared with their public sector counterpart at the MOH. Notwithstanding, private providers are influential and politically well connected to negotiate for time space and leniency on the compliance. It appears that MOH is politically constraint in discharging its regulatory duties. The lack of "political will" and the inadequate resources have hampered the enforcement capacity to achieve the intended health objectives of accessibility, equity and quality care. Although this study examines the impact of the Act 586 and its regulations on the private hospitals in Malaysia is the first of its kind, some comparisons

have been made with the previous regulatory study done on the private health sector in Malaysia conducted by Nik Rosnah Wan Abdullah (2002) before the implementation of Act 586. The comparison of the outcome of both studies provides an insight into the effectiveness and performance of the Act 586 in achieving the intended national health objectives. It also serves to fill the research gap prior to this study. In addition, the findings of this study also made some distinctive comparisons and contrasts with some similar regulatory studies done in the developing countries and the developed countries presented in the literature review of this thesis.

## **CHAPTER 9 : CONCLUSION AND RECOMMENDATIONS**

### **9.1 Conclusion**

The main objective of this thesis has been to bridge the research gap and contribute to the academic debate on the future of the health services in Malaysia through the analysis of regulation. This chapter draws the conclusion regarding the empirical findings of the study and its implications. Besides, it summarises the thematic findings in answering the research questions pertaining to the impact of the Act 586 and its regulations on the private hospitals in terms of achieving the intended national health objectives.

The findings reveal some major impact on the private hospitals despite the complexity in the policy implementation and the enforcement of the statute. It heralds a new historical landmark in the health regulatory reforms in the private hospitals to ensure patient's safety, equitable access to quality care and rationalise the medical charges to more affordable levels. The new legislation with its regulations has expressed explicitly on the patient's rights and the accountability of the private providers. However, there have been some major concerns over some core thematic findings on the impact of the Act 586 on the private hospitals. These among others include the themes on policy, power, governance, compliance, non-compliance, cost, inequity, quality of care, politics, and the enforcement. Invariably these thematic issues are closely interrelated and interlinked. These thematic findings support the theoretical underpinnings and similar regulatory studies done especially in the developing countries as discussed in the literature review in Chapter 2. However, the thematic issues arising from this research study are a marked contrast from the developed countries. Lastly, this study provides some recommendations and in particular to address some inherent weaknesses in the enforcement capacity of the regulatory body. The study also recommends a further research to be carried out to

contribute to the field of knowledge, and provide feedback to the government on the impact of policies to improve the performance of services in the private hospitals.

Nevertheless, the policy of mandatory approval and licensing of private hospitals under Act 586 has immense impact in ensuring minimum standards for patient's safety and the accessibility to quality care in the country. With the enforcement of Act 586 no person or corporation is permitted to operate a private hospital establishment without the prior approval and licensing from the regulatory body under the institution of MOH. It is an offence operating a private hospital without the mandatory approval and licensing. This offence upon conviction is punishable with a hefty penalty or imprisonment, or both. The implementation of the Act 586 eradicates the perennial issue of illegal establishment of private hospitals and unregistered healthcare professionals including bogus doctors which posed public health safety hazards. The Act 586 emphasises the importance of having a good compliance system in place in the private hospitals with the various provisions to safeguard patients' safety and equitable access to quality care. These empirical findings reveal that the policy of enforcement of the Act 586 is a precursor to the proposed establishment of the controversial National Health Financing Scheme (NHFS) which has been shrouded with secrecy over the last three decades. The proposed NHFS has been under severe criticism for the lack of transparency and the fear of another major healthcare privatisation which may be another financial burden to the tax payers (Chee & Por, 2015). Interestingly, Hanafiah (2014) cynically argues whether the Malaysian policymakers have learned anything significantly and worthwhile to share with the general public after over three decades of undisclosed studies.

Another crucial theme that emerged from the empirical findings is the concern on the power or authority. The Minister and the Director General Health are vested with vast

statutory authority on the approval of a license to establish a private hospital under Act 586. This statutory power was not available under the previous Private Hospitals Act 1971. The wide powers conferred on the Minister and Director General are prone to abuse and corrupt practice which may hamper the enforcement capacity of the MOH. Although the extensive power vested in the provisions is essential to ensure that the minimum standards for patient's safety and appropriate quality of care are complied at all times in the private hospitals, but the major concern is the lack of safeguards against any abuse of arbitrary power. For instance under Section 18 of Act 586, the Director General may decline to approve or renew a license if he is dissatisfied as "to the character and fitness of the applicant be it a natural person, a body corporate, partnership or society without providing any reasons". In addition, the Director General is empowered the refusal if in his opinion the hospital "premises in respect of which the application is made are unsafe, unclean or unsanitary, or inadequately equipped" and "the staff is inadequate or incompetent for the purpose of a private healthcare facility or service" (Malaysia, 1998). Furthermore under Section 19, the Director-General "shall have the discretion to refuse the application with or without assigning any reason for such refusal" (Malaysia, 1998).

In the case where the Director General has declined to give reasons for a particular refusal, there are limited provisions to safeguard that he has exercised his powers in good faith and in accordance with the legislation. The only option available for any aggrieved party is to file an appeal to the Minister as provided for under the Act 586. The Minister may vary or rescind the decision of the Director General, and in the process impose such terms as he considers just or necessary. Thereafter the decision of the Minister is final and conclusive. The concern is there is no judicial review in this matter. This statutory power is subject to a challenge as a test case in the Appellate Court in the future. Besides the restricted mechanism available under the Act 586, in practice is the issue of how effective

is this safeguard when the Minister seeks the advice and in consultation with the Director General. Further, the Minister is also an elected politician who represents the various influential interest groups in the country. Invariably, the Minister has self interests and in exercising his statutory authority may affect the enforcement capability of the regulatory agency of the MOH which is vulnerable to political constraints.

This thematic finding supports the public interest or interest group theory which takes into consideration of the diverse interests groups' expectations and mutual reconciliations. Inevitably, the diverse interest groups shall pursue their self interests if the policy decision of the state affects their well being (Laffont & Martimort, 2009; Morris et al. 2012; Santerre & Neun 2013). These interest groups are politically influential and have the financial means to influence the public decision makers through the various channels. One of such channels is through discreet monetary gratifications or corrupt practices (Laffont & Martimort, 2009; Morris et al. 2012; Santerre & Neun 2013). Besides, more prevalent are the hope for future employments for regulatory officials with the regulated organisations. Nevertheless, this bilateral relationship provides incentives for bureaucrats to treat their industry stakeholders cordially. Alternatively, the industry can also operate discreetly through key officials in the regulatory agency vide political contributions and donations. Public interest theorists argue that regulation can be captured by the powerful and influential group who are able to negotiate the complex matters such as standards, compliance and enforcement (Walshe & Boyd, 2007; Laffont & Martimort, 2009; Morris et al. 2012; Santerre & Neun 2013).

On the issues of governance in terms of authority, accountability and transparency, the rhetoric post-expectation of Act 586 is a physician-led private hospital with the responsibility vested in the PIC who shall be a registered medical practitioner. Based on

the interpretation of the provisions under Section 2 of Act 586, the PIC “shall be responsible for the management and control of the private health facility or service to which a license or registration relates” (Malaysia, 1998). This study reveals that the PIC is not in control of the management of the private hospital. In reality, the PIC is normally designated as a Medical Director (MD) who is accountable for all clinical matters in the provision of quality care in a private hospital. This among others include policy statement encompassing patient’s rights and the obligations of the private provider. However, in practice the MD as an employee is answerable to the Chief Executive Officer who is the head of a private hospital institution and responsible to the Board of Management. Although two members from the MDAC are appointed on the Board of Management as stipulated under Act 586, the majority of the board members are businessmen by profession and are driven by profit motivations. Hence, in most cases the CEO is responsible for overall financial management of the private hospital in terms of cost containment, profitability and the business sustainability. This study reveals that private hospitals encounter multifaceted complexities not only in the governance but also on the compliance of the Act 586.

Despite the complexity and the challenges faced by the private hospitals with the enforcement of Act 586, there has been mixed outcomes on the regulatory compliance and non-compliance. The findings indicate that the Act 586 has a significant impact in influencing the behavior of the private health providers to ensure better accessibility and the provision of quality care. In particular the Act 586 provides stringent guidelines for the establishment of a private hospital in ensuring minimum standards for patient’s safety and the appropriateness of care. These stringent guidelines were non-existence under the old legislation Private Hospitals Act 1971. Nevertheless the new mandated requirements for adequate fresh air ventilation system in critical areas and the additional special

requirements for emergency services, most of the large private hospitals which are GLC-owned are able to comply with the regulations to have a good compliance system. Although a good compliance system involves substantial capital investment, these tertiary care private hospitals have the capacity and undergone major developments to comply with the legislation. The findings reveal that even some older established private hospitals facing major challenges have even migrated to new purpose built hospital premises in terms of regulatory compliance.

While the small and medium-sized private hospitals face various challenges in compliance as they do not have the financial means and prefer to adopt a “wait and see approach”. The study reveals that some private hospitals managed to do some “creative compliance” hoping to satisfy the regulators. Invariably, patient’s safety measures have been compromised especially on the mandated requirements on the adequate fresh air ventilation system and the special requirements for emergency care services. This situation of creative compliance is more prevalent especially in the non-purpose built hospital premises. Since there were no proper regulatory guidelines under the old legislation i.e. Private Hospitals Act 1971, there were wide variations in the building design and structure of the private hospitals. This phenomenon poses challenges to the regulators in the enforcement of the Act 586 on these private hospitals even though they are deemed registered under the new legislation by virtue of being registered under the old statute. In most cases, the MOH has issued reminders to these private hospitals to comply before the next license renewal due in two years. Invariably, these private hospitals have taken various measures to comply with the regulations.

Another impact of the enforcement of Act 586 is that some of the private hospitals facing challenges in term of compliance due to financial constraints have been taken over by the

influential GLC group hospitals through mergers and acquisitions exercise. These GLC group hospitals are corporate conglomerates with strong financial and organisational capacity. With the new change of management, these private hospitals are able to comply with the new regulations.

Nevertheless the commercialisation of the private hospitals poses considerable constraint on the PIC to act in good faith and make rational decisions in terms of compliance with the regulations. The findings indicate that the PIC of a licensed private hospital is legally accountable among others, “shall not indulge in any form corrupt practice of fee-splitting and shall ensure that all healthcare professionals do not practise fee splitting too. A contravention of the regulations commits an offence and shall be liable on conviction to a fine not exceeding RM 10,000 or to imprisonment for a term not exceeding three months or both” (Malaysia, 2006).

In spite of the legal responsibility and accountability sanctioned, the PIC faces huge challenges in overcoming the complex issue of non-compliance of fee-splitting between the private medical specialists and the MCOs. This study reveals the controversial fee-splitting issue is a widespread and discreet practice in the private hospitals. The non-compliance issue remained unresolved despite the enforcement of Act 586.

Another area of concern in the thematic findings is the escalating cost of medical care in the private hospitals which is deemed to be exorbitant and at time seen as outrageous. The private hospital's medical bills consist of two major components of charges. The regulated doctors' professional fees form one component of the medical bill while the other component consists of the unregulated hospital charges. This distinction is of significant importance in view of the serious issues of agency problem and information

asymmetries in the private hospitals sector. In most cases, the doctors are usually held accountable for any prohibitive medical bills. This is in view of the public perception that the doctors are deemed to be symbolic with the healthcare system. The findings indicate that the medical specialists have asserted explicitly that their professional fees are now being regulated whereas the private hospital ancillary charges are unregulated, and arbitrarily exorbitant. This study provides evidence that private hospital charges are high in view of the controversial unanticipated charges which the patients are not informed inspite of the enforcement of the regulations. The fundamental issue is whether the regulated professional fee is seen as an effective safeguard to contain the spiralling cost of medical care in the private hospitals while the hospital ancillary charges remains unregulated.

Despite the regulated fee schedule, there is a major concern of the increasing trend of opportunistic practice by the medical professionals overcharging their inpatients with multiple ward visitations per day. For instance, overcharging patients as much as 15 times in a day in the Intensive Care Unit. Besides, there are also evidence of medical specialists resorting to the practice of “fragmentation or unbundling” of a single surgical procedure using multiple procedure charge codes to increase their professional income. Basically, it is the doctor doing a single surgical procedure but charging arbitrarily with additional surgical procedures codes to justify the increase professional fees without the patient’s knowledge. Undeniably, this opportunistic practice is done discretely without much conscience. The feedback gathered from the study hospitals and MCOs have concurred on this controversial issue of medical specialists not only overcharging their patients in the medical bills but also grossly violating the fee schedule. Inevitably this opportunistic practice has contributed to the overall cost of escalating medical bills. This study indicates that the MOH is fully aware of this non-compliance of the regulated fee schedule, and yet

there is no evidence of a firm action taken by the enforcement authority. Instead the regulatory body could only urge diplomatically that all private practitioners in the private hospitals to comply with the Fee Schedule and refrain from fragmenting or unbundling the procedure fees.

The evidence of opportunistic practice and the general behaviour of the private providers arbitrarily overcharging their patients resulting in exorbitant cost in the medical bills are of major concerns. The rising trend of opportunistic behaviour of specialist doctors overcharging patients is alarming as it would not only tarnish the medical profession but also public trust and confidence. Particularly, the surgical procedures have been “creatively fragmented or unbundled” to include multiple charge codes to increase the doctors’ professional income. These private hospitals are fully aware of this practice, and yet no action has been taken because of mutual self interests. Undeniably, the more professional income generated, the better is the performance of private hospitals’ cash flow and the business profitability. This is evident with the policy of the private hospitals charging an average of 10 percent on the gross professional income of doctors as management fees for the purported amenities provided. However, this excludes the consultation room rentals and other utilities charges. Therefore, it appears that private hospitals are in congruent with the opportunistic practice. Further, there is no incentive for private hospitals to refrain the doctors from overcharging their patients despite the regulated professional fees under Act 586. Hence, this ambivalent policy of the private hospitals has lead to the growing trend of opportunistic practice by medical specialists stretching their professional procedure fees to the maximum and beyond the Fee Schedule often with questionable justifications.

Despite the growing trend of opportunistic practice by some doctors, but there are also caring doctors who complied with the regulated professional fees and provided charitable discount on their fees to deserving patients under the Act 586. This study also discloses that there are also a few caring doctors who have been magnanimous in waiving their professional surgical fees on humanitarian grounds without much publicity. Besides, there are also altruistic doctors providing voluntary services to the various communities without gaining publicity in the mass media as it may be construed as an advertisement and violates the professional code of conduct.

Yet, it is surprising that the medical practice with its fundamentally altruistic and patient's welfare first philosophy has gradually evolved into a complex, profit driven corporate system with capitalistic values (Blake, 1996; McCoy, 2009). These capitalistic values emphasise on profit, competition, and the accountability on the return of investment. Currently the medical practice is perceived as the market driven services, and standards are influenced by the external market forces. Traditionally, the medical profession has been emphasising on the core value of service, advocacy, and altruism. Similarly, the medical professional service has been driven by the application of a specialised body of knowledge, and the ethical code of self regulations (McCoy, 2009). However, over the years the crass commercialisation of medicine has come under close scrutiny and debates (Blake, 1996; Sirajoon & Yazard, 2008; McCoy, 2009). The crass commercialisation has also impinged on the equitable access to quality care in the private hospitals.

These thematic findings support the theoretical underpinnings discussed in the Literature Review. A typical example of this principal-agent theory in the health sector is the bilateral relationship between the physician and the patient (Schneider & Mathios, 2006; Poth & Selck, 2009; Nguyen, 2011; Morris et al. 2012; Folland et al. 2013). Many patients

do not know the effect of medical care on health, and have to depend on the doctors by virtue of their specialised knowledge. Hence, doctors are perceived to be acting in an advisory capacity in informing the patients' level of health and the treatments that may restore their health status. As a result of this information asymmetry in the health sector, the doctor is seen to be an agent acting on behalf of the patient who is the principal, in deciding on what medical treatment is most appropriate. Assuming that the doctor made decisions in good faith to the choices of the patient and without personal self-interests, then the doctor is considered to be a perfect agent. Nevertheless, several empirical studies have revealed that doctors do not appear to be perfect agents (Evans, 1974; McGuire, 2001; Nguyen, 2011; Morris et al. 2012; Folland et al. 2013; Santerre & Neun, 2013). In a similar note, Evans (1974) hypothesises the theory of supplier-induced demand in the doctor and patient relationship which has its relevancy with the agency theory. This supplier-induced demand theory is sometime referred to as the provider-induced demand whereby the doctor engaged in some subtle form of persuasive activity to influence the patient's demand according to the doctor's self-interests (McGuire, 2001; Morris et al. 2012). In 2012, Morris et al. threading on the work of McGuire (2001) argue that doctors do respond positively toward financial incentives, and they appear to influence demand partly due to self interests.

The agency theory is also relevant to describe and analyze the relationship between the state and the regulated organisations (Schneider & Mathios, 2006; Morris et al. 2012; Folland et al. 2013; Santerre & Neun, 2013). The main issue under this theory is how to tackle the asymmetry of relationship. Precisely, the state as the principal has certain statutory power, while the regulated organisation as agent has more information and the resources to invest in the efforts to secure an advantage in the relationship. Generally, the principal and agent have divergent objectives and conflict of interests is often inevitable

(Walshe & Boyd, 2007; Poth & Selck 2009; Morris et al. 2012; Folland et al. 2013; Santerre & Neun 2013).

Likewise, Arrow (1963) argues the bilateral relationship between the state and the health care providers which further exemplifies the agency theory almost perfectly. As healthcare is a social good, the state as a principal has a responsibility to ensure the accessibility to quality healthcare and services to all segments of its population (Straube, 2013; Roscam Abbing, 2015). Invariably, a divergent of objectives between the state and the private health care providers can be anticipated (Schneider & Mathios, 2006; Morris et al. 2012; Folland et al. 2013; Bloom et al. 2014b). The state's intended national goals are toward an affordable, equitable access to quality healthcare service, while the private healthcare providers' objectives "inevitably seek to segment markets so as to exploit the profitable niches" (Saltman & Busse, 2002, p.5). The major concern is how the principals can protect themselves against the opportunistic behaviour of the agents (Walshe & Boyd, 2007; Morris et al. 2012; Santerre & Neun 2013). Faced with such circumstances, the state can design an incentive plan to induce the private health provider to act in favour of the principal (Walshe & Boyd, 2007; Poth & Selck, 2009; Morris et al. 2012; Santerre & Neun 2013). Hence the principal influences the agent's behaviours in some way either through a contractual relationship, or a legislative instrument (Arrow, 1963, 1985; Schneider & Mathios, 2006; Walshe & Boyd, 2007; Poth & Selck, 2009; Santerre & Neun, 2013).

The findings also reveal the thematic concern of inequity where the majority of private patients (about 60 percent) are paying out-of-pocket (OPP), approximately 35 percent of the patients are with insurance coverage, while the rest of 5 percent of the patients are from corporations and the government paying out-sourcing services in the private

hospitals. This phenomenon suggests that the beneficiaries are mostly the rich and upper income segment of the population. The majority of the population including the poor and marginalised groups may be denied of an equitable access to quality medical care. As such the government's attempt of achieving the objectives of universal health coverage is under threat. The high OPP hampers the achievement of the government's intended national health objectives of accessibility, equity and quality care. This findings share some common characteristics found in similar studies done in the developing countries (Patouillard et al. 2007; Berendes et al. 2011; Tung & Bennett, 2014). Further, the phenomenon of rich-poor disparity is more prevalent seen in tertiary and secondary care as compared to primary care in the private health sector (Chee & Wong, 2007; Meyer et al. 2013; Tung & Bennett, 2014).

In spite of the challenges posed to achieve the intended health objectives of equitable access to quality care, Act 586 has the provisions to address the inequitable distribution of private hospitals and resources. It is widely recognized that leaving health care to the market forces does not necessarily lead to an effective and efficient health care system (Rosenthal & Newbrander, 1996; Chee & Barraclough, 2007; Nik Rosnah, 2007; Chee & Por, 2015). Inevitably, the primary objective of the private providers is to seek the profitable segment of the market. The demand for healthcare is where there is high density of population with disposable income which normally prevails in the urban areas. This notion concurs with the findings of this case study which reveals that the most developed states of Selangor and WP Kuala Lumpur (Malaysia, 2006) have the highest number of approved licensed private hospitals after the enforcement of Act 586.

The statistical data clearly indicate that there is gross disparity and inequitable geographical distribution of not only licensed private and public hospitals but also the

human resources capacity. This gross disparity affects the national health objectives of accessibility, equity and quality care in Malaysia. Although the Act 586 aims to address the inequitable distribution of private hospitals, but the enforcement of the law appears to have been compromised to some extent affecting the equitable access to quality care.

With the inequitable distribution and multiple private providers, there is the concern on the quality care issues. Section 74 of Act 586 has its relevance in mandating quality care initiatives and services in a private hospital (Malaysia, 1998). This study reveals that although each private hospital has initiated its own quality programs to “ensure the quality and appropriateness of healthcare facilities and services” including infection control (Malaysia, 1998) but there are wide variations and no standardisation of care. For instance Section 37 of the Act 586 which mandates incident reporting in the private hospital is too cursory as it stands for quality improvement (Malaysia, 1998).

Nevertheless, this important information on incident reporting of adverse events in private hospitals remains highly confidential and not disclosed. Patients have high expectations and there is the growing trend of the lack of acceptance of adverse events in private hospitals. This is evidence with the increase in medico litigations over recent years. Hambali and Khodapanshandeh (2014) argue that the average number of medical negligence cases has risen by 46.8 percent in the five years from 2007 to 2011 compared to 2002-2006. What is more surprising is that there is asymmetric information even at the regulatory body. This is despite the legal provision which mandates “the information regarding such programmes and activities must be furnished to the Director General of Health as and when required by him” (Malaysia, 1998).

In addition, this study also reveals that there is no centralised system for the collection of data and information on the treatment and clinical outcome in the private hospitals sector. This is a marked contrast with the public hospitals under MOH where the National Indicator Approach in the Quality Assurance Program is currently being practised (MOH, 2011). Similarly, there is no mechanism or system which will enable private doctors to compare clinical outcomes or for the general public to compare the performance of providers when deciding where to seek treatment. Besides, there is also the concern of an underutilisation of scarce resources in the private hospitals sector. This study indicates that more than 75 percent of the private specialists have at least 10 years clinical experience, only 25 percent of the cases managed by these medical specialists could be classified as complex cases which justified the expertise of the specialists. Studies have shown that patients' clinical outcomes and quality care are better off in the hospitals where medical specialists responsible for the surgical procedures performed large number of such cases frequently. In comparison, the private hospitals and their medical specialists do not seem to have such scale and frequency of surgical procedures (MOH, 2011).

While the findings reveal that there is scarcity of public disseminated information on performance of quality care, an appropriate yardstick available is probably to determine whether these private hospitals have some form of accreditation certification. Currently, the practice of hospital accreditation is voluntary. The Malaysian Society of Quality in Health (MSQH) in collaboration with the MOH and the APHM, is the accreditation body entrusted to ensure Malaysian hospitals meet accreditation standards. Among the quality dimensions surveyed by MSQH encompass patient's safety, appropriateness of care, and competency of the healthcare provider.

Findings reveal that only nine private hospitals have been accorded with accreditation certifications by the MSQH. The objective of this accreditation certification is to ensure that the minimum standards in the provision of quality patient care in a safe hospital environment. Furthermore, four tertiary care GLC private hospitals have been conferred accreditations with the prestigious Joint Commission International Accreditation and Certification award (JCI) for high quality assurance. These accredited private hospitals have been selected by the MOH for the promotion of health tourism. However, the remaining six study hospitals have yet to achieve any accreditations but have indicated their interest in the future. The findings also disclose that these private hospitals are either not ready for accreditations or due to financial reasons. The accreditation exercise involves substantial transaction costs which may be a financial burden to small and medium private hospitals.

Nonetheless, the medical professionals have a crucial role in ensuring the provision of quality care in private hospitals. The Act 586 mandates the establishment of a Medical and Dental Advisory Committee (MDAC) “representing all practitioners practising in the facility and service to advise the Board of Management, the licensee and the PIC on all matters relating to the medical and dental practices” in all private hospitals (Malaysia, 1998). This provision in the Act 586 is seen as most relevant as these professionals are able to oversee the day to day maintenance of the standard of ethical care and safeguard patients’ rights in a private hospital (Loh, 2006). However, in most cases the views of the professionals are not necessary similar to that of the hospital management. Despite the purpose of MDAC in private hospitals to advise on clinical matters, this important role and functions have not been expressed explicitly in the legislation. This gap complicates the important role of the MDAC in its advisory functions in relation to the impact of Act 586 on the private hospitals.

Notwithstanding, the MDAC is also expected to advise the Board of Management but the crucial issue is what if the advice is not acceptable to the management. The irony is that Act 586 does not compel the management to accept the views of the MDAC. In reality, the medical and dental professionals do not seem to demonstrate strong influence on management's decision making and policies especially on quality assurance initiatives which may affect their business profitability. One classic example is in the decision making and policy on contracts with MCOs and medical insurers where clinical patient management on quality care may have been compromised. Invariably, the medical specialists have raised strong objections on the interference of MCOs in the clinical management of patients and the controversial issue of fee-splitting. Yet, there appears to be no apparent enforcement of this matter instead MOH bureaucrats urge the private hospitals to consult the MDAC on the contracts with insurers and the issue of fee splitting. There is no positive outcomes and issues remain unresolved. This phenomenon supports the public choice theory where public officials do not know what remedial actions to take and could only advocate for open market competition and this is usually the choice over any regulatory control. In addition, this phenomenon is evident where the regulatory authority is unable to perform its function because of the political power of the influential private providers (Laffont & Martimort, 2009; Folland et al. 2013).

This study further reveals that the provisions under Act 586 provides adequate and comprehensive provisions of enforcement capacity to ensure a good compliant system in the private hospitals. However, the study also indicates the lack of "political will" of the government to provide adequate financial allocation to enhance the human resource capacity and the adequate information. This lack of sufficient resources has hampered the enforcement capacity at the MOH. For instance, the enforcement team is led by a few senior medical officers, while the majority of the newly recruited medical officers are

inexperienced to face the influential and powerful medical providers. This phenomenon concurs with the previous study done by Nik Rosnah Wan Abdullah (2002). The government has not allocated sufficient resources and expertise to enable the regulatory body to be effective in regulating the private providers adequately. It is without doubt that the regulatory institution and its enforcement functions appear to be weak. On the other hand the intervention of the “political invisible hand” has further impinged on the enforcement capacity. In encountering these challenges, the MOH appears to embark on a more cautious and optimistic approach of row less but steer more in its role in driving the private health sector. Hence the national health objectives of accessibility, equity, and quality care have yet to be achieved fully with the enforcement of Act 586.

## **9.2 Recommendations**

The findings suggest some imperative approaches toward improving the current regulatory functions and landscape. Undoubtly, Act 586 is a modern legislation to address the weaknesses of the previous Private Hospitals Act 1971 but there are areas of concern in the enforcement capacity. There is an urgent need to strengthen the regulatory functions with an adequate information, financial and human resources allocation. The government has to have the “political will” in its regulatory functions to provide adequate financial resources to enable the regulatory body to be effective in regulating the private hospitals as in the developed countries such as United Kingdom. In view of the perpetual principal-agent problems and asymmetric information, there is an urgency to consider the setting up of a similar Commission of Healthcare Audit and Inspection in United Kingdom (Department of Health 2002) albeit in the local context. This is to secure more effective information gathering, monitoring and surveillance within the regulatory body. In addition, the Commission will ensure a good compliance system in the private hospitals.

Under the Commission of Healthcare Audit and Inspection, a Medical Intelligence Unit is recommended to be set up and responsible for a covert network of voluntary informers for information gathering and intelligence operation. These informers can be recruited from the private hospitals, professional bodies, MCOs, patients, and civil society. This study reveals that there are many potential informers who are passionate in upholding patient's rights and ethical practice in the private hospitals. Hence, data collected from these whistle-blowers are rich information that could be channelled to a centralised dossier system to enhance the intelligence work and enforcement capacity. However, as a prerequisite to the setting up of the Intelligence Unit, it is pertinent to establish a secret service fund which is an off-budget allocation to finance the intelligence network efficiently and effectively. Secret service funds for intelligence work are currently been used in law enforcement authorities such as the Malaysian Anti-Corruption Commission and the Royal Malaysian Police. In this respect, any credible information on infraction of the regulations by the private hospitals gathered by this Medical Intelligence Unit will be scrutinised in the dossier system and subsequently forward the information of alleged offence to the Investigation Unit for further action. Thereafter the medical investigators will initiate investigation under Section 87 of Act 586 on the alleged offences at the private hospitals (Malaysia, 1998).

Upon completion of the investigation, a recommendation shall be made either to charge or no further action based on the strength of the evidence gathered. The Investigation Paper will then be forwarded to the Attorney-General's Chamber for consent to prosecute. Once the consent to prosecute is granted, the offender shall be charged accordingly in the Court. This action will not only serve as a serious deterrence to offenders under Act 586 but also create greater public awareness and confidence in the enforcement authority.

Henceforth with the specialisation of work, it is expected that the regulatory body will be able to secure quality information and to enhance its enforcement capacity under Act 586. In particular, the MOH will be able to focus and find long term solutions to the current critical issues confronting the private health sector despite the enforcement of Act 586. This among the others includes the exorbitant cost of medical bills and the difference in charges between private patients paying out-of-pocket (OPP) and insured patients. These controversial issues have also contributed to the overall escalating healthcare costs over the years. In this context, the MOH will be able to monitor private hospitals and private medical practitioners much closely to ensure they do not abuse the patients' medical benefits provided for in their insurance by unnecessary procedures and diagnostic tests.

Besides, MOH will also be able to monitor closely the hospital charges and professional fees to ensure transparency and accountability of the medical providers. It is hoped that this close monitoring will eventually eradicate the opportunistic practice in the private hospitals. In this process, the controversial fee-splitting issue between the private hospitals and the medical professionals can be monitored, and only allow discounts for hospital charges to the MCOs. With these measures taken, it is expected that it will provide a positive solution to the contentious fee-splitting issue between the medical specialists and the MCOs eventually.

It is also imperative that MOH adopts an inclusive strategy to continue engaging more frequently with the key stakeholders to ensure that the hospitalisation charges are fair and reasonable under Act 586. These important stakeholders such as the private medical and dental professionals, private hospitals, MCOs, pharmaceutical companies, civil society, universities and the mainstream media have significant roles to play in the management of cost containment without having to compromise on quality care. Particularly in terms

of governance, private hospitals have to be directed to be more accountable, transparent and inform all patients upfront about the estimated costs of treatment including the professional fees as stipulated in the regulations. In addition, MOH has to continue insisting that all charges be itemised and transparent so that patients can make an informed choice of where to seek treatment as long as they have adequate information about the charges. Besides, private hospitals must provide information on their websites on the estimated total costs for hospitalisation of common medical conditions and procedures to potential patients to have an alternative option. It is crucial that private hospitals conduct periodic medical reviews to ensure hospital charges undergo a peer review process to check and eradicate those who do not comply or resort to unethical practice. In this context, private hospitals must also validate the charges imposed by both the medical professionals and hospitals before submitting to the MCOs and insurance companies for reimbursement to ensure good compliance system. This is the expectation of MOH and it is seen as a prelude to the ultimate commissioning of the intended National Health Financing Scheme.

However, the multiple fragmented private providers, the wide variation in care, and scarcity of disseminated public information on the issue of quality care are of major concerns. It is crucial for the Director General of Health to invoke Section 75 of Act 586 to direct the setting up of a systematic collection of treatment and outcome data in the private hospitals in relation to the provision of quality care. The commissioning of this centralised database can be similar to the counterpart in the public sector such as the National Indicator Approach in Quality Assurance Program. This centralised system of data collection is essential to enable medical practitioners and private hospitals to share and compare information on clinical outcomes. The availability of such information is also of paramount importance to the patients or health consumers to be well informed

when deciding which hospital to seek treatment. On the other hand the MCOs and insurers are also able to direct their clients to the various private hospitals for quality care. Similarly, periodic publication of thematic reports of outcome of inspections by the regulatory body on private hospitals under Act 586 are essential to guide health consumers and medical insurers to secure services from reputable private medical institutions offering better quality care and services.

Currently, the provisions under Act 586 and its regulations are supposed to be the minimum standards to ensure patient safety, equitable access and the provision of quality care. These minimum requirements may be lagging behind in the very near future with the fast changing development in the private healthcare sector. The advancement in medical technology, demographic and epidemiological changes, commercialised medical care and higher patients' expectations may need innovations and further amendments to the regulations. Despite the prescriptive Act 586 and its regulations are extensive but some provisions are found to be ambiguous and debateable. Some clauses of the legislation prescribe authority to the Director General are widely drafted which are prone to uncertainty, confusion and abuse. For instance under Section 112 (1), the Director General is empowered at any time to direct a private hospital "to furnish information relating to (a) its staff, (b) apparatus, equipment, or instrument used, (c) the condition, treatment or diagnosis of any of its patients, (d) any analytical methods or procedure used in carrying out any test; or (e) its operation" (Malaysia, 1998). Failure to comply or give misleading information is a punishable offence with a fine or imprisonment, or both.

On the contrary, Section 112(4) stipulates explicitly that "nothing in this section shall authorise (a) the Director General or any officer to inspect the medical record of any person treated in a private healthcare facility or service; or (b) the Director General to

obtain any information in respect of any person on any matter in paragraph 112(1) (c), without the prior consent of that person or his representative” (Malaysia, 1998). In this context, the Director General is not authorised to inspect the medical record of any person treated in the private hospital without the prior consent of that person or his representative. Therefore in order to have compliance it is crucial to have clarity and certainty in the provisions of the law. Many medical specialists have been critical and voiced concerns that regulations are not clinically driven but rather too legally driven and are micromanaging the private hospitals. Besides, it is short of clinical relevance which is supposed to be the original aim and spirit of the Act 586 according to several key informants who are senior private medical specialists. Most importantly, Act 586 has hardly made any mention about clinical governance and audit. Surely, these fundamental issues such as clinical audit, clinical practice guidelines, peer review, incident reporting, clinical risk management, mortality and mobility merit more attention according to the key informants. These crucial issues are matters to be taken into considerations in the future amendments to Act 586 and its regulations.

Notwithstanding, the Act 586 and its regulations is a modern legislation which has the potential to push for development of modern healthcare delivery system. Undeniably, the legislation emphasizes the patient’s rights to be its main priority and the accountability of the private providers. Implementation of patients’ right in the legislation is to ensure safety, and equitable access to quality care (Saltman & Brusse, 2002; Roscam Abbing, 2012; Rodney & Hill, 2014). However, implementation of patients’ right bill may not be effective if they are “neither enforced by statute, externally regulated, nor, as yet, monitored in an official way” (Silver 1997, p.213). In theory, the Act 586 provides adequate regulatory framework to address the policy makers’ concern of achieving the national objectives of accessibility, equity and quality care. However, full compliance for

equitable access to quality care, correcting the imbalance for an equitable distribution of private hospitals nationwide, and rationalising the medical charges to an affordable level remain an insurmountable challenge yet to be realised. The rhetoric implementation of Act 586 has not been seen to meet the general public expectations other than the mandatory approval and licensing the influential private healthcare providers. The findings have provided answers to the research questions and objectives of the study.

Although this case study is the first of its kind, it has its own limitations. The empirical findings provide only a tip of the iceberg on the impact of Act 586 on the private hospitals in Malaysia. Henceforth, this study recommends a further research on the impact of the regulatory intervention on the private hospitals in the near future. This effort will not only provide scholarly debates and inputs to the government on the impact of its public policies but also to improve the performance of the private hospitals in the delivery of health care. In the mean time efforts are also been made for publication of more academic papers based on the latest findings and as a contribution to the field of knowledge.

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## LIST OF PUBLICATIONS AND PAPER PRESENTED

1. Nik Rosnah, W.A, & Lee, Kwee-Heng. (2011a). Impact of the Private Healthcare Facilities and Services Act 1998 & Regulations 2006 on the medical practice in corporate hospitals in Malaysia. *OIDA International Journal of Sustainable Development*, Vol.2 (9) pp. 89-106; Ontario, Canada. Available at <http://www.ssrn.com/link/OIDA-Intl-Journal-Sustainable-Dev.html>.
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