
Case study

Malaysia

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Malaysia

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Abbreviations

Abbreviation	Term
B40	Bottom 40
BUPA	British United Provident Association
DRGs	Diagnosis-related Groups
FPP	Full Paying Patient
GDP	Gross Domestic Product
GLC	Government-linked Companies
GoM	Government of Malaysia
GPs	General Practitioners
HIC	Health Insurance Committee
MARA	Majlis Amanah Rakyat, or Peoples' Trust Council
MAS	Micro Accounting System
MCO	Manage Care Organisation
MHI	Medical and Health Insurance
MMA	Malaysian Medical Association
MNHA	Malaysia National Health Accounts
MoH	Ministry of Health
MPC	Malaysia Productivity Corporation
NHSF	National Health Security Fund
OOPP	Out-of-pocket payment
PHFSA	Private Healthcare Facilities and Services Act
RM	Ringgit Malaysia
RVS	Relative Value Scales
T&CM	Traditional and Complementary Medicine
THE	Total Health Expenditures
UHC	Universal Health Coverage
UM	University of Malaya
UMMC	University of Malaya Medical Centre
UMSC	University of Malaya Specialist Centre
WHO	World Health Organization

Abstract

Malaysia is an upper-middle income country of 32 million inhabitants. The Malaysian health system is composed of parallel public and private sectors where the public can choose to purchase care from either sector. The Government of Malaysia (GoM) has thus far not used pricing as a tool to negotiate with public providers for improvement in the quality or efficiency of care. However, the GoM regulates user fees for public care, and fees have been set to balance the policy goal of affordability against that of cost recovery. The GoM also sets and regulates pricing in the private sector in response to public demands for affordable private care. High private sector prices are translated to high user fees in the Malaysian private system, which predominantly depends on patients paying out-of-pocket to receive care.

Health care in the public sector is subsidized by the GoM using funds from general taxation. The application of user fees in the public sector has enabled cost sharing to be progressively increased over time, although to date, such fees are still much lower than needed for cost recovery. This is in line with GoM's stated welfare objectives of affordable public health care and that the public health sector needs to be maintained as the safety net for the poor. The basis for the regulation of user fees in the private sector, which is predominantly funded through out-of-pocket payments, was to ensure affordability of care. However, legislated private medical fees cover only the professional fees charged by health care professionals. Thus, only a portion of total bills incurred by patients using private health care facilities is regulated. It has become apparent that regulation of private medical fees, as is practiced in Malaysia, has not been able to contain rising costs of private health care. Furthermore, high private medical bills are a barrier to private health care for many.

The practice of medical fee setting is still in its infancy in Malaysia since a) there is little incentive within its stated welfare goals for the public sector to set fees, and b) since the vibrant private health sector today is a relatively recent development. However, there is increasing public demand for access to private care through reasonable private fees, and the government has just recently announced an initiative to purchase private service to expand health screening services to the poor. In view of these developments, it is envisaged that the Ministry of Health would need to invest in building infrastructure for fee setting. This would include training dedicated personnel to capture and analyse costs as well as a system for better collaboration among policy stakeholders both within and without the ministry.

1

Introduction

Malaysia is an upper-middle income country of 32 million inhabitants. The Malaysian health system is composed of parallel public and private sectors, where the public can choose to purchase care from either sector. The Government of Malaysia (GoM) has thus far not used pricing as a tool to negotiate with public providers for improvement in quality or efficiency of care. However, the GoM regulates user fees for public care, and fees have been set to balance the policy goal of affordability against that of cost recovery. The GoM also sets and regulates pricing in the private sector in response to public demands for affordable private care. High private sector prices are translated to high user fees in the Malaysian private system, which predominantly depends on patients paying out-of-pocket to receive care.

By and large, fees are set by the Ministry of Health (MoH), and the fees are enforced through legislations. Health care in the public sector is subsidized by the GoM using general taxation (Ministry of Health, 2017b). Such public funding is substantial and over the past two decades has paid for more than half of the annual total health expenditures (THE) of the country. The application of user fees in the public sector has enabled cost sharing to be progressively increased over time, although to date, such fees are still much lower than needed for cost recovery.¹ This is in line with GoM's stated welfare objectives of affordable public care and the need to maintain the public sector as the safety net for the poor (Rohaizat, 2004). The basis for the regulation of user fees in the private sector, which is predominantly funded through out-of-pocket payments (OOPPs), was to ensure the affordability of care. However, legislated private medical fees cover only the professional fees² charged by health care professionals. Thus, only a portion of total bills incurred by patients using private health care facilities is regulated. It has become apparent that the regulation of private medical fees as practiced in Malaysia has not been able to contain rising costs of private health care and that high private medical bills are a barrier to private health care for many (The Edge Financial Daily, 2017).

This case study describes the rationales, processes, and effects of setting and regulating user fees in the Malaysian healthcare system. The work to develop this report took place between August and October 2018 and involved the identification and consolidation of information using the question guide provided by the World Health Organization (WHO) Kobe Centre,

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- 1 For example, the fee for a general outpatient clinic visit obtained from a public clinic was just RM (Ringgit Malaysia) 1, or approximately US\$ 0.23, in 2017. Payment of this fee would entitle the patient to a medical consultation, simple laboratory investigations and medication for two weeks.
 - 2 Fees paid to health care professionals, predominantly doctors and dentists for the conduct of medical consultations or procedures, including the interpretation of radiology and laboratory tests. Professional fees exclude that portion of hospital bills for hotel services such as for food and accommodation and fees for the use of equipment and facilities such as operating rooms and drugs.

supplemented by a wider literature review relating to medical fees in Malaysia, and interviews with key informants with knowledge of past and current medical fees setting practices in the country.

This report begins with a description of the Malaysian healthcare system to understand the context in which medical fees are applied, followed by descriptions of the processes of fee setting in the public and private health sector, respectively. The report concludes with a discussion on the overall effect of medical fees on the healthcare system in Malaysia.

2 Malaysian healthcare system

Malaysian health care delivery system

Malaysia, a sovereign nation formed in 1963, is a federation made up of 13 states; 11 in the Malay Peninsula, and two, Sabah and Sarawak, in the northern part of the island of Borneo.³ These two land masses are separated by the South China Sea. Malaysia practices a constitutional monarchy system in which the nine⁴ hereditary state rulers elect among themselves a Yang di-Pertuan Agung, or King, who will rule the country for a five-year term. In 2017, the country was home to an estimated 31.6 million people, of which 3.3 million, or 10.2% were non-citizens (Department of Statistics Malaysia, 2017). Of the remaining 28.3 million people, 68.6% were Bumiputeras,⁵ 23.4% Chinese, 7.0% Indians and 1.0% people from other ethnic groups.

Health is a federal government responsibility, and the main federal agency regulating the health sector is the MoH. However, health care in Malaysia is delivered through a parallel public-private delivery system. The MoH is the largest provider of public care, and in 2016 it owned 144 hospitals and special medical institutions, with nearly 42 000 beds, as well as over 3000 static or mobile clinics distributed throughout the land (Ministry of Health Malaysia, 2017a). There were an additional four teaching hospitals owned by the Ministry of Education, each of which is affiliated with the public medical schools of the University of Malaya (UM), National University of Malaysia, Science University of Malaysia and MARA⁶ University of Technology, as well as five military hospitals owned by the Ministry of Defence to provide care to military personnel and their dependents. These nine non-MoH public hospitals

3 All 13 states were former British colonies. In 1957, the 11 states in the Malay Peninsula achieved independence from British rule and formed the Federation of Malaya. Malaysia was formed in 1963 when Sabah, Sarawak and Singapore joined the federation. In 1965, Singapore left the federation.

4 The other four states are ruled by Governors who are appointed by the Yang di-Pertuan Agung.

5 Bumiputera, a Malay term meaning 'prince of the earth', refers to the combined grouping of the orang asli and people from the Malay ethnic group. The term orang asli refers to diverse groupings of indigenous tribes residing in the Malay Peninsula as well as in the states of Sabah and Sarawak.

6 Majlis Amanah Rakyat (MARA), or People's Trust Council, is a government agency set up to aid, train and guide bumiputeras in the areas of business and industry.

contribute another 3700 hospital beds. Several local authorities and town councils, which are under the purview of the Ministry of Local Government and Housing, also provide some health care services, mainly in areas of sanitation, food quality control and vector control services in larger towns.

Although public sector health facilities are mainly restricted to hospitals and clinics, the range of private sector facilities is more diverse. In 2016, there were 187 private hospitals with a combined bed complement of nearly 14 000 beds, over 7000 private medical clinics and nearly 2000 private dental clinics as well as 423 private haemodialysis centres, 73 private ambulatory care centres, 17 private nursing homes, 10 private maternity homes, four private blood banks, two private hospices, one private community mental health centre and two private facilities combining haemodialysis as well as ambulatory care services (Ministry of Health Malaysia, 2017a).

In Malaysia, the classification of health care facilities to public or private sectors is based not on ownership but rather on the business model adopted by the management of the health facilities. Private health care facilities are those which operate on a commercial for-profit basis (Chan, 2014). This is especially relevant in the private hospital sector where many private hospitals are fully or partially owned by government-linked companies⁷ (GLCs) but operate as commercial for-profit enterprises (Chan, 2014). Currently, the proportion of private hospital beds owned by GLCs exceeds 50% of total private hospital beds in the country⁸ (figure 1).

Figure 1
Distribution of hospitals and doctors working in the public and private sectors in Malaysia, 2016

	Public Sector		Private Sector	
	MoH	Non-MoH	GLC-linked ¹	Others
No. of hospitals	144	9	45	142
No. of hospital beds	41995	3683	7401 ²	6,556
No. of doctors	36403	na	13684 ³	

Source: Ministry of Health Malaysia, 2017a, and information obtained from the websites of GLC hospitals. Notes: GLCs are defined as companies that have a primary commercial objective and in which the GoM has a direct controlling stake and not just percentage ownership; 1: hospitals owned by Khazanah Nasional Berhad, Ramsay Sime Darby, the Terengganu and Malacca state governments; 2: Estimated from information obtained from the websites of GLC hospitals; 3: Published information refers to all doctors practicing in the private sector; na: Not available.

7 GLCs are defined as companies that have a primary commercial objective and in which the GoM has a direct controlling stake and not just percentage ownership.

8 These GLCs include IHH Healthcare Berhad, a subsidiary of the Khazanah Nasional Berhad, the federal government sovereign wealth fund and KPJ Healthcare Berhad, a public-listed company belonging to the Johor Corporation, the investment arm of the Johor state government. Other state governments, including the Terengganu and Malacca state governments, are also involved in providing private health care. Sime Darby, another GLC, owns hospitals through Ramsay Sime Darby, a joint venture with Ramsay Health Limited, an Australian company.

The GoM launched the Privatisation Policy in 1983 (Chee and Barraclough, 2007). The policy was intended to encourage the private sector to be the main engine of economic growth and to allow the government to reduce its presence in the economy, thus reducing its level and scope of public spending (Abu Bakar, n.d.). Incentives were provided to enhance development of the private health sector, which coupled with increasing public demand for private care, led to a rapid expansion of private hospitals - from 50 hospitals in 1980 to 219 hospitals in 2003 (Chee and Barraclough, 2007). Operating private hospitals came to be seen as a lucrative business venture, which in turn encouraged further participation of private companies and eventually GLCs (Rasiah et al., 2009; 2011). Despite these developments in the private sector, welfare sentiments are still prevalent in the provision of public care.

The then (and current) Prime Minister of Malaysia, Mahathir Mohamad,⁹ delivered a speech at the inaugural meeting of the Malaysia Business Council on 28 February 1991, in which he outlined nine strategic challenges for the country to achieve developed nation status by 2020. His aspirations for the country, as contained in this landmark speech, are now widely known as Vision 2020.¹⁰ In it, the Prime Minister stressed that the developed Malaysian society should be an “economically just society” and to obtain this, the country should, amongst others, “provide enough by way of essential shelter, access to health facilities and all the basic essentials”(Abu Bakar and Jegathesan, 2001: p. 12). However, this needs to be understood against the backdrop of what he had mentioned earlier in the same speech concerning the strategic challenges in the path towards national development. In the seventh of these challenges, Mahathir emphasized the need to establish a fully caring society, in which “the welfare of the people will revolve not around the state or the individual but around a strong and resilient family system” (Abu Bakar and Jegathesan, 2001: p. 12). Taken together, these statements provide a rationale for the policy directions with regards to the application of medical fees in Malaysia, especially in the public sector, which emphasizes the need to provide basic health care for all based on a shared responsibility between the state and the people. This sentiment is also reflected in the MoH’s Vision for Health.

Vision 2020 was intended to provide a direction for national economic growth. After its release, the MoH developed the Vision for Health to guide development of the health sector towards the attainment of Vision 2020. The guiding principle of shared responsibility towards health has been echoed in the Vision for Health, which states that “Malaysia is to be a nation of healthy individuals, families and communities, through a health system that is equitable, affordable, efficient,

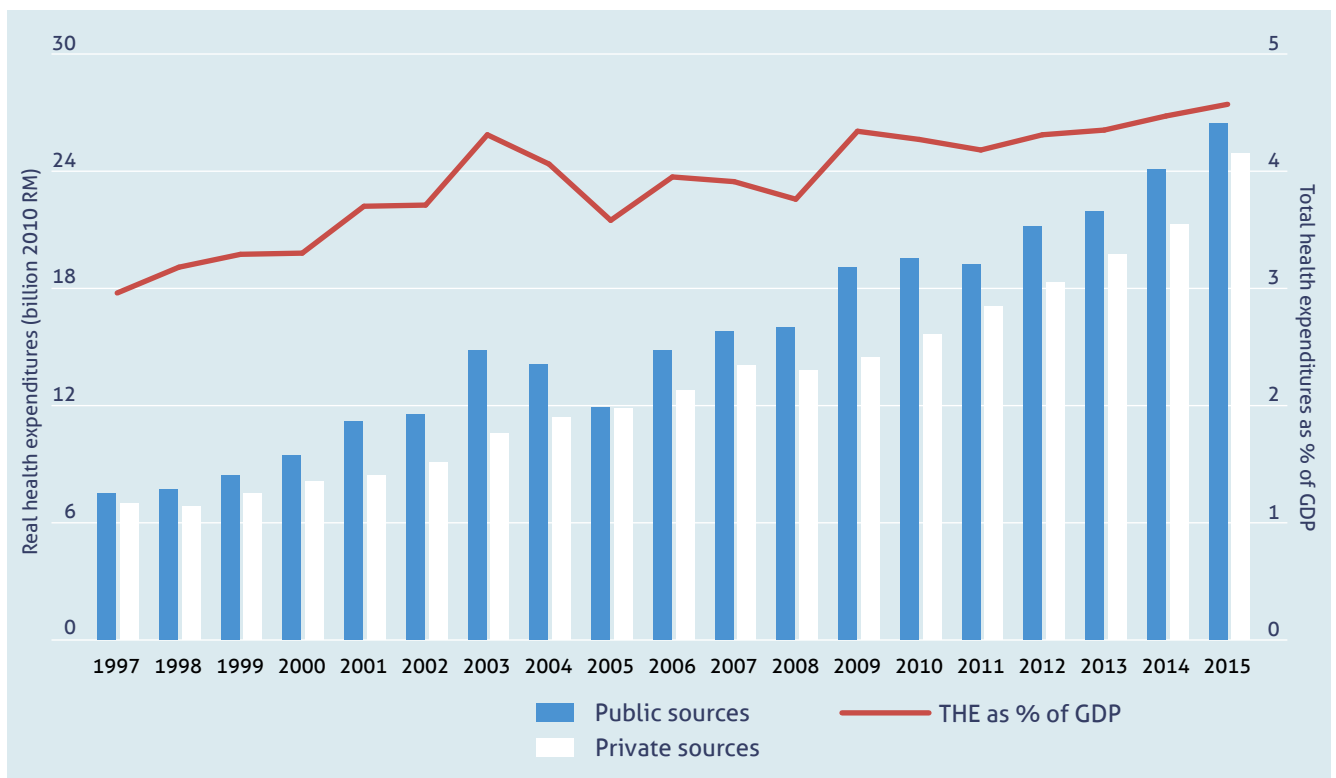
9 Mahathir Mohammad first served as the fourth Prime Minister of Malaysia from 1981 to 2003. In May 2018, he was again appointed to the same position as the seventh Prime Minister of the country.

10 The full speech can be downloaded from <http://unpan1.un.org/intradoc/groups/public/documents/apcity/unpan003223.pdf>.

technologically appropriate, environmentally adaptable and consumer friendly, with emphasis on quality, innovation, health promotion and respect for human dignity and which promotes individual responsibility and community participation towards an enhanced quality of life” (Abu Bakar and Jegathesan, 2001: p. 12). The mention of an ‘affordable’ health system here could have easily been thought to refer to medical fees set at a level which patients can pay and thus afford. However, it has since been clarified that the ‘affordable’ health system in the Vision for Health is seen from the more macro perspective of what the country can afford to provide to the people (Abu Bakar and Jegathesan, 2001: p. 12).

The MoH had set up the Malaysia National Health Accounts (MNHA) Project in 2001 to capture details of the national health care expenditures in Malaysia. To date, MNHA has published expenditure estimates and trends for years 1997 to 2015 (Ministry of Health Malaysia, 2017b). Throughout this period, the country’s THE as a percentage of Gross Domestic Product (GDP) did not exceed five percent, and public sources of funding, which are predominantly made up of general taxation, contributed more than half of THE annually (figure 2). Though accurate estimates of private financing of health care in Malaysia were not routinely available prior to 1997 and thus THE were not known, the MoH was aware of the increasing cost of providing public care and the need to mobilize other sources of funding for health.

Figure 2
Public and private health financing sources, Malaysia 1997 to 2015



Source: Ministry of Health Malaysia, 2017b.

General socio-economic policies in Malaysia are laid down in a series of five-year development plans known as Malaysia Plans. The first Malaysia Plan covered the years 1966 to 1970. This and the next three Malaysia Plans, covering the years 1971 to 1985, focused mainly on the expansion of health services, especially to enable better access to care for rural populations (Government of Malaysia, 1966; 1970; 1976; 1981). However, from the fifth Malaysia Plan (1986 to 1990) onwards, the Malaysian public were slowly being sensitized to the growing financial burden shouldered by the GoM to provide public health care and subsequently the need for cost sharing. In particular, there was a specific mention of improvements in hospital billing systems and efforts to revise user fees in order to “initiate nominal cost recovery in hospitals and clinics” (Government of Malaysia, 1990: p. 353). It was also noted that large numbers of migrants had used public health facilities and were paying the same fees paid by citizens. In 1994, medical fees for migrants were increased to encourage them to use private medical facilities (Government of Malaysia, 1996: p. 540).

The rapid expansion of private health care since the 1980s has generally been welcomed. The GoM intends for the private sector provision to complement the public sector provision of medical services especially for those who can afford private care. However, the GoM saw fit to add that legislations should be reviewed to ensure that the profit motive would not compromise quality and accessibility to private care. Subsequently, a new legislation governing the provision of private medical care, the Private Healthcare Facilities and Services Act (PHFSA), was enacted in 1998 to “improve access to health care, correct imbalances in standards and quality of care as well as to rationalize medical charges in the private health sector to more affordable levels” (Government of Malaysia, 1996: p. 549). The GoM also made known its intention to reform the country’s health care financing system to provide “consumers with a wider choice in the purchase of health services from both the public and private sectors” (Government of Malaysia, 2001: p. 495). However, to date, there has been no major reforms to the country’s financing system which has provided public funding to support the public provision of care and in turn, contributed to the achievement of universal health coverage (UHC).

Achievement of Universal Health Coverage

Malaysia has claimed to have achieved UHC since the 1980s, when health services had been provided to over 90% of the population.¹¹ UHC has mainly been provided by the public health sector. At that point in time, the focus was on the expansion of primary care services for rural people who made up the majority of the population in the country (Jayesuria, 1967). Health clinics remain an important component of the

11 The then Minister of Health, S. Subramaniam, had made this claim in a speech delivered at the 27th Commonwealth Health Ministers Meeting held in Geneva, Switzerland on 17th May 2015. The speech can be obtained from www.moh.gov.my/index.php/database_stores/attach_download/337/679.

MoH primary care delivery system to this day. Clinics vary in size and complexity, with the smaller ones staffed by a single community nurse providing basic nursing care and advice. These community clinics are connected to a network of progressively larger and more complex clinics. At the top of the chain are polyclinics, where the public can access the full range of primary care services from general outpatient consultations to ante and postnatal care, vaccinations against infectious diseases, growth monitoring for children, health screening and health education services as well as dental care. The larger clinics are also equipped with pharmacies, laboratories and x-ray machines.

The MoH also established hospitals to provide secondary and tertiary care. Similar to clinics, the network of MoH hospitals range from small secondary care hospitals in rural districts to tertiary referral hospitals in large towns such as Putrajaya, the administrative capital of the country. A national referral system has been established to link facilities providing different levels of care and to enable patients to be referred from the clinics to the level of care that they require. The public teaching hospitals are also part of this referral system.¹² Thus, the public health system in Malaysia has been structured to provide comprehensive health care, from primary to tertiary levels, to individuals in need.

User fees have long been a feature in the Malaysian healthcare system. However, such fees in the public sector have often been waived for the poor (Rohaizat, 2004). A national household health survey conducted by the MoH in 1988 found that, "almost all outpatient visits to government clinics were free, as were 60% of visits to government hospitals." (Public Health Institute, 1988: p. 9). An earlier study noted similar findings, "small personal charges are made to patients, but they are seldom collected for class III services, which apply to the majority of the beds" (Westinghouse Health Systems, 1985: p. 107). The same study reported that public hospitals were provided with government allocations on a quarterly basis and that a supplemental allocation was provided in the event of a shortfall of funds. Since these early studies, there has been several upward revision of fees, but as late as 2015, more than half of the public hospital admissions and public outpatient consultations had been free (Institute for Public Health, 2015: pp. 347-383).

In 2011, it was estimated that on average, each person in Malaysia had 4.3 outpatient consultations and that there were 111 inpatient discharges per 1000 population in the country (Health Policy Research Associates et al., 2013: p. 20). The outpatient consultations were equally distributed between public and private health care providers. However, inpatient admissions were predominantly public. Admissions to public hospitals made up 74% of all admissions. But what is more interesting to note is that there was no income gradient in the

¹² However, the five military hospitals do not normally accept non-military personnel except in emergencies. These hospitals mainly provide care for military personnel and their families. Such services are free at the point of delivery.

utilisation of outpatient and inpatient care services in Malaysia. Whilst outpatient and inpatient utilisation were the same across income quintiles, there was a distinct pro-rich distribution to the use of private health care services and, conversely, a pro-poor distribution for public care (Health Policy Research Associates et al., 2013: pp. 55-56). It was argued that this equitable finding can be attributed to sustained government investments into the public health sector, not just in terms of development and expansion of health facilities but also in efforts to keep user fees low to maintain affordability for the poor.

3

Setting medical fees in the private sector

Estimating the cost of providing services in MoH facilities

Although the MoH has knowledge of the expenditures spent by its various programmes as well as the number of care episodes provided by its facilities, this information has not been fully mined to yield comprehensive information on the costs of services.

In 1992, the GoM had introduced the Micro Accounting System (MAS) into the public sector to determine the costs of outputs produced by public agencies. Such information was to be used to assist management in the planning, implementation, control and evaluation processes. The MAS was implemented by the MoH in phases from 1995 to cover hospitals, clinics and health management departments within the ministry.¹³ This system was designed to produce inpatient and outpatient unit costs of inpatient and outpatient services provided by MoH facilities. However, the MAS system is currently no longer in use by the ministry.

In 1996, the MoH started exploring the use of case-mix systems for hospital budgeting purposes.¹⁴ Initial efforts were hampered by the high cost of purchasing and maintaining the case-mix software sourced commercially. In 2010, the ministry commissioned the design of a system known as the Malaysia diagnosis-related groups (DRGs) utilising case-mix weights developed for hospital inpatient care. This system is currently in use in 59 out of the 144 MoH hospitals nationwide. Thus far, only costs by DRGs for inpatient care are known. The ministry is working towards extending the system to include outpatient and day care services as well as to improve the accuracy of clinical coding in MoH hospitals. These efforts would be required if case-mix information is to be used to support the development of hospital budgets.

13 Information on MAS within the MoH was obtained from a paper entitled, "Micro Accounting System for Costing of Services" presented by Mr Tan Eng Hock, Secretary of the Finance Division, MoH at the Conference of Directors, MoH held from 15th to 17th April 1998.

14 Information on the use of case-mix systems was obtained from the MoH.

Prior to 1997, total health expenditures in Malaysia covering both public and private sources of funding were not routinely and systematically captured. The MNHA Project established in 2001 was to capture the totality of health expenditure flows within the health system in Malaysia. As part of the data capture process, the MNHA conducted cost accounting projects in selected MoH hospitals to enable disaggregation of hospital expenditures to inpatient, outpatient and day care costs (Ministry of Health Malaysia, 2006: p. 5). Conceptually these exercises have the potential to produce estimates of unit costs for services in the selected hospitals, but to date such information, if estimated, has not been made public.

A legacy from the British Colonial administration, the MoH has a strong and long-standing culture of systematically collecting health statistics from MoH facilities (Health Informatics Centre, 2013: pp. 8-9). Since the 1960s, there has been a dedicated unit responsible for the collection and analysis of health information. This unit has evolved over time, and its role has expanded to include the development of standards, ensuring quality of the data collected, analysed and disseminated to support policy decision-making in the ministry. The current form of the unit is known as the Health Informatics Centre (HIC), which was established in 2007 to manage health statistics from the public as well as the private sector. One of the stated objectives of the HIC is to provide data support for the conduct of cost-effectiveness analyses (Health Informatics Centre, 2013: p. 13). However, the centre does not appear to collect data on costs of care.

In summary, though the MoH keeps track of the overall expenditures of the ministry, comprehensive cost information by services is currently not fully available.

Legislating medical fees for MoH facilities

In the public sector, matters pertaining to fees for services provided or financial penalties imposed by all public offices and departments of the GoM are governed by the Fees Act 1951 (Government of Malaysia, 1951). In accordance with Article 97(1) of the Federal Constitution, all funds collected are paid into the Federal Consolidated Fund. These funds cannot be retained by the public agencies that collected them.¹⁵

Medical fees collected from MoH patients make up a very small portion of overall government revenues. In 2014, collected medical fees totalled RM 269.3 million, or US\$ 82.4 million, which was less than 0.5% of all non-tax government revenues and less than 0.1% of total government revenues for the year (Ministry of Health Malaysia, 2015a: p. 36; Ministry of Finance Malaysia, 2015: p. 4-6).

The fees for MoH medical services are gazetted as regulations under the Fees Act 1951 and are enforced by the MoH. The earliest regulation was gazetted in 1957 and later revised in

¹⁵ An exception was made for fees collected from the FPP scheme. The Ministry of Finance has clarified that the portion of fees meant to be paid to attending doctors could be maintained in a trust fund and eventually be disbursed to the doctors concerned.

1976 and 1982 (Government of Malaysia, 1982). The fees included in the 1982 regulation were listed in eight schedules covering inpatient and outpatient care services. Fees for all inpatient services, such as for treatment, investigations and operations, differed by class of accommodation. Higher fees were charged for patients admitted to first and second class wards compared to third class wards. The regulations also included fee exemptions for certain groups of people including members of the royal families, government pensioners and civil servants. Hospital directors were also permitted to waive fees for the destitute. In addition, fee exemptions were included for specified health care services such as ante and postnatal care for mothers, outpatient treatment for infants and inpatient care for persons suffering from one of the 24 listed infectious diseases (including malaria and cholera).

Since 1982, the regulations have been revisited several times.

1. The current version applicable for citizens using MoH facilities was gazetted in 2017 (Government of Malaysia, 2017) to include a revision of the 1982 fees and the inclusion of additional surgical procedures and services such as physiotherapy, occupational therapy, dietetics and traditional and complementary medicine (T&CM) services¹⁶ not provided for in the 1982 regulations.
2. In 2003, a new regulation was gazetted to include medical fees for non-citizens¹⁷ utilising MoH services (Government of Malaysia, 2003), and these fees were revised in 2014 (Government of Malaysia, 2014).
3. Fees for patients using the Full Paying Patients (FPP) services¹⁸ were gazetted in 2007 (Government of Malaysia, 2007).

A comparison of current medical fees charged for selected services or procedures for patients obtaining care in MoH facilities is provided in figure 3.

16 T&CM based on Malay, Chinese, Indian, Orang Asli and complementary medical practices co-exist with Western allopathic medical practices in Malaysia. T&CM care is mainly available in the private sector and is mostly paid for using OOPPs. The MoH has provided a limited range of T&CM services, such as Chinese acupuncture, Malay massage, Indian ayurvedic therapy, chiropractic and Chinese herbal oncology services in selected hospitals since 2007. It was only in 2017 that the fees for these services had been gazetted. Prior to that, the services had been provided for free.

17 All citizens above the age of 12 years are issued a Malaysian Identity Card, known as MyKad. These cards are used as proof of citizenship during patient registration processes. Birth certificates are used for the same purpose in the case of children.

18 Patients who choose to use the FPP services in MoH hospitals are provided with additional services such as being allowed to choose their doctors and staying in better appointed rooms.

Figure 3

Comparison of selected medical fees for Malaysians, Non-citizens and FPP obtaining care in MoH facilities

	Malaysian	Non-Citizens	Fully paying patients (FPPs)
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Outpatient Care

Clinic ^a	RM 1	RM 40	na ^b
Specialist Outpatient Clinic ^c	Referred by public sector doctors – free for 1st visit and RM 5 for subsequent visits Referred by private sector doctors – RM 30 for 1st visit and RM 5 for subsequent visits	RM 120 per visit	RM 110 for 1st visit and RM 60 for subsequent visits

Daily Ward Charges^d

First Class			
- Single bed	RM 90	RM 320	RM 160
- Two beds	RM 60	RM 240	RM 130
- Three or more beds	RM 45	RM 200	RM 80
Second Class	RM 25	RM 180	na ^e
Third Class	RM 3	RM 160	na ^e

Source: Government of Malaysia, 2003; 2007; 2014.

Note: FPP: fully paying patients; ^a standalone MoH clinics; ^b not applicable, since FPP scheme available only in selected MoH hospitals; ^c specialist outpatient clinics in MoH hospitals; ^d fees for food and accommodation; ^e not applicable since second and third class wards are not available under the FPP scheme. RM: Malaysian ringgit 4.30 = US\$ 1 in 2017.

Mechanism to set fees for MoH facilities

It was not possible to obtain information on how fees included in the three earliest regulations were set. What is known is that later fee revisions were based on the fees and fee structure of the 1982 regulations. The frequency of fee revisions is not stipulated in the law, and the timing of revisions appeared to be a top-down management decision that could have come from outside the ministry, perhaps in support of wider public policy directions of the government. Indeed, this may have been the case for setting separate fees for non-citizens, which is in line with government policies of restricting access to social services, such as subsidized education, for non-citizens.

The mechanism of fee revisions is illustrated using the work flow of the latest fee revision exercise in 2017. The MoH was instructed to revise the 1982 fees to incorporate greater

cost-sharing between the government and patients. However, there was no target set for the levels of cost-sharing. One of the first tasks was to update the list of medical investigations, procedures and services. Over the past few decades since the 1982 fee regulation was gazetted, the MoH had started new services for which fees were not available. Patients who use such services were not charged for care obtained. One such service was for T&CM care, which had been provided in selected hospitals since 2007. MoH officers conducted a small survey of private T&CM practitioners to obtain the range of fees for similar services to those provided in MoH hospitals. The recommended fees for inclusion into the 2017 fee regulations were generally less than the private fees for the same service. For other services, MoH officers consulted with the heads of various medical and surgical disciplines within the ministry who are senior specialist doctors appointed to take on advisory roles in matters pertaining to their specialty. They would in turn consult specialist colleagues within the ministry as well as specialists who work in the private sector to obtain information on fees in the private sector before making a recommendation to the ministry. In certain cases, fee recommendations may be based on available cost information. This may be more relevant for laboratory and radiological investigations.

For the 2017 fee revision, a policy decision was made to focus on revising the fees set for patients in first and second class wards. Since the precise cost of providing MoH services is not known, the general principle guiding the exercise had been that patients should not have to pay higher fees for care in MoH hospitals compared to private hospitals for the same medical condition. MoH officers had surveyed fees charged in private hospitals for a sample of common medical conditions. In 2017, the fees for services provided to patients opting for first class wards were eventually raised by 50% and fees for patients in second class wards were raised by 25% from the fees set in 1982 (figure 4).

Figure 4
Comparison of selected medical fees for Malaysians,
1998 and 2017

	1982	2017
Outpatient Care		
Clinic ^a	RM 1	RM 1
Specialist Outpatient Clinic ^b	Referred by public sector doctors – free for 1st visit and RM 5 for subsequent visits	Referred by public sector doctors – free for 1st visit and RM 5 for subsequent visits
	Referred by private sector doctors – RM 30 for 1st visit and RM 5 for subsequent visits	Referred by private sector doctors – RM 30 for 1st visit and RM 5 for subsequent visits
Daily Ward Charges^c		
First Class		
- Single bed	RM 60	RM 90
- Two beds	RM 40	RM 60
- Three or more beds	RM 30	RM 45
Second Class	RM 20	RM 25
Third Class	RM 3	RM 3

Source: Government of Malaysia, 1982; 2017.

Note: ^a standalone MoH clinics; ^b specialist outpatient clinics in MoH hospitals; ^c fees for food and accommodation; RM: Malaysian Ringgit 4.30 = US\$ 1 in 2017.

Collection of user fees in MoH facilities

MoH patients who are not exempted from payment would be charged fees according to the relevant regulated fees. However, patients are not charged for services received if the fees for such services had not been gazetted. This was the case for T&CM services introduced in 2007 but for which fees were only gazetted in 2017.

The ministry has faced challenges in collecting due payments from patients. In 2014, the total medical fees billed to patients amounted to RM 296.6 million (US\$ 90.7 million) or 1.4% of the ministry's operating expenditures (Ministry of Health Malaysia, 2015a: pp. 32-36). Unpaid medical bills amounted to RM 27.3 million (US\$ 8.3 million) or approximately 9.2% of the total billed, more than half of which came from unpaid bills of non-citizens.

Setting medical fees for public teaching hospitals

Unlike the case of MoH facilities, the medical fees charged by the four public teaching hospitals are not legislated, and the full details of these fees are not routinely made known to the public. One such hospital is the University of Malaya Medical Centre (UMMC), the teaching hospital of the University of Malaya (UM). UMMC is a statutory body established under the Ministry of Education, Malaysia.¹⁹ As a public teaching hospital, the UMMC is funded by UM through the Ministry of Education. The UMMC Hospital Board of Management, made up of representatives from UM, the Ministries of Health, Education and Finance, as well as two representatives of the public nominated by the Chancellor of UM, oversee the policy directions of the hospital. The Board is also responsible for the financial management of the hospital including approving fees charged for hospital services. The UMMC conducts micro-cost accounting exercises, which are used to inform the revisions of fees. In general, UMMC fees are higher than that for MoH hospitals, reflecting the higher pressure for public teaching hospitals under the Ministry of Education to generate revenue compared to their MoH counterparts.

Use of medical fees for the remuneration of public sector doctors

Health care professionals, including specialist and non-specialist doctors, working in public hospitals and clinics are salaried workers. Their salary scales are determined by their qualifications and training as well as seniority in service. However, there have been efforts by the public universities as well as the MoH to allow senior specialist doctors restricted private practice²⁰ to stem movement of these doctors to the private sector. Public specialist doctors who conduct private practice in this manner are allowed to retain a portion of the fees collected from patients. The premise behind the move is that the additional income from private practice will increase doctors' satisfaction and thus enhance the retention of these specialist doctors in public service.

One of the first universities to allow its specialist doctors restricted private practice was UM. The University of Malaya Specialist Centre (UMSC) was established in 1998 as a subsidiary of UM and currently has specialist clinics and a 65-bedded facility located within the grounds of the university.²¹ Specialist doctors working in UMSC are salaried academic staff of UM and are also affiliated to UMMC. Unlike UMMC, which is a public hospital, UMSC was conceptualized as a private hospital. Whilst it is the norm for UMMC patients to be managed by teams of health care professionals, UMSC patients can choose their specialist doctors and these doctors are held

19 Information on UMMC can be obtained from <https://www.ummc.edu.my/introduction.asp>.

20 Restricted in the sense that these specialist doctors are not allowed full-time private practice since they have to fulfil responsibilities to care for public patients as well. Their places for private practice are also usually stipulated by their employers. In most instances, public specialist doctors are only allowed to conduct private practice in the public hospitals they are attached to.

21 Information on UMSC can be obtained from https://umsc.my/?page_id=2843890.

fully responsible for the private patients that they manage. In return for their services, these doctors are allowed to retain most of the professional fees paid by patients. The UMSC charges these doctors an administrative fee, which is calculated as a percentage of the professional fees that patients pay. The rest of the fees paid by patients, such as for accommodation and use of equipment are retained by the UMSC. The professional fees charged by UMSC specialist doctors are the same as that charged by doctors working in other private hospitals in Malaysia.

UMMC and its private counterpart, the UMSC, exist in close proximity, which could give rise to some ethical concerns for specialist doctors working in both institutions concurrently. For one, there is a concern that the specialist doctors would neglect their public practice obligations in order to spend more time in their private practice. For another, there may be a concern that specialist doctors would coerce public patients from UMMC to seek care in UMSC. In order to prevent such unethical behaviours, the management of UMSC has set up an ethics committee made up of senior specialist doctors to ensure that doctors adhere to an ethical code of conduct.

The MoH has a similar programme in which senior specialist doctors are allowed to provide clinical care to private patients admitted to MoH hospitals under the FPP scheme. FPPs are permitted to choose their attending doctors, a privilege not extended to other MoH patients, and they stay in better appointed rooms. The scheme was started in 2007 involving specialist doctors from two MoH hospitals, but since then the ministry has expanded the scheme to 35 main MoH hospitals throughout the country. FPPs are charged fees which purportedly²² reflect the cost of care provided to them (Ministry of Health Malaysia, 2015b: p. 1). The categories and quantum of fees charged for FPP services were gazetted in 2007 (Government of Malaysia, 2007). A portion of the fees collected by the hospitals is shared with the attending doctors in which the doctors' shares are dependent on the category of fees. For instance, doctors receive all the consultation fees,²³ but only half of the treatment fees²⁴ paid by FPPs (Ministry of Health Malaysia, 2015b: p. 24). The MoH has developed a set of guidelines for specialist doctors to ensure that their service to other public patients is not adversely affected by their participation in the FPP scheme. Among others, the ministry has stated that the additional income from the FPP scheme must not exceed three times the doctors' gross monthly salary (Ministry of Health Malaysia, 2015b: p. 26).

²² Since the actual cost of care in MoH hospitals is not fully known.

²³ Consultation fees are fees for consultation by a specialist to any patient that may include examination or comprehensive treatment planning.

²⁴ Treatment fees are fees for any therapeutic service provided to any patient.

Regulating private healthcare facilities

Prior to 1998, the MoH regulated private health facilities using provisions laid down in the Private Hospitals Act 1971 (Government of Malaysia, 1971). This law imposes basic physical standards for the licensing of private hospitals, private maternity homes and private nursing homes in the country (Nik Rosnah, 2007). The regulation of medical fees was not then within the ambit of the law. Partially due to the expansion in the numbers and nature of health care facilities in the country, a new legislation to regulate all categories of private health care facilities, the PHFSA, was enacted in 1998 (Government of Malaysia, 1998). This new law provides regulations for private hospitals, maternity homes and nursing homes as well as nine other distinct categories of health care facilities, namely psychiatric hospitals, ambulatory care centres, psychiatric nursing homes, blood banks, haemodialysis centres, hospices, community mental health centres, and medical and dental clinics.

The PHFSA was enacted primarily to safeguard the interests and safety of patients who receive private care. In additions to sections covering areas such as the physical standards for facilities, qualifications of personnel managing private facilities, medical practice governance and oversight structures, the law also made it mandatory for private facilities to make social and welfare contributions to society and to empower the MoH to set fees for private health care. Private facilities regulated under the PHFSA 1998 are also required to submit patient statistics to the HIC. However, the centre mainly collects patient use and not cost data. It is assumed that each private health facility, being commercial based entities, would have internal accounting mechanisms to track their own cost of services. There is no legal requirement to share this information with the MoH.

Fees for services provided by private clinics and hospitals under the PHFSA 1998 were gazetted in 2006 (Government of Malaysia, 2006a; 2006b). In 2013, the MoH revised the fees for private hospitals (Government of Malaysia, 2013). The long gestation period of eight years between the enactment of the PHFSA in 1998 and the gazettelement of fees in 2006 hints of the difficulties encountered by the MoH to set fees for private care in the country. Though the intention of PHFSA 1998, Section 106, was to regulate fees to ensure affordability of private care (Malaysia, 1996: p. 549), the eventual regulated fees covered only professional medical fees for doctors practicing in private facilities. The fees gazetted under the law refer to the maximum allowable professional fees that can be charged by health care professionals. They are permitted to charge less than the legislated fees if they wish to do so. All

other fees paid by patients receiving care in these facilities, including fees for laboratory investigations, nursing care, use of equipment, operation room and drugs, are not regulated due to the “varying costs in operating and maintaining a private hospital in different areas of the country”.²⁵ The professional fees included in the law were based on the fee schedules developed by the Malaysian Medical Association (MMA).

Mechanism to set private medical fees

Prior to the enactment of the PHFSA in 1998, private medical fees were mainly determined by the market. The professional fees charged by private doctors were nominally guided by the schedules of fees released by the MMA, but doctors were not legally bound to do so. The MMA is a registered society whose membership consists of doctors practicing in Malaysia. Membership is on a voluntary basis, but sufficiently large enough for the association to claim representation of the medical fraternity in the country, including public and private sector doctors working in hospitals or clinics.

The MMA had set up a HIC in the 1980s to develop a fee schedule as a pre-emptive move in the event that a national health insurance scheme was to be introduced in the country (Malaysia Medical Association, 2014: pp. 121-124). During that time, the GoM had commissioned a study of the Malaysian health financing system to seek solutions to raising health care costs and rapid development of the private health sector (Westinghouse Health Systems, 1985). One of the recommendations of this report was to introduce a national health insurance scheme, referred to as the National Health Security Fund (NHSF). Members of the MMA had felt that the development of professional fees to be used in such a scheme should be led by the medical profession itself and thus set up the HIC to accomplish this.

The first edition of the MMA fee schedule was released in 1987 (Committee on Health Insurance, 1987) and listed professional fees in four categories outpatient primary care consultations, outpatient specialist consultations, procedural fees charged by doctors and miscellaneous services such as the preparation of medical reports. The second edition of the fee schedule was released in 1992, the third in 1997, the fourth in 2002²⁶ and the fifth in 2008 (Malaysian Medical Association, 2008).

In the development of the fee schedule, the HIC took into consideration factors such as complexity of the service/procedure, time taken and likelihood of complications, which were factored into the Relative Value Scales (RVC) used. The first edition of the MMA fee schedule had used the Californian RVS. The second edition used the RVS developed by the British

25 This explanation was contained in a press release by the then Minister of Health, Dr S. Subramaniam, in March 2014 to announce the revision of the 13th fees schedule for private hospitals. The press statement is available from http://www.moh.gov.my/index.php/database_stores/attach_download/337/485.

26 Information obtained from the article entitled, “Evolution of the MMA Schedule of Fees”, published online by the Malaysian Society of Anaesthesiologists and the College of Anaesthesiologists, and Academy of Medicine of Malaysia available from <http://www.msa.net.my/newsmaster.cfm?&menuid=21&action=view&retrieveid=21>.

United Provident Association (BUPA). In this 1992 fee schedule, the HIC decided to give a RVS point the value of RM 2.50 as opposed to £1.00 used by BUPA at the time, even though the currency conversion rate then was RM 4.20 to the pound. Subsequent revisions of the fee schedules used the BUPA RVS in use at the time of the revisions. Revisions also took into consideration the rate of inflation in the interim time from the last schedule. The fees included in the fourth edition was approximately 10% higher than fees in the third edition.

The fourth edition of the MMA fee schedule was eventually incorporated by the MoH into the PHFSA as the professional fees for care obtained from private clinics and hospitals. The MoH revised the fees for private hospitals in 2013. These revised fees were on average 14.4% higher to partially cater to the inflation rate of 23% during the period from 2006 to 2010 when the revision exercise started (The Star, 2014). The highest increases had been for General Practitioner (GP)²⁷ consultation fees for which the ministry had explained was due to the "rental costs in various locations" (The Star, 2014). The ministry announced that this revision had taken into consideration feedback from various stakeholders including the MMA. A comparison of professional fees charged for selected services in private clinics and hospitals is provided in figure 5.

²⁷ GPs refer to non-specialist doctors who provide private primary care services usually on outpatient basis.

Figure 5

Comparison of legislated professional fees for selected services in private clinics and hospitals

	Private Clinic -2006	Private Hospital (2006)	Private Hospital (2013)
Outpatient Care			
Non-specialist consultation	RM 10 – RM 35	RM 10 – RM 35	RM 30 – RM 125
Specialist consultation	RM 60 – RM 180	RM 60 – RM 180	RM 80 – RM 235
	(1st visit)	(1st visit)	(1st visit)
	RM 35 – RM 90	RM 35 – RM 90	RM 40 – RM 105
	(follow-up visits)	(follow-up visits)	(follow-up visits)
Procedures (including anesthetist's fees)			
Appendicectomy		RM 1850	RM 2135
Simple mastectomy including axillary lymph node biopsy		RM 1970	RM 2250
Extracapsular extraction of lens with implant		RM 3065	RM 3510
Caesarean section		RM 2365	RM 2710

Source: Government of Malaysia, 2006a; 2006b; 2013.

Note: RM= Malaysian Ringgit 4.30 = US\$ 1 in 2017.

Bundled payments in private facilities

Private hospitals may offer packages of health services for which a bundled payment is charged. These include obstetric packages (antenatal, normal vaginal deliveries and postnatal care) as well as executive health screening packages. However, bundled payments for these packages are based not just on legislated professional fees for doctors but also on other components of hospital fees. Thus, bundled payments may differ across hospitals even for the same package of care.

Relationship between official fees and actual prices paid for private care

The fees for private care as detailed in the regulations of the PHFSA 1998 refer to the maximum professional fees that can be charged by health care professionals. Under the Act, these professionals are not permitted to exceed the limits set. However, since professional fees are but one component of patient bills, the actual payment made by patients will be higher than fees charged by doctors.

Mechanisms to monitor provider behaviour in the private sector

PHFSA 1998, Section 36, requires all licensed private hospitals in the country to set up a patient grievance mechanism to handle complaints from patients including those who are not satisfied with their hospital bills. If the patients are dissatisfied with the explanations provided by the hospital management, they can dispute fees with the MoH. However, since total hospital charges are not regulated under the law, there is little that the MoH can do to hospitals that purportedly overcharge patients except to mediate between the patient and the hospital. The only area that the MoH can act upon is in the matter of medical professional fees.

Use of medical fees in the remuneration of private sector doctors

Most specialist doctors working full-time in the private sector are not employed by the hospitals they practice in. They are considered independent contractors. These specialist doctors may admit patients to the private hospitals and use the hospital equipment and other available facilities such as laboratories and operation rooms. The doctors will then stipulate their professional fees for services rendered, and the hospital concerned will include these fees in the overall hospital bill given to the patient. In addition to the doctors' professional fees, these itemized bills will include fees for other service components received by patients such as ward fees, fees for investigations and drugs,²⁸ which will be retained by the hospital concerned. Specialist doctors can expect to receive the professional fees charged net of payments to the hospital for the admitting privileges enjoyed by them. The professional fees charged by doctors working in private hospitals are regulated via the PHFSA 1998 (Government of Malaysia, 1998). It is a common practice for private specialist doctors to have admitting privileges to several hospitals concurrently. Some doctors have also invested in the hospitals they practice in. As such, they may receive a portion of the profits due to them as company shareholders.

Contractual arrangements for private specialist outpatient services are varied. Some specialist doctors rent or may even have bought clinic premises within private hospitals or other locations such as commercial shop lots. They manage these clinics autonomously, including hiring their own clinic support staff. In such cases, the doctors may bill patients directly for all services provided including minor procedures, such as laser therapy for dermatological conditions, performed in the clinics. The professional fees charged by doctors working in standalone private clinics are regulated via the PHFSA 1998. Some specialist doctors rent sessions from the hospitals where they provide outpatient consultations in clinics managed by the hospitals. In such cases, they continue to use most of the

²⁸ In general, profits from the sale of pharmaceuticals are retained by the private hospitals and not shared with health care professionals.

hospital support staff and facilities, including laboratories and pharmacies, and charge patients only professional consultation fees listed in the PHFSA 1998.

GPs are mainly located in residential areas for the convenience of patients. Whilst most GPs provide primary care services, some clinics also provide simple laboratory and radiological examinations. Doctors in Malaysia do not practice the separation of prescribing and dispensing drugs. Patients who obtain care from GPs or even specialist doctors practicing in standalone clinics²⁹ would expect to obtain their medications in the same premises directly after the consultation with the doctors unless the drugs are not in stock, in which case the patients are referred to private pharmacies. Unlike doctors practicing in private hospitals, GPs generally prescribe generic medicines, since their patients would also expect that these medications be included in the consultation fees paid to the GPs (Malaysian Competition Commission, 2017: p. 62).

Discussion

The practice of medical fee setting is still in its infancy in Malaysia. Although such fees are a common feature in the public health sector, cost recovery for public care is not yet high on the priority list for the GoM. The welfare philosophy underlying the delivery of public care does not incentivize the MoH to fine-tune mechanisms or to train and maintain dedicated personnel to set public fees. However, the need to develop such resources may become more apparent as years pass in tandem with increasing public demand for reasonably priced private health care.

The vibrant private health sector found in Malaysia today is a relatively new phenomenon. Malaysia experienced rapid economic growth in the 1980s. Private health care services have been viewed by many in Malaysia as being of higher quality compared to care provided by public sector providers. Unlike the primary care gate-keeping mechanism in operation in the public sector, patients can access any level of private health care that they desire and have the means to pay for. The practice of private health care in the country allows patients to choose their doctor and to be assured clinical management by their chosen doctor unlike the less personal practice of clinical team management in most public health settings. Private health facilities are better equipped with expensive advanced technology than most public health facilities, especially those in rural areas. The ability to obtain higher income in the private sector has contributed to the movement of public health care professionals to the private sector, especially senior specialist doctors (Merican and bin Yon, 2002). Another important reason for choosing private care appears to be that of a shorter waiting time. In a 1996 national household survey, more than half of the respondents did not seek care from the nearest health facility to their homes, and 61.3% of this more than half by-passed public health facilities in favour of a private clinic or

²⁹ Doctors who practice in a hospital setting may refer their patients to the hospital pharmacies to obtain their medications.

private hospital³⁰ (Institute for Public Health, 1997). The most common reason given for this was because of long waiting times at the public health facilities.

Armed with higher purchasing power, consumers have become appreciative of private care, especially the expanding cohort of middle-income families. Private facilities developed to meet this demand and are characterized not just in increasing numbers but also changes in delivery structure. During this time, private health care providers evolved from single doctor clinics and small secondary care hospitals to the large networks of clinics and hospitals in existence, especially in urban areas, today. The early hospitals were mainly charitable entities owned by philanthropists or missionary organisations. Later, many doctors also invested in private hospitals. It has been argued that profit making was not the *raison d'être* of the early hospitals. High hospital bills were not a pressing issue then as they are now. Over the past decade or so, many doctors have sold their stakes to private investors or even to GLCs. GLCs may have government ownership but are managed as commercial for-profit enterprises. There are anecdotal accounts that high private hospital bills have prevented access to private care and thus may have led to poorer health outcomes, but such statistics are not routinely collected (The Star, ; 2009; 2011; 2012).

Private hospital bills affect not just the patients who pay OOPP for care, but also health insurers. The most common form of medical and health insurance (MHI) is hospitalisation and surgical indemnity insurance policies, which provide for the reimbursement of medical, surgical and hospitalisation expenses incurred by those insured. In 2005, about 15% of the population had some form of health insurance cover (Central Bank of Malaysia, 2005: p. 58). By 2014, the coverage increased to 45% of the population, or about 14.7 million people (Malaysian Productivity Corporation, 2016: p.112). It is important to note that people in Malaysia buy health insurance mainly to gain access to private care (Chan, 2014). This is due to the general perception that private care is of higher quality compared to care received from public providers. Private insurers are wary of private hospitals charging insured patients higher fees for the same level of care compared to those who do not have insurance coverage (Chan, 2014; Lee et al., 2018). Thus far, the law has not provided protection from such practices since legislated professional fees cover only a portion of total hospital bills. The MoH is aware of the need to close this loophole in the law, not just to protect third party payers such as insurers but also the public at large. In 2018, the previous Minister of Health announced that the ministry is exploring the option of a 'bundling system' for private hospital fees (Sundaily, 18th January 2018). Such 'bundles' would include all fees, professional or otherwise, for a package of care. He acknowledged that the task was not easy and involved consultations with all stakeholders, including the Central

30 The rest mainly by-passed one category of public facilities for another.

Bank,³¹ private insurers and private hospitals. There has been no further announcement of developments to date.

Insurers may feel that they have valid reasons to call upon the MoH to help them control patient bills. On the flip side, some doctors have also raised concerns that certain insurance practices place them at a disadvantage resulting in an unfair reduction of income. This issue relates to their dealings with Managed Care Organisations (MCOs), which include insurers. MCOs in Malaysia work on behalf of companies or insurers to help them contain health care costs of their employees or those insured. It has been estimated that the market for MCO services grew from a coverage of 300 000 persons in 1997 to 16.36 million in 2014 (Malaysian Productivity Corporation, 2016: p. 99). The modus operandi of MCOs is to recruit and appoint private hospitals and clinics as their panel providers to service their enrollees. In return for the promise of high patient volume, these companies would negotiate for lower fees, which invariably affect the professional fees charged by doctors. This is permitted under the law, as legislated private fees are the maximum allowed for the service charged. Doctors under contract to work in private hospitals have no choice but to accept the lower fees negotiated by the hospital management. In order to gain a share of the patient pool, GPs have had to acquiesce to the MCOs' demand for lower fees as well. GPs working in standalone clinics are particularly hit hard. GP fees were legislated in 2006, and the fees for GP consultations were between RM 10 to RM 25 (Government of Malaysia, 2006b). Unlike legislated fees for private hospitals, which were revised in 2013, GP fees have remained unchanged since 2006. It was claimed that the allowable fees have not kept up with the increasing clinic maintenance costs (Malaysian Productivity Corporation, 2016: p.106). To make matters worse, there is now a discrepancy in GP fees between doctors who work in private hospitals (RM 35 to RM 125, as stated in the 2013 private hospital fee revision) and those working in standalone clinics (RM 10 to RM 35, as per the 2006 private GP regulations). The MoH has announced that it will look into revising these fees to assuage discontent among GPs (The Star, 5th October 2018). In January 2019, the MoH announced a scheme to buy care from GPs as a move to expand health screening services for the poor. However, progress has stalled because the GPs rejected the proposal by the MoH to use the 2006 fees as the basis for negotiations (The Malay Mail, 2nd February 2019).

³¹ Bank Negara Malaysia, or the Malaysian Central Bank, is the regulator of all banking and insurance activities in the country.

5 Conclusions

The Malaysian health care system is changing rapidly to cater to the more discerning tastes of middle- and high-income households, while at the same time trying to expand accessibility of care to the poor. The GoM is making efforts to set fees for public care, which is apparent in its efforts to recover the cost of care provided to non-citizens. However, in the absence of accurate information on costs, these efforts seem arbitrary in nature. The current focus appears to be on refining fees for private care. This is in response to public demand for reasonable fees and also in view of the government's expectation for the private sector to shoulder a greater share of care provision in the country. If the government is serious in its intentions to control medical fees and to develop fees acceptable to all stakeholders in the country, then it needs to invest in building the infrastructure needed for fee setting. This would include training dedicated personnel to capture and analyse costs as well as a system for better collaboration among policy stakeholders both within and without the ministry.

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