

FEA Working Paper No. 2004-3

**THE PRIVATE HEALTH SECTOR
AND PUBLIC POLICY OBJECTIVES:
THE CASE OF MALAYSIA**

Dr. Nik Rosnah Wan Abdullah

**Department of Administrative Studies and Politics,
Faculty of Economics and Administration
University of Malaya
50603 Kuala Lumpur
MALAYSIA**

E-mail: nrosnah@um.edu.my

Regulating the Private Health Sector: What's In It?

Introduction

Since independence in 1957, the Malaysian health system has been able to deliver health care to communities throughout the country. The government provides the major health and health related facilities, financed from public revenue. Twenty-five years after independence, Malaysia had attained a health standard that was almost at par with those of the developed countries . The system has been described as egalitarian in character with its focus on primary health care and accessibility assured in geographic and financial terms (Meerman 1979, Balasubramaniam 1996).

In the mid 1980's, the Malaysian government initiated a program of economic liberalization and deregulation relating to the concept of 'Malaysia Incorporated' that included a comprehensive privatization policy (Economic Planning Unit (EPU) 1985, 1991). With government encouragement in the 1980's, there has been a steady rise in the number of private hospitals and private clinics. The unprecedented growth of the private medical sector in recent years has wide ranging implications for the Malaysian health care system and the overall healthcare costs (EPU 1996). It has been reported that private health care affects the distribution which resulted in unequitable medical and health resources and in poorer quality of care (ibid). The problems experienced in Malaysia are certainly not unique (see Bhat 1996, Bloom 2000). It is well-known that leaving health care to market forces does not necessarily lead to an effective and efficient health care system (Rosenthal and Newbrander 1996).

In the Mid-Term Review of the Sixth Malaysia Plan 1991-1995 it states:

While the government will still remain a provider of basic health services, the role of the Ministry of Health will gradually shift towards more policymaking and regulatory aspects as well as setting standards to ensure **quality, affordability and appropriateness of**

care.¹ At the same time the Ministry of Health will ensure an **equitable distribution**² in the provision of health services and health manpower between the public and private sectors (Malaysia 1993:244).

And in the Seventh Malaysia Plan (1996-2000) it states that the government “will gradually reduce its role in the provision of health services and increase its regulatory and enforcement functions”(Malaysia 1996:544).

This paper considers the role of the regulatory agencies in addressing such concerns. This paper presents two case studies³: a. regulation on the private health facilities, and b. the professional regulation of doctors; with regards to the issues of equitability and accessibility of health resources and the quality of health care services. The aim of these case studies is to assess the degree to which regulation achieves the government’s objectives of ensuring quality of health care services, and is seen to do so. These studies were conducted during the transition period i.e the period when a new act called the Private Healthcare Facilities and Services Act 1998 was newly implemented.

Issues in regulation

In social sectors such as health care where there is imperfect information in which consumers have only a limited understanding of what will or will not restore health, and the provider, on the other hand, has much better information on what the patient requires and usually has considerable influence over what is supplied and consumed, the key issue

¹Emboldenment is mine.

² Ibid.

³ The findings of these case studies are mainly drawn from a review of documentary sources and interviews with key informants and other interviewees. The author conducted a series of interviews with the personnel of Ministry of Health (MOH), the Malaysian Medical Council (MMC), the Malaysian Medical Association (MMA), and with officials of the NGOs such as the Federation of Malaysian Consumers’ Association (FOMCA), Citizen’s Health Initiatives (CHI), Malaysia Trades Union Congress (MTUC), Institute of Islamic Understanding (IKIM), advocates and solicitors, members of the Preliminary Investigations Committee (PIC) of the MMC, the Medico-legal Society of Malaysia, doctors both from the public and private sector, managers of six private hospitals, fellow academician and some members of the general public. In all, a total of 105 respondents were interviewed. The author also had the opportunity to follow an inspection tour made by the Inspecting Officers at the district level of the Ministry of Health (MOH) on newly established hospitals for purposes of issuing hospital license, in which the author followed as an observer.

is how the regulatory system deals with informational problem and the logistics of collecting and processing information to regulate private providers (Mills et al 2001).

Another concern is the hazard of regulation that is regulatory capture by those they are meant to regulate (Stigler 1971; Laffont and Tirole 1991, Soderlund and Tangcharoensathien 2000, Mills et al. 2001). Freidson (1970a,1970b, 1988a, 1988b) suggests that the deal between professions and the state is that the professions will ensure safe and competent services and in exchange have the exclusive right to provide certain services. Other authors have suggested that professions use their powers to further their professional interests rather than the interests they are presumed to serve i.e those of the general public (Stigler 1971; Posner 1974; Peltzman 1976; Hancher 1990). The challenge is therefore to identify mechanisms and structures which includes monitoring systems and must be shown to work.

Case Study on regulation of the private health facilities^{4 5}

The following institutions are involved in regulating the private hospitals in Malaysia:

- The municipal council and the local authorities.
- Radiation Safety Unit of the Engineering Services, and
- Licensing Unit of the Medical Practice Division..

The Radiation Safety Unit and the Licensing Unit are under the auspices of the Ministry of Health (MOH).

The stated concerns of the Government with regards to private hospitals can be summarized as: a. quality in terms of health services and manpower, ⁶ and b. equity in terms of geographical location and accessibility in terms of price and tariff. ⁷

⁴ This study focuses on six private hospitals, one in the Federal Territory Kuala Lumpur and five in the state of Selangor. The hospitals selected for detailed study included relatively newly established ones and those which have existed for a number of years.

⁵ In 1999, Kuala Lumpur had 43 private hospitals, the highest number in the country, and Selangor had 40, the second highest number besides Kuala Lumpur. The local authorities of Selangor and Kuala Lumpur City Hall (also known as DBKL) have had more experience of regulating private hospitals than other local authorities in the country.

⁶ Keynote address by Tan Sri Dato' (Dr) Abu Bakar Suleiman, Director General of Health in a seminar: The future of health services in Malaysia October 19-20 1996, Kuala Lumpur:5

Have the stated objectives of the Government with regards to the private hospitals been translated into a legal framework?

The main Acts to regulate the private hospitals are:

The Atomic Energy Licensing Act 1984 (Laws of Malaysia Act 304) which provides for control and licensing of installation and usage of radiation apparatus and radioactive materials and for the establishment of standards, liability for nuclear damage and for matters related to it.

The Private Hospitals Act 1971 (Laws of Malaysia Act 43) which provides for control through registration, licensing and inspection on existing private hospitals, nursing homes and maternity homes. A licence issued or renewed is valid for a year. It sets the basic service standards and minimum requirements for the operation of clinics or hospitals. However, the Private Hospitals Act 1971 and Private Hospitals Regulations 1973 do not provide adequate provisions to regulate the private health facilities. Many services and facilities such as medical and dental clinics, x-ray clinics, day surgeries, service for screening and diagnosis and health related services and facilities such as ambulance services, clinical laboratories haemodialysis and hospice are not covered under the existing Act. The government is aware of these limitations and omissions, as a result, a new act called the Private Healthcare facilities and Services Act 1998 was newly implemented.

The Local Government Act 1976 (Act 171) which confers on local government a wide sweep of powers and functions. These laws and regulations are about standard local government planning permission and building regulation procedures and are not specific to health facilities.

The regulatory procedures

⁷ see paper by the EPU (1996) "Policies and objectives under the Seventh Malaysia Plan" paper prepared for the 1996 National Healthcare Conference 13-14 June 1996, Kuala Lumpur : 14.

The Government control of private health facilities is mainly through licensing. There are 3 types of licenses for new private health facilities to adhere to before they can begin their business operation:

- (1) Development Order and Building License or Certificate of Fitness for Building Occupation, issued by the municipal council of the municipality in which the hospital situate;
- (2) License for installation and usage of radiation equipment issued by the Radiation Safety Unit , Ministry of Health (MOH), and
- (3) License to operate issued by the Licensing Unit of Medical Practice Division, MOH

Regulation at work

Siting of hospitals

The author examines the degree to which the objective of the government for equity through siting of hospitals is achieved. It seeks to find if there are any directives, circulars, clear guidelines regarding siting of hospitals; the opinion of the regulators and private hospitals on the realism of the policy; and in applying for a licence, the information required regarding the siting of hospitals; as well as tracing evidences of monitoring.

The *Guidelines to Application for Planning Approval* issued by MPAJ made no mention of any requirement on the siting of health facilities. Interviews with the various key informants at MPAJ suggest that there are no guidelines issued by the MPAJ regarding the siting of facilities. According to one of the key informants⁸ , “there are no directives from the higher authority or the MOH on the issue of siting of facilities.” Hence he does not see it relevant to take the siting of facilities into account in licensing the hospital buildings.

On reviewing the application for planning approval for a proposed health facility, information such as the population to be served and distance from the nearest health

⁸ J2

facility for the siting of facilities was not requested. Issuance of *Certificate of Fitness for Building Occupation* is based mainly on the quality and safety of the building.

Under the Private Healthcare Facilities and Services Act 1998 approval to establish or maintain private healthcare facilities or services other than private clinics would consider matters such as the extent to which the healthcare facilities or services are already available in an area, and the need for the healthcare facility and services. The key informants of the MPAJ⁹ interviewed implied that the ruling for siting of hospitals in the rural areas would be difficult to impose. They also do not know of any survey made on the location of new facilities over the past few years and do not keep such records.

The focus group discussions with informants of the Healthcare Technical Services¹⁰ suggest that factors that are taken into account in their planning to set up a hospital pertain mainly to the viability of business. They said it would not be economical to site hospitals in rural areas. According to one CEO¹¹ *“the private hospitals are meant for those who can afford to pay, not for the poor... It is therefore the responsibility of the government to take care of (the health services for) the poor.”*

Control of hospital charges¹²

The author seeks to find if there are any directives, circulars or guidelines regarding fee and charges of the private hospitals; and whether or not the the control of hospital charges is implemented.

Interviews with key informants¹³ of all six hospitals suggest no relevant information on fees and hospital charges are required as part of an for application for a licence and that applications for licenses do not require disclosure of fees.

⁹From informants at MPAJ (J3 and J4)

¹⁰ The company was involved in establishing the Damansara Specialist Hospital of Kumpulan Perubatan Johor.

¹¹ P12.

¹² Information in this section and the following section contains sensitive matters in terms of the business of the hospitals under study and the informants wished that the name of their hospitals would not be disclosed. The hospitals under study are referred to as Hospitals A, B, C, D, E and F.

In reviewing the procedures during the inspection made on a newly established hospital, which the author followed as an observer, there were no questions asked regarding fees and hospital charges. Under the Private healthcare facilities and Services Act 1998, it states that the Minister may make regulations prescribing a fee schedule for private health facilities or services. The author was informed that they have not received any information pertaining to the new act, hence they adhere to the existing Hospital Act 1971. Under the '*Checklist for inspections of private hospitals regarding the requirement under the Hospital Act 1971 and Regulations 1973,*' there was no information required on fees and hospital charges.

From an interview with a key informant¹⁴ of MOH, in his study on private hospital charges, the study indicates that charges on services component¹⁵ which range from 15-28% of the hospital bills and medication which makes up about 15% of the bill is not made known to patient. It was also found that the lower charges of hotel (room charges) and food is compensated by increasing fees for services and medications. Professional fees take up almost half of the bill. The study found that the present system does not promote price control.

However on the positive side, the Government called for the private sector to shoulder some social responsibilities, and this has been well-responded by some private hospitals which provide some forms of social/community services¹⁶. In 1998 the forms of social community services provided by the private hospitals are as shown in Table 1 below. Other forms of social services include public education, free medical services to special groups (inmates of old folks home, handicapped), medical screening, Accident and Emergency services.

¹³P14 and P17 of Hospital A , P12 of Hospital B, P10 of Hospital C, P11 of Hospital D, P9 of Hospital E and P4 of Hospital F.

¹⁴ H1.

¹⁵ which include rental of operation theatre, labour room/nursery, equipment such as monitors, ECG and CTG, and ambulance), other personnel charges (nursing services, x-ray on call fees., physiotherapy) and sundry (consummables and procedure sets).

Table 1: Social/Community Services Responded by Private Hospitals.

Forms of social service	Hospital size					Total
	<10 beds	11-50 beds	51-100 beds	101-200 beds	>200 beds	
Special Fund			2 RM4,099- 30,000	3 RM94,000 Welfare fund RM600,000	3 RM207,730 – 1,000,000	8
Discount for charges	1 RM1,000	9 RM150 – 44,000	14 RM3594.38- 143,000	13 RM5,220 – 700,000	9 RM65,000 – 2,349,237	46
Welfare ward	1 bed			2 5-6 bedded ward–51 beds	1 28 beds	3

Source: Medical Practice Division, MOH 1999 (adapted).

Note: Figures do not include responses from maternity homes.

A review of the regulatory conduct and processes of the regulatory agencies

Interviews with an inspecting officer¹⁷ at the district level of MOH suggest that inspecting officers faced difficulties inspecting these private facilities :

- a. *“The private hospitals always complain that the MOH does not provide them a guideline before hand on the procedures to establish a hospital. It is easier rather than we come in and say this is not right, that is not right”* (key informant D1 at MOH)
- b. *“No guidelines. Even at the development stage for example, I am a medical practitioner and interested in building a hospital, and I go for advice from MOH, I do not think there’s any guidelines. There is none. Even now.”*(Key informant D1 at MOH).

On the licensing of new hospitals, drawing upon the interviews with a CEO¹⁸ of a newly established private hospital, the non- participant observation on inspection of a new hospital which the author followed, and interviews with a key informant¹⁹ of MOH who is also the inspecting officer to these hospitals, it suggest that:

- a. the inspection on the technical requirement of the facility relies upon the planning made by the consultant engaged by the corporate body of the private hospital, and

¹⁶ Interview information from M1 and M2 of MOH

¹⁷ D1.

¹⁸ P10.

- b. the availability of qualified personnel relies upon who the medical consultants are who head the various medical disciplines.

The decision in ensuring quality in technical aspects and medical care indicates that there is a heavy reliance on information supplied and initiatives made by the private proprietors.

The focus group discussion with personnel of Healthcare Technical Services Sdn. Bhd., however, confirmed that decisions by many large hospitals to engage well-known medical consultants for their hospitals is made based mainly on business considerations to attract clients. Interviews with informants²⁰ from the MPAJ also confirmed that there is not much capacity to assess technical information received from the private sector on the establishment of hospitals. Mostly the technical departments would give their agreement to the plan submitted by private sector which suggests a lack of technical appraisals made by the technical departments of the government agencies.

Monitoring and enforcement

There is evidence that due attention is not present. On issuing of licenses for use of radiation and medical equipment, for newly established health facilities, evidence indicates that the issuing of a licence is heavily based on the reports of testing by the physicist engaged by the supplier.

On the existing hospitals, the Radiation Safety Unit which monitors the performance of x-ray machines, record keeping, radiation leakage and dark room facilities, made random visits on request from the public for them to check particular premises, or on receiving

¹⁹ D1.

²⁰ J2 and J3.

complaints from the public. From 1996-1999, it was found that less than 10 % of the premises visited complied fully with the Acts and Regulations.²¹ Warnings were issued to hospitals/clinics that were not in compliance with regulations. However, due to the shortage of manpower, further visits could not be made to these premises as follow-up.

A review of the record on complaints shows that there are complaints made by the general public as shown in the Table 2. The record of complaints shows only from 1998. Prior to that date, information was not made available. There were very few complaints despite the fact that these premises had low compliance to the regulation standards. It appears that there is no published information made known to members of the public of what is considered detrimental to health regarding radiation exposures and where and how to lodge complaints.

Table 2: Complaints from the Public

Year	No. of complaints
1998	10
1999	2

Source: Engineering Services Division, MOH

Sanctions for violations and non-compliance

Two cases were brought to court in 1999 (Table 2). Both of these cases were found guilty of employing unqualified person to man the x-ray machine and providing examinations such as IVP on patients. Section 40 (2) of the Atomic Energy

²¹ Interview information from key informants of MOH.

Licensing Act 1984 states that for any person who commits an offence on conviction is liable to imprisonment for a term not exceeding ten years or a fine not exceeding RM100,000 or both. However, despite the strong provision of the Act, the two cases were brought to a magistrate court and were fined for RM5000 and RM 3000 each.

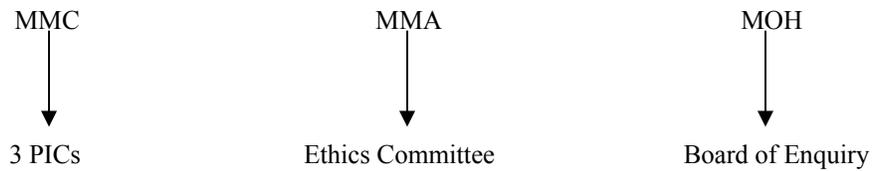
The author was not allowed to review records but evidence seem to point that there are a number of hospitals running in operation without a hospital licence, for various reasons.²² These hospitals have been advised not to take in patients, instead to operate as clinics. Currently, under the Hospital Act 1971, the penalty for hospitals operating without a valid hospital license is only RM1000. Therefore, the MOH does not have the power to close the premises and it is restricted in the powers of regulating the private hospitals. However, under the Private Healthcare Facilities and Services Act 1998 which would be implemented soon, an unlicensed private healthcare facility is liable to a fine of RM3000, 000.00 or six years imprisonment or both. The MOH envisaged that the new Act Private Healthcare Facilities and Services Act 1998 would provide them enough power to control the Private hospitals and clinics.

Regulation of the Medical Professionals

Currently the regulatory framework for the Malaysian medical professionals are provided for by three main bodies: the Malaysian Medical Council (MMC), the Malaysian Medical Association (MMA) and the government through its Ministry of Health (MOH). All the main regulatory bodies have their own disciplinary committees as summarised below in Figure 1.

²² The reasons could be due to staff strength having been reduced but the number of beds are still retained, the waiting period for the hospital license to be released took too long as it is dependent on the recommendation certificate from Fire Services Department, the hospital staff do not have the Annual Practicing License, or the information in the application form is not complete.

Figure 1
The Disciplinary Committees of Each Regulatory Bodies.



1. *The MMC:* The functions of the MMC are to register medical practitioners intending to practise in the country and to ensure that medical practice is of reasonable and acceptable standards(MMC 1994). In exercising its powers to protect the public from malpractices and negligence, and in disciplining those who fail to come up to expectations, the MMC establishes Preliminary Investigation Committees (PICs) to make preliminary investigations into complaints or information touching on disciplinary matters (Medical Regulations 1974).

2. *The MMA:* The MMA is a representative body of the medical profession and it had an established Ethics Committee. One of the functions of the Ethics Committee of the MMA is to consider complaints by its members or members of the public. The Constitution of the MMA empowers it to expel its members in accordance with the procedure prescribed by its Code of Ethics and Rules of the Ethics Committee (MMA 1997).

3. *The MOH:* Doctors in the public sector are regulated under three tiers of regulatory structure: the state level, the ministerial level, that is the MOH and ultimately the Public Service Department. They are also subject to regulations by the MMC and, if they are members of the MMA, regulations of the MMA. The MOH establishes the Board of Inquiry Committee to look into ethical and disciplinary matters of the doctors in the public service. The Board of Inquiry is usually conducted at the state level. The MOH does not play a role in regulating the medical professionals in the private sector.

Membership of the Regulatory Bodies of the Medical Professionals

Composition of MMC

Under the Medical Act 1971, the Director-General of Health is the President of the MMC. The members of the MMC are drawn from three main sources: nomination by universities, election by registered medical practitioners from West Malaysia and Sabah and Sarawak, and appointed members from the public services. The membership is for three years (Medical Act 1971). In 1999 there were 24 members. The membership is summarised in Table 3 below:

Table 3
Membership of the MMC in 1999

The Director-General of Health as President	1
Nominated from Faculties of Medicine	9 (3 each from University of Malaya, Science University of Malaysia and National University Malaysia)
Elected by registered medical practitioners:	11 (9 in West Malaysia, 1 in Sabah and 1 in Sarawak)
Appointed from the public services	3
<i>Total members</i>	24

Out of the 24 members, a total of 20 represent the stakeholders of the medical profession and medical organisation and three members representing the public services (Table 3). There is no representation of advocacy groups or representative of other stakeholders. Neither is there a representation of the general public or the users. From 1993 through to 1999, the membership of the MMC consisted solely of doctors. There have not been any 'lay' or non-medical members. Even the 3 appointed members from the public services were doctors. The composition of the MMC suggests that the viewpoints of doctors and their interests have an important influence.

During the same period, the members of the MMC were mostly male with only two female member nominees of the university medical faculties. Despite the government's stated commitment in the Sixth Malaysia Plan (1991-1995) (Malaysia 1991) to ensure 'equitable sharing in the acquisition of resources and information as well as access to opportunities and benefits of development for both men and women' and of 'integrating women in all sector of national development', Ng (1999) observes, gender subordination

still continues in various forms at both the personal and structural levels, both of which are conditioned by the socio-cultural trends in the society. The under representation of women in the composition of MMC confirms this observation.

Composition of the MMA

Membership of the MMA consists of 7 categories namely: ordinary, life, honorary, Overseas, Associate, student and Exempt membership (MMA 1997). In all of the seven categories, the membership is open to medical practitioners, with the exception of student membership which are open to registered medical students who are Malaysian citizens. No lay members or representatives of advocacy groups or other stakeholders are co-opted into any of these committees.

Membership of the Disciplinary Committees of the MMC, the MMA and the MOH

a. *The Preliminary Investigations Committees (PICs) of the MMC*: All the members of the PICs are appointed by the President of the MMC from among the medical practitioners (Medical Regulations 1974). All complaints to the MMC are considered first by the PIC. It holds a formal inquiry to establish whether there is a prima facie case of professional misconduct which would then be referred to the MMC (Medical Regulations 1974). Much depends on the way complaints are dealt with by the PICs. Their membership strongly influences the regulating process.

The membership of the PICs is for 3 years. There are three PICs consisting of not less than three and not more than six members each (Medical Regulations 1974). All of its members are doctors. Between 1993-1999, all PIC members were in senior positions and most were specialists. There were two female members out of the 17 members.

A number of informants from among the NGOs and academics raised concerns that the PIC is not large enough to reflect a wide range of opinions and to allow differences of opinion. This is further exacerbated by the fact that these committees do not include lay members, thus making it difficult for the small group to disagree.

b. *The Ethics Committee of the MMA*: The Ethics Committee has nine members, elected from among the registered members of the medical professionals (MMA1997). There are no lay members or representatives of advocacy groups or other stakeholders co-opted into this committee.

c. *The MOH Board of Enquiry*: There are at least three members on the Board of Enquiry. The membership comprises of two specialists in the relevant specialty, one of which chairs the Board, another member from other specialty and any other co-opted member it deems necessary.

How does the system of the MMC and the MMA actually works?

The MMC and the MMA identifies competent practitioners through various means.

Licensing and Establishing standards

The power of the MMC lies in its control of the registers for licensing medical professionals. The MMC may remove persons from the register temporarily or permanently if they are found to be unfit to perform their professional duty. It published a statement on Medical Ethics in 1975, which was later replaced by a Code of Professional Conduct in 1987 (MMC1987), which is similar to that of the UK General Medical Council. The code outlines minimum standards. Breaches of these standards are referred to as ‘infamous conduct in professional respect’ or ‘serious professional misconduct.’ The MMA too produced its own Ethical Code in 1998, similar to the MMC’s Code of Professional Conduct. It includes brief guidelines on good medical practice; relationship of doctors with other professionals, relationship with commercial undertakings; advertising and canvassing, and setting up practice (MMA1999b).

Disciplinary inquiries

Disciplinary inquiries are usually made following complaints. The MMC caters complaints for both the public and private sectors; the government caters for complaints on doctors in the public hospitals and clinics; and the courts of law.

Through the PICs, the MMC holds a tribunal or a kind of court to inquire into complaints about medical professionals. One of the PICs is specially assigned to look into matters pertaining to advertisements, whilst the other two look into matters of ethics and conduct. The conduct of disciplinary inquiries is governed by the Medical Regulations 1974 and guided by the Code of Professional Conduct. The PICs can summarily dismiss an allegation if it is found to be unsustainable (Medical Regulations 1974). If a PIC finds there are grounds to support a charge it may recommend an inquiry by the MMC.

The MMA also considers complaints about professional conduct of individuals upon receiving a report from a member or non-member of the Association, or a member of the public. The Ethics Committee of the MMA is empowered to investigate, and take action as it deems fit on complaints about breach of ethics by the registered members of the Association (MMA1997). Following investigation, it may decide that (a) the case be dismissed; (b) the doctor has committed an error of judgment but the conduct does not call for censure; (c) that the doctor be censured; (d) a recommendation to MMA for expulsion from its membership or (e) complaint be made to the Malaysian Medical Council. According to the President of the MMA, if a case is found, the Ethics committee will act as a complainant by filing a report to the MMC for further action.

Complaints about doctors in public hospitals and clinics are dealt by the Board of Inquiry at the state level. Following investigations by the Board of Inquiry a report is sent to the ministerial level: the Medico-legal Unit for complaints on doctors in public hospitals and the Public Health Division of the MOH for complaints against the government's health clinics. At the ministerial level, the report of the findings is then submitted to the Disciplinary Board for its action.

Review of the System

This section reviews the instances of regulation in action.

Mechanism to Regulate Clinical Competence

Several interviewees²³ pointed out that beyond issuing the Code of Professional Conduct (by the MMC) and Ethical Code (by the MMA), there is little mechanism to regulate the clinical competence of practising doctors particularly in the private sector. An informant at the MMC²⁴ confirmed that there are no specific guidelines to define the minimum benchmark of acceptable standard of competence. A key informant from the public sector as well as some doctors interviewed point out that the MMC has no mechanism to ensure that doctors keep up with developments in their area and for ensuring improvements for doctors who slacken in their performance. In the public sector, the Government addresses this issue by sending government doctors overseas for training and to conferences. Some public hospitals and teaching hospitals have adopted medical audit, whereby doctors of the specialty or department meet to review complicated cases, deaths or unusual cases. The aim is for the doctors to learn from each other and improve the quality of service. According to informants at some private hospitals, medical audit is rarely done.

The MMC's primary mode of regulating the profession is by maintaining the register of qualified medical practitioners such that the public may be able to distinguish to whom they may safely go for advice and treatment. However, the MMC has not established an inspectorate to carry out its responsibilities by ensuring, for example, that those registered with MMC are practising in accordance with the conditions on their licensing certificates and that they practise competently. Some doctors²⁵ and a CEO²⁶ of a private hospital interviewed, opined that practitioners can continue to practise incompetently as long as they are not caught. This opinion is confirmed in interviews with key informants in the MMC and MOH who said that the only way the MMC may know about breaches in the standard of competence is when there is a complaint.

²³ U4, P1, P6 and P15,

²⁴ C2

²⁵ P1, P2 and P15

²⁶ P11

Channels for Complaints:

Since the regulatory bodies rely on complaints, specific channels are needed for doctors and members of the public to be heard. The processing of complaints is reviewed in the MMC, MMA and the government through its court.

a. *Channels for Complaints by Colleagues and Peers:* The report *The Handling of Complaints Against Doctors* (Allen et al. 1996) is a useful tool in assigning complaints to two categories: (i) complaints that are primarily of professional interest: unacceptable behaviour but not principally detrimental to medical treatment of patients, and (ii) complaints which concerned primarily to public interest: the personal behaviour of doctors towards patients which either led to criminal convictions or raised issues of serious professional misconduct that relate principally to the medical treatment of patients.

In the MMA, in the ten years beginning 1987/88, 43.5% of complaints it received were on issues categorized as primarily of professional interest, whilst 56.5% were on issues of public interest. Among the issues of professional interests, the largest number of complaints was regarding advertising, whilst among issues of public interests, the largest number of complaints was on clarification/advice (Table 4).

Most complaints from medical professionals were related to advertisements. According to two members of the PIC²⁷, complaints relating principally to personal behaviour of doctors which could raise serious professional misconduct were lesser in comparison to complaints pertaining to advertisement. Regulation of advertisement deters quacks from advertising, however, it is also important to the medical professionals in reducing competition. This sentiment seems to be raised by many interviewees from the advocacy groups and also from among doctors interviewed.

²⁷ H1 and P21.

Table 4
Complaints Received by the MMA Ethics Committee 1987-1997

Complaint/ Year	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/9 5	95/96	96/97	Total
Primarily of professional interest											
<i>Advertising</i>	39	24	14	17	15	6	11	8	8	16	158
<i>Exorbitant charges</i>	2	2	6	9	9	5	4	10	6	12	65
<i>Medical Certificate</i>	2	2	2	2	1	5	7	5	6	4	36
<i>Total</i>	43	28	22	28	25	16	22	23	20	32	259 (43.5%)
Primarily of public interests											
<i>Unsatisfactory treatment</i>	15	14	8	12	17	5	1	4	9	4	89
<i>Alleged negligence</i>	-	-	10	4	4	6	15	6	4	8	57
<i>Clarification/ advice</i>	15	12	8	13	10	11	19	10	11	16	125
<i>Unprofessional conduct</i>	-	-	3	-	14	4	6	6	4	4	41
<i>Refusal to label drugs</i>	-	-	-	2	1	-	2	1	-	-	6
<i>Refusal to give medical report</i>	-	-	-	1	-	2	3	-	3	5	14
<i>Refusal to make house call</i>	-	-	-	-	-	2	-	-	3	-	5
<i>Total</i>	30	26	29	32	46	30	46	27	34	37	337 (56.5%)
Grand Total	73	54	51	60	71	46	68	50	54	69	596 (100%)
<i>Cases referred to MMC</i>	11	7	10	5	-	1	-	-	2	1	37

Source: Adapted from the MMA Annual Reports.

b. *Channels for complaints by public:* The MMC receives complaints from many sources including written complaints to the MMC, by telephone, through newspapers or through hospitals. Interviews with PIC members also reveal that they receive complaints through various means. This seem to confirm that there is no proper, established channel for complaints and no information made public as to whom complaints should be addressed, how and on what reasons.

In conducting investigations, an interview with the key informant at the MMC confirms that the MMC usually goes by the decisions of the PIC. Therefore the first hearing of a case before the PIC is crucial. However, besides the panel of the PIC being small and not representative of the users, the decision is by a majority (Medical Regulation 1974), with no right to a dissenting opinion. Once a majority is secured further discussion is not necessary.

Any person who is aggrieved by the decision of the MMC may appeal to the High Court (Medical Act 1971). Ranjan (1998) argues, it would be extremely difficult to set aside the findings or decision of the tribunal unless it can be shown that there is a substantial error of law or procedure or the findings are inconsistent with the evidence.

In the course of interview with an informant at the MOH, it emerged that in the public sector, there are cases where while there is inquiry pending, the medical professionals resign from the post in the government and join the private sector and thus no inquiry is made into the case. And no mention of it is made to the MMC as according to the informant, the MOH has no authority on private cases. This seems to support Freidson's (1988) observation that doctors give the benefit of the doubt to each other to an extent not done in other professions.

c. The Court: There are also cases of complaints on medical negligence from the public and the private sector that are brought to court. Information on the number of private cases settled out of court or private cases brought to court was not obtainable. According to key informants, cases brought to the civil court can take up to seven years to be settled. And many private practitioners and private hospitals usually settle their cases out of court to avoid bad publicity. This was confirmed by managers of some private hospitals²⁸ and the advocates and solicitors²⁹ who deal with medico-legal cases.

²⁸ U4, P1, P6 and P15,

²⁹ C2.

An out of court settlement is not made public and colleagues do not get to know of the offence and hence they do not stop referring patients.

According to Ranjan,³⁰ an advocate and solicitor, it can be very difficult to establish medical negligence: First, the courts recognise that there are differences of opinion in the medical profession, and so long as the actions taken are in accordance with the standard of an informed body of medical opinion, the doctor cannot be held negligent. Second, for the plaintiff to succeed, it must be shown that the injury was foreseeable at the time that the breach of duty was committed. This would depend on the state of medical knowledge of the patient at the time of the incident in question. The frequent problem is that many patients would already have been suffering from some pre-existing ailment at the time of being seen or treated by the doctor. As such it would be difficult to say if the injury that was the subject of the complaint was caused by the doctor's action.

Ranjan (1998) observes, in Malaysia, patients often face difficulties as there is inadequate law relating to disclosure of and access to their medical records for them to obtain a complete clinical picture of their case and to obtain expert opinion before their case goes to court or trial. This situation is exacerbated by the doctor's ethical and legal duty of confidentiality:

“A practitioner may not improperly disclose information which he obtains in confidence from or about a patient.” (paragraph 2.22 The Code of Professional Conduct of the MMC 1987).

According to Ranjan and an informant of another advocates and solicitors firms dealing with litigation cases, medico-legal cases in Malaysia are on the rise but there is no official statistic on it. The majority of the claims are filed against doctors in the private sector. There is an average of 13-15 per cent claims filed against the government annually. According to the interviewees this percentage is low which could also mean that there is a reasonable standard of care in the government. The majority of the claims appear to be in the private sector.

³⁰. Personal interview

d. *Institutional Support/Channels of Consultation:* A joint meeting of principal office bearers of the MMA, the Malaysian Dental Association (MDA), the Bar Council and the Medico-legal Society was reactivated in October 1998, which provide a channel of consultation between doctors, dentists and lawyers. The joint meeting meets once in six months to discuss matters affecting doctors, dentists and lawyers, in particular, problems that doctors face when they are required to attend court as witnesses. It was also noted that lawyers also faced problems in obtaining the services of doctors to obtain a medical opinion and/or to attend court as witness as “most doctors were not prepared to come forward to give medical evidence against another doctor” (Medico-legal Society 1999:10-11).

There are no organizations in Malaysia specifically concerned with patients’ problems or victims of malpractices such as the Victims of Medical Accidents in Britain. The aggrieved parties also have not attempted to work as a group to pursue justice from the regulatory institutions of the medical profession or health institutions. Individual victims most often go through newspapers to tell their woes in the hope that it gives bad publicity for the institution concern. There is no institutional support or channel for patients who need to utilise the legal system to consult on their cases except to rely on their counsel.

The Patients Charter, which states the right to redress of grievances, has not been effective and lacks ‘teeth’ as it lacks the backing of the relevant machinery. This is confirmed in the interview with the President of FOMCA, that the Patients’ Charter is not effective because of the absence of a platform to address health matters. Although the Patients Charter was embraced by consumer representatives five years ago, it has been reported in the media that the charter still has not seen formal implementation.

In October 1999 the Ministry of Domestic Trade and Consumer Affairs enforced the Consumer Protection Act 1999. The Act aimed to protect consumers especially the low-income group, via a tribunal comprising people from legal fraternity appointed by the

Ministry of Trade (Sunday Star August 29, 1999). Under the Act, the tribunal would conduct civil claims of RM 10,000 and below and would handle all cases, but not those linked to the medical profession. However, cases concerning medicines that are not registered as official medicines and not prescribed by hospitals can be taken to the tribunal (Consumer Protection Act 1999). An informant at the MOH commented that this was rather strange as the omission on protection against matters concerning medical profession meant that the consumers are not effectively protected as this leaves the consumer having to consult his counsel and no one else.

Conclusion and recommendation

Regulation involves complex issues of gathering and processing information. The study of hospital licensing emphasised the difficulties government has in coping with the information problem. The Government also has little information on which to base a regulation or control function. Its performance with respect to the implementation of regulation showed many weaknesses. One of the basic aspects of regulation is the gathering of information about fees and charges, maintenance of record on location of new facilities and definition of the poor patients were currently lacking.

The government needs to establish effective systems of record-keeping about the private sector. The regulatory units within the MOH do not register private facilities routinely. Some facilities have been operating without a hospital licence since 1992. Both case studies demonstrated the weak implementation of regulations. Despite the strong provisions of the Acts, the two cases uncovered by the Radiation Safety Unit and the case of 13 unregistered premises uncovered by the Licensing Unit confirmed that not only is its monitoring low but its enforcement of the law is also weak.

The predominance of the medical profession in the key regulatory institutions raised concerns on the objectivity of these regulatory institutions and the rational judgment of cases brought to their committees. It also suggests that the viewpoints of the doctors and their interests have an important influence. This suggestion seems to be reinforced by the procedures and processes of the MMC. There is lack of proper machinery to deal with

poorly performing doctors except through the court of law. Cases of medical negligence or malpractices are excessively difficult to prove and take a very long time to settle. The inadequate laws to access medical records exacerbate this problem.

Both the regulatory agencies such as the Radiation Safety Unit and the MMC tended to adopt passive approach to regulation, waiting for the users to complain and failing to inform the general public of what is considered a breach of care, how and to whom to complain. The MMC appeared to play a minimal role in controlling poor conduct by professionals. Although the MMC organises disciplinary hearings and the initiation of procedures to revoke the licence to practice, the use of such sanctions is rare. The same with the regulatory agencies.

The findings from the study of medical regulation suggest that there is a need for a review of the composition of the regulatory bodies and their disciplinary committees so that they represent all relevant stakeholders. So too with the problem of inspection to ensure that those registered are practising according to conditions stipulated in the licensing certificates.

The broader social and cultural context is also an important influence on the effectiveness of government legislation. In Malaysia the imbalance is marked between the weak consumer protection under the law and weak consumer voice compared to the well-informed, organised medical profession. There are no organizations in Malaysia specifically concerned with patients problems or victims of malpractices. There is no institutional support or channel for patients who need to utilise the legal system to consult on their cases except to rely on their counsel. The Patients Charter has not been effective and lacks ‘teeth’ as it lacks the backing of the relevant machinery and lacks the platform to address health matters. The Consumer Protection Act 1999 does not conduct civil claims on cases linked to the medical profession although cases concerning medicines which are not registered as official medicines and not prescribed by hospitals can be taken to the tribunal. In a broader context, consumers have little protection apart from the existing provision governing the licensing of the medical professionals.

From this standpoint, there is an evident need for an explicit programming of the sector as a whole which needs to be addressed by the central authority. The findings suggest a number of ways to improve the functioning of the current regulatory environment. Adequate laws relating to disclosure and access of medical records are needed so that plaintiffs and defendants can obtain complete clinical information on their cases.

The dominance of the medical profession in the regulatory bodies contributes to the general perception that they act for the narrow interest groups. The government needs to institute a fair representation of interest groups in the professional regulatory bodies to ensure that their decisions are in the interests of both the professionals and the users.

Consumers can play a significant role in promoting regulatory effectiveness, but the role needs to be developed within the context of the current regulatory framework.

This research was conducted in a transition period just soon after the implementation of the new Act, the Private Healthcare Facilities and Services Act 1998. Additional research is needed to inform the implementation of the Act.

Bibliography

Allen, I; Perkins, E. and Witherspoon, S. (1996) 'The Handling of Complaints Against Doctors', Report by Policy Studies Institute For the Racial Equality Group of The General Medical Council, London: Policy Studies Institute.

Anderson J.E., (1994) **Public Policymaking: An Introduction** 2nd edition Boston: Houghton Mifflin Co.

Bennett, S. (1997) 'Private health care and public policy objectives', in C. Colclough, (ed) **Marketizing Education and Health in Developing Countries: Miracle or Mirage**, Oxford: Clarendon Press.

_____, McPake, B. and Mills, A. (1997) **Private Health Providers in Developing Countries: Serving the Public Interest?** London: Zed Books Ltd.

Bhat, R. 1996(a) 'Regulation of the private health sector in India', **International Journal of Health Planning and Management** 11: 253-274

_____ (1996b) 'Regulating the private health care sector: the case of the Indian Consumer Protection Act', **Health Policy and Planning** 11(3): 265-279

Bloom, G. (2000) 'Equity in health in unequal societies: towards health equity during rapid social change', **IDS Working Paper** 112, Brighton: Institute of Development Studies.

_____ and Standing, H. (2001) 'Pluralism and marketisation in the health sector: meeting health needs in contexts of social change in low and middle-income countries', **IDS Working Paper 136**, Brighton: Institute of Developing Studies.

Broomberg, J. (1994) 'Managing the health care market in developing countries: prospects and problems', **Health Policy and Planning** 9 (3): 237-251

Cassels, A. (1995) 'Health sector reform: key issues in less developed countries', **Journal of International Development** 7(3): 329-348.

Chernichovsky, D (1995) 'What can developing economies learn from health system reforms of developed economies?', in P. Berman, (ed) **Health Sector Reform in Developing Countries**, Boston :Harvard University Press,

Economic Planning Unit (EPU) (1996) 'Policies and objectives under the Seventh Malaysia Plan', paper prepared for The 1996 National Healthcare Conference, Kuala Lumpur 13-14 June 1996.

Friedson, E. (1970a) **Professional Dominance: The Social Structure of Medical Care**, New York: Atherton Press Inc.

_____ (1970b) **Profession of Medicine: A Study in the Sociology of Applied Knowledge**, New York: Dodd Mead

_____ (1988a) **Professional Powers: A Study of the Institutionalization of Formal Knowledge**, London: University of Chicago Press

_____ (1988b) **Profession of Medicine**, 2nd Edition, Chicago: The University of Chicago Press

Hancher, L (1990) **Regulating for Competition**. Oxford: Clarendon Press

Heffron F.A [with N.McFeely](1983) **The Administrative Regulatory Process**, New York: Longman

Hongoro, C. and Kumaranayake, L. (2000) 'Do they work? Regulating for-profit providers in Zimbabwe', **Health Policy and Planning** 15(4): 368-377

Laffont J-J. and Tirole J (1991) 'The politics of government decision-making: a theory of regulatory capture', **Quarterly Journal of Economics** November: 1089-1127

Laws of Malaysia Act 50 Medical Act 1971 and Medical Regulations 1974

Malaysia (1993) **Mid-Term Review of the Sixth Malaysia Plan 1991-1995**, Kuala Lumpur: Percetakan Nasional Malaysia Berhad.

Mills, A, Bennett, S and Russel, S (2001) **The Challenge of Health Sector Reform: What Must Governments Do?** Basingstoke: Palgrave

Malaysian Medical Council (MMC) (1987) **Code of Professional Conduct**, Kuala Lumpur: Malaysian Medical Council.

_____ (1993) **Annual Report**, Kuala Lumpur: Malaysian Medical Council.

Malaysian Medical Association (MMA) (1980) 'The future of the health services in Malaysia', a report for the Ministry of Health, Kuala Lumpur: Malaysian Medical Association
_____ (1997) **The Constitution, Articles and By-Laws**, Kuala Lumpur: Malaysian Medical Association

_____ (1999a) **Annual Report 1998/99**, Kuala Lumpur: Malaysian Medical Association.

_____ (1999b) **Ethical Code**, Kuala Lumpur: Malaysian Medical Association

Medico-legal Society (1999) **Annual report 1998/1999**, Kuala Lumpur: Medico-legal Society, Malaysia.

_____ (2000) **Malaysia Annual Report 1999/2000**, Kuala Lumpur: Medico-legal Society, Malaysia.

Ministry of Health (1987) **Annual Report**, Kuala Lumpur: Ministry of Health.

_____ (1994) **Annual Report**, Kuala Lumpur: Ministry of Health.

Ng, C. (1999) **Positioning Women in Malaysia: Class and Gender in an Industrializing State**, Great Britain: McMillan

Peltzman S.L. (1976) 'Towards a more general theory of regulation', **Journal of Law and Economics**, August.

Posner R.A. (1974) 'The theories of economic regulation', **Bell Journal of Economics and Management Sciences**, Autumn

Ranjan, P.S (1998) The law and practice relating to medical negligence, **Malaysian Medical Association**, May 1998

Soderlund, N. and Tangcharoensathien, V. (2000) Health sector regulation – understanding the range of responses from Government, **Health Policy and Planning** 15(4):347-348.

Spulber, D.F (1989) **Regulation and Market**, London: MIT Press.

Stigler G.J. (1971) 'The theory of economic regulation', **Bell Journal of Economics and Management Sciences** 2: pp.3-21

Stigler G.J. (1971) 'The theory of economic regulation', **Bell Journal of Economics and Management Sciences 2**: pp.3-21

Sun Valley October 21, 2000.

Tan C.S Dato' Dr. (1997) 'Prospects For a Non-Profit Sector in Health Care: The Experience of Lam Wah Ee Hospital', paper prepared for the National Conference on Privatisation & health care Financing in Malaysia: Emerging Issues and Concerns, penang, Malaysia 5-6 April, 1997

World Bank (1993) **World Development Report 1993: Investing in Health**, Oxford Univ Press published for the World Bank

Malaysian Laws and documents reviewed:

Laws of Malaysia Act 304 Atomic Energy Licensing Act 1984
Radiation Protection (Basic Safety Standards) Regulations 1988,
Radiation Protection (Licensing) Regulation 1986 Radiation Protection (Transport).
Laws of Malaysia Act 43 Private Hospital Act 1971 and Regulations 1973,
Laws of Malaysia Act 133 Uniform Building by-laws 1984 (revised)
Laws of Malaysia Act 171 Local Government Act 1976
Laws of Malaysia Act 172 Town & Country Planning Act 1976.

The Town Planning Department of MPAJ- *Panduan Permohonan Kelulusan Perancangan* (Guidelines for Planning Approval) enforced on 20/5/93 in accordance to the Town Planning Act 1976.

MPAJ - 'Guidelines on Application for Development Order' enforced on 1st January 1997

MPAJ – *Sijil Layak Menduduki* (Certificate of Fitness for Building Occupation)

DBKL - *Panduan Pengemukaan Pelan Untuk Kelulusan DBKL* (Guidelines to Submit Plan for Approval by DBKL).

MOH – *Borang A – Permohonan untul Lesen/ Pembaharuan Lesen Bagi Hospital Swasta* Peraturan 3(2) (Form A - Application For A Licence/ Renewal Of A Licence For A Private Hospital)

MOH – *Senarai Semak untuk Pemeriksaan di Hospital Swasta* (Checklist for Inspection of Private Hospitals)

MOH – '*Borang Permohonan untuk Mendapatkan, Meminda atau Membaharui Lesen* (Peraturan 13 dan 14) LPTA3'

