

Private Healthcare Expenditure: Absolute and Relative Changes

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Abstract

The unprecedented growth of the private medical sector has had wide ranging implications for the Malaysian healthcare system. High levels of private expenditures pose serious challenges to policy makers because most of these expenditures are out-of-pocket with insurance claims only covering a small segment of population. It is not clear whether these expenditures are sustainable as it can have a number of undesirable consequences so as to make healthcare services costly, unaffordable and uncertain. Out-of-pocket expenditure can lead to debt for those who cannot afford it. Catastrophic out-of-pocket payment can lead a household into poverty. Hence, this study investigates the changes of private healthcare expenditure in Malaysia. The interpretative approach was used to obtain a greater scope to address the issues. Trend analysis and broad-based review of research literature is combined to identify the kind of experiences of healthcare that can matter with considerations of why these experiences are important and relate to each other. The data in this study covers from 1997 to 2014. The evidence shows that Malaysia's healthcare cost had faced a significant shift in the expenditure structure with private providers growing rapidly to account highest of the expenditure. The swift growth of private healthcare has transformed the healthcare system in Malaysia from one dominated by the public sector in both provision and financing, to one in which the private sector has an increasing presence in hospital and specialist care, as well as financing.

Keywords: private medical centre, health expenditure, out-of-pocket, catastrophic, poverty.

1 Introduction

Most countries undergoing structural change from low to high value-added activities of healthcare have been characterized by the private providers. The process of privatization and contracting of services to the private businesses has led to an increasing shift in

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healthcare from being delivered as an essential public utility to a profit seeking target by private providers. Privatization has also been used frequently by governments as a policy instrument to reduce the financial burden of the public sector.

In Malaysia, while the government allocates funds to improve the health infrastructure by building new hospitals and clinics, the private sector has also played an increasingly important role in the growth of the sector. Indeed, the private healthcare sector has become a major player in delivering healthcare services alongside with the government healthcare. However, the unprecedented growth of private healthcare has had wide-ranging implications for the Malaysian healthcare system. This has raised concerns as it is well known that leaving healthcare to market forces does not necessarily lead to an effective and efficient healthcare system (Rossenthal & Newbrander, 1996).

Privatization in the Malaysian health sector has raised a number of issues, some of which have been discussed in public and some of which remained serene. While the government is concerned over the burgeoning cost of public expenditure going to healthcare, the public is concerned over the spiraling costs of private healthcare. The total healthcare expenditure of private sectors has been rising steadily over the years and raising questions over its sustainability over the long term.

The high private healthcare expenditure is also a cause of concern because most of these expenditures are out-of-pocket with insurance claims only covering a small segment of the population. It is not clear whether these expenditures are sustainable as it can have a number of undesirable consequences so as to make healthcare services costly unaffordable and uncertain. Out-of-pocket expenditure can lead to debt for those who cannot afford it. Catastrophic out-of-pocket expenditure can lead a household into poverty.

Hence, there is a serious need to study the issues addressed above in order to generate an elucidating set of findings that can help check the problems currently faced by healthcare system in Malaysia. The main objective of this study is to investigate the changes of private healthcare expenditures in Malaysia.

2 Healthcare System

There are four basic healthcare models in the world; Beveridge Model, National Health Insurance Model, Bismarck model and Market-Driven Healthcare Model.

2.1 Beveridge Model

Healthcare is provided and financed by the government through tax payment. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. These systems tend to have low costs per capita, because the government, as sole payer, controls what doctors can do and what they can charge. Example of countries; Great Britain, Ireland, Mediterranean countries (EU), New Zealand, Hong Kong, Cuba and etc.

2.2 National Health Insurance Model

Hospitals and doctors are privately run but the government regulates the healthcare market and payment of healthcare procedures. Hospital stay (sometimes including prescription drugs) comes from a government-run insurance program that every tax paying citizen pays into. Canada and Taiwan are the countries that use this model.

2.3 Bismarck Model

In this model, hospitals are usually private, as well as doctors' practices. People are free to choose their general practitioners (GP), or the specialists they want to see and the hospitals where they want to be treated. Their sickness fund will simply pay the bills. There are smaller numbers of co-payment patients who are required to pay, but there are many exemptions. The healthcare system in Germany and Japan falls under the Bismarck model.

2.4 Market Driven Healthcare Model

Private insurance plays a major role in this healthcare system. Individuals need to buy insurance from the private sector in order to cover their healthcare cost. This system is famous in United States.

Most of the healthcare systems discussed above is generally used in developed countries. Developing countries, however, do not usually fall neatly into any of the four categories above. More are characterised by large private, sometimes informal providers due to inadequacy of state healthcare; and financing is often made out-of-pocket. Malaysia is one of the countries that falls under this category.

3 Theory Discussion

The efficient provision of healthcare has always been a subject of debate among economists since the earlier years. Neoclassical economists argue that healthcare can best

be allocated by the market mechanism while evolutionary economists argue that healthcare is not a normal economic service that must reach those who “need” rather than “demand” it, hence is best allocated through a state-controlled governance mechanisms.

The supporters of the state’s role in health, such as Arrow (1963), Titmus (1967), Evans (1984), Baumol (1980, 1988), Weisbrod (1988), North (1990), Bennett (1997) and Leonard (1999) argue that healthcare processes characteristics which require either the modification or replacement of the market mechanisms, and that the conditions for markets to work optimally do not exist in healthcare practice. This is due to the special characteristics of healthcare as stated below:

- a. Element of risk and uncertainty of illness. At the point of need, healthcare costs can be very high and most people are risk adverse. Therefore, there is an imperfect market or risk (Arrow, 1969).
- b. Healthcare has merit good characteristic. People are concerned about the healthcare of others because it may affect their own welfare. The consumption of such goods will always be less than socially optimal unless they are subsidised (Bennett, 1997).
- c. Certain forms of healthcare such as the prevention or treatment of infectious diseases have positive externalities (Russo, 1994).
- d. There is “asymmetric information” between patient and the provider (Arrow, 1963).
- e. Due to such informational problems, there are high transaction costs in the health sector (North, 1990).

Those who advocate the market mechanism, such as Friedman (1962) and Hayek (1966) claim that these characteristics do not in themselves mean that healthcare cannot be treated in the same way as other commodities, and that such characteristics are not strange to healthcare. Like any other commodity, it is scarce and therefore, requires institutions to organise this allocation. The argument is simply that markets are efficient mechanisms for the automatic coordination of a large number of activities. The claims for the superiority of market mechanisms are usually made with reference to “perfect competition” (Nik Rosnah, 2005).

According to Flood (2000), it is broadly accepted that markets in healthcare are subject to failures, and the “healthcare market” is therefore a theoretical anomaly. Evans (1997) and Light (2000) remarked that even though the problem of “healthcare market” is acknowledged, the “market solutions” and privatisation in healthcare

continue to be pursued by economists and policy makers. The belief is that market competition will lead to greater cost-effectiveness and efficiency, while state involvement is fraught with inefficiencies and lack of responsiveness to users, besides not allowing for consumer choice (Chan 2007).

4 Literature Review

While the ground theories reviewed earlier provide insights on our understanding of governance mechanisms focusing on production and delivery, and demand and supply of healthcare services, the policy of the services globally have raised peculiar issues.

The World Development Report 1993 entitled “Investing in Health” had identified four main problems of health system; namely misallocation of resources inequity, inefficiency and exploding costs. The report argues that “as world health spending is huge, there is potential for misallocation, waste and inequitable distribution of resources”. It was estimated that in 1990 the world spending on health reached a total about US\$1,700 billion or 8% of the global income. Of this, governments expanded more for nearly 60% and the private sector the remaining 40%. Of the US\$170 billion spent on healthcare in developing countries of Africa, Asia and Latin America, government spend half of the total amount, or 2% of those regions’ GNP.

The private healthcare expenditures are one of the causes of concern because most of these expenditures are out-of-pocket payments. According to Arredondo and Najera (2005), in the middle income countries, out-of-pocket payments by consumers of health services have become an important public health issue. Such payments can have catastrophic economic effects on individuals and their approach to healthcare, which has implications for strategies for healthcare reform.

The private healthcare systems are primarily based on fee-for-services. There have been frequent complaints that the private hospitals are charging excessively high fees. Especially, the large corporations have been aggressively pushing profit margins higher and higher. The threat that OOP payments pose to household living standards is an important issue in Malaysia. The extent to which such concern is justified depends on the unpredictability of OOP payments and the distributions of the income. Increasing of private healthcare expenditure based on OOP can have a number of undesirable consequences so as to make healthcare services costly, unaffordable and uncertain. OOP expenditure can lead to debt for those who cannot afford it. Catastrophic OOP can lead a household into poverty (Devaraj, 2004).

Gross (1999) reported that despite corporatisation and privatisation, medical costs have continued to escalate. Thus many Malaysians, particularly poor and average wage earners, have been denied free access to healthcare. For example, since the corporatisation of the University Hospital, the costs of basic diagnostics, such as, blood tests and x-rays have shot up by as much as 150-200% since 1997-1998 financial crises.

Saksena et al. (2012) summarised that individuals in the richest quantile were more likely to use private facilities than those in the lowest quantile income group. However, the use of the private sector was not limited to the elite. Even in the poorest quantile, private facilities were occupied by more than 20 per cent of outpatient visits in the majority of the countries. This result is in line with previous studies that have also noted a considerable use of private health services by the poor (Bhatia & Cleland (2001); Prata et al. (2005); Loevinsohn & Harding (2005); World Bank (2011).

The issue of escalating costs and the need to identify the most appropriate and acceptable healthcare financing model has been identified as key issues by the government of Malaysia. Rasiah, et al. (2009) addressed this phenomenon can be attributed to factors, such as, the unnecessary usage of an ever-expanding array of sophisticated and costly technologies for diagnostic tests and surgical procedures, the open-ended fees for service compensation for health providers, which have encouraged the development of new equipment, drugs and procedures of increasing costs because neither providers nor patients have strong incentives to minimize the utilisation and spending.

Onn (2015) had pointed out that with the rising cost of healthcare, the government are facing increasing pressure and the involvement of government-linked companies in the private healthcare sector has raise conflict of interest issues. The author also state that Malaysia practised a free market economy and a price deregulation system in which manufacturers, distributors and retailers set medicine prices without government control. The private sector prescribers cost to six to eight times international bulk purchase prices. Sometimes poor have been forced to buy the medicines from private pharmacies and clinics due to the low availability of drugs in Public Hospitals.

5 Methodology

5.1 Conceptual Framework

Health system in Malaysia is a dual system where it involves public and private sector. Meanwhile, health policy aims to improve health system performance and promoting

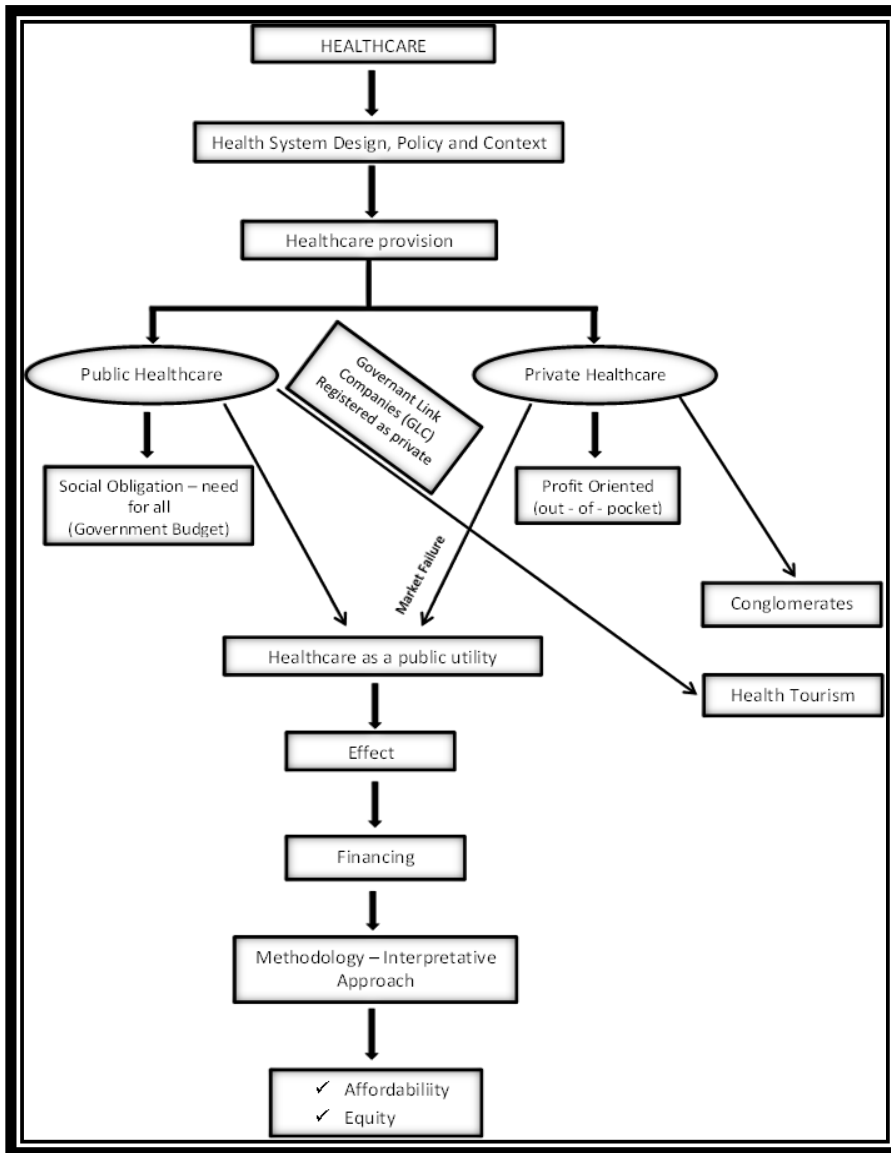
health to people. Health policies are important because they directly or indirectly affect all aspects of daily life, actions, behaviours and decisions. Policies about health system can have insightful impacts on citizens, patients and health professionals. Hence this paper is based on the current health system design, policy and context in Malaysia.

Healthcare provision in Malaysia can be divided into two; public healthcare and private healthcare. Public healthcare is a social obligation and it is a need for all, meanwhile private healthcare is a profit oriented and it is based on fee-for-service or out-of-pocket. The formalisation of privatisation accelerated the increase of private hospitals and government policy on health tourism helped further the expansion of private healthcare, especially by conglomerates. A conglomerate is a combination of two or more corporations engaged entirely in different businesses that fall under one corporate group, usually involving a parent company and many subsidiaries.

Citizens are likely to see healthcare delivery as a kind of public utility and subject it to the regulation usually imposed on utility. Public utility here refers to the universal access and quality services. Healthcare should be treated as a public utility to some extent. However, healthcare in Malaysia has been pushed by strong political forces away from regulation in the direction of pure competition. The importance of regulation has been underappreciated. Leaving healthcare to the market may cause market failure as discussed earlier.

Inefficiency of public utilities undeniably contributes to the healthcare problems in Malaysia especially in the dimension of financing. This study will undertake the dimensions of financing in discussing the impact of privatisation in Malaysia. The factors that will be evaluated in discussing the dimension of financing are affordability and equity.

Figure 1: Conceptual Framework



Source: Latifa Bibi (2014)

5.2 Interpretive Approach

Interpretive approach is concerned on understanding a specific phenomenon. This approach was introduced by Jonathan Smith, in his seminal paper on 1996 as an alternative for other qualitative approaches such as grounded theory, conversation analysis, narrative psychology and others (Smith, 2004). This method thrived in health psychology and also has attracted interest in related fields such as social, clinical and counselling psychology (Brocki and Wearden, 2006).

In the field of healthcare, the interpretive approach gives a greater scope to address issues of influence and impact and to answer questions such as ‘why’ and ‘how’. According to Pringle et al. (2011), the approach offers a form of analysis that brings together the various elements of phenomenology and moves beyond description. It does not seek to find one single answer or truth, but rather a coherent and legitimate explanation. Analyses of this approach involve identifying the essence of the phenomenon under investigation, based on the data obtained and how the data are presented. It allows rigorous exploration. Interpretive approach can provide valuable information for future work.

In this study, trend analysis and broad-based review of research literature is combined to identify the kind of experiences of healthcare that can matter with considerations of why these experiences might be important and how it relate to each other. The trend analysis allows seeing the effect of changes that has been made to improve performance over the years. The data in this study covers from the year 1997 till 2014.

6 Discussions

Corporate private sector, viewed healthcare as a developing industry since 1980s and as a result more private hospitals were built and owned by businesses. These hospitals were set up solely for profit and the trend was followed by other corporate entities. Large Malaysian conglomerates, corporations and companies were formed by medical specialists, including those involving foreign investors who have invested in private hospitals with government encouragement. The tremendous increase of private hospitals can be observed after the Asian Financial Crisis and when the health tourism was introduced by the government.

The unprecedented growth of private healthcare since the 1980s had wide-ranging implications for the Malaysian healthcare system. Leaving healthcare to market forces does not necessarily lead to an effective and efficient healthcare system. The private sector

development in Malaysia did not happen solely in response to the opportunity provided by the increase in consumer demand for health.

The private healthcare expenditure increased tremendously over the years since the privatization policy was introduced in Malaysia. Table 1 shows the private healthcare expenditure from the year 1997 to 2014.

Table 1: Private Healthcare Expenditure

Year	Million (RM)
1997	3873
1998	4147
1999	4520
2000	5383
2001	5571
2002	6210
2003	7452
2004	8591
2005	9743
2006	10932
2007	12276
2008	13343
2009	13539
2010	15878
2011	18235
2012	19877
2013	21652
2014	23917

Source: Malaysian National Health Accounts 2016

In the year 1997, the private healthcare expenditure was RM3, 873 million and it reached RM23, 918 million in the year of 2014. The private healthcare expenditure started to increase tremendously starting from the year 1999, an increase of 19% from the previous year.

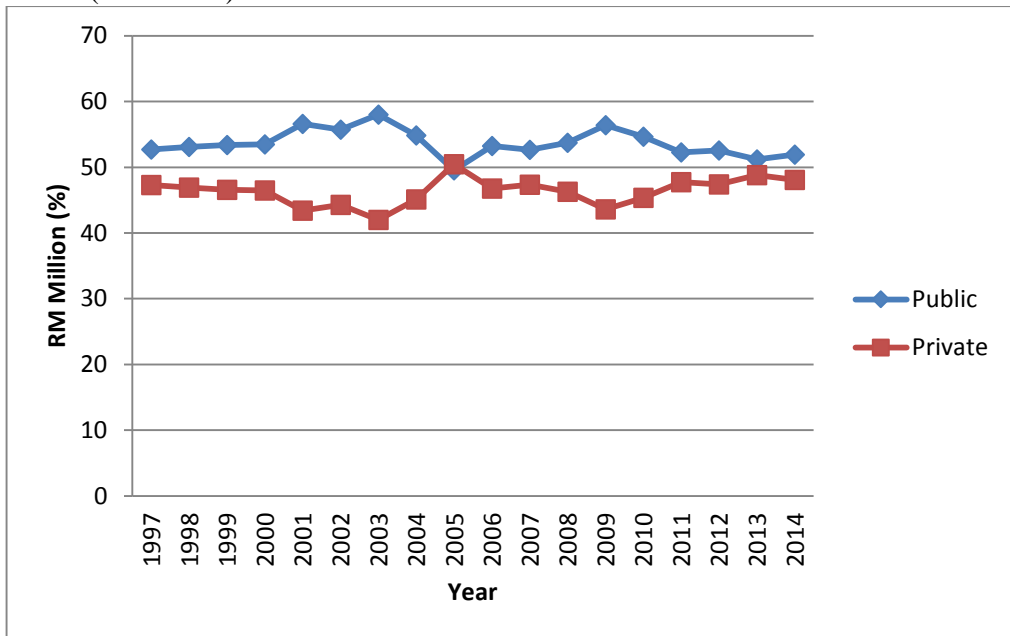
The Asian financial crisis of 1997 caused businesses in private hospitals to fall by 18-20% and 3 to 4 years delay in the development of new private hospitals. Ringgit depreciation led to cost increase in imported drugs and technology. According to Gross (1999) and Barraclough (1999), private hospitals had to bear additional 20 to 120% drug costs and a 30% rise in surgical costs.

As domestic demand contracted following the 1997 to 1998 financial crisis, the government promoted medical tourism to assist the private healthcare providers to attract demand from abroad. The emphasis on medical tourism as another engine growth helped

expand markets for private providers at the end of 1990s. Medical tourism has been earmarked as a key revenue generator since 2000. Nevertheless, the Malaysian Government has targeted more private sector initiatives to promote Malaysia as a healthcare hub for both traditional and modern medical treatment (Malaysia, 2006). The development helped boost the growth of private health expenditure since 2000.

The growth of private sector obviously fuelled the private share of the healthcare expenditure. Especially the large corporations have been aggressively pushing profit margins higher and higher. Evidence shows that the private healthcare sector is expanding at the expense of a rather than as a complement to the public healthcare sector (refer figure 2).

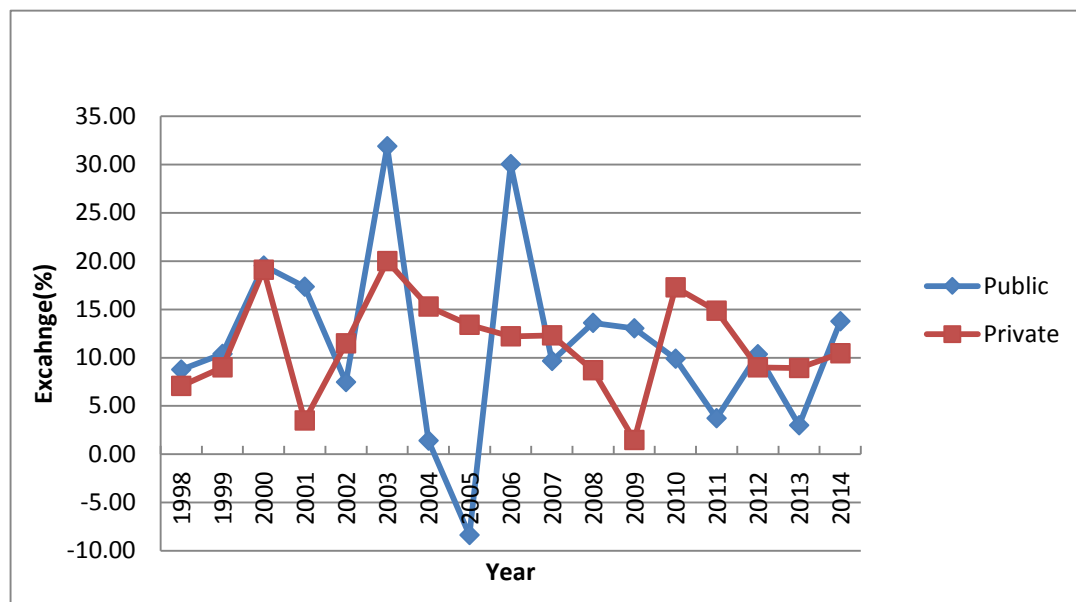
Figure 2: Total Expenditure on Health by Source of Financing by Public and Private Sector (1997-2014)



Source: Malaysian National Health Accounts 2016

Based from the figure 2, the private share in total healthcare expenditure is increasing greatly over the years. The average contribution of public healthcare expenditure was 52% in 1997 and it decline to 51% in 2014, meanwhile private healthcare expenditure contribution was 47% in 1997 and it increases to 48% in 2014. Interestingly, in 2005, the expenditure of private healthcare almost overtakes the expenditure of public healthcare.

Figure 3: Changes of Total Expenditure on Health by Source of Financing by Public and Private Sector (1997-2014).



Source: Malaysian National Health Accounts 2016

Figure 3 shows that the expenditure of public healthcare expenditure generally is in a decreasing trend since 1997.

Backed by strong government support and growing local and international demand, private healthcare has firmly established itself as a pillar in the strategic plans of the Malaysian government. According to Rasiah (et al. 2009), In the efforts to stimulate development of the private healthcare system in Malaysia and to reduce dependence on public hospitals, government has offered incentives and grants to further enhance private healthcare services in the country.

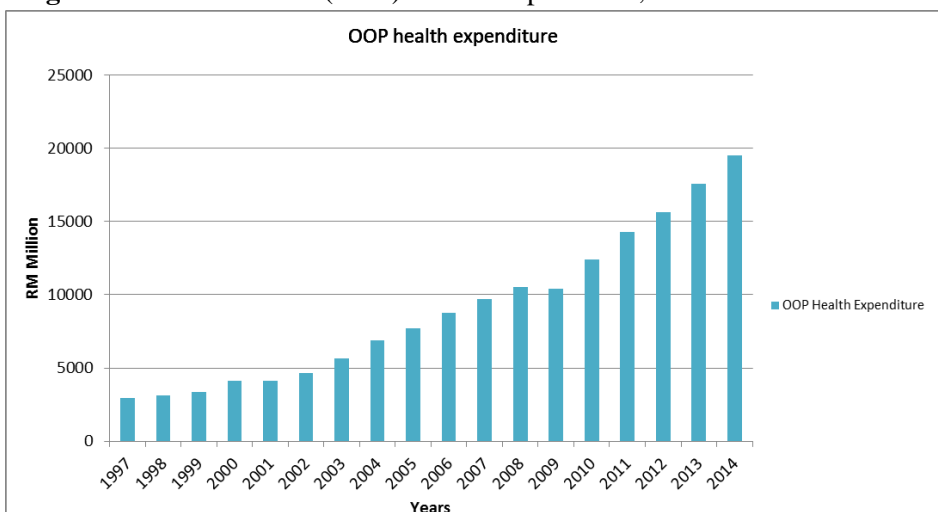
The largest private healthcare provider in Malaysia is KPJ Healthcare (KPJ, 2010). KPJ Healthcare is the healthcare division of Johor Corporation. Listed on the Malaysian Stock Exchange, KPJ has a network of 19 hospitals in Malaysia and 6 overseas, and a nursing college. Meanwhile, the Pantai Group of Hospitals, fully supported by its shareholders Khazanah Nasional, the investment arm of the Government of Malaysia, and Parkway Holdings, is another large healthcare group in Malaysia.

Sime Darby, one of Malaysia’s oldest and largest conglomerates with a global presence in more than 20 countries, is also active in healthcare provision through the Sime Darby Healthcare Group. In addition the flagship hospital, Sime Darby Medical Centre Subang Jaya, the group’s portfolio features the Sime Darby Specialist Centre Megah and a nursing college. With another hospital in construction and ambitious international expansion plans, healthcare remains of strategic relevance for Sime Darby.

PETRONAS, Malaysia’s national petroleum company is the healthcare industry’s newest corporate player. After a landmark investment of USD 150 million, the purpose built Prince Court Medical Centre in the heart of Kuala Lumpur, is poised to set new standards in healthcare at regional level (Malaysian Health, 2009). Interestingly, all the above major private healthcare providers are actually controlled by the government.

The assertively expanding private sector in healthcare is not supported by a well-placed health financing system, which partly explains the ballooning of out-of pocket payments to finance the use of private medical care. Malaysian private household out-of pocket (OOP) spending forms the largest component of private healthcare expenditure. The OOP spending can result in catastrophic financial burden on households leading to poverty, and if large enough, eventually lead to a poor economic status of a nation. There is ample evidence that payments for healthcare though out-of-pocket can easily become catastrophic part of health expenditure especially when the public healthcare system is weak or unattractive, and poor people have to make use of private services.

Figure 4: Out-Of-Pocket (OOP) Health Expenditure, 1997-2014

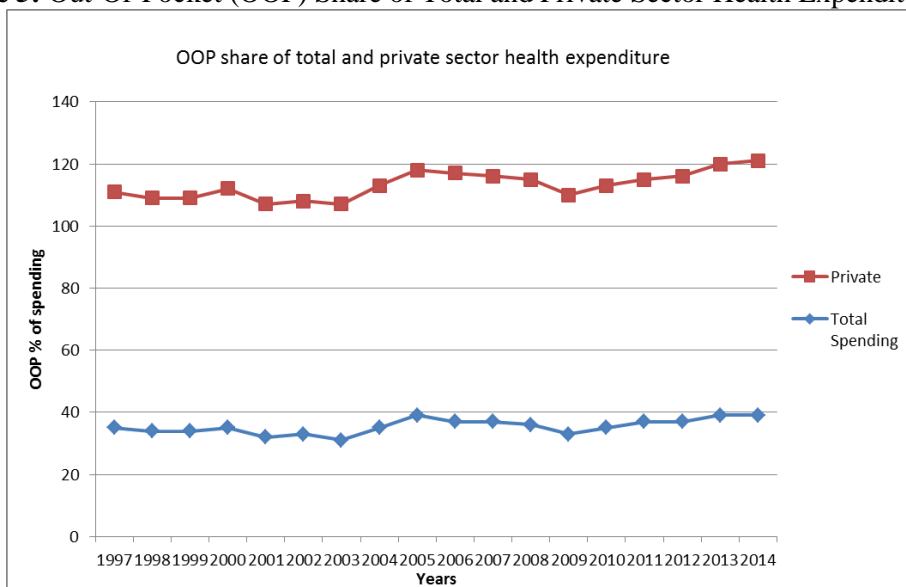


Source: National Health Accounts (2016)

The OOP expenditure from 1997 to 2014 has increased from RM2, 930 to RM19, 544 which is increase of 567% (see figure 4). The tremendous increase of OOP expenditure can be observed in the year 2000, 2003, 2004 and 2010 when it is compared with the percentage increase of previous years; 22%, 21%, 22% and 19% respectively. 36% of the OOP healthcare expenditure came from the out-patient care services.

Household OOP expenditure remains the largest single source of funding throughout the period of 1997 to 2014 (see figure 5). Household OOP contributes between 31 to 39 percent of the total expenditure, on average of 78 percent of private healthcare expenditure. Figure 5 clearly shows that the main revenue for private healthcare expenditure is from the OOP.

Figure 5: Out-Of-Pocket (OOP) Share of Total and Private Sector Health Expenditure



Source: National Health Accounts (2016)

The private hospitals generally are visited by the richer class who can afford it. However, an inadequacy in public hospitals such as the lack of treatment facilities and doctors, overcrowding and long waiting lists (Rasiah, Wan Yusof & Nwagbara, 2010) forces the poor to seek treatment in private hospitals. Under the stress and anxiety of disease some people have no choice but to pay the fees requested by private health providers even when the cost is more than what they can afford. Thus future welfare is put at risk by incurring debts, selling off productive assets, or sacrificing investment in future productivity.

The swift growth of private health sector has transformed the healthcare system

in Malaysia from one dominated by the public sector in both provision and financing, to one in which the private sector has an increasing presence in hospital and specialist care, as well as financing. The government through its privatisation policy has been the main architect of this transition.

7 Conclusions

The Malaysian government had repeatedly stated that corporatization and privatization of the public healthcare was targeted as the solution for the government's financial and administrative burden. However, in reality the reduction in the relative share of public healthcare expenditure in total healthcare expenditures raises services concerns. The rapid growth of private healthcare operators had changed the landscape of the healthcare system in Malaysia from one dominated by public sector to one in which the private sector had an increasing presence in financing.

Leaving healthcare to the market can cause market failure and increasing of costs makes the poor patients caught in a dilemma. This result contradicts with the neo-classical economists' argument that the market will be the most efficient allocator of economic goods and services for healthcare (c.f. Buchanan, 1975). Social goods like healthcare have to be out of the dominant privatised goods because when healthcare is privatized it tends to create difficulty for the poor to access due to high treatment costs and the poor will not be affordable.

Healthcare is demand inelastic; it is a necessity that no matter the cost, people are in need of the services. Healthcare does not fit efficiently in a free market because one cannot dispense with equilibrium clearing prices as it must reach even those below such prices. Since healthcare is a public utility rather than private good, it must reach everyone. However in Malaysia, the healthcare delivery is highly lucrative since the rise and proliferation of private for profit healthcare services. Contrary to the claims that the privatization policy is targeted at ameliorating the problem of burgeoning costs of the public healthcare sector, the trend shows that the move was largely targeted at benefitting the private owners through incentives and grants.

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