# Perceptual Study on Managed Care Organisations (MCOs) in Malaysia

**Prepared for:**


**Prepared by:**

**Dr. Kamal Kenny, PhD**

**Introduction**

Managed Care Organisations (MCOs) are now part of the Malaysian medical landscape. Managed Care is a global term for healthcare systems that integrate the delivery and financing of health care. "Managed Care" can be defined as healthcare services supplied by or through organisations that also take active steps to influence the care-seeking behavior of patients ("healthcare consumers") and the care-providing behavior of doctors and other health professionals ("healthcare providers") (Robinson and Steiner, 1998). It contrasts with liberal medical practice, which allows doctors to make clinical decision and bill for their services without interference from managers or payers. The two major goals are to encourage appropriate utilization of health services by consumers and to encourage appropriate supply of health services by providers (Folland, Goodman and Stano, 1993).

In the Guidelines for Managed Care Organisations and Private Healthcare Facilities and Services (Section 82), MCO is interpreted as:

Any Organisation or body, with whom a private healthcare facility or service provider makes a contract or has an arrangement or intends to make a contract or have an arrangement to provide specified types or quality or quantity of healthcare within a specified financing system through or a combination of the following mechanisms:

(a) delivering or giving healthcare to consumers through the organisation or body's own healthcare provider or a third party healthcare provider in accordance with the contract or arrangement between all parties concerned;

(b) administering healthcare services to employees or enrollees on behalf of payers including individuals, employers or financiers in accordance with contractual agreements between all parties concerned.

The minister, may, from time to time by notification in the Gazette declare any type of healthcare delivery arrangement other than those specified in the interpretation above.

Third Party Administrators (TPAs), on the other hand, are organisations that process insurance claims or certain aspects of employee benefit plans for a separate entity. TPAs provide administrative and processing services for medical claims to insurance companies and employers of corporations. It has medical networks, IT systems and expertise to efficiently process claims on behalf of clients. TPAs scrutinise the medical claims to ensure that there's no abuse or fraud and are paid a fixed fee by insurance companies (The Star Online, 13 October 2013).

MCOs act as middlemen used by the employers to contain the health care cost of their employees. They consist of hospitals, doctors, clinics and other medical providers joined in a network to control the cost (Zafar Ahmed, 1990). At the simplest level, the MCOs take over the administrative work now carried out by the company's human resource department each time an employee seeks medical treatment. The employee's entitlement, payments to the clinics and issuance of guarantee letter is determined by them (Malaysian Business, 2000).

In Malaysia, the vast majority of doctors first heard the term "Managed Care" in late 1995 when General Practitioners (GPs) who were on the panels of Telekoms Berhad and Tenaga

Berhad were informed that their services would not only be monitored, but also paid for by a third party. The medical profession, especially the Federation of Private Medical Practitioners Associations (FPMPA), drew this to the attention of the public and the authorities to elicit response from the Ministry of Health, consumer bodies and trade unions. The Guidelines for Managed Care Organisations (MCOs) was announced in early 1996 and a section on "Managed Care" was included in the Private Health Care Facilities and Services Act 1998 (PHFSA) (Lum, 2007).

As of end March 2000, some 49 Managed Care Organisations had been formed and registered in Malaysia. The spiraling growth of these MCOs attest to the belief that Malaysia's healthcare system was moving towards some great paradigmatic shift which somehow benefits their existence (Quek, 2000). The biggest MCO is the Ministry of Health (MOH) which is publicly funded and operates out of a global budget. There is limited or no choice of the primary care doctor, who decides on referrals for specialist care. Many other MCOs have come and gone, primarily because they did not get their arithmetic right.

This study attempts to highlight the current practices of MCOs with GPs in Malaysia. In addition, it also hopes to highlight the benefits and challenges faced by GPs in the process and put forward recommendations to enable a more positive relationship between the two parties for the benefit of the end users i.e patients. The study will give a clearer picture on whether the goals of managed care are achieved or if the actual implementation contradicts its initial purpose.

**Global Overview**

Managed care began with prepaid group practices which first appeared in the United States in the late 1920s (Raymond, 1994). These group practices allowed healthcare consumers to contract for the supply of a fixed range of services with a group of providers. The providers were paid a fixed fee per enrollee in advance known as "capitation". In 1965, Medicare and Medicaid prorammes were introduced and this contributed to the accelerating healthcare costs (Feldstein, 1979). This led to the Health Maintenance Organisations (HMOs) and other kinds of MCOs such as PPO (Preferred Provider Organisation), POS (Point of Service) Plan and so on. Although MCOs' growth was slow during the 70s, it has become a dominant part of the US medical landscape in recent years. In 1997, 92% of all American doctors held at least one contract with an MCO (Washington Post, 1999). More than 80% of all Americans with employer-sponsored health insurance were enrolled with MCOs (Phua, 2000).

***Asian Regional Experiences***

Before 1992, only large companies in Indonesia provided health benefits to their employees on a voluntary basis (WHO, 2005). In response, the Health Act of 1992 under Health Law number 23/1992 launched *Jaminan Pemeliharaan Kesehatan Masyarakat* (JPKM) or Community Health Social Security, a voluntary, state-run, for-profit program (Mazolf 2002, Than 2004). JPKM was launched to unify widely diversified insurance schemes.

In The Philippines, the healthcare system has traditionally been based on the fee-for-service system with the coexistence of Managed Care. It has a two-tiered healthcare system

comprising public and private sectors (with the former perceived to be of lower quality). The first HMO was established in 1982 and unlike Malaysia, its growth was due to private rather than public initiative. Managed Care aimed to control the rising costs (10% inflation rate) caused by imports (drugs, instruments, supplies) and a plunge of the Filipino Peso: the Asian economic crisis sent hospital and health-related expenditures skyrocketing, fueling support for HMO-modeled financing schemes (Simonet, 2009).

In Hong Kong, the Asian forerunner, contract medicine existed well before medical insurance became available and offered primary care services that were not provided by government health services (Brudevold, McGhee and Ho, 2000). The Hong Kong healthcare system had been quite cost effective without Managed Care. Healthcare expenses have remained low and the population's health status is high. The characteristics of Managed Care in Hong Kong; providers contract with larger employers and are less constrained (in terms of utilization review and control) than their US counterparts (Brudevold et al., 2000). Specific schemes that aimed to control costs and prospective payments that impose a fixed payment for a particular diagnosis were also adopted. Despite its unpopularity, Managed Care grew quickly in Hong Kong.

Though Managed Care had been in Singapore for almost a decade, it has not become a dominant insurance scheme. In 2000, there were only about ten MCOs and that number has remained stable. The largest had only 22,000 patients (Phua, 2000).

***The Malaysian Experience***

A wide variety of arrangements exist in Malaysia. The "panel doctor" system is perceived by some as MCOs. This is because the system has many features of the preferred provider organisations in the United States. Panel doctors have been in existence since *Merdeka* and they provide primary care to the employees of companies that have arrangements with them. The fundamental difference between "panel doctor" and MCOs that appeared since 1995 is that there is no intermediary in the patient-doctor relationship (The Star, 2007). Healthcare costs were rising and conditions related to harmful lifestyles were becoming increasingly common. In addition, the population is aging, technologies are more expensive and healthcare consumerism is growing. In the 1985 Asian Development Bank (ADB) Report, measures to optimize healthcare costs were outlined and MCOs were embraced.

MCOs emerged in the early 1990s to cater to the private sector. It aimed to increase accountability and lower government subsidies to patients. In 1996, the Malaysian government stated that "Managed Care is being practiced in Malaysia and has growth potential" (Abdul Hamid bin Abdul Kadir, 2000). MCOs were defined under section 82, subsection 1 of the PHFSA of 1998. The MOH intended to play the role of regulator and established the National Committee on Managed Care. The HMO began operations in 1995. The enrolments rose to 600,000 in 1999 from 300,000 in 1997 (Rauber 1999). By 2000, there were 32 registered MCOs (Phua, 2000), 45 according to MMA and 50 according to Abdul Hamid Bin Abdul Bakar. Since 1998, most MCOs have implemented fee-for-service payment and taken multiple forms including insurance companies, cooperatives, companies and not-for-profit organisations and have combined features of HMOs, IPAs and PPOs.

**Study Methodology**

Structured interview questions and literature reviews were the primary methods used in this descriptive analysis. The structured interview questions were sent out to General Practitioners from a total of 11 states and Federal Territory in Malaysia – Kedah, Pulau Pinang, Perak, Selangor, Negeri Sembilan, Melaka, Johor, Pahang, Terengganu, Kelantan, Sarawak and also Wilayah Persekutuan. The methodology employed for the interview phase was convenience sampling whereby the doctors have indicated interest to participate in the survey. The purpose of this interview was to identify the following:

1. GPs and MCOs: The Malaysian landscape and practices
2. Benefits and challenges faced with MCOs in Malaysia
3. Recommendations to move forward

A total of 120 GPs were interviewed for this study. In addition, this study also compiled findings discussed in various other documents such as journals, articles, speeches etc.

**Survey Findings**

In general, findings of this survey revealed that although MCOs continue to play an important role in today's healthcare environment, there is still much room for improvement. GPs in this survey expressed their concerns, grievances and future hopes for this partnership. The ultimate goal is to ensure that the overall medical cost is reduced without putting financial burden on the GPs or the patients and to create an environment which allows GPs

to provide optimum care and services to their patients as outlined in the Guidelines for Managed Care Organisations and Private Healthcare Facilities and Services.

***GPs and MCOs: The Malaysian Landscape and Practices***

As stated earlier, Managed Care Organisation (MCO) is an organisation regulated under the provisions in Part XV of the PHFSA 1998 (Act 585) and acts as the "middlemen" used to contain the health care costs of their employees. MCOs are healthcare facilitators between corporations and GPs, and they are in charge of selecting doctors into the company panel. When corporations reimburse to panel doctors, they pay through MCOs who will then earn a surcharge from both sides (Malaysian Insider, 2014).

All Malaysians are entitled to government healthcare services provided in public hospitals, but the services are usually in high demand and some of the services may not be up to the expectation of some consumers. That's where private hospitals and General Practitioners come in to fill the gap. However, the charges in private hospitals are much higher as it is not subsidised by the government. Although otherwise stated in the PHFSA 1998, MCOs stipulate when, where, how and what treatments are to be offered by the selected GPs to employees. Today, they play the role of determining what services will be covered and most importantly, how much the GPs will be compensated for these services.

Simonet (2009) in his writing stated that around 8 million of the Malaysian population was covered by the employer sponsored health care plan. Most of that coverage is through some form of Managed Care Organisations. In Malaysia, there were approximately 45 MCOs

established then, with most of the members consisting of big corporations. The more MCOs come into the market, the more they are forced to lower premium to remain competitive. This is done by curtailing services offered and therefore affecting the quality of care. In other words, the health of the patient is not well protected and the cost of treatment is not effectively controlled. There are various factors that have contributed to Managed Care development in Southeast Asia. In Malaysia, corporations signed the Managed Care contracts in the belief that costs could be contained. Having experienced faulty practices by early entrants and negative feedback from their employee and healthcare providers, many companies have become less receptive to MCO services (Association of Private Hospitals of Malaysia, 2011). The Ministry of Health found little integration in MCOs' medical benefits, non-uniform fee schedules and underutilization of IT. The MOH guidelines were also not closely followed (Association of Private Hospitals of Malaysia, 2011) and therefore leaving GPs feeling frustrated.

***Benefits and Challenges faced by General Practitioners (GPs) in Malaysia***

When asked about the challenges faced by the GPs in their work relationship with the MCOs, many provided their input and expressed their grievances. Firstly, respondents expressed their concern and dissatisfaction towards the low consultation rates determined by the MCOs. According to them, the rates that were fixed by the MCOs were not compliant to the Ministry of Health's Schedule. Some MCOs pay as low as RM 10-15 per patient. After 12 long years, the 13$^{th}$ Schedule was incorporated into the Private Healthcare and Facilities Act 2006. Unfortunately, MCOs do not adhere to these rates and therefore GPs are paid much lower than the norm. The following table outlines the details of the consultation fee:

**Table 1: Consultation Fees for Non-specialist**

| (a) First visit/Early consultation | |
|---|---|
| **DETAILS** | **FEES (RM)** |
| Consultation only<br>Consultation and examination<br>Consultation, examination and treatment plan | 30-125 |
| Consultation after Clinic Hours | Up to 50% exceeding the normal rate |
| House calls/visit | Up to 100% exceeding the normal rate |
| (b) Follow-up visit/Consultation | |
| Consultation only<br>Consultation and examination<br>Consultation, examination and treatment plan | 35-145 |
| Consultation after Clinic Hours | Up to 50% exceeding the normal rate |
| House calls/visit | Up to 100% exceeding the normal rate |

**Table 2: Consultation Fees for Specialists**

| (a) First visit/Early consultation | |
|---|---|
| **DETAILS** | **FEES (RM)** |
| Consultation only<br>Consultation and examination<br>Consultation, examination and treatment plan | 80-335 |
| Consultation after Clinic Hours | Up to 50% exceeding the normal rate |
| House calls/visit | Up to 100% exceeding the normal rate |
| (b) Follow-up visit/Consultation | |
| Consultation only<br>Consultation and examination<br>Consultation, examination and treatment plan | 40-105 |
| Consultation after Clinic Hours | Up to 50% exceeding the normal rate |
| House calls/visit | Up to 100% exceeding the normal rate |

*(Source: Private Healthcare Facilities and Services (Amendments) Order 13, Federal Government Gazette,)*

Lum, (2007) even quoted in his article in The Star, that the most senior chest physicians in the country received a letter from the MCO of an insurance company informing him of a delay in reimbursement with a request for discounts on consultation fees of RM 70-80. When there are middle men involved, the same amount will have to include their staff and marketing expenditures as well as its profits since none of the MCOs in the country are not-for-profit organisations (Lum, 2007).

Another such case was in 2008 when the negotiations between doctors represented by the Joint Inter-hospital Healthcare Committee (JIHC) and ING Insurance Bhd reached a stalemate. ING, a major health insurance provider in Malaysia, had refused to budge from its proposed terms and conditions in their new Healthcare Service Panel Agreement (HSPA). ING demanded discounts on professional fees from doctors and was compiling a list of preferred healthcare providers (doctors who agreed to give discounts) and a blacklist of those who don't. ING finally retreated its position when prompted by Tan Sri Dr Mohd Ismail Merican, Director General of Health's statement that "discount for professional fee is not allowed because it would be infringing on the regulations and the code".

One such case occurred in Seremban in 2006. The doctor, a pioneer consultant in a private hospital refused to sign a new contract which required him to give a discount. The hospital terminated his service and the doctor took the hospital to court for wrongful dismissal. Eventually the hospital backed off and the case was settled. This particular case confirms that there are firm grounds to have this issue tested in court (Taken from the Message from the President of Federation of Private Medical Practitioners' Associations Malaysia: Private Medical Practice in Malaysia-State of Health 2013)

The Director General, in an open letter to The Star on April 3 of the same year, reiterated that such discounts constituted fee-splitting, which is prohibited under the Code of Professional Conduct (CPC) for Practitioners of the Malaysian Medical Council. Any form of discount on professional fees can be construed as intention to induce that doctor to compromise his professional judgment for financial gain which may lead to the detriment of his patient. More than one million people were covered under ING Insurance's employment benefit scheme. Fee-splitting is a serious offence and can bring about disciplinary action under CPC. Doctors and hospitals who did not comply have been delisted from the MCOs preferred provider network.

MCOs have varying reimbursement systems with complex benefit packages and sometimes, referral restrictions. With the exception of a few, most MCOs use their non-qualified employees to vet doctors' decisions. At times, MCOs dictate what medicines can be given to the patients and what is deemed unaffordable. Limitation in the choice of medicine and specific instructions on medications to be offered to patients makes it difficult for doctors to give optimum and fair care to patients. In fact, the vast majority of enrollees do not even get a copy of the policy. In reality, the doctor is obligated to disclose treatment alternatives but there may be limitations in the policy coverage or referral restriction.

Default of payment by MCOs is another challenge faced and expressed by majority of respondents. Late payments can take up to 365 days. This has become a recurrent issue and disrupts continuity of patient care. Doctors involved are under constant worry that they may not be paid at the end of the day. MCOs come and go and some have left without paying. Doctors, hospitals and patients are left hanging high and dry. One such case is when

the bankruptcy of a Managed Care company in the Klang Valley prompted medical centres to bar enrollees from receiving due medical treatments. Operations resumed when the parent company agreed to reimburse the unpaid bills and to compensate healthcare professionals, although with significant delay (Quek 2000). This is the real "business of medicine" which the PHFSA was suppose to regulate but have failed to do so. There have also been complaints from GPs that certain MCOs with long outstanding payments had terminated their contracts with GPs that follow up vigorously for payment. The only recourse for GPs to protect themselves against the unfair trade practices of MCOs is to call for concerted nationwide action.

The next challenge shared by respondents in this study was the fact that MCOs choose and change the clinics to appoint based on their preference. Patients are not given a choice. When a company decides to change their appointed clinics, patients, particularly those with systemic diseases and currently receiving treatment and attending follow-up sessions at a specific clinic will need to start all over again. This hampers the quality of care promised by doctors to their patients. Inappropriate channeling or referring patients exclusively to MCO-contracted hospitals even though they may not be the most appropriate and quality below standard is also some of the issues faced. As a signatory to the 1978 Alma Ata Declaration, Malaysia affirms health as a fundamental human right. The privacy of patient medical records and other health information are legally protected as is disclosure to recognized third parties. Patients' rights also are observed in relation to informed consent, right to cease treatment and right to second opinion. The doctor-patient relationship may be threatened by new financial and organisational arrangements that raise concerns about conflicts of interest and trust.

In relation to the above, the MCOs in our country, unlike many in the US, do not disclose anything to their enrollees. No information is provided about the benefits and the exclusions in the policy. In fact, the majority of enrollees do not even get a copy of the policy. The doctor has an obligation to disclose treatment alternatives. However, there are limitations in the policy coverage and referral restrictions. In cases such as this, the patient-doctor relationship is broken and the provision of care is disrupted (Lum, 2007).

Loss of autonomy amongst GPs was also another area of concern for the respondents. This is in line with most surveys that reveal strong oppositions from physicians. The Medical Association in Malaysia, a well-established group in socio-political circles was against Managed Care because it might lead to further inequity. Despite regulations that were adopted to preserve equity, affordability and accessibility, GPs still felt concern. This is also probably due to the fact that many of those who enter the Managed Care are ignorant of such ethical practices. Doctors' decisions are increasingly vetted by non-qualified MCO employees. Although there are some nurses who do the vetting, it is incomprehensible how such decisions can be done when the responsible MCO employee is remote from the patient. This raises serious questions about the claims and the provision of quality care (Lum, 2007).

Apart from the above challenges and concerns, the study also brought to light a disturbing phenomenon that was faced by some GPs. It was reported that certain MCOs demanded bribes from GPs using the service of "middlemen". These bribes can range from RM 5000 up to RM 30000 and serves as "insurance" for the inclusion of the particular GP as part of the list of clinics. In another unrelated incident, in February 2014, The Malaysian Medical Association and Medical Practitioners Coalition Association of Malaysia (MPCAM) called for

a nationwide boycott to force the suspension of cashless services to all Etiqa Insurance and Takaful panels. This was a protest against Etiqa's removal of GP as panel doctors if they do not have a current account with its affiliate, Maybank. The two medical unions which jointly group 18,000 members then called for the boycott for Etiqa for unfair treatment. Etiqa, in addition, also had a record of poor management policies. The company had delayed payments to doctors via a MCO called Medijaring which became defunct in 2013 (Malaysian Insider, 2014)

The findings of this study were generally in line with a study by S. Ibrahim et al. (2015) which found that the majority of their 102 GPs reported a negative, low perception towards managed care arrangement. Almost all of the respondents' believe that they have managed to withhold their professional autonomy, bestowed access to patients and maintained quality of care even though they are working with managed care restrictions and interference.

Although most of the feedback received from the respondents highlighted challenges faced and concerns regarding MCO practices in Malaysia, there is much need to also see the benefits of MCOs in the Malaysian context. Employees of companies engaged with this service are guaranteed availability of healthcare services. With this system, patients are also encouraged to seek early check-up and detections (where relevant). Serious conditions that are detected early makes it possible for early treatment.

**Survey Results**

A nationwide short survey has been conducted to determine the level of satisfaction with the services provided by MCOs. A structure questionnaire was distributed by mail to all GPs with MCOs facilities. After two weeks, a total of 434 GPs agreed to participate in the survey by returning the survey form. Among them, majority (21.7%) were from Selangor state, followed by Kedah (9.4%) and Kuala Lumpur (9.4%) while Perlis and Labuan had the least participating GPs with two apiece (Table 3). In terms of the areas, nearly half of the clinics were located at semi-urban settings (48.8%) while another 30.0% were in urban settings. Clinics in rural settings made up 11.0% while only 2.1% were located in industrial settings.

**Table 3: Distribution of GP surveyed in the study (n=434)**

| Characteristics | n | % |
|---|---|---|
| **State** | | |
| Selangor | 94 | 21.7 |
| Kedah | 41 | 9.4 |
| Kuala Lumpur | 41 | 9.4 |
| Johor | 39 | 9.0 |
| Sabah | 39 | 9.0 |
| Penang | 33 | 7.6 |
| Negeri Sembilan | 31 | 7.1 |
| Perak | 27 | 6.2 |
| Pahang | 24 | 5.5 |
| Kelantan | 18 | 4.1 |
| Melaka | 15 | 3.5 |
| Terengganu | 14 | 3.2 |
| Sarawak | 11 | 2.5 |
| Putrajaya | 3 | 0.7 |
| Perlis | 2 | 0.5 |
| Labuan | 2 | 0.5 |
| | | |
| **Area** | | |
| Urban | 130 | 30.0 |
| Semi-urban | 212 | 48.8 |
| Industrial/in-house | 9 | 2.1 |
| Rural | 50 | 11.5 |

| | | |
|---|---|---|
| Solo practitioner | 21 | 4.8 |
| Big group practice | 10 | 2.3 |
| Small group practice | 2 | 0.5 |

Table 4 presents the GP's perception on the quality of services offered by MCOs. The GPs were relatively divided when asked about whether their number of patients increased as a result of MCOs. On the other hand, they were in agreement on whether MCOs made payment promptly within the stipulated duration with 80.8% felt that MCOs failed to deliver in this aspect.

**Table 4: GP's perception on the quality of service offered by MCOs (n=434)**

| No. | Statement(s) | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|---|---|
| | | | | n (%) | | |
| 1. | My clinic has an increased number of patients because of MCO. | 50 (11.5) | 89 (20.5) | 110 (25.3) | 164 (37.8) | 21 (4.8) |
| 2. | The payment by MCOs to me are usually more than 60 days. | 24 (5.5) | 20 (4.6) | 39 (9.0) | 159 (36.6) | 192 (44.2) |
| 3. | I am happy with the fee capitation set for MCO cases | 217 (50.0) | 152 (35.1) | 40 (9.2) | 12 (2.8) | 12 (2.8) |
| 4. | MCOs should follow the consultation fee laid down by structure proposed by the Ministry. | 10 (2.3) | 8 (1.8) | 21 (4.8) | 101 (23.3) | 294 (67.7) |
| 5. | Claims made through MCOs often encounter problems. | 13 (3.0) | 24 (5.5) | 41 (9.4) | 182 (41.9) | 174 (40.1) |
| 6. | MCOs restrict me from conforming to the patients' confidentiality ethics in my profession. | 6 (1.4) | 28 (6.5) | 102 (23.5) | 189 (43.5) | 109 (25.1) |
| 7. | MCOs often interferes with my decision making by providers | 5 (1.2) | 43 (9.9) | 116 (26.7) | 174 (40.1) | 96 (22.1) |
| 8. | There should be a fairer selection process for appointment of panel in the system. | 6 (1.4) | 1 (0.2) | 41 (9.4) | 195 (44.9) | 190 (43.8) |
| 9. | There should be a platform for doctors, MCOs and MOH | 8 (1.8) | 11 (2.5) | 152 (35.0) | 262 (60.4) | 1 (0.2) |

| | | | | | | |
|---|---|---|---|---|---|---|
| | authorities to share their concerns for the best interest of their patients. | | | | | |
| 10. | Terms and conditions set by MCO can lead to a compromise in the medical and healthcare services provided by GPs. | 11 (2.5) | 10 (2.3) | 25 (5.8) | 159 (36.6) | 228 (52.5) |
| 11. | The existence of 3rd party requesting payment for selection of clinic as panel is an unethical practice which should be viewed seriously by MCOs | 6 (1.4) | 5 (1.2) | 33 (7.6) | 115 (26.5) | 274 (63.1) |
| 12. | The selection of clinics by MCOs may affect the medical management of patients who have been receiving treatments by a particular GP. | 6 (1.4) | 6 (1.4) | 39 (9.0) | 180 (41.5) | 202 (46.5) |
| 13. | Electronic Data Capture methods by MCOs are time-consuming for doctors and patients , which may be otherwise dedicated for patients' care | 8 (1.8) | 17 (3.9) | 67 (15.4) | 176 (40.6) | 165 (38.0) |
| 14. | I prefer a common MCO EDC terminal for all clinics | 21 (4.8) | 18 (4.1) | 79 (18.2) | 140 (32.3) | 174 (40.1) |

In addition, they also felt unhappy with the current fee capitation set by MCOs (85.1%). A large proportion of them (90.0%) felt that the current fee allotted from MCOs is far below the recommended fee as stipulated by the MOH. Many of them are also encountering problems with claims made to MCOs with regards to payment (82.0%).

The current system, the GPs felt that the confidentiality of their patients were not well-protected given the fact that they need to furnish MCOs with details regarding each case in order to be eligible for payment claims to be made (68.6%). Furthermore, majority of the GPs (62.2%) had the opinion that MCOs often interferes with my decision making by

providers. Adherence to medical ethics and professionalism is a critical component of the medical practice and should be respected and upheld.

In terms of the panel clinic selection process, 88.7% either agreed or strongly agreed that there should be a fairer selection process for appointment of panel in the system. They also felt that the current terms and conditions set by MCO can lead to a compromise in the medical and healthcare services provided by GPs (89.1%). The GPs viewed that the existence of 3rd party requesting for payment for the selection of clinic as panel is an unethical practice which should be viewed seriously by MCOs (89.6%). In addition, the current system of allocating patients to certain clinics also posed an issue to GPs with their existing patients being reallocated to other clinics and this can lead to poor follow-up and medical compliance (88.0%).

The computer system that is currently being used by MCOs also received numerous dissatisfaction with 78.6% of the GPs felt that the Electronic Data Capture methods are time-consuming for doctors and patients, which may be otherwise be dedicated for better patients' care. Approximately 72.4% of the GPs prefer a common MCO EDC terminal for all clinics for standardization purpose.

During the survey, the GPs were also given an opportunity to raise their concerns and related issues pertaining to the MCOs services. Table 5 shows a collection of the common issues raised by the GPs. Among them, the most frequently mentioned issue was delayed payment made to GPs by MCOs (30.0%). The payment was frequently delayed and created plenty of tensions between the GPs and MCOs. The GPs also felt that the current

management of MCOs was poor and plenty of dissatisfaction were recorded. Besides that, low consultation fee is another matter of concern raise by 3.5% of the GPs participated in the survey. One of the GPs mentioned the fact that the current fee structure has not been revised for more than 10 years and thus deserves a review to keep up with the rising cost of operation. Other issues that made the list were issues related to low capitation of medications price, poor customer service for patients and doctors as well as conflict of interest for services by ASP.

**Table 5: Issues highlighted by GP (n=434)**

| Issues | n | % |
|---|---|---|
| Delayed payment | 130 | 30.0 |
| Poor management | 25 | 5.8 |
| Low consultation fee | 15 | 3.5 |
| Unreasonably low capitation of medications price | 8 | 1.8 |
| Conflict of interest – ASP | 2 | 0.5 |
| Poor customer service | 1 | 0.2 |

**Recommendations**

Based on the problems and challenges brought forth by the respondents and discovered during the literature reviews, this study is able to highlight a few recommendations. Under the right circumstances; with the enforcement of appropriate laws and in the presence of an educated public, MCO can be a great tool in containing costs of healthcare. Until such scenarios exist, parties involved in monitoring and using the services provided by the MCOs have to be constantly aware of the changes in healthcare practices and expenditures and possible exploitation or mismanagement of MCOs. At the same time, MCOs may need to aim to be less profit-oriented and more socially responsible (Aidalina, 2010).

Before implementing any new rules affecting doctors, the authorities should seek the opinion of doctors who are well informed and knowledgeable of their own profession for discussions. This is in the best interest of the public as well as the medical profession. In line with the PHFSA's principle, it is agreed that there is a continued need for legislation to regulate healthcare facilities and services in the country, especially to prevent the setting up of such facilities by untrained and unqualified persons, and the provision of services which may be below the accepted standards of medical care. The only concern is that these may in the end to be counter-productive and negate the primary objectives and spirit of the Act and Regulations (PHFSA Memorandum, 2006).

Certain innovations arising from the managed care movement in America can possibly be considered for adoption in Malaysia (Robinson and Steiner, 1998). For example, several groups of GPs have begun suing MCOs for deliberate delay in reimbursement, despite the contractual processing time of less than 60 days. It is perhaps timely for GPs in Malaysia to consider the same course of action for much delayed reimbursements. At the very least, some recourse for late payment interests should be allowed but punitive measures are probably needed to expedite the demise of such bad business tactics (Quek, 2000).

Although it is important to have penalties for deterring payments, it is, however, not sufficient. There were reports of MCOs going bankrupt and unable to pay anything. As stated by Quek (2000), re-insurable premiums with a Central Bank could be made a mandatory requirement which can then serve to protect plan-buyer. A proper documentation and systematic monitoring of managed care operations may assist in reducing the number of problems faced.

There has been increasing pressure for doctors to adopt business strategies, which is in direct conflict with their professional ideals. Doctors must be trained and persuaded to resist such trends. Medical ethics must never be compromised but made a priority in the medical practice. Instead, as a group, doctors should lobby for the government to work harder towards seeking a fair solution to ensure the continuity of comprehensive healthcare coverage for all Malaysians today and in the future. Respondents also suggested that all MCOs be merged into one entity and all clinics be appointed as a partner to provide healthcare services.

Dr. Steven Chow, President of FPMPAM, in his speech made at the Perak Medical Practitioners Society's President Installation Dinner (2013), expressed his concern that Malaysia is now seeing the dawn of commercialization of medicine. He further stressed that it the duty of doctors to inform their patients and the public of the sad state of health that will confront them if all these trends of commercialization of medical education and medical care are left unchecked.

The survey also managed to gather some recommendations proposed by the GPs themselves as shown in Table 6. The recommendation that top the list is to impose late charges on MCOs for delayed payment as compensation for the loss of operation cost and time. On another matter, the GPs also recommended that MCOs removes the capitation for medication prices in order to allow GPs with more liberty on decision to provide the best treatment possible in the interest of the patients. A handful of them also suggested MCOs to have regular review of their operation and existing system to ensure continuous growth

and better development. Other recommendations were listed in Table 6 for future considerations and improvements.

**Table 6: Recommendations suggested by GP (n=434)**

| Recommendations | n | % |
|---|---|---|
| Late charges to MCO for delayed payment | 57 | 13.1 |
| No cap on medication prices | 29 | 6.7 |
| Regular review system | 24 | 5.5 |
| Revise fee | 15 | 3.5 |
| Stop MCO from keeping part of medical fee | 11 | 2.5 |
| Independent body for patients to complain | 11 | 2.5 |
| Respect doctors and medical ethics | 9 | 2.1 |
| Abolish MCO | 6 | 1.4 |
| Common terms for all clinics | 6 | 1.4 |
| Transparency | 5 | 1.2 |
| No limit to claimable amount | 4 | 0.9 |
| Must be properly regulated | 4 | 0.9 |
| Application is opened to all clinics | 2 | 0.5 |
| To seek patient consent before revealing info to MCO | 2 | 0.5 |
| Special rate for house calls and overtime charges | 1 | 0.2 |

**Summary**

This is a general study on the problems and challenges faced in Malaysia with regards to MCO services. The outcome of this study provides insight into the everyday challenge of the healthcare system with MCOs. The findings will hopefully be used as evidence for health policy makers to seriously look into the management of MCOs for the betterment of our healthcare. The study focuses on the challenges faced by GPs who are providing the services but it may serve as a platform to assess the magnitude of this problem and its impact on the patients. Further study is vital to understand the overall impact of MCO services in the country because its growth has many implications for patients, doctors, healthcare institutions, employers, medical education and research.

**References**


Abdul Hamid bin Abdul Kadir. (2000). Managed Care: Implications of Managed Care for Health Systems, Clinicians and Patients. *Paper presented at the 2nd Annual Medico-Legal Conference*

Aidalina Mahmud. (2010). Kajian ke atas Doktor-doktor Swasta di Kuala Lumpur dan Selangor. UKM

*Asian Development Bank (ADB) Annual Report*. (1985). Health Services Planning in Malaysia (Paper presented at a Seminar held on June 22, 1998)

Association of Private Hospitals in Malaysia. (2001). *Consensus Paper on Managed Care Organisations.*

Brudevold, C. McGhee, SM. Ho, LM. (2000). Contract Medicine Arrangements in Hong Kong, *Social Science & Medicine*, Vol 51, No.8 (Oct)

Chow, Steven. (2013). Private Medical Practice in Malaysia-State of Health 2013, S*peech made at the Perak Medical Practitioners Society's President Installation on 8th September 2013 at Impiana Hotel, Ipoh, Perak*

Feldstein, P.J. (1979). *Health Care Economics*. New York. John Wiley and Sons

Folland, S., Goodman, A.C. and Stano, M. (1993). The Economics of Health and Health Care. Earglewood Cliffs, New Jersey: Prentice Hall

Lum, Milton. (May 2007). Middlemen in Healthcare, *The Star*

*Malaysian Business*. (2000). Your Money or Your Life

*Malaysian Insider*. (2014). Doctors boycott insurance company over unreasonable terms

Marzolf, J.R. (2002). The Indonesian Private Health Sector (Discussion Paper). *World Bank*

Phua, K.L. (2000). HMOs and Managed Care in Malaysia: What Can We Anticipate from the Experience of Singapore and the United States? *Buletin Kesihatan Masyarakat Isu Khas*

Rauber, C. (1999). Managed Care Storms Malaysia, *Modern Healthcare*, Vol. 29, No. 46 (November) pp 50-55

Raymond, A.G. (1994). The HMO Health Care Companion. New York: Harper Perenial

Robinson, R. and Steiner, A. (1998). Managed Health Care: U.S. Evidence and Lessons for the National Health Service. Buckingham and Philadephioa: Open University Press

S. Ibrahim, Mohd. Rizal and A.N. Aizudding. (2015). Managed Care: What do Private General Practitioners (GPs) Think?. *GTAR-2015*, Vol 2, 87-89

Simonet, Daniel (2009). Managed Care Expansion to Asia: A Critical Review, *Asian-Pacific Economic Literature*, Vol. 23, Issue 2, pp 29-51

*The Star. (October 2013), Choking from High Medical Fees.*

*The Star*. (April 2008). Docs and ING in Stalemate over Proposal

*The Star*. (April 2008). Managing Healthcare,

*The Star*. (April 2008) MCOs yet to register with ministry-Open Letter from Tan Sri Dr Mohd Ismail Merican, Director General of Health, Malaysia

Quek, David. (2000). Changing Paradigms in Malaysian Health Care: What future managed care portends for Malaysian doctors

*Washington Post*. (April 1999). Cutting Health Costs Slices into Charity

World Health Organization (WHO). 2005. Social Health Insurance. Selected Case Studies from Asia and the Pacific.

Zafer Ahmed (1990). Managed Care-Malaysian Perspective. *Health Care Financing in Malaysia*