2016

MALAYSIAN MEDICAL ASSOCIATION

A Study on the Landscape of General Practitioners in Malaysia

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INTRODUCTION

Malaysia's healthcare system is divided into the public and the private sector. The public health care sector is heavily funded by the government, with patients paying a nominal sum for treatment. Meanwhile, medical fees for private health care services are paid fully by the patients themselves, their employers or by insurance companies. The number of hospitals, clinics and dental surgeries has increased tremendously in Malaysia over the last decade. At present, both the private and public health care sectors are both still expanding (Inside Malaysia, July 2012).

In the public sector, although there are other ministries providing health care services, the Ministry of Health (MoH) is the main government agency responsible for the delivery of health care services in the country (Chee, 1990). Other ministries would include Ministry of Higher Education and the Ministry of Women, Family and Community Development. Under the MoH, there are four types of hospitals (district hospitals, state general hospitals, national referral centres and special institutions. There are also several non-MoH hospitals (Inside Malaysia, July 2012).

One of the first components of the private healthcare system of this country is the General Practitioners or also known as GPs. In Malaysia, GPs were the first private health care service providers in the country and were well respected by the local

community. Specialists were only a handful in the 70s and 80s and therefore GPs were considered ‘family specialists’. This group of doctors started providing primary health care services to the general public till late evenings and have historically been important healthcare providers in urban areas in Malaysia. In Malaysia, all doctors have to first serve their housemanship in public hospitals before seeking to join private service.

Polyclinics were not many in existence then and the 1Malaysia Clinic had not been introduced. General Practitioners were attending to various types of health issues in families. They were able to provide the best health care possible directly to the patients. There were no third party involved and treatments were rarely compromised. GPs had the upper-hand of deciding what was best for the patient without the influence and involvement of external parties.

In terms of regulations, GPs in the early years were not bogged down by various rules and regulations particularly in relation to their infrastructure and medical equipment. They only had the Medical Act 1971 and needed to abide to their professional conduct which was monitored by the Malaysian Medical Council (MMC). After completing 4 years of compulsory service with the government, GPs are allowed to start their own private health care facility.

To start a clinic then, a doctor only needed to register with the MMC to make certain that they are qualified to practise as a doctor. The Annual Practicing Certificate (APC) was not a requirement. In the early years, the main routine work of a private clinic was to keep decent medical records, a precise record of drugs stocked, and maintain an accurate financial account for the Inland Revenue Board (The Star Online, January 2011).

Presently, the setting up of medical and health care practice requires the intended professional to register with the Companies Commissions of Malaysia (CCM) under the Registration of Business Act 1956 or incorporate a company under the Companies Act, 1965. The following are the necessary licensing conditions specified by the respective licensing authorities of the accredited professional services:

Table 1 : Licensing Conditions for Persons Intending to Set Up Private Practices

Accredited Professional Services	Licensing Conditions	Licensing Authorities
Medical Services	Full Registration Certificate and Annual Practicing Certificate	Malaysia Medical Council
Dental Services	Annual Practicing Certificate	Malaysia Dental Council
Pharmacy Services	Full Registration Certificate Licence A under Poisons Act, 1952	Pharmacy Board of Malaysia Licensing Officer

Source: Medical and Healthcare Services Booklet

The Malaysian Ministry of Health's vision is for Malaysia to be a nation of healthy individuals, families and communities, through a health system that is equitable, efficient, technologically appropriate, environmentally adaptable and consumer-friendly, with emphasis on quality, innovation, health promotion and respect for human dignity and which promotes individual's responsibility and community participation towards an enhanced quality of life. Although the main focus of the health sector is to achieve "Quality of Life of an Advanced Nation", the health sector also has roles to play in the other strategic directions i.e complementing other agencies in their transformation programmes.

As part of the government's health initiatives, the formation of *1Malaysia Clinics* was being announced in the 2010 Budget. The clinics, with over 50 outlets nationwide, are located in various housing areas. It was formed for residents who either lived too far from private clinics or could not afford its services (Utusan Online, 2010). However, the recent years has witnessed the sprouting of many new 1Malaysia Clinics, sometimes in the midst of GP Clinics in the same row of shop. In situations such as this, the objective of this government clinic is not met and the wrong groups of community are targeted for public health care services.

Despite this, the landscape of the Malaysian health is constantly changing. Provision of private care, especially in large urban towns, has grown due to an increase in public demand (Ng, Noran, Ng and Adeeba, 2012). Findings of recent years had indicated that despite the development and improvement in the public health care

system, there has been an increase in demand for private care. Some evidence indicated that there is a continued maintenance of Universal Health Care (UHC) in Malaysia, despite the rapid development and increase of demand for private health care in this country (Health Policy Research Associates, 2013). Such findings reflect positively on the role of General Practitioners and Private Health care as a whole in this country. With the combination of quality clinical practice, compulsory vocational training prior to entry into General Practice along with a positive move towards preventive health care and chronic disease management, GPs have a lot to offer to the improvement of health care in Malaysia. It is important, therefore, for the Malaysian government to acknowledge the significant role GPs play in this country and complement each other accordingly.

According to Gilson, Doherty, Loewenson and Francis (2007), a country is said to have achieved UHC *"when the whole population of a country has access to good quality services according to the needs and preferences, regardless of income levels, objectives of equity in payments (where the rich pays more than the poor), financial protection (where people should not become poor as a result of using health care) and equity in access or utilisation (where care received is according to need rather than ability to pay)"*.

In order to meet this goal of UHC, a strong, efficient, well-run health system is needed. A system for financing health services, access to essential medicines and technologies and a sufficient capacity of well-trained, motivated health workers is

also required (www.who.int/universal_health_coverage/en/). Based on how important UHC is to the health care system of a country, it is vital that all health care facilities (public and private) in Malaysia work towards making UHC a reality in this nation. General Practitioners who are already serving the people with the UHC in mind should be given visibility, funding and support to continue their good work in serving the community.

Therefore, this study attempts to reinstate the importance of General Practitioners in this country. Despite the improvement in the public health care system and the services offered by the Malaysian government, the long-standing roles of GPs have not only stood the test of time but have also proven to be more flexible, adaptable, accessible and relevant in these recent years. Therefore, it is timely and important to document the current landscape of General Practitioners in Malaysia and to identify some of the interventions needed to enable them to make larger contributions to the country. It also hopes to highlight some of the challenges and issues surrounding GPs today and identify collaborations needed with various agencies in addressing these issues. Hence the specific aim of this study is as follows:

1. To understand the issues and challenges surrounding GP practice;
2. To describe the current health economics aspects of the GP practice; and
3. To identify relevant interventions to enable the GP to move forward in the public health care system.

PRIVATISATION OF HEALTH CARE SERVICES IN MALAYSIA

Private practitioners have historically been important healthcare providers in urban areas in Malaysia. Private hospitals and specialists clinics have been mushrooming since the 1980s (Chee, 1990). In the mid 1980s, the Malaysian government initiated a programme on economic liberalisation and deregulation that included a comprehensive privatisation policy. This was in connection with the "Malaysia incorporated" concept which saw the government as the provider of an enabling environment and the private sector as the engine of growth (Economic Planning Unit, 1985).

The launch of the Privatisation Master Plan (PMP) in 1991 included healthcare for private ownership. In 1980, there were 50 private hospitals and this grew to 220 in 2011. By 2011, there were 6,589 General Practitioners in this country (Awang Bulgiba, 2013). The increase in the number of GPs throughout these years indicates that these are still a relevant group of professionals and that their services are very much in demand.

Presently, the private health care system in Malaysia makes up about one third of the medical treatment available here. The doctors practicing in this sector carry excellent credentials with training background in the public sector. GPs receive appropriate and extensive training prior to joining the practice. Most GPs, particularly

the older one, had excellent training as the number of doctors in government hospitals was low and the workload was heavy. In short, these doctors have the experience of both worlds and the credentials to offer the best comprehensive universal health care to their patients (www.malaysia-healthcare-insurance.com).

Private clinics are divided into two; Single ownership (Solo-practitioner) and Group practices. The first is small in size and number of clinics. It always runs on small capital and operates very few hours. These types of clinics may have very limited facilities/equipment. In reverse, group practices have a chain of clinics. It operates on larger capital and longer hours. These clinics may have more expensive equipment in place. The majority of GPs are now in group practice particularly because it provides for the financial health of their clinics.

According to Syed Mohd Aljunid (2014), patients prefer private health care facilities due to its nature of business. This includes opening during weekends, shorter waiting time and better interpersonal relationships. Private clinics also offer comfort and personalised services for its patients. There is still personalised treatment between doctors and patients today, but it is not the same relationship as before. The existence of healthcare financers influence this relationship as they dictate many aspects of the health care services offered to the clients (New Straits Times Online, 12 May 2016). Therefore, taking into account the importance of proximity between GPs and the community they serve, it is then vital for the Malaysian government to

acknowledge the problems these financers present and seek recommendations from GPs on how to address the issues at hand.

With the privatisation of health care services in Malaysia, patients now are spoilt for choices when it comes to specialty treatment, whether in government, university or private practice. Therefore, GPs simply become a conduit for referrals and patients avoid getting full course of treatment from them. GPs are known to treat patients holistically, especially if they require treatment for diseases that are not critical (NST Online, 12 May 2016). Their role in primary health care cannot be short-changed and should be revived.

HISTORY OF HEALTH CARE IN MALAYSIA

Health care is defined as 'services provided to individuals or communities by health service providers for the purpose of promoting, monitoring and restoring health' (WHO, 2004). The health care system of Malaysia has experienced great changes over time since the establishment of the first hospital in Malaysia – Taiping Hospital in the year 1880. Currently, there are 139 government hospitals and 2836 health clinics serving the public as front liners.

Although not much is known about the early history of health care in Malaysia, its early provision was centred on Malay traditional medicine, Hindu mythology, muslim orthodoxy and Arab pharmacopoeia (Awang Bulgiba, 2013). According to Bulgiba (2013), the Malaysian experience was that the government has always been the main provider of health care in Malaysia with preventive care being exclusively theirs. In the 1950s, the Malaysian government was the only one providing preventive care whilst the private sector concentrated on curative care (Bulgiba, 2013). Now, private practices like GPs have taken on the same role to complement the government's services for a different set of clients.

Under the 11th Malaysian Plan, Malaysia is targeted to have a 1:400 doctor to population ratio by the year 2020. In addition to that, the GP settings have also grown tremendously to complement the gaps in services and serves as alternatives for the people. With the ever-increasing number of health care facilities and professionals, the need to continuously review the current setup is essential. The health care industry can be a robust economic engine and one that directly creates significant social impact.

THE MALAYSIAN HEALTH CARE SYSTEM

Malaysia's existing health care system comprising of the public and private system is a two-tier system. The private system mainly caters for the urban population and those who can pay while the public system provides access to everyone (including

civil servants) with token payments being imposed. The existing two-tier system has so far served Malaysia well and any consideration for restructuring must take into account a few pertinent issues.

Firstly, equity must be ensured with better access to health. There must also be universal coverage and the values of a “caring society” must be internalized into the system. It must also be consistent with the vision for health, Telehealth Blueprint (an initiative by the Malaysian government to employ the use of telehealth in the country’s health care system) and the eight goals of the health system. Finally, the system must be efficient, effective and affordable (Abu Bakar Suleiman, 2002). The GP services takes into account all these issues in their daily dealings with the public and should be given significance in the process of restructuring.

Health system refers to the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities. A health system is usually organized at various levels, starting at the community level or the primary level of health care and proceeding through the intermediate to the central level (WHO, 2004).

The Malaysian health care system is a publicly funded system which has been successful at a moderate cost in dealing with the major public health priorities. The public health system caters for the health care needs of the majority of the population. The private sector plays a significant role in healthcare especially in the urban areas. This system is self-sustainable and replicates the public system from primary care general practitioner clinics to tertiary care services. A study by Yu, Whynes and Sach (2008) showed that Malaysia's two-tier health system, of a heavily subsidised public sector and a user charged private sector, has produced a progressive health financing system.

Without sidelining the importance of public health facilities, it is also pertinent to note that without the private health care services such as GPs, the government clinics and hospitals will be flooded with patients from all walks of life and operated by doctors who would be overwhelmed and burdened with such a situation. Malaysia is an example of a middle income country with a long established system providing universal access to a comprehensive package of health care services to all level of society. This can only be maintained through a progressive health care development both in the public and private sector. Figure 1 depicts the overview of the current Malaysian Health System.

Health Policy in Malaysia

According to World Health Organization (WHO), health policy refers to decisions, plans and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can define a vision for the future, which in turn helps to establish targets and points of reference for the short and medium term. Once the policies are in place, priorities and the expected roles of different groups and outlined, consensus are built and people are informed (WHO, 2004).

In Malaysia, the National Health Policy indicates the types and magnitudes of expected changes in the health sector by 2020, the values that guide the policy, the future health service delivery and the role of stakeholders. The policy development has improved over the years particularly in the development of the 5-year rolling health plan. In its five-year plans, MoH adopts both rational and pragmatic approaches to health planning by incorporating a strategy of setting priorities.

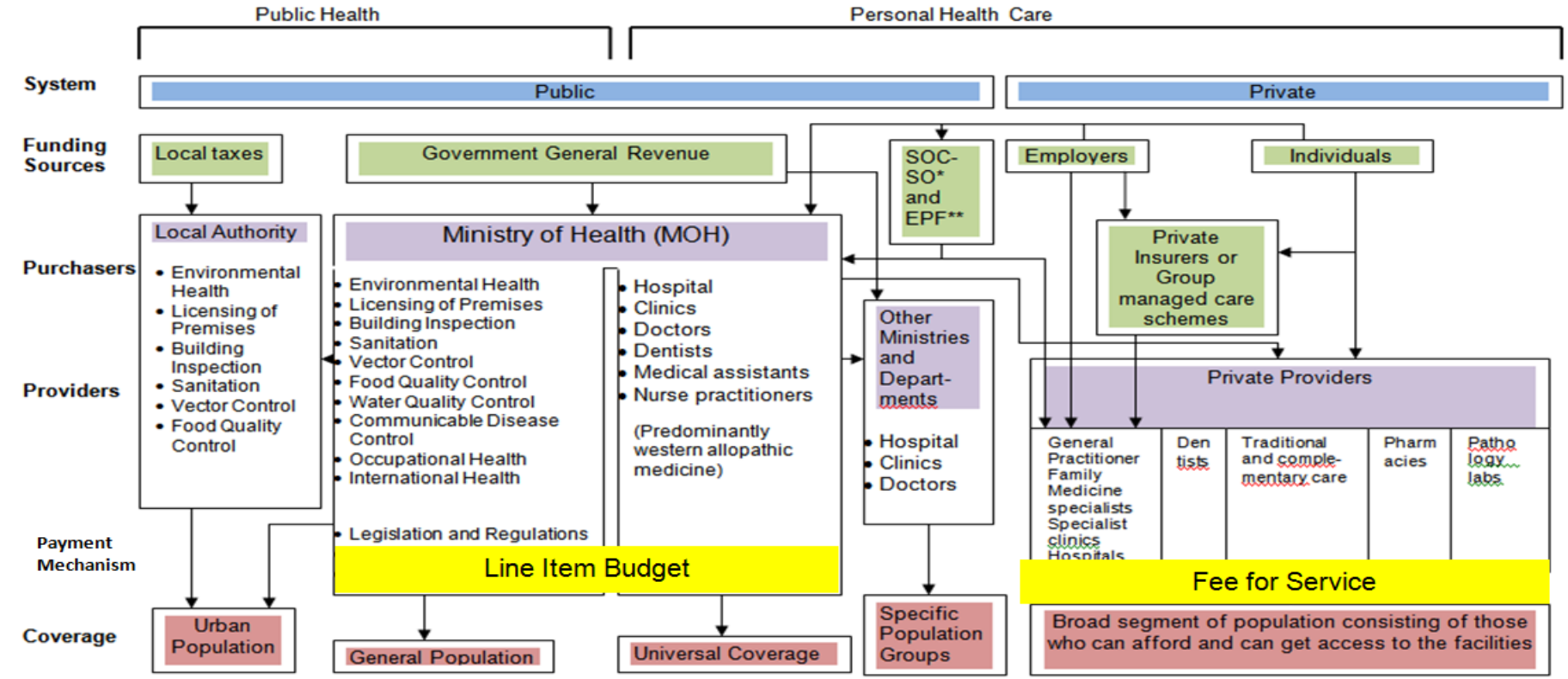
There are at least three (3) main policy issues that are important in the present health care scenario in Malaysia. One of the major challenges in facing the Malaysian health system currently is the development of sustainable policy to address changing health care needs of the population. At present, all policies pertaining to health matters are developed by the Ministry of Health. Even at the central, there is minimal consultation with other ministries and stakeholders during

the development of policies. The “Health in all Policies” is not possible without the involvement and constructive input from various parties such as GPs.

Therefore, whenever new policies are developed for implementation, they fail to address important issues that might affect the provision off quality care and efficient services. The policies often do no not reflect the demand and need of the local population. The Ministry should also make it a norm to consult with health experts in other sectors prior to developing important policies. Stakeholders of various health policies should also be consulted from time to time for their valuable inputs. The various policies that are currently in place includes (but not limited to) the following:

i) Emergency Medicine and Trauma Services Policy
ii) Psychiatric and Mental Health Service Operational Policy
iii) Unrelated Living Organ Donation: Policy & Procedures
iv) Policies and Procedures on Infection Control
v) Malaysian National Medicines Policy (MNMP)

Figure 1: Overview of the Current Malaysian Health System



NHMS2011 – only medical visit)

Hospital Admissions - 74% : 26%
Outpatient contacts - 49% : 51%

HCDA study

* SOCSO - Social Security Organisation
** EPF - Employee Provident Fund

Source: *Rozita Halina Hussein,* **Asia Pacific Region Country Health Financing Profiles: Malaysia,** *Institute for Health Systems Research*

The Health Management Information System (HMIS) was established in Malaysia to assist in the development of policy and health planning. However, this is also very centralized. Collated data from the district and state level are normally sent to MoH headquarters for processing and storing. Sharing of these analysed data is unheard of. One would have to cut through bureaucratic tapes in order to have access to these data. Therefore, although GPs are requested to provide certain clinical data for the purpose of information sharing, the same unfortunately may not apply to MoH. In order to achieve a more holistic health care service and in order to complement each others' effort, a certain level of transparency and accountability is needed from all parties.

Most of the policies, therefore, are likely to be influenced by political agenda than professionalism (Syed Mohamed Aljunid, 2014). Health policies reveal the values and the strategic direction that drives the country's health system towards achieving its vision. Unfortunately in Malaysia, the health care policy in place creates a divide between the public and all other sectors. What should be in place is the "Health in all Policies" concept. With this concept, the Ministry can ensure the inclusion of health in various ministries and offer a more holistic approach in solving the health care issues of the country.

Major Challenges for Public Health in Malaysia

The 3 major challenges for the future in terms of public health is the rise in lifestyle diseases, ageing population and the rapid spread of infectious diseases (Awang Bulgiba, 2013).

(i) Rise in Non-communicable Diseases (NCD)

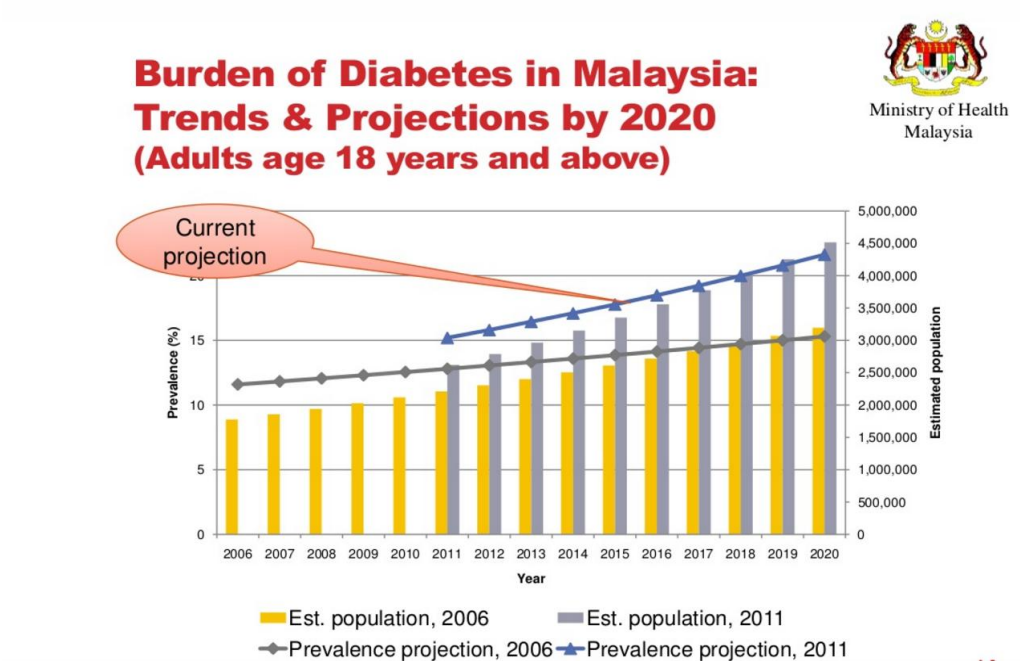
The rise in lifestyle diseases such as diabetic, heart disease and cancer is in tandem with sedentary lifestyles and environmental changes. The increasing prevalence of Non Communicable Disease (NCD) around the world is well-documented and its projection suggests a frightening increase in prevalence around the world (Shajahan, Chan, Reidpath and Allotey, 2012).

In 2012, an estimated 52% of all deaths under the age of 70 were due to NCDs, and three quarters of those deaths were caused by cardiovascular diseases (CVD), cancer, diabetes and chronic respiratory disease (CRD). NCDs are estimated to kill around 38 million people per year, accounting for 68% of all deaths worldwide. It is fast replacing infectious diseases and malnutrition and is the leading causes of disability and premature deaths (WHO, 2015).

According to RAM Ratings (a ratings agency), as the country's middle class group expands, more money will be spent on health care in Malaysia. Higher health care spending is expected in Malaysia and three other South East Asian countries, spurred by growing income levels and increased awareness on health. There is high probability of this segment of the population turning to private healthcare. Therefore, the demand for GP services is expected to rise in the future to meet the needs of this population.

The lifestyle of the young middle class population may also lead to many Non Communicable Diseases such as diabetic. Malaysia is among the top ten countries in the world with high percentage of adult population living with diabetes (Shajahan, Chan, Reidpath & Allotey, 2012). Figure 2 presents the burden of diabetics in Malaysia by 2020.

Figure 2: Burden of Diabetics in Malaysia by 2020



Source: Ministry of Health

It is difficult to overstate the importance of health promotion and disease prevention in regard to NCDs, which are associated with a number of risk factors that present excellent opportunities for interventions at the population level. As such, it is undeniable that GPs play an important role at the population level. A multi-sectoral consultation and collaboration is needed to form relevant policies in the effort to combat NCDs in the country. The Ministry of Health, on its own, would not be able to address this issue which has not only affected our country but all over the world.

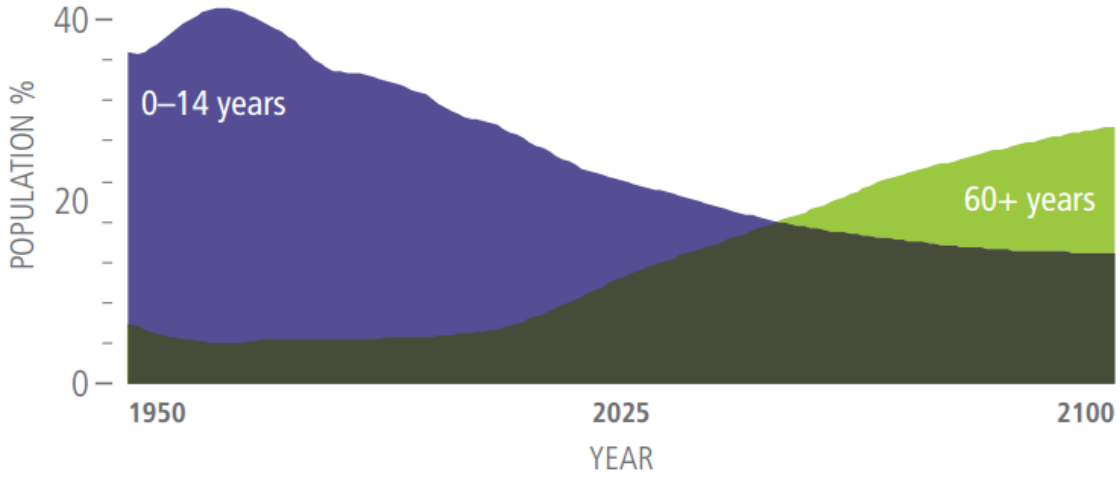
The Health-in-All-Policies approach can only take place in such a platform. Early detection, diagnosis and treatment of NCDs particularly by General Practitioners need to be highlighted. Awareness and early detection of NCDs can prevent major health issues and help reduce any future financial burdens particularly for our aging community. NCD incidence and mortality has shown to increase sharply with age (WHO, 2015). Therefore, with the projected increase of the ageing population in years to come, the Malaysian government should welcome any and all medical assistance particularly from GPs who have the experience of preventing and treating these diseases.

(ii) Ageing population

It has been reported that Malaysia will be an ageing nation by 2035, when 15 per cent of the population are classified as senior citizens (The News Straits Times,

2016). According to the World Health Organization, the population of Malaysia will increase by 31.2% over the next two decades, reaching over 37 million by 2030. The proportion of the population aged 60 years and above is projected to increase from 7.7% of the population in 2010 to 14.7% in 2030 and is projected to exceed that of the younger population aged 0–14 years in 2049. Figure 3 depicts the population trend in the younger and the older group in Malaysia.

Figure 3. Population trend in the younger and the older group in Malaysia.



Source: WHO Western Pacific Region (2014)

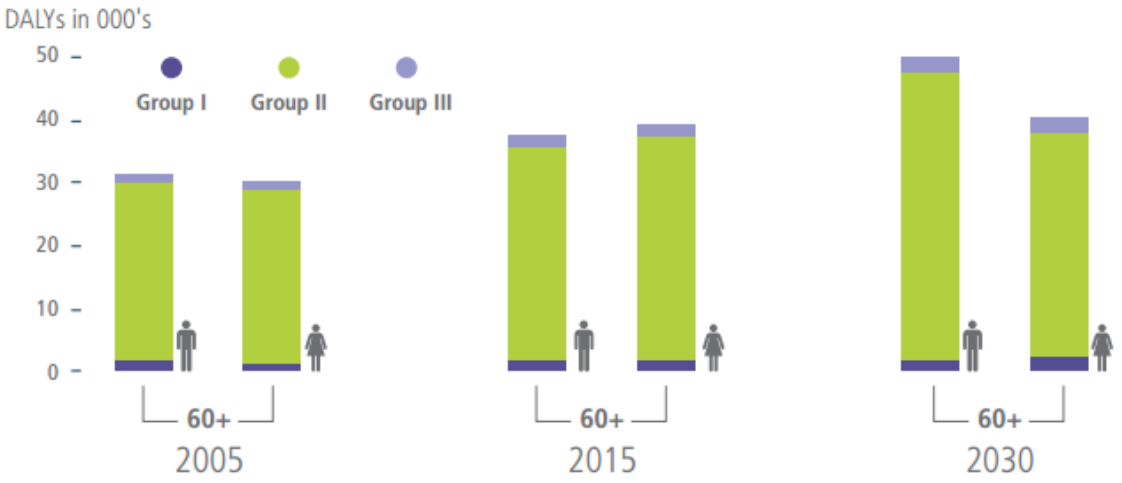
The population pyramid for Malaysia shows a large number of people in the younger age bracket and a steady decline of number of people at old ages. However, compared to 2010, the 2030 pyramid shows a greater number of people will be present in the middle and older age group. Figure 4 depicts the population comparison by age and sex in 2010 compared to 2030.

With the increase in the ageing population, the burden of disease is expected to also increase in Malaysia. Figure 5 depicts the burden of disease estimates and projections for persons aged 60 years and above in the Western Pacific region by major disease. The figure shows that Group II conditions which refers to NCD will continue to increase and hold the leading position for burden in disease in the Western Pacific Region where Malaysia is within this region. Therefore it is important for Malaysia to adapt health systems and to account for the professional services from GP within the healthcare system reforms to serve a growing number and proportion of older persons and to maximize health and well-being at all ages.

Figure 4. Population comparison by age and sex in 2010-2030.

Source: WHO Western Pacific Region (2014)

Figure 5. Burden of disease estimates and projections for persons aged 60 years and above in the Western Pacific Region by major disease group and gender, 205, 2015, 2030.



Source: WHO Western Pacific Region (2014)

(iii) Rapid spread of infectious diseases

In addition, there is also a rise in the number of cases related to infectious diseases. High risk behaviors such as unprotected sex with multiple partners and substance abuse may also lead to risk of various conditions or infections like Hepatitis C, HIV and other Sexually Transmitted Infections (STIs). The rise in such diseases will need the assistance of various parties. GPs are usually viewed as “non-judgmental” and more frequently visited in connection to STIs in comparison to government clinics and hospitals. The fear of being stigmatised and discriminated discourages them from seeking consultation and treatment from government-run health care facilities.

Therefore, the role of GPs is still relevant and important in providing consultation and carrying out early detection particularly in health areas that are considered a taboo in society. Without the services offered by GPs, patients of infectious diseases like HIV and other STIs may go unidentified and untreated for years. Infectious diseases that remain undiagnosed and untreated can be considered a national threat.

Taking this into consideration, due recognition and appreciation towards the contribution of GPs in this country should be met with assistance and support by MoH and other relevant agencies. The role of GPs in the community cannot be undermined and they should not be treated like strangers in the health care system of this country. Their opinions should matter and their voices must be heard. This is vital in ensuring that the health care of the community is protected.

The Malaysian Medical Association and its role

The Malaysian Medical Association or better known as MMA is the premier organization for the medical profession in Malaysia. Its aim and objectives are:

- To promote and maintain the honour and interest of the profession of medicine in all its branches and in every one of its segments and to sustain the professional standards of medical ethics.

- To serve as the vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to

education and directing public opinion on the problems of public health and affecting the community at large.

- To participate in the conduct of medical education, as may be appropriate.
- To promote social, cultural and charitable activities in building a united Malaysian Nation.
- To participate in, or invest a portion of the Association's funds in any entity corporation, association or by way of joint venture, business partnership, commercial agreement, transaction and/or any legal means permitted which would be in the interest of the association, and beneficial to, and be advantageous, profitable or calculated directly or indirectly to enhance any or all of the Association's fixed, current, liquid assets, properties, business, investments, commercial arrangements, and rights, provided always that they be not in conflict with the Code of Medical Ethics.

MMA was established in the 1950s to take over the functions of the Malayan Branch of the British Association following its dissolution in Malaya. The 1970s proved to be a fruitful and active decade for MMA. It consolidated its objectives and became deeply rooted in the medical profession. In the early 80s, MMA's membership experienced a growth spurt. In October 1990, MMA turned 30 years old and established its online presence. It continued to make important contributions to major health care issues.

In this millennium, MMA is steadily growing. It shows significant growth in health-related activities and campaigns and has ventured into new areas in the health sector. As the premier organization for the medical profession in this country, MMA continues to voice concerns of the doctors who are members of its association. The relationship between the Ministry of Health and the Malaysian Medical Association is one that is steadfast and symbiotic. However, there are still many areas for improvement. Therefore, in order to complement each other, a comprehensive understanding of the Malaysian health care situation is needed and GPs need to be understood and viewed as an important wing of the country's health care.

METHODOLOGY

This study used both a quantitative and qualitative study design. A descriptive and correlational survey research design was used to describe the current landscape of General Practitioners in Malaysia and to identify some of the interventions needed to enable them to make larger contributions to the country.

Meanwhile, the qualitative study design was used to understand the issues surrounding general practice in private clinics. A focus group discussion (FGD) was used to elicit information from the GPs who are the main stake holder in this study. A focus group discussion is a method of qualitative research that involves discussing a specific set of issues with a pre-determined group of people (Hennik, 2007). In this study the FGD were called stake holder engagement. The stakeholder engagements

were organised in each state. The purpose of this engagement was to better understand and highlight the following issues:

1. Perceived factors that have influenced public perception on General Practitioners.
2. Third Party Agencies and Patient Quality Care
3. Effects of various parties (i.e Third Party Administrators, Managed Care Organizations, Insurance Companies) on Patient Quality Care.
4. Implications of fee capping on GP services.
5. Role of Ministry of Health with regards to GP businesses.
6. Key factors affecting health economics of GP services.
7. Interventions for a more comprehensive GP system.

Study sample

For the quantitative study, the study sample comprised of 1800 General Practitioners throughout Malaysia selected using convenient sampling technique based on respondents' willingness to participate in the study.

For the qualitative study, a total of 78 GPs took part in the discussion group discussion (FGD) referred as stakeholder engagements. A total of 13 FGDs was conducted involving the GP throughout Malaysia. Each FGD comprises of to 5-7GPs.

Study Instrument

For the focus group discussion, the discussion was held guided by six (6) questions posed to the GPs to discover some of the main issues surrounding the GPs in Malaysia.

In addition, this study also compiled findings from secondary data from various other documents.

RESULT

Stakeholder Engagement

The following are the major points and issues highlighted in the discussions:

A. Relevancy of General Practitioners

All of the GPs who participated in the stakeholders' engagement believe that their profession has not lost its place in the eyes of the public. In their opinion, they are still an important component of the private health care services of the country and should not be sidelined. They have been in existence since the early years have and served many families in the local community. Many doctors have built a strong relationship with the community and continue to serve different generation of family

members. This is evidenced by the fact that their profession is still given great importance by the community they serve and their expertise is appreciated and respected by the people.

B. The need for collaboration between GP private clinics and the Ministry of Health

General Practitioners serve patients from different walks of life. Although many are existing and returning patients, there are also new patients who require their services. With 1Malaysia Clinics mushrooming in various parts of the states in Malaysia, most of GPs in this study state that they are now treating patients who may have earlier visited the said government clinics and obtained basic medications for their conditions. For further consultation, these patients visited the GP clinics in the neighbourhood and be treated accordingly. Health care that was once straightforward has now led people to a wider, but not necessarily effective range of services.

This could be made effective if the Malaysian government could work in collaboration with GPs and use the existing network of private clinics to provide the services intended for the urban poor. With government resources and through the network and expertise of GPs, a more comprehensive and effective quality health care may be made available for the surrounding community. This emphasizes the importance

of the development of a one-tier health system by neither compromising quality care nor creating added financial burden on private practitioners.

C. Growing confidence in Specialist Centers: A need to redirect

The stakeholder engagement also highlighted another pertinent issue. Many GPs shared that more and more patients today want to be referred almost immediately to Specialist Centers. Due to a growing number of Specialists in the country, patients, particularly from the middle-income groups are inclined towards these health care providers. Primary health care is now secondary as patients expect a quick and fast approach to their self-diagnosed medical conditions. They no longer need GPs to treat them holistically, which is of utmost important to the full recovery of a patient.

The community as a whole needs to be redirected towards the importance of primary health care services where early detection and treatment of diseases and ailments are done. GPs and other health care providers must also constantly and consistently upgrade their knowledge and skills to provide a range of services for patients. A surgical practice like stitching is apparently a service not offered by all doctors and this may compromise the health care offered at the clinics.

The GP clinics in the past used to be a place for anything and everything concerning family health. Many GPs described it as a place “from womb to tomb”. All GPs in this engagement claimed that they were respected and sought after for their expertise. With the growing number of Specialist Centers in this country, GPs believe that it is

timely to revive the interest of the public in their practices and upgrade their knowledge and skills in accordance to the health issues of today. They must once again be the “One Stop Centre” of the people they serve.

D. Fee capping and Patient Quality Care (PQC)

When asked about the challenges faced by the GPs in their work relationship with the TPAs (Third Party Administrators), Managed Care Organizations (MCOs) and other third parties, all 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.

After 12 long years, the 13th Schedule was incorporated into the Private Healthcare and Facilities Act 2006. Unfortunately, these parties do not always adhere to these rates and therefore GPs are paid much lower than the norm. According to the GPs during the discussion, even if a capping system is required, it should be done by a professional doctor who would understand the medical scenario. They have also expressed a sense of biasness when doctor’s fees are controlled yet hospitals are cap-free. This scenario may cause patient immediate care to be compromised and create a negative effect to a certain degree.

The problem also arises when budget allocation of an employee seeking treatment at a GP clinic has been exhausted. All GPs in this study feel that the role of medical practitioners is to provide health care services and not to sit and discuss exhausted budgets. There were also times when the GPs were unaware of the exhausted budget and had to end up absorbing the over-limit charges. Table 2 and Table 3 outlines the details of the consultation fee as stipulated in the *Private Healthcare Facilities and Services (PHFSA-(Amendments) Order 13*.

Table 2: Consultation Fees for Non-specialist

(a) First visit/Early consultation	
DETAILS	**FEES (RM)**
Consultation only Consultation and examination 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 Consultation and examination 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 3: Consultation Fees for Specialists

(a) First visit/Early consultation	
DETAILS	**FEES (RM)**
Consultation only Consultation and examination 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 Consultation and examination 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 (PHFSA-(Amendments) Order 13, Federal Government Gazette,)

Apart from that, most of GPs also stated during the FGD that fee capping influences the type of treatment given to patients. Better medication and treatment may not be covered by the health care packages and GPs are left with the option to either offset the charges and bear the added expenses or provide alternatives. Again, optimum health coverage is compromised and doctors are left with the feeling of helpless in order to remain in their practices.

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.

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. Therefore, all GPs suggested that a strict set of rules and regulations should be introduced and enforced. Similar to visits made at GP clinics, MoH officials should also make regular visits to MCOs and TPAs and closely monitor their operations in order to prevent any violations. It is also important to take note that the safety of patients is also compromised when they are required to travel far to seek treatment from panel doctors.

E. Influx of fresh graduate doctors

Although GPs who were interviewed were not in agreement that their profession may now be seen as a sun-set profession, all GPs felt that too many doctors are graduating now in comparison to yesteryears. With the influx of new doctors and the fee capping in their hardly-ever revised consultation fees, GPs feel that their profession is not as financially rewarding as it used to be. Therefore, there are groups of thoughts that consider this profession less than attractive particularly for the young in their families. The investment needed for education in this field would exceed the future returns.

Apart from that, oversupply of medical doctors in health care facilities would also mean that the quality of doctors graduating in the recent years may have been compromised. The issue is then to ensure that the Ministry of Health works hand-in-hand with the various educational institutions to ensure that the programmes offered are not just academically compliant but also enables the undergraduates to obtain sufficient practical experiences.

It is vital to ensure that the future doctors produced by this country are able to meet the health challenges that await the nation in years to come. In the words of a GP *"We hope that the future doctors are capable enough to take care of our health when we become old and need health care assistance ourselves".*

F. Role of Ministry of Health (MOH) in managing issues concerning GPs

At present, the GPs interviewed felt that the Ministry of Health has not been playing a major role, if any, in facilitating their businesses. Although the health system in Malaysia is currently two-tiers, all GPs feel like they have been sidelined throughout these years despite their contribution towards the primary health care of the nation. The Government's role, at present, feels authoritative and merely there to "put collar and chain" on GPs and does not seem "GP-friendly". Although GPs are placed with various rules and regulations and frequently visited by MOH officials, no follow-ups are done when grievances and concerns are raised. These issues were not followed-through and left GPs feeling frustrated.

Most of the issues raised by GPs are regarding MoH regulations particularly in terms of physical requirements for the clinic (eg. Door size, signboard). All GPs felt that these regulations, as important as they may be, have to be practical. 90% of all GPs also feel that while it is good for MoH to call GPs for suggestions, particularly through the Malaysian Medical Association, it is their hope that the suggestions would also be taken into serious consideration.

In the late 80s, the Malaysian government was encouraging doctors to open private clinics in order to meet the needs of a larger number of Malaysians requiring health care services. At that time, the government was unable to cope with the number of patients that were visiting the government health care facilities. GPs then stepped in

to help relieve the government's burden. It was a relationship that was complementing each other. Fast forward to the present time, the Malaysian government has now risen as a competitor for GP clinics particularly with the 1Malaysia Clinics. Therefore, all GPs feel that it is timely to now cash on the assistance once provided to MoH and search for ways to meet the expectations of both parties.

The Private Healthcare Facilities and Services Act 1998 that was designed for private practitioners consists of many good points. However, 70% of GPs in the stakeholder's engagement stated that GPs need to be brought in to play a more significant role and provide constructive input towards the development of various Acts and policies in the country. This is particularly for those concerning this group of professionals.

The Malaysian Medical Association should not just be a platform to voice out suggestions concerning various policies but should also represent GPs in various committees set up by the Ministry of Health for policy development. With such inclusion, regulations set up by MoH will be more practical and relevant to those in the industry. Representatives to such committees should not just comprise of lecturers in this field but more importantly the practicing family medicine doctors.

G. Health economics of GPs

Overall, the socio-economic situation of the country has contributed to the financial situation of GP businesses. With the increase in the number of doctors, the list of clientele is to be shared and the portion obtained by each doctor has somewhat reduced substantially. According to the all GPs, the introduction of Good and Services Tax (GST) in April 2015 has also taken a toll on their business.

Special services like Fomema had also taken a toll on the GPs. In the past few years, there was no increase in the x-ray fees. With the increase in the price of drugs, the cost of many of these services was actually absorbed by the GPs in order to maintain their clientele. In a recent study, the GPs interviewed stated that the cost of each x-ray is approximately RM 50- RM66 and Fomema only pays RM 25 per worker. It was expressed that Fomema refused to acknowledge the rising cost of x-ray facilities and this leads to the “out of pocket” expenses for GPs. The x-ray allocations via Fomema is without limit and termination of this service by GPs may cost them to lose out on providing medical services (Kenny, 2015).

In addition to the rising cost of x-rays yet refusal to increase payment from Fomema, GPs are now expected to upgrade to digital x-ray services. According to a GP in the said study, over the last two years, service providers have been asked to adhere to this upgrade request or risk the x-ray allocations being withdrawn. This led to many GPs spending approximately RM 60k for the upgrade with no sign of payment

increase from Fomema. In addition, GPs have to pay approximately RM 4 to a third party to transmit each x-ray (Kenny, 2015).

Fomema is also said to be contemplating that each x-ray report is to be done by a Radiologist, at the expense of the GP. This adds to the GP's financial strain. GPs also stressed that hiring of such positions is difficult especially for clinics far away from the city. Most of them are also overqualified to handle simple x-rays and may find their work less than challenging. Lower salaries will also not attract suitable candidates. A fresh out of college candidate will take up to 3 months to train due to high turnovers (Kenny, 2015)

Other costs that have had an impact on the GP businesses are utility bills, which increase 30%-40% every 5 years. According to all GPs, the increase in staff salary has also taken a toll on their businesses. The introduction of minimum wage by the Malaysian government has played a role in the increase in salary. The price of medication has also increased, sometimes twice a year. Therefore, the imposition of certain requirements and rules by the government with regards to the physical structure of the clinics (eg. Door size, toilet and signage) is seen as punitive and oppressive by 90% of the GPs in this session.

All GPs expressed that the increase in the cost of running their clinics is to be expected. However, these increased expenses can only be met by the local GPs with proper and continuous revision to their consultation fees. As the cost of running

a clinic witnesses a hike, so must the ability of GPs in the country to earn better income in comparison to years ago. With the involvement of TPAs and MCOs, GPs receive payments at a much later and irregular time. This irregularity sometimes causes GPs to fall behind in tracking the payments and therefore having to bear the costs on their own. The Inland Revenue also charges based on the invoice sent and not on payments received. This causes a problem as invoice sent may sometimes not translate into payments received from TPAs and MCOs and therefore adds to the financial burden of the GPs.

Survey Findings

The following are findings from the survey carried out throughout Malaysia. The main purpose of the survey is to describe the current landscape focusing on the health economics of GP practice in Malaysia.

A. Part A: Demographics

This section presents the demographic characteristics of the respondents. The aspects covered in this section include sex, ethnicity, clinic's location, clinic's locality, business startup costs, age of the respondent, year of clinic establishment, number of full-time doctors and part-time doctors. There are 1,142 male and 658 female in this study (Table 5). About half of the respondents were Malays, and the remaining respondents are Indian (24.8%), Chinese (21.4) and others (2.7%) and indigenous group (2.3%). A similar distribution trend ethnicity was observed compared with Malaysia 2000 census data where the *Population and Housing Census of Malaysia*

2000 census reviewed that Malaysia is made up of several ethnic groups, comprising of Malay (63%), Chinese (24%), Indians (7%) and 6% “others”.

In terms of location and locality, most of the clinics in this study are situated in semi urban area (46%) and urban area (35.5%). Few rural clinics (n=321) is reported in this study. A closer inspection in Table 2 found that Selangor (20.1%), Kedah (12.3%) and Kuala Lumpur (12.1) ranked the top three highest distributions in terms of clinic’s location.

About half of the respondents in this study used less than hundred thousand to start up their business, while few of them (5.6%) spent more than three hundred thousand to start up their business. Cross tabulation analysis found that those Urban and Semi Urban clinics tend to report with higher business startup costs than rural clinics (not shown in the table).

Looking at the mean age in Table 4, the average age reported in this study is 48 years old. Further analysis found that male has a higher mean age of 49 compared to 46 for female (not shown in the table). In terms of year of establishment, some clinics have operated up to nine years while some have just started their clinic this year. In average, the average year of establishment reported in this study is 2.5 years. Table 4 shows the number of full time and part time doctors who are currently working in the clinic. Full time doctors are reported up to a maximum of five but eight

is reported for part time doctors. No significant differences was observed if compared the mean score of full-time doctors (Mean=1.45) with part-time doctors (mean=1.67).

Table 4: Respondents and Clinics' Characteristics

Variable	Mean
Age as at 1 Jan 2016	48.83
Year of Clinic Establishment	2.59
Number of full-time doctors in the clinic	1.45
Number of part-time doctors in the clinic	1.67

Table 5: Respondents and Clinics' Characteristics

Variable	Frequency	Percentage
Gender		
Female	658	36.6
Male	1142	63.4
Ethnicity		
Malay	876	48.7
Chinese	386	21.4
Indian	447	24.8
Indigenous Group	42	2.3
Others	49	2.7
Clinic's location		
Perlis	21	1.2
Melaka	55	3.1
Pahang	61	3.4
Negri Sembilan	65	3.6
Sarawak	67	3.7
Terengganu	83	4.6
Perak	109	6.1
Kelantan	114	6.3
Sabah	126	7.0
Penang	148	8.2
Johor	149	8.3
Wilayah Persekutuan	218	12.1
Kedah	222	12.3
Selangor	362	20.1
Clinic's Locality		
In-house	12	0.7
Rural (Local Council)	321	17.8
Urban(Under City Council	639	35.5
Semi Urban (Under Town Council)	828	46.0
Business Startup Costs		
Less than RM100,000	827	45.9
RM 101,000 - RM200,000	696	38.7
RM 201,000- RM300,000	163	9.1
RM301,000 and above	101	5.6

B. Part B: Nature of Business

This section covered 13 different aspects pertaining to the nature of clinic business among the respondents. To start, majority of the respondents in this study preferred to start their business in sole proprietorship (61.1%). About a quarter of them (26.4%) had chosen to set up their business in private Limited (Sdn. Bhd) setting.

Looking into the length of operating hours, majority of them operate their clinic more than ten hours a day (54.7%), where some clinics (38.85) have less than ten operating hours in a day. Few clinics (6.6%) are reported to work in 24 hours basis. Cross tabulation analysis found that those rural clinics and In house clinics tend to report with lower operating hours than urban and semi urban clinics (not shown in the table).

The respondents were asked to state the average number of patient visits per week by giving five choices “less than 100”, “101-300”, “301-500”, “501-700” and “701 and above”. In overall, 26.3% of the clinics in this study did receive less than 100 patients in a week. About 44.1% reported had patients range from 101-300; 19.1% reported had patients range from 301-500; 10.5% reported had more than 500 patients in a week.

In terms of TPA/MCO status, majority of them are under TPA/MCO (78.2%). Based on their past experiences, 57.1 of them stated that TPA/MCO used to interfere in choice of treatment and consultancy of patients. Again, when asked about the duration for how long the TPA/MCO usually takes to reimburse the payment, 8.7% of the clinics in this study did receive the reimbursement in less than 60 days. About 36.3% reported in the range of 60-90 days; 30% reported between 90-120 days while 12.3% reported had experienced in more than 120 days. Moreover, Table 6 shows that about 76.1% of the clinics used to receive the reimbursement that is less than the actual charges or invoices and 69.3% of them have experienced non-reimbursement cases from TPA/MCO.

Table 6: Nature of Business Related Questions, in Percentage

Information on nature of business	Frequency	Percentage
Nature of Business		
Partnership	214	11.9
Private Limited partly owned by a Medical Practitioner	99	5.5
Private Limited solely owned by Medical Practitioners	376	20.9
Society	12	.7
Sole Proprietorship	1099	61.1
What are the operating hours of this clinic?		
< 10 Hours	698	38.8
>10 Hours - 20 Hours	984	54.7
24 Hours	118	6.6
Average number of patient visits per week		
Less Than 100	473	26.3
101 – 300	794	44.1
301 – 500	343	19.1
501 – 700	103	5.7
701 and above	87	4.8

Information on nature of business	Frequency	Percentage
Is this clinic under any TPA/MCO?		
YES	1408	78.2
NO	392	21.8
Based on past experiences, have the MCO/TPAs ever interfered in choice of treatment and consultation of patients?		
YES	1027	57.1
NO	563	31.3
How long does TPA/MCO usually takes to reimburse your clinic?		
<60 days	157	8.7
60-90 days	654	36.3
90-120 days	540	30.0
>120 days	222	12.3
Have you been reimbursed less than the actual charges		
YES	1216	76.1
NO	381	23.9
Have you ever experienced NON-REIMBURSEMENT?		
YES	1103	69.3
NO	489	30.7
If your answer is YES to B8, how much percentage is bad debt?		
<25	1002	85.3
25-50	135	11.5
>50	37	3.2

Table 7 shows the types of drugs used and payment practices among the respondents. A distinct picture was observed in Table 7, where those clinics that had high percentage in original drugs purchased tend to have a low percentage in generic drugs purchased. Similarly, those clinics that had high percentage in cash paying patients tends to have a low percentage in cashless patients.

Table 7 : Types of Drugs used and Mode of payment

Percentage of drugs purchased per month	Percentage (%) of **Original drugs** purchased by clinic in a month	Percentage (%) of **Generic drugs** purchased by clinic in a month
<10 percent	32.8	3.9
11-30 percent	41.2	11.9
31-50 percent	18.4	23.5
>50 percent	7.6	60.7
Percentage of type of payment by patients	**Percentage(%) of (Cash Paying) patients**	**Percentage(%) of Cashless patients**
<10 percent	3.8	24.9
11-30 percent	14.2	24.3
31-50 percent	25.2	24.4
51-70 percent	23.8	18.9
71-90 percent	17.1	5.9
>90 percent	15.9	1.4

C. Part C: Revenue and Expenses

This section covers the revenue and other aspects of the respondents' clinics. The aspects covered in this section include monthly gross revenue, business competition and staffing matter and different types of fixed expenses.

Table 8 present the average gross monthly revenue earned by the clinics. Looking at the monthly gross revenue, about 21% of the total 1,800 clinics earned less than RM 20,000 per month, which ranked as the lowest level. About 32 % of the total 1,800 clinics earned in between RM 20,000 to RM 39,999. In stark contrast, few clinics (5. 2%) managed to earn monthly gross revenue of one to 1.2 million or even up to 1.2 million and above (6.4%). The high revenue is generated mostly from clinics in the Urban and Semi Urban location. Compared to all four locality, the result revealed that clinics located in the urban and semi urban clinics tend to report to have a higher monthly gross revenue than those clinics situated in the rural area.

Table 8: Average Gross Monthly Revenue by Locality

Monthly Gross Revenue	Overall		In-house		Rural		Semi-Urban		Urban	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
< 20,000	380	21.1	0	0.0	67.0	17.6	194.0	51.1	119.0	31.3
20,000-39,999	583	32.4	4	0.7	128.0	22.0	261.0	44.8	190.0	32.6
40,000-59,999	332	18.4	2	0.6	61.0	18.4	153.0	46.1	116.0	34.9
60,000-79,999	184	10.2	1	0.5	26.0	14.1	87.0	10.5	70.0	11.0
80,000-99,999	112	6.2	2	1.8	19.0	5.0	40.0	10.5	51.0	13.4
1 – 1.2 million	94	5.2	1	1.1	10.0	10.6	37.0	39.4	46.0	48.9
>1.2 million & above	115	6.4	2	1.7	10.0	8.7	56.0	48.7	47.0	40.9

In terms of monthly fixed cost, on an average, clinics in this study were reported to have a mean expenditure of RM 8409.2 for staff salary; RM 1867.9 for utilities and, RM 3578.4 for rental (Table 9). In general, the highest monthly expenditure for the clinics is for staff salary.

Table 9: Average monthly expenditure

	Monthly, in average cost for…	Mean (RM)	Median (RM)	Range (RM)
C5A	Staff Salary (admin, clinic assistance, cleaners)	8409.2	5000	500-451,000
C5B	Utilities (Electrical/Water/Telekom/Internet)	1867.9	1100	120-100,000
C5C	Premise Rental	3578.4	3000	100-50,000

In terms of market competitiveness as presented in Table 10, when asked in terms of competition to get patients, majority of the respondents in this study felt that they could feel the business pressure between their clinic compared with (1) other private clinics (52.1%); (2) other pharmacy (70%) and; government clinics (55.4%). Similarly, most of them agreed (77.6%) that the business market is getting more competitive as compared to five years ago.

Question C4 refers to the number of staffs employed in their clinic and the results shows that about 39 % of the clinics have averagely 1-3 staffs, while about 42 % of the clinics have an average of 4-6 staffs. Only few clinics (less than 20%) employ more than seven or above staffs in this study.

Table 10: Revenue and Expenses Related Questions

	Market Competitiveness	Frequency	Percentage
C2A	**In terms of competition to get patients, do you feel the pressure between this clinic and other private clinics?**		
	NO	862	47.9
	YES	938	52.1
C2B	**In terms of competition to get patients, do you feel the pressure between this clinic and community pharmacy?**		
	NO	540	30.0
	YES	1260	70.0
C2C	**In terms of competition to get patients, do you feel the pressure between this clinic and Public Clinics (Klinik Kesihatan/Klinik 1 Malaysia)?**		
	NO	802	44.6
	YES	998	55.4
C3	**In terms of competition to get patients, how do you feel the current competition as compared to 5 years ago in relation to this clinic and other clinics within its location ?**		
	Less competitive	49	2.7
	More Competitive	1396	77.6
	The same	355	19.7
C4	**How many staffs do you employ in your clinic**		
	1-3	703	39.1
	4-6	764	42.4
	7-9	208	11.6
	10 and above	125	6.9

D. Part D: Lab Services

In general, clinics depend on laboratory for lab service purposes. They need to send samples for testing and disclosing the results to their patients. In fact 851 out of 1,800 clinics in this study do engage laboratory services to cater those walk-in patients. When asked, most of the clinics answered that they do not impose high lab service charges on the total bill, where most of the clinics (59.7%) reported that less than ten percentage of the clinic revenue is from the lab services.

The key consideration in the selection of pathological laboratory services is the accuracy of the lab result (mean=4.56; sd=.81), followed by cost competitiveness (mean=4.36; sd=.92). The least consideration is the frequency of sample collection and geotracking-logistics services.

A total of twelve lab services options was provided and each respondent need to select the top three most lab services they patronise. The scoring procedures were as follows: Three points were given if the lab service is the most frequently used or priority option. Two points were given if the lab service is frequently used or second priority option. One point was given if lab service is their last option. Hence, greater score indicates the more favourable among the respondents.

In this study, Gribbles (sum score= 1578), Quantum Diagnosis (sum score= 1298), and BP Diagnosis (sum score= 1,052) are the top three most favourable lab used by the respondents in this study. Pantai Premier (sum score= 165); Lablink (sum score= 207) and Integrated Lab (sum score= 287) are the top three least favourable lab used in this study. A total of 82 clinics do not send any samples for general testing. Instead they refer their patients directly to the lab.

Table 11: Lab services

D1	**What percentage (%) of your clinic revenue is from lab services?**	**Frequency**	**Percentage**
	< 10	1074	59.7
	10-20	517	28.7
	21-30	146	8.1
	31-40	46	2.6
	>40	17	.9
	Key considerations in selecting Pathological Lab	**Mean**	**SD**
D3A	Cost Competiveness	4.36	.92
D3B	Turnaround time	4.08	1.02
D3C	Results Accuracy	4.56	.81
D3D	Frequency of sample collection and geotracking-logistics services	3.98	1.20
D4	**Would you pay more knowing that results from one lab is more accurate than another lab?**	**Frequency**	**Percentage**
	YES	1462	81.2
	NO	338	18.8
D5	**Do you engage laboratory services that cater to walk- in patients?**	**Frequency**	**Percentage**
	YES	851	71.5
	NO	338	28.5
	Which lab services you use frequently?	**Frequency**	**Score**
D2A	BP Diagnostic	590	1052
D2B	Clinipath	291	553
D2C	Dunia Wellness	423	671
D2D	Gribbles	965	1578
D2E	Integrated Lab	149	287
D2F	Lablink	92	207
D2G	Mediscan	180	361
D2H	Pantai Premier	69	165
D2I	Pathlab	458	738
D2J	Quantum Diagnostics	831	1298
D2K	Other labs	68	159
D2L	I do not send any samples for general testing but refer the patient directly to the lab.	82	

E. Part E: Health Promotion and Education

Besides visiting the doctors and seeking treatments, the respondents stated that many patients at most times are also exploring or seeking for the health related information provided in at the clinics. Only few small fractions (5.3%) of respondents stated that patients rarely or never read the provided health related information in the clinics. In general, most of the respondents agreed that patients nowadays are getting more active (73.5%) in seeking health related information from clinic compared to the past five years.

To ease the data collection process, in terms of how each clinic channel the health related information to their patients, this study has outlined eleven types of channels and each respondent just need to determine whether they do provide these channels or not in their clinic, in “Yes” and “No”.

Table 12 shows that, 1681 out of 1800, (94%) clinics do provide one-to-one explanation to patients upon request. Most of the clinics did post health related photographs (61.4%); printed materials (61.4%); Brochures/flyers (53.4%) to their patients at waiting area. Alternately, some clinics choose to display real object or models at waiting areas (13.4%); display videotape (6.8%) or display their clinic website (11.4%) at waiting area.

Table 12: Health Promotion/Education Related Questions, In Percentage

	Variable	Frequency	Percentage
E1	**Besides seeking treatments, do patients at your clinic seek health related information from your clinic?**		
	None at all	9	0.5
	Rarely	86	4.8
	Sometimes	703	39.1
	Frequently	661	36.7
	Always	341	18.9
E2	**How active are your patients in seeking health related information from your clinic compared to the last 5 years**		
	Less active	127	7.1
	No difference	350	19.4
	More active	1323	73.5
E3	**How do you provide health related information to your patients? (Multiple answer)**		
	Fotonovela	22	1.2
	Displaying Videotape at waiting area	122	6.8
	Health related workshops/campaigns by the clinic	139	7.2
	Educational and community based programs by your clinic	144	8.0
	Displaying Clinic website.	206	11.4
	Displaying real object or models at waiting areas	248	13.8
	Provide one to one demonstration to patients	680	37.8
	Brochures/flyers made available at waiting areas	960	53.3
	Print materials pasted on the clinic walls/display board	1105	61.4
	Photographs pasted on the clinic walls/display board	1105	61.4
	Provide one to one explanation to patients	1681	93.4
E4	**How do you see your clinic's role in the public health promotion and education?**		
	Very important	1013	56.3
	Important	745	41.4
	Not Important	42	2.3
E5	**How often do you attend a CME Program as part of continuing education for yourself?**		
	0-5 times per year	1044	58.0
	6-10 times per year	527	29.3
	more than times per year	229	12.7

Approximately 98% of the respondents agreed that their clinic is playing an important role (41.4%) and very important role (56.35) in the public health promotion and education.

In terms of the respondents' initiatives for their own professional development, the result revealed that more than half of the respondents (58%) in this study have attended CME program less than five times a year. Some (29.3%) are quite active in attending these programs (6-10 times per year). A small fraction (12.7%) of them will attend more than ten times in those programs yearly.

INTERVENTIONS AND MOVING FORWARD

Working in collaboration with MOH

The private clinics in Malaysia have a wide network of GPs from various backgrounds. It consists of a pool of doctors with great credentials who provide excellent primary health care services for the local community. Most of these clinics are already operating 24 hours with GPs offering services based on doctor rotation. The clinics are mostly strategically located and well-equipped. This existing set-up is a more concrete and effective way for the government to reach out to the community using doctors that they are already familiar and comfortable with. With the available resources from the government and the expertise of the GPs, a more accessible, affordable and sustainable health care can be made available to the local community.

It was also noted that 50% of the GPs felt that MoH cannot play both the role of an enforcer and a player in the same field. Being the main health care provider in this country, their focus should be on ensuring that the services provided by the government are in line with its objectives. All GPs were in the opinion that MoH is currently not managing the enforcement of regulations with regards to TPAs and MCOs effectively. According to them, the ministry had promised to take this matter at hand and discuss various issues faced by GPs today. However, the GPs felt that the Ministry have fallen short on this promise and have not taken necessary measures to solve these issues.

In short, many GPs felt that MoH has not done enough for them. Their issues have been taken lightly and they have only be burdened by more and more rules and regulations that seem punitive in nature. Many GPs suggested that if private practices were required to comply to the Act and the various rules imposed by the government, then the same must apply to Polyclinics and other government clinics. After all, the rules and regulations were put in place for the benefit of all Malaysians and therefore should be imposed on all health care facilities.

Strategic locations for 1Malaysia Clinics

It was noted that the 1Malaysia Clinics are currently mushrooming with two clinics sometimes located in the same area. This is sometimes located between private clinics. The initial concept of the 1Malaysia Clinic was to extend health care services to people who were unable to reach private clinics or afford its services. With the presence of 1Malaysia Clinics literally doors away from private clinics, affordability is no longer an issue. Convenience to the cheapest form of health care services is priority. Everyone, including the middle-income group, would definitely seek out the government clinics if they are in the same neighbourhood.

In the end, the main objective for the set up of 1Malaysia Clinics around the country is not entirely met and the GPs in this country would eventually lose their source of income. Patients who visit these government clinics for cough and cold may lose the opportunity for a thorough primary health care check-up and a personalized

consultation from doctors like GPs. There may also be an oversight in the early detection of diseases due to the large number of patients in government clinics. The following table indicated the number of 1Malaysia Clinics in each state in Malaysia. It shows that a large percentage of the clinic is located in Selangor, Kuala Lumpur and Johor. The percentage of the 1Malaysia Clinic is relatively small considering the magnitude of the area.

Table 13: Number of 1Malaysia Clinics in each State in Malaysia

State	Number of Clinics	Percentage
Melaka	12	6.98
Negeri Sembilan	9	5.23
Johor	18	10.47
Selangor	17	9.88
WP Kuala Lumpur	19	11.05
Pahang	10	5.81
Perak	13	7.56
Kedah	17	9.88
Perlis	4	2.33
Kelantan	11	6.40
Terengganu	7	4.07
Sabah	19	11.05
Sarawak	16	9.30
Total	**172**	**6.98**

(Source: Official Portal of Ministry of Health)

This study found that many GPs were supportive of the idea of upgrading their knowledge and skills in this field via mandatory courses. This was felt as important in order to meet the needs of the ever-changing world of health care. As mentioned in the FGDs, 90% of GPs suggested that various trainings and courses be offered to practitioners on a yearly basis and be rewarded CPD points accordingly. This is to ensure life-long learning and the continuous need for career development. GPs from East Malaysia suggested that MoH mobilize trainings at smaller districts such as *Bintulu* to also upgrade and improve the knowledge of its local GPs.

60% of GPs in the FGDs also expressed their concerns that MBBS alone is no longer enough to start a private practice. It was suggested that a Diploma in Family Medicine (obtained within a certain period of time) be introduced as a minimum qualification to practice as a GP. However, there was a clause stating that “those with 20 and above years of experience should be exempted from such requirements”.

80% of the GPs in the stakeholder engagement indicated that the attitude and knowledge of many new doctors did not fit the profession. It was suggested that a proper screening of students be done at the MBBS level followed by an examination equivalent. This is a comprehensive test of the knowledge actually needed in today’s medical office (www.healthpronet.org).

Tighter enforcement on TPAs/MCOs and Insurance Companies

All GPs suggested for MoH to monitor closely and audit TPAs, MCOs and any other related parties. Specific rules and regulations need to be implemented, monitored and enforced by relevant government officials. For example, the Patient Medical Record cannot be placed everywhere and in plain sight for all to see. The privacy of clients needs to be upheld even if health care services were obtained via their employment with a specific company.

It was suggested that MoH officials make frequent visits to these agencies to ensure that documentation and business is conducted based on the regulations set for them and that the universal health care and national health care policy is upheld. It was also suggested that heavy repercussion be placed upon those that are found non-compliant to the regulations. Termination of licenses should be done to set the right message to these parties and protect the welfare and health care of the community they serve.

In addition, it was also noted that there are many more TPAs and MCOs sprouting in the country. The development of an Act for these parties was suggested. A proper Act and possible yearly licensing renewal programmes should be introduced to ensure that the services they provide is in line with the government's vision of health care for the country.

Working in partnership with the media

The Malaysian Medical Association should play a more proactive role in engaging the media and highlighting the role of General Practitioners in the country. This is in line with the associations' objectives "to promote and maintain the honour and interest of the profession of medicine in all its branches and in every one of its segment". The Association also aims to serve as a vehicle of the integrated voice of the whole profession (www.mma.org.my). Health issues like diabetic should be highlighted in the media with a focus on early detection and primary health care with a family physician. The advantages of seeking consultation and treatment at a nearby GP Clinic should be shared in the media to create awareness among the community. Radio and TV interviews would also assist in creating awareness on the excellent and important role of GPs in this country and encourage people to once again place their faith in this group of doctors that have been there for them and their families throughout the years.

Improving the financial health of GPs

With the rise of various cost of running a clinic, many doctors now fear the challenge of starting their own practice. However, with the increase in ageing population and the rise in lifestyle diseases, GPs are more than needed in this country. Therefore, it is important to ensure that their livelihood is maintained and the future generation of this county feels encouraged to get into this profession. There must be a proper and realistic revision to the consultation fees of doctors and this should be done regularly.

Only with the improved fee structure can GPs absorb more government doctors into their practice. There is a lack of understanding that private practices have business elements attached to them in order to survive and maintain the workforce and other facilities in the clinic. Although states like Sabah and Sarawak may not be experiencing this entirely at the moment, proactive measures need to be taken to ensure that this scenario does not creep into East Malaysia.

The MoH should also assist GPs by enabling them to complement their services particularly for the middle-income group. Strategic locations for the 1Malaysia Clinics is vital to ensure that they do not encroach into the livelihood of GPs who have been serving in that particular community for years. This is also in line with the initial concept of these clinics in serving those who are unable to reach or afford these clinics.

In view of this, there should also be specific criteria for the groups of people entitled to obtain consultation and health care services at the 1Malaysia Clinics. The criteria should be based on the early objectives of these clinics. Proper enforcement towards adherence to these criteria must also be in place. This will surely enable the government to achieve its intended objective and serve the targeted groups of community. GPs will also be given the opportunity to complement the work of the government by extending health care services to those who can afford it.

In addition, MoH could also assist in finding suitable locations for new GPs. It would also be helpful if MoH could provide financial assistance in the form of start-up costs, medication or equipment.

GP for GP

Findings from the stakeholder engagement indicated that GPs believe that they are now divided. They have become somewhat competitive in the attempt to stay above water in this current health care and economic situation. However, according to them, GPs now are facing the same issues and must therefore come together and form a society to monitor the GP businesses and watching over the welfare of GPs in this country. The members of this society can assist in the development of specific guidelines for GPs based on their vast experience and years of knowledge in this field. This information can then be directed to the Ministry of Health and assist in the formation of rules and regulations for GPs.

This society may also raise any concerns of the GPs in various platforms and serve to complement the work and contribution of MMA in this country. Based on the information gathered in this study, not all GPs are united and this leads to unethical practices by TPAs and other third parties. GPs must stand united and seek for the imposition of stringent policies on TPAs and MCOs and disallow them to dictate fee capping. Confidentiality of the patients must also not be compromised.

In terms of confidentiality, GPs should also raise the issue of STI data collection by MoH. At present, confidentiality is being compromised when names and I/C numbers of clients are required by MoH. GPs must voice out their stand on patient confidentiality and expose such requirements that encroach on the rights of their patients. Issues like these are amongst the many issues that can be brought to the attention of MoH is GPs stand united with one voice.

Implementation and follow-up of issues

GPs have constantly and consistently raised various issues concerning their business using different platforms. In most cases, these issues and concerns are well-received and documented. However, GPs feel that documentation alone is not sufficient. There must be proper follow-up both by MMA and the MoH regarding vital issues concerning the health care of our nation. Now is the time to not react but be proactive in taking positive measures towards solving these problems. Visits by government officers are not sufficient as it has to be accompanied by proper follow-ups and effective measures.

The issues of TPAs and MCOs cannot be taken lightly and must be addressed appropriately. Although East Malaysia is currently rarely experiencing problems with these parties, however, a proper set of regulations and licensing requirements must

be in place to ensure that these problems do not arise in that part of the nation someday. Proactive measures need to be taken to 'nip the problem in the bud'.

SUMMARY

This is a general study on the landscape of General Practitioners in Malaysia. The findings of this study hopes to provide insights into the contribution of GPs in the history of health care in Malaysia and its evolution towards today's health care system. It also hopes to give a better understanding on the important roles of General Practitioners, the challenges they face and the assistance required particularly from MoH. 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 and the health care of the country's population as a whole. The growth of the healthcare industry in Malaysia has been organic in nature and is primarily driven by consumption of healthcare products and services. It is now time to reframe and position healthcare as an engine of economic growth.

Although over the years there has been many challenges faced by GPs because of the involvement of 3rd parties, it is imperative to note the important role of GPs in providing affordable and accessible health care services to the local community. Despite the government policies and interventions over the years, General Practitioners have continuously been relevant and sought after by the general public

due to its accessibility and affordability and the continuous quality of care rendered by GPs. The study concludes that the GP services in this country is significantly relevant for the general public and should not be revamped based on the healthcare models of other countries.

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