

PENYATA JAWATANKUASA KIRA – KIRA WANG NEGARA (PAC)

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PENINGKATAN BAYARAN PREMIUM INSURANS KESIHATAN, CAJ HOSPITAL SWASTA DAN IMPAK KEPADA KESIHATAN AWAM DI BAWAH KEMENTERIAN KEWANGAN, KEMENTERIAN KESIHATAN DAN BANK NEGARA MALAYSIA



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WAKIL TETAP KERAJAAN DALAM PAC (*EX-OFFICIO* PAC PARLIMEN)

1. Kementerian Kewangan Malaysia (MOF)
2. Kementerian Ekonomi (KE)
3. Jabatan Perkhidmatan Awam (JPA)
4. Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
5. Jabatan Audit Negara (JAN)
6. Jabatan Akauntan Negara Malaysia (JANM)
7. Penasihat Undang-Undang (PUU) Parlimen Malaysia

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GLOSARI

GLOSARI

APHM	Persatuan Hospital Swasta Malaysia / *Association of Private Hospitals of Malaysia*
ASPMP	Persatuan Pakar Amalan Perubatan Swasta
BNM	Bank Negara Malaysia
CKAPS	Pusat Kompentensi dan Pematuhan Amalan Kesihatan Swasta
COI	*Cost of Insurance (Kos Insurans)*
DOSM	Jabatan Perangkaan Malaysia / Department of Statistics Malaysia
DRG	Penetapan Harga Kumpulan Berkaitan Diagnostik / *Diagnosis Related Group*
FFS	*Fee-for-service* (Bayaran mengikut perkhidmatan)
FPMPAM	*Federation Of Private Medical Practitioners' Associations, Malaysia*
FSA	Akta Perkhidmatan Kewangan 2013 / *Financial Service Act 2013*
GL	Surat Jaminan / *Guarantee Letter*
GP	Doktor Am / *General Practitioner*
HTO	Pejabat Transformasi Kesihatan / *Health Transformation Office*
ICU	Unit Rawatan Rapi / *Intensive Care Unit*
ILP	Polisi Insurans Berkaitan Pelaburan / *Investment-linked Insurance Policies*
ITO	Syarikat Penanggung Insurans dan Pengendali Takaful / *Insurance and Takaful Operators*
JAN	Jabatan Audit Negara
JANM	Jabatan Akauntan Negara Malaysia
JBMKKS	Jawatankuasa Bersama Peringkat Menteri Mengenai Kos Penjagaan Kesihatan Swasta
JKPK	Jawatankuasa Pilihan Khas

JPA	Jabatan Perkhidmatan Awam
KE	Kementerian Ekonomi
KKM/MOH	Kementerian Kesihatan Malaysia / *Ministry of Health*
KPE	Ketua Pegawai Eksekutif
KSP	Ketua Setiausaha Perbendaharaan
KSU	Ketua Setiausaha
LIAM	*Life Insurance Association Of Malaysia*
MAPS	*Malaysian Association Of Pharmaceutical Suppliers*
MDA	Pihak Berkuasa Peranti Perubatan / *Medical Device Authority*
MHIT	Premium Insurans dan Takaful Perubatan dan Kesihatan / *Medical and Health Insurance and Takaful*
MMA	*Malaysian Medical Association*
MMC	Majlis Perubatan Malaysia / *Malaysian Medical Council*
MOF	Kementerian Kewangan
MOPI	*Malaysian Organisation Of Pharmaceutical Industries*
MTA	Persatuan Takaful Malaysia / *Malaysian Takaful Association*
NACCOL	Majlis Tindakan Sara Hidup Negara
NAMLIFA	*National Association of Malaysian Life Insurance and Family Takaful Advisors*
NCB	Bonus Tanpa Tuntutan / *No Claim Bonus*
NCD	Penyakit Tidak Berjangki*t / Non-Communicable Diseases*
NEML	Senarai Ubat-ubat Penting Kebangsaan / *National Essential Medicines List*
NGO	*Pertubuhan Bukan Kerajaan* / *Non-Governmental Organisation*
PAC	Jawatankuasa Kira-kira Wang Negara
PBT	Margin Keuntungan Sebelum Cukai / *Profit Before Tax*
PhAMA	*Pharmaceutical Association Of Malaysia*
PHI	Insurans Kesihatan Swasta / *Private Health Insurance*

PIAM	Pertubuhan Insurans Am Malaysia
PM	Peraturan Mesyuarat
PPMMDR	Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat
PPUM	Pusat Perubatan Universiti Malaya
SHI	Insurans Sosial / *Social Health Insurance*
SPRM	Suruhanjaya Pencegahan Rasuah Malaysia
SST	Cukai Jualan dan Perkhidmatan / *Sales and Service Tax*
TKSU	Timbalan Ketua Setiausaha
UM	Universiti Malaya
YB	Yang Berhormat

PARLIMEN MALAYSIA

PENYATA JAWATANKUASA KIRA-KIRA WANG NEGARA (PAC) PARLIMEN BERHUBUNG PENINGKATAN BAYARAN PREMIUM INSURANS KESIHATAN, CAJ HOSPITAL SWASTA DAN IMPAK KEPADA KESIHATAN AWAM

DI BAWAH KEMENTERIAN KEWANGAN, KEMENTERIAN KESIHATAN DAN BANK NEGARA MALAYSIA

LATAR BELAKANG



Isu Utama

Peningkatan kos penjagaan kesihatan yang drastik, terutamanya premium insurans kesihatan dan caj hospital swasta yang terus meningkat.

Impak

Menjejaskan kebolehcapaian rawatan, menambah beban kewangan individu, dan memberi kesan langsung kepada kesihatan awam.

Matlamat Prosiding

Mengenalpasti punca peningkatan premium, menilai kesan kepada pengguna, dan mengesyorkan langkah untuk memastikan harga yang adil, telus, serta mampu milik.

SAKSI YANG TERLIBAT

- Kementerian Kewangan Malaysia (MOF)
- Kementerian Kesihatan Malaysia (KKM)
- Bank Negara Malaysia (BNM)
- Pertubuhan Bukan Kerajaan (NGO)
- Wakil Akademik
- Ejen Insurans/ National Association of Malaysian. Life Insurance and Family Takaful Advisors (NAMLIFA)
- Life Insurance Association Of Malaysia (LIAM)
- Persatuan Insurans Am Malaysia (PIAM)
- Malaysian Takaful Association (MTA)
- Malaysian Medical Association (MMA)
- Federation Of Private Medical Practitioners' Associations, Malaysia (FPMPAM)
- Persatuan Pakar Amalan Perubatan Swasta (ASPMP)
- Pusat Perubatan Universiti Malaya (PPUM)
- Hospital Tung Shin
- Persatuan Hospital Swasta Malaysia (APHM)
- Pharmaceutical Association Of Malaysia (PhAMA)
- Malaysian Organisation Of Pharmaceutical Industries (MOPI)
- Malaysian Association Of Pharmaceutical Suppliers (MAPS)
- Persatuan Farmasi Malaysia
- CompuMed Services Sdn. Bhd.
- PMcare Sdn. Bhd.

PENEMUAN PAC

1. Syarikat Insurans & Struktur Polisi

Mandat BNM Terhad
Peranan Bank Negara Malaysia (BNM) mengawal selia kestabilan ITO adalah kukuh tetapi bersifat reaktif, serta tiada instrumen undang-undang untuk mengawal kos rawatan hospital swasta.

Closed Pool
Amalan menutup kumpulan risiko lama bagi menawarkan harga murah kepada peserta baharu menindas pelanggan setia kerana premium mereka melonjak mendadak akibat kumpulan yang mengecil dan tinggi tuntutan.

Risiko Polisi ILP
Produk *Investment-linked Insurance Policies* (ILP) memindahkan risiko pelaburan dan kenaikan *Cost of Insurance* (COI) mengikut usia sepenuhnya kepada pengguna tanpa disedari.

Kejutan Semakan Harga *(Repricing Shock)*
Model penetapan harga berkala mencatatkan kenaikan premium mendadak sekali gus antara 40% hingga 70%.

Warga Emas Kehilangan Perlindungan
Lonjakan premium yang tidak mampu dibayar memaksa segolongan pemegang polisi berusia 60 tahun ke atas membatalkan polisi mereka pada waktu perlindungan paling diperlukan.

2. Hospital Swasta & Struktur Caj Rawatan

Pengebilan Tidak Standard
Ketiadaan pengebilan hospital yang standard menyebabkan kos sebenar tidak telus, di mana harga ubat sengaja dinaikkan *(mark-up)* bagi menampung kos operasi lain yang tidak dicaj terus (cth: kos utiliti dan kejururawatan).

Caj Dipecahkan *(Unbundling Charges)*
Wujud amalan mengecaj item asas secara berasingan dan kreatif (cth: pelupusan sisa klinikal, sarung bantal, alkohol swab) yang sepatutnya termasuk dalam perkhidmatan asas bilik.

Diskriminasi Harga Surat Jaminan (GL)
Hospital mengenakan kadar caj rawatan yang jauh lebih tinggi kepada pesakit yang menggunakan GL berbanding pesakit bayaran tunai atau *pay-and-claim*.

Yuran Doktor Bukan Punca Inflasi
Fi profesional doktor telah dikawal dan pegun sejak 2013. Punca utama inflasi adalah lonjakan komponen bukan profesional seperti ujian makmal, peralatan perubatan, kos utiliti, dan amalan perubatan defensif.

3. Rantaian Bekalan & Monopoli Farmaseutikal

Tokokan Harga *(Mark-Up)* Melampau
Wujud *mark-up* median yang sangat tinggi pada rantaian bekalan, sehingga ubat generik di hospital kadangkala dicaj lebih mahal berbanding ubat berjenama *(innovator)*.

Monopoli Bekalan Ubat
Terdapat lebih 1,500 jenis ubat yang hanya mempunyai satu pengeluar berdaftar di Malaysia, sekali gus mengehadkan pilihan alternatif dan membolehkan penetapan harga tinggi.

4. Isu Tadbir Urus & Regulasi

Kelemahan Akta 586
Kegagalan Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 berkembang mengikut zaman membolehkan hospital menggunakan "caj kreatif" yang sah di sisi undang-undang tetapi membebankan rakyat.

Kebebasan Ombudsman Diragui
Wujud persepsi negatif terhadap kebebasan Ombudsman Perkhidmatan Kewangan (FMOS) kerana model pembiayaannya datang daripada industri insurans sendiri.

Inisiatif RESET & Hambatan DRG
Pelan 11 inisiatif RESET dan model pembayaran DRG mampu mengalihkan fokus kepada kecekapan klinikal, namun kejayaannya memerlukan prasyarat komprehensif seperti data lengkap dan sistem Rekod Perubatan Elektronik (EMR) bersepadu.

5. Kesan Domino Kepada Sektor Kesihatan Awam

Kurang Kesedaran Pencegahan
Majoriti rakyat kurang melakukan saringan kesihatan awal, menyumbang kepada pengesanan penyakit yang lewat dan meningkatkan tuntutan kos rawatan peringkat akhir yang jauh lebih mahal.

Kesesakan Hospital Kerajaan memuncak
Kegagalan mengekalkan perlindungan insurans swasta akibat premium tinggi menyebabkan perpindahan pesakit secara besar-besaran ke hospital kerajaan.

Tekanan Operasional Negara
Limpahan pesakit ini memanjangkan tempoh menunggu dan memberikan tekanan fiskal serta operasional yang kritikal kepada sistem kesihatan awam.

RUMUSAN PAC PARLIMEN

1. BNM beroperasi mengikut mandat yang menggalakkan kestabilan dan kemampanan sektor insurans dan takaful bagi melindungi kepentingan pemegang polisi. Walaupun mempunyai kuasa punitif, ia bersifat reaktif dan BNM tidak mempunyai instrumen undang-undang untuk mengawal punca luaran kenaikan premium, iaitu kos rawatan di hospital swasta.

2. Konsep insurans sedia ada di Malaysia terdedah kepada amalan pemilihan risiko *(risk selection).* Strategi segregasi risiko oleh syarikat insurans menyebabkan golongan yang paling memerlukan perlindungan sering dipinggirkan melalui mekanisme harga.

3. Terdapat amalan menutup kumpulan risiko lama *(closed pool)* untuk menawarkan harga kompetitif kepada peserta baharu. Amalan ini boleh memberi kesan kepada peserta setia yang lama kerana apabila kumpulan tersebut mengecil dan hanya tinggal peserta yang sakit, kadar tuntutan melonjak dan memaksa kenaikan premium yang mendadak.

4. Polisi insurans berkaitan pelaburan (ILP) memindahkan sebahagian risiko pelaburan dan kenaikan kos perubatan kepada pengguna. Ramai pengguna tidak menyedari bahawa *Cost of Insurance* (COI) akan meningkat mengikut usia, yang menjejaskan kelestarian perlindungan jangka panjang.

5. Model penetapan harga berkala *(cyclical repricing)* oleh industri yang bertujuan menyelaraskan harga premium sering mencetuskan kejutan kewangan kepada pengguna dengan kenaikan sekaligus mencecah 40% hingga 70%.

6. Kenaikan harga premium yang tinggi mengakibatkan terdapat segolongan pemegang polisi yang berusia 60 tahun ke atas terpaksa membatalkan polisi insurans mereka akibat faktor ketidakmampuan kewangan, sekali gus mendedahkan mereka kepada risiko tanpa perlindungan pada waktu ia amat diperlukan.

7. Mekanisme pasaran bebas tidak dapat mengekalkan harga premium yang stabil dan konsisten kerana inflasi perubatan secara berterusan melebihi inflasi umum. Kenaikan premium berkait rapat dengan peningkatan kos rawatan kesihatan yang memerlukan pendekatan menyeluruh merangkumi sektor kesihatan dan bukan sektor insurans semata-mata.

8. Ketiadaan struktur pengebilan hospital swasta yang standard ketika ini menyebabkan kos sebenar perkhidmatan dan item-item asas tidak dapat dicerminkan secara telus. Isu harga ubat yang tinggi sering digunakan sebagai alat untuk menutup kos operasi lain yang tidak dicaj secara langsung, seperti kos kejururawatan dan utiliti.

9. Terdapat amalan memecahkan caj *(unbundling)* bagi item-item asas seperti pelupusan sisa klinikal, sarung bantal, dan alkohol swab, yang sepatutnya termasuk dalam caj bilik atau perkhidmatan asas.

10. Wujud amalan diskriminasi harga di mana hospital mengenakan kadar caj yang lebih tinggi kepada pesakit yang menggunakan surat jaminan (GL) berbanding pesakit yang membayar tunai atau *pay-and-claim.*

11. Faktor utama inflasi bukanlah yuran profesional doktor yang telah dikawal sejak 2013, tetapi lonjakan caj komponen bukan profesional. Ini termasuk bekalan dan peralatan ubat-ubatan, peningkatan harga ubatan, caj ujian diagnostik dan makmal, penggunaan teknologi dan rawatan yang lebih mahal, kos operasi hospital swasta yang semakin meningkat seperti tenaga kerja, utiliti dan teknologi. Dalam masa yang sama kos litigasi dan rawatan defensif juga semakin memberi tekanan.

12. RESET merupakan pelan komprehensif 11 inisiatif yang merangkumi ketelusan harga, transformasi insurans, pemantapan sistem digital dan pelaksanaan pelan asas MHIT. Namun, kejayaannya bergantung kepada penyelarasan dasar dan kerjasama merentas agensi jika kerjasama industri tidak mencukupi.

13. *Diagnosis-Related Group* (DRG) ialah satu kaedah untuk menentukan bayaran rawatan kesihatan berdasarkan jenis penyakit atau keadaan pesakit dan bukannya berdasarkan setiap ujian, ubat atau prosedur yang dilakukan satu per satu.

14. Pelaksanaan DRG antara lain dilihat mampu mengalihkan model berasaskan keuntungan prosedur kepada kecekapan klinikal. Walau bagaimanapun, ia perlu memenuhi beberapa prasyarat terlebih dahulu termasuk pangkalan data yang lengkap dan sistem Rekod Perubatan Elektronik (EMR) yang bersepadu.

15. Wujud mark-up median yang sangat tinggi pada pelbagai peringkat rantaian bekalan ubat, di mana ubat generik di hospital kadangkala dicaj lebih mahal daripada ubat berjenama *(innovator).*

16. Terdapat lebih 1,500 jenis ubat yang hanya mempunyai satu pengeluar berdaftar di Malaysia, mewujudkan monopoli yang membolehkan penetapan harga tinggi tanpa persaingan.

17. Wujud persepsi terhadap kebebasan Ombudsman Perkhidmatan Kewangan (FMOS) kerana model pembiayaannya datang daripada industri insurans sendiri.

18. Kegagalan Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 (Akta 586) berkembang mengikut peredaran zaman membolehkan hospital mengenakan "caj kreatif" yang sah di sisi undang-undang tetapi membebankan rakyat secara moral dan ekonomi.

19. Data menunjukkan bahawa kebanyakan rakyat Malaysia kurang kesedaran dan minat untuk melakukan saringan kesihatan yang seterusnya menyumbang kepada peningkatan tuntutan rawatan serta kelewatan rawatan yang lazimnya melibatkan kos yang lebih tinggi berbanding rawatan pengesanan awal.

20. Berlakunya kesan domino terhadap Sektor Kesihatan Awam di mana kegagalan rakyat untuk mengamalkan gaya hidup sihat selain kemampuan untuk terus mengekalkan perlindungan insurans swasta telah menyumbang kepada peningkatan pesakit di hospital kerajaan. Ini meningkatkan lagi kesesakan di fasiliti kesihatan awam, memanjangkan tempoh menunggu, dan memberikan tekanan fiskal serta operasional yang hebat kepada sistem kesihatan negara.

SYOR PAC PARLIMEN

1. BNM diminta untuk menambahbaik keperluan untuk mengukuhkan pengumpulan risiko merentas kumpulan *(cohort)* yang serupa, termasuk portfolio tertutup, dan mengesyorkan agar keberkesanannya terus dipantau.

2. BNM harus mengeluarkan garis panduan operasi yang lebih terperinci dan seragam *(standardized FAQ)* bagi mengelakkan syarikat insurans memanipulasi tafsiran langkah-langkah interim.

3. Bagi menjamin keberkesanan intervensi kerajaan, BNM perlu mengenakan tindakan punitif yang tegas ke atas mana-mana pengendali insurans yang dikesan memanipulasi tafsiran atau gagal mematuhi langkah interim sehingga menjejaskan kebajikan dan kepentingan pemegang polisi.

4. BNM perlu memastikan industri insurans dan takaful perlu beralih kepada pelarasan premium tahunan yang lebih kecil dan stabil *(incremental annual repricing)* untuk mengelakkan kejutan kenaikan kewangan yang besar terhadap pemegang polisi.

5. BNM harus mengkaji semula penetapan premium mengikut kumpulan *(cohort)* dan mempertimbangkan pendekatan yang bersesuaian dan mengkalibrasi dengan teliti bagi memperkukuh keadilan dalam perkongsian risiko sambil mengekalkan kemampuan serta kemampanan jangka panjang.

6. Suruhanjaya Persaingan Malaysia (MyCC) perlu memberi panduan kepada pihak yang berkepentingan supaya amalan rundingan diskaun antara pihak hospital dan insurans bagi memastikan proses tersebut adil dan tidak menjejaskan akses pesakit.

7. KKM perlu memastikan pelaksanaan sistem DRG di sektor swasta disegerakan untuk menggalakkan kecekapan kos.

8. KKM hendaklah memastikan pindaan Akta 586 dilaksanakan bagi memberi kuasa kepada Kementerian Kesihatan (KKM) mengawal selia caj perkhidmatan hospital swasta selain yuran doktor.

9. KKM dan BNM hendaklah memperkasakan saluran/mekanisme penyelesaian aduan bagi isu insurans dan kos perubatan supaya dapat diselesaikan dengan efisien dan berkesan.

10. KKM dengan kerjasama KPDN perlu menetapkan mekanisme pengawalan harga bagi ubat-ubatan dan peralatan perubatan agar kekal munasabah untuk mengelakkan tiada pihak yang mengambil keuntungan berlebihan.

11. KKM perlu meneroka sumber bekalan dari pengeluar secara terus *(outsourcing)* dengan mengutamakan pengeluar tempatan bagi mengurangkan kebergantungan kepada dominasi pembekal atau kartel tertentu.

12. MOF, BNM dan KKM perlu mewujudkan tadbir urus yang baru dan bebas untuk penjagaan kesihatan swasta bagi melindungi pengguna termasuklah untuk menyemak dan mengawal selia caj dan manfaat insurans kesihatan.

13. KKM perlu memperkasakan dan meneroka inisiatif-inisiatif yang meluaskan akses kepada perubatan mampu milik sekali gus bertindak sebagai penanda aras harga *(benchmark)* bagi industri kesihatan swasta.

14. MOF, BNM dan KKM hendaklah menyegerakan pelaksanaan sepenuhnya inisiatif RESET dan semua pihak berkepentingan perlu memberi sokongan berterusan bagi memastikan kos rawatan di sektor swasta dan premium insurans dapat dikawal dalam jangka masa panjang.

15. MOF, BNM, KKM dan Kerajaan secara keseluruhannya bersama industri insurans dan takaful serta industri perkhidmatan kesihatan, perlu menggalakkan gaya hidup sihat dan penjagaan kesihatan pencegahan melalui insentif serta penawaran produk insurans dan takaful yang bersifat preventif.

16. KKM hendaklah mempergiat kempen kesedaran awam dan pembudayaan gaya hidup sihat secara komprehensif. Dalam hal ini, semua Kementerian, Agensi Kerajaan, GLC dan institusi pendidikan di semua peringkat perlu diwajibkan untuk menggalakkan amalan kesihatan bagi mengurangkan risiko penyakit tidak berjangkit (NCD), membendung inflasi kos perubatan serta mengatasi isu kesesakan pesakit yang kritikal di hospital-hospital kerajaan.

17. MOF, BNM dan KKM perlu menetapkan satu garis masa pelaksanaan yang munasabah dan jelas bagi semua langkah inisiatif RESET dan memastikan semua persiapan dilaksanakan secara tersusun bagi menjamin kesan yang mampan dan berterusan.



PENYATA JAWATANKUASA KIRA-KIRA WANG NEGARA (PAC) PARLIMEN



PENYATA
JAWATANKUASA KIRA-KIRA WANG NEGARA (PAC) PARLIMEN
BERHUBUNG
PENINGKATAN BAYARAN PREMIUM INSURANS KESIHATAN, CAJ HOSPITAL SWASTA DAN IMPAK KEPADA KESIHATAN AWAM
DI BAWAH
KEMENTERIAN KEWANGAN, KEMENTERIAN KESIHATAN DAN BANK NEGARA MALAYSIA

1. PENDAHULUAN

Peningkatan kos penjagaan kesihatan di Malaysia telah menjadi isu yang semakin membimbangkan, terutamanya melibatkan bayaran premium insurans kesihatan yang tinggi dan caj hospital swasta yang terus meningkat. Fenomena ini mempunyai implikasi yang signifikan terhadap aksesibiliti penjagaan kesihatan, beban kewangan individu, dan secara langsung memberi kesan kepada kesihatan awam secara keseluruhan. Isu ini melibatkan pelbagai pihak berkepentingan utama termasuk Kementerian Kewangan (MOF), Kementerian Kesihatan Malaysia (KKM), dan Bank Negara Malaysia (BNM).

Pada Disember 2024, Bank Negara Malaysia (BNM) telah membuat pengumuman penting mengenai langkah-langkah interim untuk menangani isu peningkatan premium insurans dan takaful perubatan dan kesihatan (MHIT) di Malaysia. Pengumuman ini dibuat berikutan kebimbangan awam yang ketara terhadap kenaikan kos penjagaan kesihatan dan impaknya terhadap kemampuan rakyat untuk mendapatkan perlindungan insurans.

Isu berhubung kesihatan awam serta penjagaan kesihatan adalah salah satu hak asasi manusia. Oleh yang demikian, PAC berpandangan adalah amat penting untuk mengetahui mendengar sendiri situasi sebenar yang dialami oleh masyarakat negara ini.

Sehubungan itu, PAC memulakan prosiding berhubung Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan Impak Kepada Kesihatan Awam di bawah Kementerian Kewangan Malaysia (MOF), Kementerian Kesihatan Malaysia (KKM) dan Bank Negara Malaysia (BNM) pada 24 Februari 2025

2. OBJEKTIF PERBINCANGAN

2.1 PAC Parlimen telah memulakan prosiding berhubung Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta Dan Impak Kepada Kesihatan Awam di bawah MOF, KKM dan BNM melalui punca kuasa dan mandat yang diberikan kepada PAC Parlimen seperti berikut

i. Peraturan Mesyuarat (PM) 77(1)(d) Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat (PPMDR);
ii. PM 83(2) PPMDR; dan
iii. Seksyen 5 (3) (d), Pekeliling Am No. 1 Tahun 2024 Organisasi Kementerian-Kementerian.

2.2 Bertujuan untuk mengenalpasti faktor-faktor yang menyumbang kepada peningkatan ketara premium insurans di Malaysia, menilai kesan peningkatan ini terhadap pengguna dan mengesyorkan langkah-langkah untuk memastikan harga yang adil, telus serta mampu milik dalam industri insurans.

Dengan melaksanakan prosiding yang komprehensif dan membuat cadangan berasaskan bukti, PAC dapat menyumbang kepada pasaran insurans yang adil, telus, dan mampu milik di Malaysia.

3. SKOP DAN METODOLOGI

3.1 Perbincangan telah dibuat melalui pendekatan berikut:

a. memanggil saksi-saksi daripada Kementerian/ Agensi/ Institusi/ Syarikat/ Pertubuhan seperti berikut:

i. Kementerian Kewangan Malaysia (MOF);
ii. Kementerian Kesihatan Malaysia (KKM);
iii. Bank Negara Malaysia (BNM);
iv. Pertubuhan Buka Kerajaan (NGO);
v. Wakil Akademik;
vi. Ejen Insurans/ National Association of Malaysian. Life Insurance and Family Takaful Advisors (NAMLIFA);
vii. Life Insurance Association Of Malaysia (LIAM);
viii. Persatuan Insurans Am Malaysia (PIAM)
ix. Malaysian Takaful Association (MTA)
x. Malaysian Medical Association (MMA);
xi. Federation Of Private Medical Practitioners' Associations, Malaysia (FPMPAM)

xii. Persatuan Pakar Amalan Perubatan Swasta (ASPMP)
xiii. Pusat Perubatan Universiti Malaya (PPUM):
xiv. Hospital Tung Shin;
xv. Persatuan Hospital Swasta Malaysia (APHM);
xvi. Pharmaceutical Association Of Malaysia (PhAMA);
xvii. Malaysian Organisation Of Pharmaceutical Industries (MOPI);
xviii. Malaysian Association Of Pharmaceutical Suppliers (MAPS);
xix. Persatuan Farmasi Malaysia;
xx. Compumed Services Sdn. Bhd.; dan
xxi. PMcare Sdn. Bhd.

untuk memberi keterangan mengenai peranan dan penglibatan mereka dalam isu yang dibincangkan;

b. menjemput *ex-officio* PAC daripada agensi Kerajaan Persekutuan seperti Kementerian Kewangan Malaysia (MOF), Jabatan Perkhidmatan Awam (JPA), Jabatan Audit Negara (JAN), Jabatan Akauntan Negara (JANM), Suruhanjaya Pencegahan Rasuah Malaysia (SPRM) dan Kementerian Ekonomi (KE) untuk menghadiri prosiding PAC Parlimen berhubung isu ini.

3.2 Prosiding yang telah diadakan adalah seperti berikut:

TARIKH/ MASA	RUJUKAN PROSIDING	SAKSI
24 Februari 2025/ 11:30 pagi	Bil. 5(a)/2025	**KEMENTERIAN KEWANGAN (MOF):** Datuk Johan Mahmood Merican, Ketua Setiausaha Perbendaharaan (KSP); **BANK NEGARA MALAYSIA (BNM):** i. Dato' Seri Abdul Rasheed Ghaffour, Gabenor BNM; dan ii. Datuk Jessica Chew Cheng Lian, Timb. Gabenor BNM.
24 Februari 2025/ 2.30 petang	Bil. 5(b)/2025	**KEMENTERIAN KESIHATAN MALAYSIA (MOH):** i. Datuk Seri Dr. Haji Dzulkefly Ahmad, Menteri Kesihatan Malaysia; dan ii. Dato' Sri Suriani binti Dato' Ahmad, Ketua Setiausaha (KSU).

TARIKH/ MASA	RUJUKAN PROSIDING	SAKSI
25 Februari 2025/ 11:30 pagi	Bil. 5(c)/2025	**RAKYAT/NGO :** i. Tuan Ng Kian Nam, Campaign to Protect Rights of Insurance Consumers in Malaysia; ii. Dato' Indrani Thuraisingham, Naib Presiden FOMCA; iii. Tuan Chan Chee Koon, Citizen's Healthcare Initiative; iv. Dr. Lim Chee Han, Senior Researcher Third World Network; v. Tuan Ethan Teh, Bendahari Persatuan Penasihat Kewangan Malaysia.
25 Februari 2025/ 2.30 petang	Bil. 5(d)/2025	**WAKIL AKADEMIK:** i. Dr. Tharani Loganathan, Universiti Malaya (UM), Associate Professor of Global Health; dan ii. Tuan Azrul Mohd Khalib, Ga!en Centre for Health And Social Policy (Code Blue)
26 Februari 2025/ 11:30 pagi	Bil. 5(e)/2025	**EJEN INSURANS, NAMLIFA:** i. Tuan Krishan Appanu, Presiden; ii. Tuan Nelson Tan, Timbalan Presiden; dan iii. Tuan G Saseedaran Gengadharan, mantan Presiden.
26 Februari 2025/ 2:30 petang	Bil. 5(f)/2025	**SYARIKAT INSURANS:** i. Tuan Mark Steven O'Dell, Ketua Pegawai Eksekutif, Life Insurance Association of Malaysia (LIAM); ii. Tuan Ben Ng Kee Heng, Ketua Pegawai Eksekutif, AIA Malaysia; iii. Dato' Koh Yaw Hui, Ketua Pegawai Eksekutif, Great Eastern Life Assurance Malaysia; iv. Tuan Ng Kok Kheng, Pengerusi, Pertubuhan Insurans Am Malaysia (PIAM); v. Tuan Zakri bin Mohd Khir, Pengerusi, Allianz Malaysia Berhad; vi. Dr. Muhammed Bin Abdul Khalid, Pengerusi, Allianz General Insurance Company (M) Berhad; vii. Tuan Lim Eng Seong, Ketua Pegawai Eksekutif, Prudential Assurance (M) Bhd; dan viii. Tuan Mohd Radzuan Mohamed, Ketua Pegawai Eksekutif, Persatuan Takaful Malaysia (MTA).
3 Mac 2025/ 2:30 petang	Bil. 5(j)/2025	**MALAYSIAN MEDICAL ASSOCIATION (MMA):** i. Dato' Dr. Kalwinder Singh Khaira, President MMA; ii. Dr Vasu Pillai Letchumanan, Setiausaha Agung Kehormat (Honorary General Secretary) MMA; dan iii. Dr Gunalan@Arumugam Palari, Member of MMA Insurance Committee/Private Specialist Committee.

TARIKH/ MASA	RUJUKAN PROSIDING	SAKSI
4 Mac 2025/ 11:30 pagi	Bil. 5(g)/2025	**DOKTOR PAKAR:** i. Dr Shanmuganathan Ganeson, Presiden Presiden Federation of Private Medical Practitioners' Associations, Malaysia (FPMPAM): ii. Datok Dr. Balwant Singh Gendeh, Presiden Persatuan Pakar Amalan Perubatan Swasta (ASPMP); iii. Dato' Dr Ahmad Faizal bin Mohd Perdaus, KPJ Damansara Specialist Hospital; dan iv. Dato' Dr. Lee Boon Chye, mantan Timbalan Menteri Kesihatan.
5 Mac 2025/ 11:30 pagi	Bil. 5(k)/2025	**PUSAT PERUBATAN UNIVERSITI MALAYA (PPUM):** i. Prof. Dato' Seri Ir. Dr. Noor Azuan Bin Abu Osman, Pengerusi PPUM & Naib Canselor Universiti Malaya (UM); dan ii. Prof. Dr. Nazirah Binti Hasnan, Pengarah. **HOSPITAL TUNG SHIN**: i. YBrs. Dr. Ashim Kumer Nandy, Pengarah Perubatan; dan ii. YBhg. Datuk Ang Chin Tat, Pengarah.
6 Mac 2025/ 11:30 pagi	Bil. 5(i)/2025	**PHARMACEUTICAL ASSOCIATION OF MALAYSIA (PhAMA):** i. Puan Kam Ai Teng, Presiden; dan ii. Puan Deepti Saraf, Naib Presiden. **MALAYSIAN ORGANISATION OF PHARMACEUTICAL INDUSTRIES (MOPI):** - Mr. Ch'ng Kien Peng, Presiden. **MALAYSIAN ASSOCIATION OF PHARMACEUTICAL SUPPLIERS (MAPS):** - Mr. Lim Teng Chyuan, Presiden. **PERSATUAN FARMASI MALAYSIA:** - Ms. Harpreet Kaur A/P Darshan Singh, Pengarah Eksekutif.
10 Mac 2025/ 10:00 pagi	Bil. 5(h)/2025	**KUMPULAN HOSPITAL:** i. Dr Kuljit Singh, President APHM; ii. Tuan Chin Keat Chyuan, Presiden & Pengarah Urusan KPJ Healthcare Berhad; iii. Tuan Jean Francois Naa, CEO IHH Healthcare; iv. Dr. Khoo Chow, Pengarah Urusan Kumpulan Sunway Healthcare; dan v. Dr. Chan Boon Kheng, Pegawai Eksekutif (Kumpulan) Asia One Healthcare (Columbia Asia)

TARIKH/ MASA	RUJUKAN PROSIDING	SAKSI
17 Jun 2025/ 10:00 pagi	Bil. 5(l)/2025	**KUMPULAN HOSPITAL:** i. Dr Tan Hui Ling, Ahli Lembaga Pengarah, Persatuan Hospital Swasta Malaysia (APHM); ii. Tuan Stanley Lam Kean Fatt, Ahli Lembaga Pengarah, APHM; iii. Tuan Anwar Anis bin Anis Ahmad, Setiausaha Kehormat, APHM; dan iv. Tuan Chin Keat Chyuan, Presiden & Pengarah Urusan, KPJ Healthcare Berhad.
17 Jun 2025/ 2:00 petang	Bil. 5(m)/2025	**THIRD PARTY PROVIDER**: i. Puan Fiona Rebecca Limus, Ketua Pegawai Eksekutif, CompuMed Services Sdn. Bhd.; dan ii. Tuan Kamal Aryf Baharuddin, Ketua Pegawai Eksekutif, PMCare Sdn. Bhd.
19 Jun 2025/ 10:00 pagi	Bil. 5(p)/2025	**SYARIKAT INSURANS:** i. Tuan Mark Steven O'Dell, Ketua Pegawai Eksekutif, Life Insurance Association of Malaysia (LIAM); ii. Tuan Ng Kok Kheng, Pengerusi, Pertubuhan Insurans Am Malaysia (PIAM); iii. Tuan Heng Zee Wang, Ketua Pegawai Penjagaan Kesihatan, AIA Malaysia; iv. Tuan Loke Chang Yueh, Ketua Pegawai Kewangan, Great Eastern Life Assurance Malaysia; v. Tuan Zakri bin Mohd Khir, Pengerusi, Allianz Malaysia Berhad; vi. Dr. Muhammed Bin Abdul Khalid, Pengerusi, Allianz General Insurance Company (M) Berhad; vii. Tuan Charles Ong, Ketua Pegawai Eksekutif, Allianz Life Insurance Malaysia; viii. Tuan Wang Wee Keong, Ketua Pegawai Eksekutif, Allianz General Insurance Company Malaysia Bhd; ix. Puan Manisha Keyal, Ketua Pegawai Penjagaan Kesihatan, Prudential Assurance (M) Bhd; dan x. Tuan Wan Saifulrizal Wan Ismail, Pengerusi, Persatuan Takaful Malaysia (MTA).
19 Jun 2025/ 2:00 petang	Bil. 5(q)/2025	**BANK NEGARA MALAYSIA (BNM):** i. Dato' Seri Abdul Rasheed Ghaffour, Gabenor BNM; dan ii. Datuk Jessica Chew Cheng Lian, Timb. Gabenor BNM.
21 Julai 2025/ 5.00 petang	Bil. 5(n)/2025	**MALAYSIAN MEDICAL COUNCIl (MMC):** - Datuk Dr. Mahathar bin Abd Wahab, Ketua Pengarah Kesihatan

TARIKH/ MASA	RUJUKAN PROSIDING	SAKSI
13 Ogos 2025/ 3.00 petang	Bil. 5(r)/2025	**MALAYSIAN REINSURANCE BERHAD [Malaysian Re]** i. Encik Ahmad Noor Azhari bin Abdul Manaf, Presiden & Ketua Pegawai Eksekutif; dan ii. Encik Mohammad Nizam bin Yahya, Naib Presiden Kanan.
14 Ogos 2025/ 12.00 tengah hari	Bil. 5(o)/2025	**KEMENTERIAN KESIHATAN MALAYSIA (KKM):** i. YBhg. Dato' Sri Zahrul Hakim bin Abdullah, Timbalan Ketua Setiausaha (Kewangan); dan ii. YBrs. Dr. Yap Wei Aun, Ketua Pegawai Eksekutif, Pejabat Transformasi Kesihatan.
14 Ogos 2025/ 3.00 petang	Bil. 5(s)/2025	**MUNICH REINSURANCE COMPANY:** i. Puan Thio Hui Ming Serena, Ketua Pegawai Eksekutif; dan ii. Puan Catherine Love Soper, Ketua Serantau Kesihatan Asia Tenggara

3.3 PAC turut merujuk kepada dokumen-dokumen berikut:

i. Slaid pembentangan pada 25 Februari 2025 hingga 14 Ogos 2025; dan
ii. Surat, dokumen dan maklumat tambahan yang telah dikemukakan.

4. LATAR BELAKANG

4.1 Peningkatan yang ketara dalam bil hospital dan premium insurans di Malaysia telah menjadi isu yang semakin membimbangkan, mencetuskan pelbagai perbincangan di media sosial, laporan media, dan kenyataan rasmi. Isu ini memberi kesan langsung kepada beban kewangan rakyat, di samping menimbulkan kebimbangan mengenai kebolehcapaian penjagaan kesihatan yang berkualiti.

4.2 Pada Disember 2024, BNM telah membuat pengumuman penting mengenai langkah-langkah interim untuk menangani isu peningkatan premium insurans dan takaful perubatan dan kesihatan (MHIT) di Malaysia seperti berikut:

i. Pelarasan Premium Secara Berperingkat (*Staggered Premium Adjustment*);

ii. Penangguhan Pelarasan Premium untuk Warga Emas untuk tempoh satu (1) tahun (*Senior Support*);
iii. Pilihan Pengembalian Polisi Tanpa *Underwriting* Tambahan (*Policy Reinstatement Option*); dan
iv. Penawaran Pelan Insurans Alternatif yang Mampu Milik (*Offering More Affordable Plans*).

4.3 Walau bagaimanapun langkah-langkah ini adalah bersifat interim dan sementara yang bertujuannya adalah untuk:

i. Mengurangkan Beban Segera:
Memberi kelegaan segera kepada pemegang polisi yang terkesan dengan kenaikan premium yang mendadak.

ii. Memberi Masa untuk Pembaharuan Jangka Panjang:
Memberi masa untuk kerajaan dan pihak berkepentingan lain seperti KKM, MOF, hospital swasta dan lain-lain agensi untuk melaksanakan pembaharuan kesihatan yang lebih meluas dan mampan. Pembaharuan ini adalah penting untuk menangani punca utama inflasi kos perubatan di Malaysia.

iii. Memastikan Kelangsungan Perlindungan:
Memastikan lebih ramai rakyat Malaysia dapat mengekalkan perlindungan insurans/takaful kesihatan mereka dalam tempoh peralihan ini.

5. SESI PENDENGARAN AWAM PAC

PAC secara kolektif dan dengan persetujuan daripada Yang DiPertua Dewan Rakyat, telah memutuskan supaya dua (2) sesi pendengaran awam bagi isu ini telah diadakan seperti berikut:

A.	Sesi I – Pulau Pinang	Tarikh : 14 Februari 2025 (Jumaat) Masa : 9.00 am hingga 12.00 Tengah hari Tempat : AC Marriott Hotel, Pulau Pinang
B.	Sesi II - Kuala Lumpur	Tarikh : 21 Februari 2025 (Jumaat) Masa : 9.00 am hingga 12.00 Tengah hari Tempat : Dewan Banquet, Blok Utama, Bangunan Parlimen Malaysia.

Sesi pendengaran ini telah mendapat sambutan yang amat menggalakkan dikalangan agensi/ syarikat/ pertubuhan dan individu. Melalui dua (2) sesi tersebut, PAC mendengar pelbagai pandangan dan maklum balas daripada orang awam serta kesan daripada isu yang berbangkit khususnya kepada rakyat, antaranya adalah seperti berikut:

A. <u>Syarikat Insurans</u>

i. **Kenaikan Premium yang Mendadak dan Tidak Mampu Dibayar**
Premium insurans kesihatan meningkat secara drastik, terutamanya apabila pemegang polisi mencapai usia tua (selepas 60 atau 65 tahun), menyebabkan ramai terpaksa membatalkan polisi mereka kerana tidak lagi berkemampuan untuk membuat bayaran premium tersebut.

ii. **Kos Pengedaran (*Distribution Cost*) yang Tinggi**
Kos pengedaran insurans yang besar, termasuk komisen ejen dan bank, menyumbang kepada premium yang tinggi.

iii. **Klausa Pengecualian dan Pengendalian Tuntutan yang Tidak Adil**
Pemegang polisi mengadu tentang klausa pengecualian yang tidak jelas, tidak adil, dan tidak konsisten dalam pengendalian tuntutan, di mana tuntutan boleh ditolak walaupun doktor memberi jaminan boleh dituntut atau polisi menyatakan "*as charged*".

iv. **Tiada Insentif untuk Gaya Hidup Sihat/Pencegahan**
Tiada bonus tanpa tuntutan (*no-claim bonus*) yang dapat menggalakkan pesakit untuk mengamalkan gaya hidup sihat dan tidak melakukan tuntutan yang tidak perlu.

v. **Polisi Berorientasikan Had Tinggi**

Terdapat kecenderungan syarikat insurans menjual polisi dengan had perlindungan yang sangat tinggi yang mungkin tidak diperlukan oleh kebanyakan pesakit, tetapi menyebabkan premium keseluruhan meningkat.

vi. **Isu Polisi Insurans Berkaitan Pelaburan [*Investment-linked Insurance Policies* (ILP)]**

Premium polisi bagi ILP boleh meningkat secara automatik tanpa persetujuan pemegang polisi, menyebabkan masalah dan pembatalan polisi.

vii. **Cukai Jualan dan Perkhidmatan (SST)**

Pengenaan SST ke atas polisi insurans peribadi juga menambah beban kepada premium.

viii. **Amalan 'Rebat' kepada Syarikat Insuran**

Hospital amal mendedahkan bahawa syarikat insuran menuntut "rebat" (5-10% daripada jumlah tuntutan perubatan, malah kini meminta 15-20%) daripada hospital, yang disifatkan tidak masuk akal.

B. <u>Hospital Swasta</u>

i. **Caj Berlebihan (*Overcharging*) dan Kenaikan Harga**

Hospital swasta didakwa mengenakan caj yang tidak munasabah dan *mark-up* yang sangat tinggi untuk barangan, perkhidmatan, dan ubat-ubatan, jauh melebihi kos sebenar.

ii. **Ujian dan Prosedur Tidak Perlu (*Unnecessary Tests and Procedures*)**

Terdapat dakwaan bahawa hospital dan doktor menggalakkan atau melakukan ujian serta prosedur yang tidak perlu, terutamanya apabila pesakit mempunyai insurans, untuk meningkatkan bil dan keuntungan.

iii. **Diskriminasi Harga**

Hospital swasta dikatakan mengenakan kadar caj yang berbeza antara pesakit berinsuran dan tidak berinsuran, di mana pesakit berinsuran dicaj lebih tinggi.

iv. **Caj Pentadbiran Berulang dan Tidak Jelas**

Hospital mengenakan pelbagai caj pentadbiran, pendaftaran, dan caj lain yang berulang serta tidak telus.

v. **Ketiadaan Kawalan Harga Hospital**

Walaupun fi atau yuran doktor pakar dikawal, caj perkhidmatan hospital swasta dan bekalan tidak dikawal selia, membolehkan hospital menetapkan harga sesuka hati dan menjana keuntungan besar.

vi. **Bil Tidak Telus dan Sukar Difahami**

Bil-bil yang dikeluarkan mengandungi istilah perubatan yang sukar difahami oleh pesakit, dan kadangkala mengenakan caj untuk perkhidmatan atau ujian yang tidak dilakukan.

6. KETERANGAN SAKSI

Prosiding telah diadakan bagi mendapatkan keterangan dari semua pihak berkepentingan. Perkara yang dibincangkan secara umumnya diringkaskan seperti berikut:

6.1 Keterangan Ketua Setiausaha Perbendaharaan (KSP)

Datuk Johan Mahmood Merican [KSP, MOF] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 memaklumkan bahawa isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta, dan impaknya kepada kesihatan awam melibatkan pelbagai faktor seperti perubahan demografi, peningkatan penyakit tidak berjangkit (NCD), penuaan populasi, serta inflasi yang menyebabkan peningkatan harga ubat-ubatan dan teknologi perubatan.

Sehubungan itu, MOF bekerjasama rapat dengan KKM dan BNM yang mengawal selia industri insurans dan takaful untuk merangka pelan tindakan menyeluruh bagi menangani isu kenaikan kos insurans ini. Selain daripada itu, beberapa langkah jangka pendek yang telah diumumkan, pihak-pihak yang terlibat juga sedang merangka cadangan jangka sederhana dan panjang bagi mengatasi isu ini.

6.2 Keterangan Gabenor Bank Negara Malaysia (BNM)

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 memaklumkan bahawa isu kenaikan premium insurans dan takaful kesihatan (MHIT) adalah kompleks, melibatkan pelbagai faktor dan pihak berkepentingan, termasuk inflasi kos perubatan, peningkatan penyakit, penuaan populasi, serta kemajuan teknologi perubatan. Beliau menegaskan bahawa isu ini memerlukan pendekatan keseluruhan negara ("*whole of nation approach*").

Kenaikan tuntutan MHIT meningkat lebih dua kali ganda dalam tempoh enam (6) tahun kebelakangan ini. Antara punca utama adalah caj hospital swasta yang tinggi dan tidak dikawal, serta ketidaktelusan dalam perbezaan caj antara pesakit yang menggunakan surat jaminan (GL) dengan pembayaran secara bayar dahulu dan tuntut kemudian. BNM telah membangkitkan isu ini sejak 10 tahun lalu, tetapi penyelesaiannya memerlukan komitmen yang teguh dan berterusan daripada semua pihak.

BNM menggariskan tiga faktor utama dalam mengawal selia pelarasan premium MHIT seperti berikut:

i. Kemampanan syarikat insurans, Syarikat Penanggung Insurans dan Pengendali Takaful (ITO) dalam membayar tuntutan;
ii. Amalan perniagaan yang adil kepada semua pemegang polisi; dan
iii. Daya kemampuan pengguna.

Untuk mengawal inflasi perubatan dan premium MHIT, BNM dan KKM telah merangka sembilan inisiatif pembaharuan sektor kesihatan berdasarkan lima teras utama, iaitu:

i. Meningkatkan ketelusan kos di perkhidmatan kesihatan swasta – termasuk penerbitan harga ubat dan semakan Akta 586 dan penerbitan julat harga rawatan.
ii. Melaksanakan model pembayaran kesihatan berdasarkan *diagnostic related group* (DRG) menggantikan sistem *fee-for-service*.
iii. Mentransformasikan reka bentuk produk MHIT supaya lebih mampan dengan ciri seperti *co-payment*.
iv. Meluaskan pilihan penjagaan kesihatan mampu milik, termasuk Rakan KKM dan hospital tanpa keuntungan.
v. Melaksanakan rekod kesihatan elektronik untuk mempertingkat kecekapan dan mengurangkan pertindihan ujian diagnostik.

Kesan yang disasarkan berdasarkan lima (5) teras utama tersebut termasuk harga rawatan yang lebih adil, pengurangan rawatan berlebihan, dan pilihan penjagaan kesihatan lebih cekap dan berkualiti.

Tiga petunjuk prestasi utama (KPI) yang perlu dipantau secara berterusan ialah:

i. Kadar inflasi perubatan lebih perlahan dan sejajar dengan trend global.
ii. Pelarasan premium MHIT yang lebih terkawal.
iii. Penjimatan kos menerusi DRG dan pembelian strategik.

BNM juga menyasarkan pengenalan produk MHIT asas yang lebih mampan dan mampu milik, yang disokong dengan struktur tadbir urus yang jelas dan kukuh dan diterajui oleh Menteri Kesihatan dan Menteri Kewangan II.

6.3 Keterangan Menteri Kesihatan

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [Menteri Kesihatan] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa ekosistem kesihatan Malaysia berasaskan dua komponen utama iaitu sektor kesihatan awam dan swasta. Perkhidmatan kesihatan awam dibiayai sepenuhnya melalui kutipan cukai umum. Pada 2025, kerajaan telah memperuntukkan sejumlah RM54.27 bilion bagi mengendalikan kemudahan kesihatan awam.

Manakala, sektor swasta pula dibiayai melalui insurans kesihatan swasta dan perbelanjaan sendiri oleh pengguna. Namun, peningkatan kos rawatan swasta menyebabkan rakyat semakin bergantung kepada sistem kesihatan awam. Oleh itu, KKM sedang mengarusperdanakan penggunaan insurans kesihatan swasta (PHI) agar beban kos tidak tertumpu kepada pengguna atau hospital awam.

KKM memilih untuk tidak melaksanakan insurans kesihatan nasional (NHI) atau sosial (SHI) kerana ia bersifat mandatori dan dianggap membebankan rakyat. Sebaliknya, kementerian berusaha bekerjasama dengan pihak insurans dan hospital swasta untuk memastikan caj lebih berpatutan, supaya sektor swasta dapat mengekalkan jumlah pesakit dan tidak menyebabkan kesesakan di hospital awam.

Selain itu, Malaysia sebagai negara berpendapatan sederhana tinggi sepatutnya membelanjakan 5–6% daripada KDNK untuk sektor kesihatan. Namun kini hanya sekitar 4.5% dibelanjakan (2.3% awam, 2.1% swasta), yang menyebabkan kemudahan kesihatan kekurangan kakitangan, sumber, dan terbeban. Oleh itu, KKM mengambil inisiatif mempelbagaikan sumber pembiayaan termasuk memperkenalkan program Rakan KKM dan menambah baik perkhidmatan sayap swasta serta pesakit bayar penuh di hospital kerajaan.

Yang Berhormat (YB) Menteri Kesihatan juga memaklumkan bahawa isu inflasi perubatan dan peningkatan premium insurans amat penting bagi Kementerian Kesihatan (KKM) dan telah mengikuti perkembangan perbincangan awam, termasuk sesi pendengaran awam PAC di Pulau Pinang dan Kuala Lumpur. Isu inflasi perubatan telah dibangkitkan sejak pertemuan pertama beliau dengan Jawatankuasa Pilihan Khas (JKPK) Kesihatan pada 2 April 2024.

KKM telah mengemukakan Pelan Transformasi Pembiayaan Kesihatan yang komprehensif, merangkumi langkah pembendungan kos melalui kerjasama dengan Bank Negara Malaysia. Pelan ini telah dibentangkan oleh Pejabat Transformasi Kesihatan (HTO) kepada JKPK Kesihatan pada 27 Ogos 2024. Beliau juga menekankan bahawa inflasi perubatan adalah isu global yang kompleks dan memerlukan pendekatan berhati-hati agar tidak menjejaskan kualiti dan akses penjagaan kesihatan.

KKM mencadangkan penyelesaian holistik dan kolaboratif jangka panjang yang memerlukan masa untuk pelaksanaan dan kematangan. Justeru itu langkah sementara jangka pendek oleh BNM adalah sesuai buat masa ini. KKM juga memohon pemahaman dan sokongan dalam usaha melibatkan semua pihak berkepentingan untuk menggerakkan sistem kesihatan negara ke arah "*value based healthcare and system of care delivery".*

6.4 Keterangan Ketua Pegawai Eksekutif (KPE), Pejabat Transformasi Kesihatan (HTO), KKM

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 memaklumkan bahawa inflasi perubatan merupakan isu serius dan kompleks yang memerlukan pendekatan menyeluruh, bukannya penyelesaian tergesa-gesa yang boleh membawa kesan sampingan tidak diingini (*unintended consequences*). Beliau menjelaskan bahawa terdapat dua (2) kategori punca inflasi perubatan Iaitu:

a. **Punca munasabah** seperti kemajuan teknologi perubatan, penuaan populasi, peningkatan penyakit tidak berjangkit, peningkatan kos input, dan ekspektasi rakyat; dan
b. **Punca tidak munasabah** seperti moral hazard dalam insurans swasta, *mark-up* harga berlebihan, kekurangan persaingan dalam hospital swasta, dan penggunaan sistem pembayaran "*fee-for-service*" (FFS) yang bersifat pro-inflasi.

Untuk menangani isu ini, KKM telah merangka strategi nasional yang merangkumi empat (4) tonggak utama:

i. **Menambah ketelusan harga** – melalui pemaparan harga ubat dan perkhidmatan di klinik serta hospital swasta, penyelarasan metodologi pengukuran inflasi, dan pengumpulan data klinikal serta harga sebagai asas kepada sistem *Diagnosis Related Groups* (DRG).
ii. **Pelaksanaan sistem DRG** – sebagai alternatif kepada FFS, di mana bayaran dibuat secara pakej berdasarkan diagnosis, bukan mengikut setiap

perkhidmatan kecil. Ini bertujuan untuk menggalakkan kecekapan tanpa menjejaskan kualiti rawatan.

iii. **Transformasi sistem insurans kesihatan swasta** – bersama Bank Negara Malaysia, satu produk insurans kesihatan asas yang lebih mampan dan berpaksikan penjagaan kesihatan berasaskan nilai (*value-based healthcare*) sedang dibangunkan.

iv. **Penambahan penyedia perkhidmatan kesihatan mampu milik** – melalui pengembangan inisiatif seperti **Rakan KKM** dan sokongan kepada hospital tidak berasaskan keuntungan sebagai alternatif kepada hospital swasta mewah.

Beliau turut menekankan bahawa kawalan harga secara mikro terhadap setiap item dalam bil hospital bukanlah jalan penyelesaian kerana ia sukar dilaksanakan dan boleh membawa kepada manipulasi oleh penyedia perkhidmatan. Sebaliknya, pembaharuan struktur sistem pembiayaan seperti DRG adalah langkah lebih berkesan tetapi memerlukan masa bertahun-tahun untuk mencapai kematangan. KKM memberi jaminan bahawa reformasi ini sedang giat dijalankan secara berfasa dengan kerjasama pelbagai kementerian dan agensi, serta disokong oleh langkah-langkah interim seperti ketelusan harga dan reformasi insurans swasta. Prinsip utama yang ditekankan ialah *"primum non nocere"*, mengutamakan untuk tidak memudaratkan dalam sebarang penyelesaian yang diambil.

6.5 Keterangan KPE, LIAM

Encik Mark Steven O'dell [KPE, LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 memaklumkan perkara-perkara berikut:

A. Struktur Insurans Perubatan:
   i. Premium dibayar oleh pemegang polisi masuk ke dalam tabung rizab.
   ii. Wang dari rizab digunakan untuk membayar tuntutan, kos operasi, komisen dan keuntungan.
   iii. Tuntutan (*claims*) adalah komponen paling tidak stabil dan menjejaskan kewangan industri.

B. Prestasi Terkini LIAM:
   i. Majoriti insurans individu di Malaysia ditulis (*written*) oleh ahli LIAM (75%).
   ii. Kerugian berterusan tiga tahun berturut-turut: -6% (2021), -15% (2022), -16% (2023).
   iii. Nisbah tuntutan meningkat sejak pandemik: dari rendah semasa COVID-19 (2021) kepada 92.96% (2023), melebihi jiran ASEAN lain kecuali Indonesia.

C. Punca Kenaikan Tuntutan & Inflasi Perubatan:
   i. Rawatan moden & teknologi mahal (immunoterapi, robotik).
   ii. Kebergantungan kepada peralatan dan ubatan import yang didagangkan dalam USD.
   iii. Penuaan populasi menaikkan kadar penggunaan rawatan.
   iv. Reka bentuk polisi yang membenarkan rawatan tanpa had (seperti kad tanpa tunai & bayaran "*as charged*").
   v. Kurangnya maklumat kepada pesakit, menyebabkan mereka tidak mampu mempersoalkan bil.
   vi. Penyalahgunaan & pembaziran oleh sesetengah penyedia perkhidmatan kesihatan.

D. Cabaran Polisi & Pengguna:
   i. Polisi menjadi tidak mampu milik untuk golongan warga emas.
   ii. Tiada pilihan mudah untuk pengguna mengekalkan perlindungan sedia ada pada kos lebih rendah.
   iii. Insentif gaya hidup sihat dan bonus tanpa tuntutan masih terhad.

E. Langkah-langkah Penstabilan Dicadangkan:
   i. Penubuhan pangkalan data tuntutan industri untuk jejak pola pembaziran dan penipuan.
   ii. Promosi polisi dengan *co-payment* untuk kurangkan *buffet syndrome*.
   iii. Peningkatan ketelusan harga dan sistem penetapan harga berasaskan prosedur (DRG).
   iv. Penyelarasan dengan hospital swasta, termasuk pembekuan harga semasa langkah interim.

v. Peranan kerajaan dalam menyokong subsidi dan penggunaan ubat generik.
vi. Kolaborasi nasional melibatkan semua pihak: penginsurans, hospital, doktor, kerajaan dan pengguna.

7. PENEMUAN PAC PARLIMEN

7.1 Struktur Sistem Insurans Kesihatan Swasta

7.1.1 Peranan Bank Negara Malaysia (BNM)

BNM beroperasi dalam kerangka mandat yang memberi pemberatan tinggi kepada kesihatan kewangan institusi. Walaupun mereka mempunyai kuasa punitif terhadap ITO yang ingkar, kuasa ini bersifat reaktif. BNM tidak mempunyai instrumen undang-undang untuk mengawal punca luaran kenaikan premium, iaitu kos rawatan di hospital swasta.

Bagaimanapun peranan BNM sebagai pengawal selia kewangan adalah kukuh, tetapi tidak mencukupi untuk menangani krisis sosial akibat kenaikan kos. Terdapat jurang regulatori di mana BNM mengawal pembayar iaitu pihak insurans tetapi tiada pihak yang mengawal secara efektif penerima bayaran iaitu pihak hospital swasta dari segi harga komponen bukan profesional. Tanpa sinergi kawalan harga di peringkat penyedia, usaha BNM menstabilkan premium hanyalah penyelesaian sementara.

Penjelasan Gabenor BNM

Dato' Seri Abdul Rasheed Ghaffour [Gabenor Bank Negara Malaysia] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa mandat utama BNM adalah untuk memastikan kestabilan kewangan dan memastikan syarikat insurans dan pengendali takaful (ITO) kekal berkeupayaan membayar tuntutan pemegang polisi. Beliau menegaskan bahawa pelarasan premium MHIT dilakukan berdasarkan keperluan menampung kos rawatan yang semakin meningkat akibat inflasi perubatan, dan bukan untuk meningkatkan keuntungan syarikat.

BNM meneliti setiap permohonan pelarasan premium bagi memastikan ia munasabah dan mesti mendapat kelulusan Lembaga Pengarah syarikat. Selain itu, ITO diwajibkan menyediakan produk alternatif yang lebih mampu milik untuk golongan yang terkesan dengan kenaikan premium. Beliau turut mengakui bahawa peningkatan umur menyumbang kepada kenaikan premium kerana risiko kesihatan meningkat. Namun, usaha sedang dijalankan untuk mengkaji semula sistem "*risk-pooling*" dan memperkenalkan produk MHIT asas yang lebih mampan. Jika didapati ada ITO yang tidak mematuhi peraturan BNM dalam penyelarasan premium, tindakan akan diambil terhadap mereka.

"Tuan Sim Tze Tzin [Ahli PAC]: *Terima kasih, Pengerusi dan terima kasih juga kepada KSP, Dato' Rasheed dan juga Datuk Jessica. Saya rasa ini adalah satu pembentangan yang sangat komprehensif. Tahniah kepada BNM dan juga MoF kerana melakarkan satu respons yang cepat dan komprehensif terhadap isu yang sangat affecting the people seriously.*

Daripada apa yang kita dapati daripada pendengaran awam, people are very concerned dan kita nampak bahawa the turn up is very overwhelming. Kita tidak jangka bahawa hampir lebih daripada 700 orang, hampir 800 orang telah menghadiri kedua-dua sesi pendengaran. Maka ini adalah satu isu yang burning and very important dan perlu mengambil tindakan.

Jadi, first, saya tahu bahawa Bank Negara Malaysia ini memang mengawal selia syarikat-syarikat ITO. Dan saya ingin mulakan dengan ada banyak soalanlah, kita slow-lah. We go slow.

First is that, kenapa apakah proses Bank Negara Malaysia mengawal selia kenaikan their premium? Sebab kita nampak bahawa daripada apa yang dilaporkan oleh kami kepada Ahli-ahli Parlimen dan juga sesi pendengaran, sememangnya mereka premium berjalan bukan bahawa setiap tiga tahun ada yang setiap dua tahun ia naik, okey. Lepas itu selepas mereka masuk satu age sahaja selepas 60 ia akan naik mendadak.

Apabila bracket 70 tahun ke atas ia akan naik lagi mendadak. Kita tahu bahawa mereka ini adalah pesara. Then, yang lagi menyayat hati adalah ada yang cancer patient. Mereka telah beli setia dengan syarikat insurans puluhan tahun. Tetapi apabila mereka paling memerlukan insurans itu mereka dikenakan insurans yang begitu tinggi naik mendadak dan ada yang cancer patient yang tengah mengalami perubatan dan mereka terpaksa surrender policy tersebut. So, boleh respons bagaimana kawal selia daripada Bank Negara Malaysia?

Dato' Seri Abdul Rasheed Ghaffour (BNM): *Terima kasih Yang Berhormat di atas soalan tadi. Mungkin kita boleh go to one of the slide on the cara-cara kita mengawal selia.*

Pertama, Yang Berhormat, saya ingin merujuk kepada mandat Bank Negara Malaysia untuk memastikan financial stability dan juga ITO kekal solvent dan mampu membayar tuntutan kepada pemegang polisi apabila mereka melakukan tuntutan. Itu adalah mandat dan juga objektif utama dari segi pengawalseliaan penyelarasan premium oleh insurans.

Ini adalah kerana apabila kita lihat produk MHIT memang semakin tidak mampan disebabkan oleh inflasi dan kos perubatan yang meningkat. Bank Negara Malaysia meneliti setiap permohonan penyelarasan premium untuk memastikan kemampanan

produk. ITO juga perlu mengambil kira pertamanya kemampuan dengan mengehadkan kenaikan premium berdasarkan dasar dalaman mereka yang diluluskan oleh Lembaga Pengarah mereka, pertamanya.

Mereka juga tidak dibenarkan untuk menyelaraskan premium untuk meningkatkan margin keuntungan mereka. Itu memang tidak dibenarkan oleh Bank Negara Malaysia. Penelitian juga dibuat untuk memastikan mereka menyediakan produk-produk alternatif bagi memastikan pihak-pihak tertentu yang mana pengalaman pembayaran premium akan meningkat, mereka mempunyai pilihan sama ada untuk beralih kepada produk yang lebih asas ataupun lebih murah setanding dengan keupayaan mereka dan juga keperluan perlindungan perubatan mereka.

Keempat, soalan Yang Berhormat tadi dari segi peralihan umur. Sebagaimana saya sebut tadi Yang Berhormat memang apabila kita beralih umur kebarangkalian sakit dan kebarangkalian tuntutan memang meningkat. Ini adalah pendorong utama dari segi peningkatan premium bagi individu-individu yang beralih brackets umur tertentu.

Namun melalui usaha kami dari segi melihat semula dari segi risk-pooling dan sebagainya kami akan cuba menangani isu ini dan juga kedua dengan adanya produk MHIT asas yang saya bentangkan tadi, ia juga memberi peluang kepada pemegang-pemegang polisi untuk memiliki produk ini yang bersesuaian dengan keperluan perlindungan perubatan mereka. So this is what we will do.

Then, sekiranya kita dapati ada penyelarasan premium yang tidak mengikuti peraturan-peraturan yang telah ditetapkan oleh Bank Negara Malaysia tindakan akan diambil ke atas ITO tersebut. ...”

[Muka surat 10 - 13, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

7.1.2 Konsep / Pelan Insurans Sedia Ada

Konsep insurans sedia ada di Malaysia adalah rapuh dan terdedah kepada manipulasi pemilihan risiko (*risk selection*). Ia gagal berfungsi sebagai jaringan keselamatan sosial jangka panjang kerana ia meminggirkan golongan yang paling memerlukan perlindungan melalui mekanisme harga.

Justeru itu, reformasi diperlukan untuk mewajibkan penyatuan kolam risiko (*pooling consolidation*) bagi menghalang strategi segregasi risiko oleh ITO. Cadangan penubuhan Insurans Kesihatan Sosial Nasional perlu dipertimbangkan serius sebagai alternatif jangka panjang untuk menampung kegagalan pasaran ini.

i. <u>Penjelasan KPE, Galen Centre For Health and Social Policy</u>

Encik Azrul Mohd Khalib [KPE, Galen Centre For Health and Social Policy] dalam Prosiding Bil. 5(d) bertarikh 25 Februari 2025 menjelaskan bahawa konsep *pool* subsidi silang adalah betul, tetapi masalah sekarang adalah cepatnya pengurangan jumlah peserta yang membayar premium. Golongan muda yang sepatutnya menyokong golongan tua kini menghadapi kenaikan premium yang tinggi, menyebabkan ramai berhenti membayar dan seterusnya menjejaskan sistem. Pada usia tua, premium terlalu mahal dan ramai tidak mampu bayar kerana sudah bersara. Beliau mencadangkan perlunya sistem insurans kesihatan dan sosial nasional untuk menangani isu ini, walaupun ia memerlukan masa lama untuk dilaksanakan dan tidak popular secara politik.

> ***"Tuan Haji Azli bin Yusof [Ahli PAC]:*** *I can understand, I mean people who purchased insurance at a later age where they are being accessed first. That one I can understand. But I mean, people like me who purchased insurance 25 years ago, I would expect that you know that saving or my contribution would cover for my medical expenses at the later age. You are right, I mean then the younger people would contribute and you know pay for my expenses. I mean that's circular and you know, cross-subsidised. I mean at that age...*
>
> ***Encik Azrul Mohd Khalib [CodeBlue]:*** *I mean the pool approach is definitely the way that it should work. The problem here is what happens when the depletion of the pool is too rapid which is what the insurance is saying lah. So, sekarang ini masalahnya your 25 years of paying insurance is irrelevant because the person whose paying for you today is the current policy holders who are 20-25 years old. But you know what, they are also seeing an increase in their premiums like 30 percent, 25 percent, these are people who just started work you know, they are early in their careers and the peningkatan of the premium itu is actually costing them to decide, "I don't want. I cannot afford the premium".*
>
> *So, when they stop their premium, they do not have the money to support you, you know and that is what's happening in the current system now.*
>
> ***...***

Encik Azrul Mohd Khalib [CodeBlue]: *Tapi, therein lies the problem. If at the age of 60s, 70s suddently your premium is so expensive, can you afford? The answer is probably no because you stop working already. Maybe you retired dan sebagainya. So, your duit pencen itu goes to paying your insurance you know and this is where we also the aging economy you know the aged population yang we always talk about. The cost of an aged person for healthcare is four times more expensive than a person who is in their 20s and 30s. Kita kena budget that in. The problem is that we don't. So, right now, we are seeing a situation where like what Prof said just now the time when you need the most is when you don't have the insurance.*

...

Encik Azrul Mohd Khalib [CodeBlue]: *The best way forward for us is really to adopt and I'm sure the previous speaker who you've heard this morning we all disagree is to adopt National Health Insurance. I would actually say that we need to adopt a national health and social insurance where part of the income goes to health and the other part goes to aged care.*

Because right now, we have nothing budgeting for aged care. So, when we look at national health and social insurance, we have preparing for needs today and needs for tomorrow. The problem here is it's not popular. It's politically problematic. It's another form of tax, maybe. But you need to enact the law. How do you go about it?

So, there's a lot of complications for that. From it takes years to introduce national health insurance. I think UK took I think six years for their NHS, the national health insurance that they have and it has taken many years in other countries.

But, when you pair national health insurance dengan DRG, you put them together, you have a good system. If you only have one, like just TRG, it won't work. The DRG is not the magic bullet, you know. It's not going to solve It's not a minyak urut that's going to solve everything. It just won't. [Dicelah] It's just a tool."

[Muka surat 33 - 35, Laporan Prosiding Bil 5(d)/2025 bertarikh 25 Februari 2025]

ii. <u>Penjelasan NAMLIFA</u>

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa kelemahan struktur pelan insurans perubatan sedia ada yang menyumbang kepada ketidaklestarian sistem. Beliau menerangkan bagaimana syarikat insurans menggunakan strategi migrasi pelan bagi menangani isu kadar tuntutan yang tinggi dalam pelan-pelan lama. Apabila sesuatu pelan menjadi tidak mampan akibat tuntutan yang banyak, syarikat akan memperkenalkan pelan baharu dengan manfaat lebih besar tetapi kadar premium yang sama, lalu menggalakkan pemegang polisi yang sihat berpindah ke pelan baharu.

Kesan daripada strategi ini adalah pelan lama akan tinggal hanya peserta yang sakit atau berisiko tinggi, menyebabkan kadar tuntutan dalam *pool* tersebut melonjak tinggi dan memaksa syarikat menaikkan premium secara mendadak. Ini mencipta *'pool'* tidak lestari yang penuh dengan peserta bermasalah dan menyebabkan beban kos meningkat secara tidak seimbang. Fenomena ini dikatakan berlaku secara meluas dalam industri.

Sebagai penyelesaian, NAMLIFA mencadangkan supaya semua *pool* yang berisiko tinggi atau berprestasi rendah digabungkan dalam satu tabungan yang lebih besar menggunakan pendekatan aktuari. Gabungan ini berpotensi menyebar risiko dengan lebih adil dan membantu menstabilkan kadar premium. Namun, cadangan ini belum dilaksanakan dan hanya difahamkan sedang dipertimbangkan oleh pihak industri melalui LIAM. Tambahan pula, wujud ketidakpastian sama ada *pool* tidak lestari ini akan terus dikekalkan atau ditutup sekiranya tidak mampu bertahan.

> ***"Tuan Sim Tze Tzin [Ahli PAC]:*** *Okey, Pengerusi. Sekarang NAMLIFA ini adalah ejen kepada syarikat-syarikat insurans. Jadi, dia orang banyak dealing dengan syarikat insurans. Sekarang, isunya adalah syarikat insurans juga dia dilihat bahawa excessive profiteering lah. Maksudnya, dia ada banyak yang menyebabkan kenaikan kos harga this premium insurance.*
>
> *Jadi, daripada perspektif NAMLIFA, apakah yang insurance company perlu buat untuk mengurangkan kosnya supaya dia boleh sustainable dia punya pool, dia sustainable dan premium tidak akan naik mendadak.*
>
> ***Encik G Saseedaran Gengadharan [NAMLIFA]:*** *Okey. Kalau kita lihat sekarang ini, banyak produk medical yang sudah tidak dijual lagi tapi masih boleh digunakan lagi. Dia migrate dari satu plan ke plan contoh ya, saya bagi contoh. Katalah syarikat insurans ini ada pelan A. Pelan A yang mana had tahunan dia, contoh ya, example RM100,000 setahun. Sekarang dia punya sustainability, dia tak boleh tahan lagi produk ini. Syarikat insurans kata nak naikkan premium sebab ramai yang claimed daripada tabungan ini, pool ini.*
>
> *Jadi, dia akan keluarkan pelan B. Apabila dia perkenalkan pelan B, dia memberikan peluang ataupun dia menjemput mereka-mereka yang dalam pelan A itu yang masih sihat ataupun belum buat sebarang tuntutan lagi untuk migrate, hijrah kepada pelan B. Apa yang berlaku ialah di pelan B ini, premiumnya serupa, the premium is the same. Tetapi, dari sini RM100,000, sini mungkin RM1 juta pula. Tabungan yang RM100,000 itu dia kata kena naikkan premium dan mereka yang sihat dalam tabungan ini akan dijemput untuk mengambil pelan B yang mana annual limit dia, limit tahunan dia jauh lebih tinggi.*

Jadi, mereka semua migrate ke pelan B. Siapa yang sekarang tertinggal dalam Pelan A? Semua yang sakit. Jadi, ini menjadi satu pool, a pool which has very high claim ratio. Sekarang ini, banyak pool macam ini dalam syarikat-syarikat insurans. Salah satu saranan kami ialah all this we said, katalah unperforming pool kah atau high claim ratio pool lah, satukan semua dalam sebarang bentuk actuarial yang dia boleh. Bila satukan semua, the pool is spread bigger, lebih besar. Jadi, kemungkinannya, kenaikan itu tidak macam apa yang kita experience sekarang.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Adakah cara ini sudah dilaksanakan?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Tidak.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Tidak ada?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Belum lagi.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Sebab mustahil?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Tapi kami dapat maklumat daripada LIAM, mungkin itu pun mereka akan sarankan kepada syarikat-syarikat insurans lah. Itu kami tidak tahulah.*

Tuan Sim Tze Tzin [Ahli PAC]: *Adakah yang high claim ratio pool ini dia akan ditutupkan kalau satu hari dia tak sustain lagi lah, dia bankrupt lah kata pool itu. Akan dia ditutupkan pool itu ke? Boleh? Tak boleh?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Setakat ini belum, tidak ada lagi. Masa depan kita tidak tahu. Itulah kita kata tadi, ketidakpastian. The uncertainties are very high because of all these factors."*

[Muka surat 18 - 20, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

iii. **<u>Penjelasan Prof. Dr. Tharani Loganathan</u>**

Prof. Dr. Tharani Loganathan (Fakulti Perubatan, Universiti Malaya) dalam Prosiding Bil. 5(d) bertarikh 25 Februari 2025 menjelaskan bahawa Sistem insurans swasta Malaysia tidak mengamalkan subsidi silang sebenar kerana insurans diklasifikasikan mengikut kumpulan umur dan risiko. Walaupun pembelian insurans pada usia muda, kos rawatan dan keperluan perubatan pada masa depan boleh berubah, menyebabkan perlindungan tidak mencukupi. Beliau menggesa agar isu ini dibawa kepada Kementerian Kesihatan untuk mempertimbangkan sistem insurans kesihatan sosial yang lebih menyeluruh. Sistem semasa juga mengehadkan liputan umur, biasanya

sehingga 70 tahun, sedangkan keperluan kesihatan tertinggi adalah pada umur 70 tahun ke atas.

"Tuan Haji Azli bin Yusof [Ahli PAC]: *I can understand, I mean people who purchased insurance at a later age where they are being assessed first. That one I can understand. But I mean, people like me who purchased insurance 25 years ago, I would expect that you know that saving or my contribution would cover for my medical expenses at the later age. You are right, I mean then the younger people would contribute and you know pay for my expenses. I mean that's circular and you know, cross-subsidised. I mean at that age...*

...

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *Ya. But I understand, I mean I don't know the details of the private health insurance and so on but what I understand from the conversation with Bank Negara, it sounds like the pool is aged. They are not like an entire pool where 20 year old is subsidising the 50 year old. No. They have a different criteria. I am not sure how would they work on it, it's packaged and so on. That's another thing to consider. Like if you bought insurance at 20 year old, I presume YB you bought it when you started working or something, right? The thing is when you buy that insurance premium, you have to think 30 years, 40 years, 50 years in the future and what is the medical needs in 40 years. Because now you buying what you think you can afford or what is the best in the market, right? Depending on your comfort and all that.*

But it may not be enough at 30 years or 40 years because the cost have gone up inflation, all that...

Tuan Haji Azli bin Yusof [Ahli PAC]: *I was looking at the coverage. So, I think that coverage is enough for me. [Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Tharani Loganathan [UM]: *At that time.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *At that time. Ya. [Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Tharani Loganathan [UM]: *But in 40 years time, it's not. So, you think about it maybe like 10-20 years ago insurance premium in Malaysia they didn't cover, they only went up to 70 years old, you know. Now the new premiums go up to 100. Okay and that's actually should happen anyway I think in Singapore, most countries' insurance goes up to 100. Why would you stop coverage at 70? That's when you need it the most right? 70 years old has the highest healthcare needs.*

...

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *I would really like you all to think I appeal to you all to think about social health insurance and bring MOH to hear about this because I think the solution needs to be broader than just looking at private health insurance. Social health insurance could cover the issue about private healthcare.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Prof, you familiar with the Australian health insurance? Is that similar?*

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *I am not totally familiar. Each of the countries has a different sort of system, okay. So, some ya."*

[Muka surat 33 - 35, Laporan Prosiding Bil 5(d)/2025 bertarikh 25 Februari 2025]

iv. Penjelasan Malaysian Medical Association (MMA)

Prof Dr Nur Aishah Mohd Taib [Ahli Malaysian Medical Association (MMA)] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa masalah terbesar dalam sistem kesihatan swasta Malaysia adalah bilangan pesakit yang ramai mempunyai insurans tetapi tidak dilindungi untuk rawatan yang diperlukan.

Syarikat insurans sering menggunakan pengecualian penyakit sedia ada (*preexisting illnesses*) untuk menolak perlindungan. Sebagai contoh, wanita yang mempunyai *benign cyst* semasa pemeriksaan rutin boleh ditolak perlindungan untuk kanser payudara di masa hadapan, menjadikan insurans sedia ada hanya melindungi individu yang sihat sahaja.

Selain itu, rawatan pesakit luar *(outpatient*) sering tidak dilindungi, termasuk terapi bersasar (*targeted therapies*) untuk kanser, walaupun pesakit mempunyai perlindungan berjuta-juta. Keadaan ini memaksa pakar onkologi perlu bersikap kreatif dengan memasukkan pesakit ke wad (*inpatient*) semata-mata untuk mendapatkan perlindungan insurans, satu amalan yang tidak perlu dan meningkatkan kos keseluruhan.

Oleh itu, beliau menggesa peralihan daripada model insurans berasaskan risiko individu kepada Insurans Kesihatan Berasaskan Risiko Komuniti bagi memastikan perlindungan yang lebih inklusif dan lestari, terutamanya menjelang status Malaysia sebagai negara tua (*super-aged stage*).

"Prof Dr Nur Aishah Mohd Taib [Malaysian Medical Association]: *Thank you so much. I think this is the first time I am actually attending one of the PACs and to have so many YBs in the room and the wait of political will is actually in your hands. [Dicelah] Because you know, honestly as a practitioner right now, we see the impact*

of people insured but not covered. So that means the insurance that the patients have do not cover for what they need. So, the instrument that we have today does not cover.

So, I am coming from a breast cancer perspective. So, some of our patients are not covered because they have preexisting illnesses. So, I would say that the current insurance that we have now is covering the healthy people. So, what are we going to do with the silver economy that has been to come up soon? So therefore, I think the support of a social sort of community risks-based insurance is extremely important at this point in our country's trajectory because we are going into the super-aged stage soon. So, I would I think we are going to you know, cut through tiny little straws trying to find out why the private insurance is increasing their premiums, but that's not sustainable at all.

So, I think you really need to go back to see how we can go towards community risks-based health insurance. So, another example is if you are a breast cancer patient and you have a coverage of a million, but guess what? Your targeted therapies may not be covered by the insurance or the oncologist has to be very creative in ensuring that the patient gets admitted for the treatments. Because you know, if you having outpatient treatments, they are not covered. So even though they are insured, they are not covered. Thank you very much

Dr Mastura Md Yusof [MMA]: *I think I can, I can…*

Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, you are just now you mentioned about community sorry, community rated, is it? Sorry, what is that?*

Prof Dr Nur Aishah Mohd Taib [MMA]: *Ya, I mean I am not an insurance person, but I think at the moment, people are the insurance is based on individual risks. So, if you have hypertension, guess what? You can't take travel insurance. They do not cover preexisting illnesses. If you have breast disease and you know, our private hospital can also be very creative, so they do screenings that there is not required. For example, ultrasound breast. Not required, but many young ladies in their 20s go for this checkup and they find a benign cyst.*

Benign cyst is a preexisting illness. So, they will not be covered for breast cancer and they have difficulty getting rejected. What do they do? They postponed. Every year, the patient will come to get a new report from the doctors hoping that their ultrasound be perfectly normal. But unfortunately, benign disease is very prevalence. So, I would say that at the moment, we are not really covering even those who are insured."

[Muka surat 37 - 38, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

7.1.3 Ketidakadilan dalam Reka Bentuk *Pool* Insurans

Terdapat pertembungan antara keperluan moral untuk melindungi peserta lama dan keperluan komersial untuk menawarkan harga kompetitif kepada peserta baharu.

Closed pool adalah mekanisme yang melindungi peserta baharu daripada beban sejarah, tetapi ia menghukum kesetiaan peserta lama.

Amalan menutup kolam risiko secara sewenang-wenangnya perlu dikawal selia dengan ketat. BNM harus mewajibkan penggabungan risiko secara dalaman (*internal risk equalization*) di mana keuntungan dari kolam baharu mesti digunakan sebahagiannya untuk menstabilkan kolam lama, memastikan kesinambungan perlindungan.

i. <u>Penjelasan KPE LIAM</u>

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 mengakui bahawa industri tidak menjangka kadar inflasi perubatan yang tinggi dan bersetuju bahawa pelan seperti "kad tanpa tunai" dan manfaat "bayar seperti dicaj" menyumbang kepada peningkatan kos. Beliau juga mengakui kelemahan dalam pengurusan *closed pool*, dan bersetuju bahawa sistem ini menyebabkan beban kewangan yang lebih tinggi kepada pelanggan lama. Isu ini sedang dibincangkan bersama BNM bagi mencari penyelesaian jangka panjang. Beliau turut menyatakan kesediaan industri untuk memperbaiki keadaan dan melaksanakan pembaharuan demi kelestarian sistem insurans kesihatan negara.

> ***"Encik Mark Steven O'dell: [LIAM]:*** *Thank you, YB. I think when it comes to premiums increasing of course this is not an excuse, it's just a reflection. When I go back, I was here in 2000 when medical plans started to become very popular.*
>
> *The old type of plans was fixed benefit nature meaning they had inner limits for everything. You know. Inner limits for different classes of surgeries. Inner limit for operating theatres and inner limits for many-many things and the history of those premium was very steady and we did not foresee in this, you can rightly blame us, we did not foresee the level of inflations that would lead to the kinds of premium increases that we have seen and raised in years. We did not as I mentioned earlier, the two things that led to that really contribute to inflation are the cashless card and 100 percent as charged. You know when companies introduced those, they might have looked at those as innovation but actually it ended up being just the wrong things to do, actually, in hindsight and forgive me your second question was?*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *Your existing the pool...*
>
> ***Encik Mark Steven O'dell [LIAM]:*** *Oh, the pool.*

Tuan Sim Tze Tzin [Ahli PAC]: *The dying pool.*

Encik Mark Steven O'dell [LIAM]: *Actually, I have to agree with you YB, the pools need to be greater, bigger, they need to be opened in new business because once you get a closed pool as you know, as you said that pool will get older and less healthier and those members of those pool will see perhaps a higher-than-average rating crisis. So, this is one of the things on our agenda to work out, hopefully we'll work the solution with Bank Negara."*

[Muka surat 12 - 13, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. <u>Penjelasan Pengerusi Persatuan Takaful Malaysia (MTA)</u>

Tuan Wan Saifulrizal Wan Ismail [Pengerusi MTA] dalam Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa mekanisme subsidi silang perlu dikendalikan dengan sangat berhati-hati kerana ia boleh membawa kesan sampingan yang tidak diingini. Subsidi silang bermaksud satu pihak terpaksa membayar lebih untuk membantu pihak lain. Sebagai contoh, jika dana insurans hayat digunakan untuk mensubsidi dana kesihatan, pelanggan yang hanya membeli insurans hayat akan terbeban dengan kos yang tidak mereka gunakan.

Begitu juga dalam isu penggabungan kolam risiko, tindakan mensubsidi pelanggan warga emas akan memaksa golongan muda membayar premium yang jauh lebih tinggi daripada kos risiko sebenar mereka. Beliau menegaskan bahawa walaupun subsidi silang boleh dilakukan dalam jangka pendek, mengikut hukum keseimbangan, kos tersebut akhirnya tetap akan ditanggung oleh pihak lain yang tidak menggunakan perkhidmatan tersebut.

"Tuan Wan Saifulrizal Wan Ismail [MTA]: *Okay. I guess YB if I may. I think the issue of cross-subsidy, we just have to be very careful of what we design and how what we wish for as well because cross-subsidy is also implying that certain parties are paying more in order to help another party.*

So, let's take two simple examples on what, how cross-subsidy may have unintended consequences. So, let's say you take life versus health, right. If your life cross-subsidise your health pool and people who are purely buying life potentially will now need to pay at higher cost even if they don't use health. Then the question is it fair for them?

If you look at young versus old let's start on the issues of a closed book itself. I mean, yes, closed book generally has older customers but in order to cross-subsidise that means you are bringing the younger pool and in order for the younger pool to cross subsidise that means you charging you're intentionally charging, over charging the younger pool in order to help the older age. So, the question also is it fair for the younger ones to actually pay more than what the actual cost is?

So, the cross-subsidy has this element of unintended consequences, which yes, we can do it in the short term but the law of equilibrium is it will have to adjust itself. The cost has to be borne by somebody else whose probably not utilising it.

***Tuan Sim Tze Tzin [Ahli PAC]:** How do you justify 183 percent hike?*

***Tuan Wan Saifulrizal Wan Ismail [MTA]:** I mean I can't speak on behalf of the company that does a 183 percent hike. But I mean I am just talking from the concept perspective that we have to be very careful in terms of asking for that cross-subsidy to happen because it will have a broader implication on the dynamics."*

[Muka surat 35, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

7.1.4 Polisi Insurans Berkaitan Pelaburan [*Investment-linked Insurance Policies* (ILP)]

ILP adalah produk yang kompleks di mana risiko pelaburan dan risiko kenaikan kos perubatan dipindahkan sepenuhnya kepada pengguna. Ramai pengguna membeli ILP dengan anggapan premium adalah rata (*level premium*), tidak menyedari risiko ketidaklestarian kewangan akibat peningkatan *Cost of Insurance* (COI) mengikut usia.

ILP mungkin tidak sesuai sebagai instrumen perlindungan kesihatan asas untuk golongan berpendapatan rendah atau mereka yang tidak memahami risiko pelaburan. Industri perlu kembali mempromosikan produk insurans bertempoh (*stand alone term medical plan*) yang lebih telus dan murah, tanpa elemen pelaburan yang mengelirukan.

<u>Penjelasan KPE LIAM</u>

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa peraturan Bank Negara menetapkan kadar peruntukan minimum, di mana sebahagian premium mesti dilaburkan sejak tahun pertama. Walaupun lebih separuh komisen dibayar kepada ejen dalam enam

tahun pertama, terdapat juga kawalan melalui peraturan kelestarian (*sustainability regulation*) yang memaksa penetapan premium mencukupi untuk menampung tempoh perlindungan. Polisi kini perlu dikaji setiap tahun untuk menilai prestasi pelaburan dan kesan terhadap jangka hayat perlindungan, termasuk kemungkinan keperluan untuk menambah premium.

"Tuan Sim Tze Tzin [Ahli PAC]: *YB Pengerusi, I want to raise another issue which is investment-link. During our public hearings, a lot of people talk about investment-link. They also feel that this sometimes is actually you promise something but deliver another thing. Say for example, investment-link the first six years, most of bigger chunk of the money actually goes to the agent, okay as their commission. Only after the six years the money actually goes into the pool, to the investment fund. The investment fund also there are management fees, the professional fees of several percent. Sometimes up to 10 percent.*

So, to them it's that actually they put in they actually don't get that kind of money to actually you know after six years only they can see something goes into that really the investment. So, this is something I think the industry must look at because I think that is also not fair to the people who pay for that. Can you comment on this please?

Encik Mark Steven O'dell [LIAM]: *Ya. First of all, there is a thing called the minimum allocation rate which by Bank Negara rules include even the first-year part of your first-year premium must go and be allocated by units. So, it is not true that it will take a number of years before there is any value in the policy. But there is an amount, it's 160 percent over six years that goes towards the total compensation. I agree with you that probably not the bulk but more than half will go to the agent. Then, as you know, there are layers, right. There are two layers right. The management fee is usually one and half of two percent. For bond fund, it could be less than one percent.*

But I think the what happened and this happened in a few years back actually. They came into play sustainability regulation. Now, it used to be you could sell investment-link at you know, almost let's say any premium. You know, for any duration, the policy would last as long as the premium was sufficient to pay for the cost. But then they put in this regulation that you have to set the premium that is sustainable rightly so for a certain number of years according to what you are telling your customer that this coverage is going to last for. So, if it is going to last for 65, you have to have enough premium to last you until 65. So, what happened is now, every year, everybody gets the sustainability statement. If they close to the line and the investment doesn't perform well, they may be asked to top-up more premium. If not, then they will say that your policy will sustain itself until whatever age that you expect. But I think it's not quite as bad as maybe you were told. Thank you.

[Muka surat 74 - 75, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.1.5 Pelaksanaan Langkah Interim oleh ITO

Langkah interim telah mengubah fokus ITO daripada "pengumpulan premium" kepada "penolakan tuntutan" sebagai strategi kelangsungan perniagaan. Ini meningkatkan geseran (*friction*) antara pesakit, hospital, dan insurans.

Mekanisme penyelesaian pertikaian bebas (Ombudsman Perkhidmatan Kewangan) perlu diperkasakan dengan kepakaran perubatan untuk mengadili kes penolakan tuntutan yang semakin meningkat, memastikan pesakit tidak menjadi mangsa birokrasi kawalan kos.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa langkah interim oleh ITO telah memberi kesan kepada keuntungan syarikat insurans, mendorong mereka mengambil langkah kawalan kos seperti menyemak semula caj hospital yang melampau. Penolakan tuntutan juga dinilai secara adil dengan penglibatan doktor pakar dan sebarang kes yang tidak wajar boleh dirujuk kepada BNM untuk disiasat. Dalam hal produk *investment-linked*, BNM sedang mengalihkan fokus kepada produk insurans berasaskan nilai yang lebih sesuai dengan keperluan dan kemampuan pengguna.

Berhubung Akta Perkhidmatan Kewangan 2013 [Financial Service Act 2013 (FSA)], BNM kini mempunyai kuasa mencukupi tetapi bersedia untuk menilai semula perundangan jika perlu, dengan sokongan Parlimen. Pelaksanaan insurans asas pula melibatkan tiga strategi: produk yang mampan dari segi harga, pembelian strategik untuk kurangkan kos, dan mekanisme rujukan doktor am (GP) sebelum ke hospital bagi mengelakkan penyalahgunaan tuntutan.

> ***"Dato' Seri Abdul Rasheed Ghaffour [BNM]:*** *Terima kasih Yang Berhormat. I will try to answer some of the questions. I was saying but there just coming to answer some of the questions that you sent it. There're a lot of questions yang semuanya memang penting. Pertamanya daripada segi rejection dan juga sebagainya. Memang apabila ITO melaksanakan interim measure, sebagaimana saya sebutkan*

tadi Yang Berhormat, memang dia melibatkan kos kepada mereka dan juga menjejaskan juga profitability mereka.

Apabila ia menjejaskan profitability mereka, dia mempunyai impak ke atas kapital mereka. Dari segi dasar, modal yang mereka perlu pegang. Akibatnya Bank Negara telah mengarahkan syarikat insurans untuk mengamalkan kos containment. Mereka perlu melaksanakan usaha-usaha untuk mengurangkan kos mereka. Cara yang diambil adalah untuk memastikan keadilan dari segi bayaran kepada pesakit dan sebagainya ataupun insurans sebagainya. Contohnya, memastikan hospital tidak overcharge dan sebagainya. Itu pertama. Itu bila kita lihat contohnya ada hospital-hospital memang caj mereka terlampau tinggi dan mereka tahu charges ini adalah lebih jauh daripada apa yang di caj oleh orang-orang lain. Jadi that's where they want to— they also need to discipline the hospital. So that's why they take that kind of action.

Kedua dari segi menangani kos-kos penjualan produk juga. Kita telah mengarahkan mereka untuk mengawal kos-kos ini. Ini adalah salah satu daripada inisiatif yang kita ambil untuk memastikan mereka dapat mengawal kos mereka. Sekiranya ada berlaku sebarang unintended consequences contohnya ada rejection tidak— tidak sepatutnya di-reject dan sebagainya, mereka boleh datang ke Bank Negara. Kita akan lihat kes itu.

Sebagaimana Jess mentioned tadi, daripada 12 kes dihantar kepada kita, 10 telah pun diselesaikan. Tetapi kalau macam alasan mereka adalah kukuh, memang sepatutnya kes macam ini, rawatan sepatutnya macam ini sahaja, bukan untuk melebihi dan sebagainya. Mereka boleh membuktikan yang rawatan yang diberikan ataupun test yang dijalankan memang melebihi daripada apa yang diperlukan. Sebab ITO juga ada doktor. ITO juga ada professional practitioners that they can know that this kind of diseases tak perlu buat tests yang tidak sesuai ini. Jadi, mereka akan reject those kind of applications lah. Itu pertama.

Kedua, dari segi investment-linked dan sebagainya, memang kita akui that's where kita akan menuju ke arah produk insurans yang berasaskan nilai, sesuai dengan keperluan individu tersebut dan juga kemampuan individu tersebut. Ini akan beralih. Kita ingin melihat peralihan kepada produk sebegini.

…

Keempat, dari segi FSA. Pada masa ini Yang Berhormat, kita mempunyai cukup kuasa untuk kita bertindak. Kita telah pun menggunakan kuasa-kuasa kita untuk mengawal selia industri insurans ini dan juga memastikan kemampanan produk. Juga kedua, dari segi memastikan keadilan kepada pemegang polisi. Tapi, kita memang akan review from time to time regulations kita dan juga perundangan kita. Sekiranya perlu, memang terima kasih kepada Yang Berhormat dan juga Ahli-ahli Parlimen untuk menyokong kami apabila kami pergi ke Parlimen untuk memohon pindaan kepada akta kami untuk memberi kami kuasa dan sebagainya yang berpatutan.

Akhir sekali, basic products I think we explained just now, ada tiga perkara. Satu, in terms of product berasaskan nilai. Memastikan harga lebih mampan dan juga

memperluaskan skala pengurusan risiko. Kedua, mempunyai mekanisme DRG. Ada juga pembelian strategik oleh government dan juga swasta di mana kita dapat mengurangkan harga pembelian. Ketiga, termasuklah memperkenalkan keperluan mendapat rujukan daripada GP dulu sebelum pergi ke hospital. Sebab kita nampak pada masa kita kadang-kadang walaupun seseorang itu tak perlu masuk hospital, bila dia pergi ke hospital sama ada patient request sendiri atau doktor yang suggest kata kalau you masuk hospital, kita boleh claim.

Jadi, dia duduk hospital sehari dua, kita boleh claim. Kita nak elakkan masalah sebegitu, jadi kita mungkin akan cadangkan pergi melalui GP. Bila GP rasa memang perlu kes ini untuk dimasukkan ke dalam wad, baru kita masuk wad. Ketiga, dari segi parameter product lah. Mungkin had yang tertentu dan sebagainya. Juga jika sesuai, ciri co-payment di mana yang berpatutan..."

[Muka surat 43 - 45, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

ii. <u>Penjelasan Timbalan Gabenor BNM</u>

Datuk Jessica Chew Cheng Lian [Timbalan Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa satu jawatankuasa khas telah ditubuhkan yang melibatkan BNM, hospital swasta, dan syarikat insurans/takaful bagi menangani isu tuntutan insurans.

"Datuk Jessica Chew Cheng Lian [BNM]: *Maybe just one thing dalam perkara pengamalan insurans untuk reject claims semua itu, kita pun sudah menubuhkan satu macam jawatankuasa kecil yang dipengerusikan oleh Bank Negara dengan pihak hospital swasta dengan industri insurans dan takaful sekali. So, kes-kes macam ini boleh dibincangkan di sana bagi mencapai penyelesaian. … "*

[Muka surat 45, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

iii. <u>Penjelasan NAMLIFA</u>

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menyatakan terdapat maklum balas daripada pemegang-pemegang polisi mengenai langkah interim BNM yang mengehadkan kenaikan premium kepada 10%. Walaupun had ini bertujuan untuk mengawal kenaikan, terdapat dua isu utama yang menimbulkan ketidakpastian seperti berikut:

i. Ramai pelanggan telah pun membayar kenaikan premium melebihi 10% (contohnya 22% atau 25%) pada tahun 2024, iaitu sebelum langkah

interim ini diperkenalkan, dan kini menunggu pelarasan (*adjustment*) daripada syarikat insurans.

ii. Wujud ketidakpastian sama ada had 10% akan dikira berdasarkan premium asal atau premium yang telah dinaikkan sebelumnya (*compounding basis*). Jika pengiraan dibuat secara kompaun, kenaikan berturut-turut akan menyebabkan premium meningkat mendadak, mengatasi had yang ditetapkan.

Selain itu, maklum balas yang diterima juga menunjukkan ramai pelanggan bimbang dengan apa yang akan berlaku selepas tahun 2026 apabila had sementara ini tamat. Beliau menegaskan bahawa fenomena yang mana pelanggan tidak mampu membayar kad perubatan apabila mereka paling memerlukannya (terutamanya warga emas) menunjukkan sesuatu yang tidak kena dengan mekanisme sedia ada.

Oleh kerana permasalahan ini turut berlaku di seluruh dunia, beliau menyeru agar industri mencari penyelesaian melalui kreativiti aktuari yang lebih baik untuk memastikan kad perubatan terus mampu dibayar oleh golongan yang semakin tua.

> ***"Tuan Sim Tze Tzin [Ahli PAC]:*** *Pengerusi, kalau boleh saya tanya. Bank Negara telah keluarkan arahan pada Januari 15 dah. Maksudnya, apa certain things lah. Number one, 10 percent had. Kedua, adalah the 60 and above moratorium tetapi sekarang limit kepada basic care, dan ketiga ada beberapa lah ya dia punya ni.*
>
> *So, from your experience daripada you punya pencarum-pencarum, I mean your customers. Adakah mereka complain atau memberi maklumat bahawa certain-certain syarikat tidak mengikuti arahan BNM?*
>
> ***Encik G Saseedaran Gengadharan [NAMLIFA]:*** *Saya rasa mungkin bila kami buat pembentangan tadi, tuan tidak ada. Kami sudah pun addressed perkara ini tadi iaitu saya ulang balik ya, iaitu kami bagi maklum balas daripada pemegang-pemegang polisi di luar sana dan maklum balas ini bersabit dengan langkah interim oleh Bank Negara.*
>
> *Langkah pertama ialah mengehadkan peratus kenaikan setiap kali ke 10 peratus, premium sedia ada ataupun caruman sedia ada. Katalah sekarang dia sedang mencarum RM1,000. Kalau dia naik, 10 percent dia naik RM100. So, itu understanding. Apa yang kita faham tetapi apa yang kita tidak tahu ialah bila dia naik 10 peratus pada tahun 2025, kita tidak tahu ramai yang sudah pun membayar premium kenaikan ini pada tahun 2024 sebelum langkah interim ini diperkenalkan. 2024, mungkin dia sudah kena 22 percent atau 25 percent kenaikan dia.*

So, mereka yang telah kena lebih ini, mungkin syarikat-syarikat insurans akan menghantar jadual untuk adjust, buat adjustment. Okey, kalau mereka yang tidak kena kenaikan pada tahun 2024 tapi hanya sekarang 2025 dia kena, kali pertama dia kena 10 percent. Dan, premium, kalau contohnya RM1,000, dia naik 10 percent maksudnya RM1,100. Kali kedua itu, adakah kenaikan itu dia kira atas RM1,100, 10 percent atas RM1,100 ataupun 10 peratus atas premium yang sebelum naik itu, RM1,000 asas itu?

So, kalau kita dia kira on compounding basis, 10 peratus itu kalau tiga kali naik sudah jadi 33 point something percent. So, ini an uncertainty. Ketidakpastian kita nak tahu satu perkara dan itu satu soalan yang kami punya customers tanya dan bagi soalan tuan tadi, apakah feedback kan? The feedback is ramai orang risau sekarang. Sekarang dia boleh membendung lah, dia bagi had sampai 2026 boleh bertahan. What happens after 2026 ini? Apakah— what will be offered by the insurance company masa itu? Katalah, they are seniors citizens contohnya who are retiring. So, the current phenomena is the simple phenomena yang pelanggan-pelanggan insurans di luar sana diceritakan ialah you don't have it when you need it most.

Kita perlukan masa kita perlukan itu, kita tak mampu. Because something is wrong dengan mechanism ini. Something is wrong dengan mechanism di mana kita boleh quote satu dunia dia kata masalah ini bukan di Malaysia sahaja. Seluruh dunia. Then, something is wrong. In this modern era, kita kena ada— we must have better actuarial creativity kita kata. So, what can we done in order to make sure mereka yang semakin tua dan sudah pun menggunakan medical card ini masih boleh mampu membayar. That is a challenge that the whole country face today. We want to see how we can help. Thank you.

[Muka surat 21 - 22, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

iv. <u>Penjelasan Pengerusi, Allianz Malaysia Berhad</u>

Tuan Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad] dalam Prosiding Bil. 5(p) bertarikh 19 Jun 2025 memaklumkan bahawa Allianz telah melaksanakan langkah-langkah proaktif bagi menyokong reformasi kesihatan, termasuk pelaksanaan penuh langkah interim BNM. Ini merangkumi pelarasan premium secara berperingkat, penangguhan pelarasan premium bagi warga emas, dan penguatkuasaan semula polisi yang luput tanpa perlu *underwriting*.

Selain itu, Allianz telah memperkenalkan pilihan produk yang lebih mampu milik, seperti pelan deduktibel, dan produk baharu yang mampan dengan ciri *'co-payment*' dan '*No Claim Discount'*. Dari segi sokongan pelanggan, syarikat ini menyediakan '*Dedicated Hotline'* dan latihan kepada ejen untuk memastikan

mereka bersedia membantu pemegang polisi. Walaupun berlaku pelarasan premium, data 2024 dan 2025 menunjukkan bahawa 90% pelanggan yang terkesan kekal mendapatkan perlindungan kesihatan berterusan (60% kekal dengan produk dilaraskan, 30% bertukar kepada produk mampu milik).

Kadar pertumbuhan Allianz juga pulih sebanyak 6% berbanding tahun sebelumnya. Bagi pembendungan kos, Allianz bekerjasama rapat dengan hospital swasta untuk mengawal kos perubatan, yang telah berjaya mengurangkan bilangan tuntutan kes ringan dan elektif sebanyak 11%. Usaha ini juga termasuk kerjasama untuk menetapkan harga pakej berpatutan dan diskaun mampan. Walau bagaimanapun, Allianz menegaskan bahawa kawalan inflasi perubatan jangka masa panjang bergantung kepada kejayaan reformasi kesihatan yang dipimpin oleh kerajaan.

> ***"Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]:*** *Pertama sekali — slaid ya. Pelaksanaan penuh langkah interim BNM. BNM sendiri beritahu pihak BNM mengetengahkan, impose interim measure dalam isu kenaikan harga polisi insurans kesihatan. So, dengan — salah satunya, pelarasan premium berperingkat, penangguhan pelarasan premium bagi warga emas, penguatkuasaan semula polisi luput tanpa perlunya pengunderaitan. Maknanya kita tak tanya soalanlah bila dia luput ya, kita aktifkan balik.*
>
> *Juga, kita memperkenalkan pilihan produk mampu milik bagi pelanggan yang terkesan. Kita introduce plan deductible, produk-produk baharu seperti Mark cakap tadi, cirikan co-payment dengan no-claim discounts. Ketiga, pembendungan kos, kolaborasi dengan hospital swastalah. Maknanya kita jumpa dengan semua hospital dan kita bincang dengan dia tentang struktur kos yang untuk mengawal inflasi perubatan.*
>
> *Slaid kedua. Dari segi khidmat pelanggan, pertama sekali tujuan kami memastikan perlindungan berterusan. Makna dia, tak ada dropout-lah ataupun kita kurangkan peluputan. Langkah-langkah yang kita menyokong pelanggan, satu, dedicated hotline. Dia apa-apa keperluan dan pertanyaan dibantu. Latihan dan penglibatan agen. Insurans di Malaysia ini dijual oleh agen. So makna dia, first contact dia selalunya dengan agen. So, kita seharusnya melatih agen untuk boleh menerangkan apa-apa perubahan fasal polisi-polisi termasuklah harga dan struktur polisi. Kita memang dari segi selepas bulan sebelas ini, kita intensify training kepada agen untuk boleh menjawab kepada pengguna-pengguna yang beli insurans. Ada satu contohnya, kalau kita ikut aduan pelanggan 2024, 14. Dan setakat ini dalam tahun ini ada 30. Kalau kita tengok carta sebelah kanan itu, bilangan pertanyaan mula-mula pada hujung tahun lepas memang tinggi dan sekarang dah start menurun. Makna dia, ada lebih banyak kefahaman antara apa yang berlaku dari segi penyelarasan premium dari segi consumer market.*

Slaid ketiga, impak pelarasan premium. Ini sebagai contoh dari segi pengalaman Allianz, yang kekal dengan produk yang dilaraskan termasuk pelarasan berperingkat, polisi dikuatkuasakan semula, 60 peratus; bertukar kepada produk mampu milik, 30 peratus; peluputan biasa, maknanya [Tidak jelas], memang dalam setiap tahun ada lapan dan sembilan peratus, tak kiralah bukan fasal premium, tapi memang ada peratusan dia, itu masih lagi ada; dan hanya dua peratus kes peluputan disebabkan oleh pelarasan premium. Makna dia walaupun ada, tapi taklah sebesar yang kita jangkakan.

Di sebelah kanan, 90 peratus pelanggan yang terkesan kekal mendapat perlindungan secara berterusan. Itu yang satu orang kata, contoh yang baik. Lagi satu, pelan perubatan baharu diperkenalkan dengan ciri-ciri co-payment five percent atau co-insurance 15 peratus. Ini saya rasa semua syarikat insurans kena buatlah. Oleh kerana itu, kami boleh pulihlah dari segi growth ataupun pertumbuhan Allianz, seperti premium Allianz, kepada enam peratus lebih berbanding dengan tahun lepas.

Slaid terakhir, ini pembendungan kos. Basically, kita duduk dengan hospital swasta dan kita bincang. Bincang, bincang, bincang, bincang dan kita line by line minta dia turunkan harga seperti mana macam dalam contoh ini, pembendungan 11 peratus bilangan tuntutan kes ringan dan elektif macam jangkitan pernafasan, gastrik, cirit-birit, denggi dan cervical fibroid — I mean, sorry, fibroid rahim. Then, kita bincang dia dengan harga berpatutan. So, benda ini kita bincang dengan hospital satu persatu ya, phase-to-phase punya discussion dan dari puratanya nampak berkesan. Makna dia, kita dapat membendungkan kos dan bolehlah katakan adalah margin untuk kami. Tapi, kawalan inflasi jangka masa panjang ini perlukan structural change. Kita masih lagi kicking the can down the road. Apa yang kita buat sekarang, hanya temporary.

So, minta-minta PAC inilah yang boleh discuss balik dengan kerajaan, macam mana kita buat satu struktur jangka masa panjang untuk to allow people to buy insurance in the long-term basis. We cannot continue this kicking the can down the road. Whatever discussion we have with the hospitals are temporarily. I think our colleague over there has mentioned, they still try to increase costs where they can. Like the unbundling, you can see they try as much as possible to recoup that cost.

So, hospital are — everything is cost. What you do is they're trying to transfer the fixed costs to somebody else. In this case, examples shown that if they don't transfer to the insurance company, they transfer to the patient directly, but they are transferring. So, this is something that perhaps the PAC can help…"

[Muka surat 12 - 13, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

7.1.6 Isu Dalam Pelaksanaan Langkah Interim (*Interim Measure*)

Langkah interim berjaya meredakan kemarahan awam secara serta-merta tetapi gagal memberikan kepastian menyeluruh akibat variasi pelaksanaan antara syarikat.

BNM perlu mengeluarkan garis panduan operasi yang lebih terperinci dan seragam (*standardized FAQ*) untuk mengelakkan ITO memanipulasi tafsiran langkah interim ini. Penalti berat perlu dikenakan kepada ITO yang didapati melanggar semangat arahan ini.

Penjelasan Gabenor BNM

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa terdapat isu dalam pelaksanaan awal langkah interim (*interim measure*) oleh ITO, termasuk kekeliruan tafsiran dan ketidakseragaman pelaksanaan oleh syarikat insurans.

BNM sedia menerima aduan daripada orang ramai bagi menyiasat kes secara individu. Mengenai isu kenaikan premium lebih 20%, kemungkinan terdapat sebab-sebab tertentu seperti faktor umur yang perlu dikenal pasti. Mengikut dasar yang telah ditetapkan, tidak membenarkan kenaikan premium bagi individu berumur 60 tahun ke atas, dan jika berlaku pelanggaran dasar ini, BNM akan menyiasat bersama ITO untuk menyelesaikannya.

> ***"Tuan Sim Tze Tzin [Ahli PAC]:*** *Okey. Pengerusi, last question about this interim measure. Selepas interim measure itu diumumkan, walaupun itu baguslah ya. We have to give the credit. Cuma, masih ada orang-orang yang dalam public hearing, dia kata, walaupun insurans sudah diumumkan, tapi tafsiran bermacam-macam. Ada orang yang katakan 60 and above tidak boleh increase kan the moratorium, no increase. Tapi ada yang kata, mereka terima adalah terima daripada ITO bahawa ia hanya untuk apply untuk the lowest band, the upper band masih increase.*
>
> *Ada yang pula kompelin kepada kami, walaupun umum 10 peratus, tapi balik-balik 20 percent, 30 percent pun ada. Ini adalah dibangkitkan semasa public hearing. Jadi, tafsiran yang bermacam-macam oleh ITO dan walaupun kita katakan start 15th of January, tetapi ada yang umum kata mereka hanya akan laksanakan 1st of March. Contohnyalah, ini adalah yang dibangkitkan. So, how do you address these issues? Terima kasih.*
>
> ***Dato' Seri Abdul Rasheed Ghaffour [BNM]:*** *Terima kasih Yang Berhormat for raising those issues. Memang betul, I think we hear that as well. So, this is where pada peringkat ini it's still in the early stage lah. As I said, I still think there is still issues there that we need to also address lah. Sekiranya ada kompelin-kompelin yang macam ini, kami ingin tahu dan kami ingin nak berhubung dengan insurance company itu kenapa*

mereka tak boleh laksanakan. Kami ingin menggalakkan pihak-pihak tertentu kalau ada aduan sebegini, kemukakan kepada kami.

Kedua, dari segi yang ada lebih daripada 20 peratus itu, mungkin ada sebab-sebab tertentu. Jadi, elok juga if mereka dapat berhubung dengan kami, kita boleh faham apakah sebab-sebabnya. Adakah sebab umur dan sebagainya dan kita boleh tangani masalah ini dengan ITO tertentulah.

Ketiga, dari segi those above 60, sepatutnya tidak ada pelarasan premium penangguhan. Memang that was the dasar yang kita persetujui. Sekiranya ada kes-kes tertentu yang berlaku di mana mereka dikenakan juga pelarasan, elok untuk kita memahami kenapa mereka diberikan pelarasan tersebutlah dan cuba untuk menangani tersebut.

[Muka surat 45 - 46, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

7.1.7 Inisiatif RESET

RESET adalah pelan komprehensif yang cuba menangani punca akar masalah inflasi perubatan sektor swasta. Namun, ia memerlukan masa dan kerjasama erat semua pihak yang mempunyai kepentingan bertentangan.

Kejayaan RESET bergantung kepada mandat. Jika penyertaan dalam produk asas atau perkongsian data adalah sukarela, ia mungkin gagal. Kerajaan perlu bersedia menggunakan kuasa undang-undang untuk memaksakan perubahan jika kerjasama industri tidak memadai.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025 memaklumkan bahawa BNM, KKM, MOF dan juga pihak berkepentingan lain telah pun bersetuju untuk melaksanakan inisiatif pembaharuan sektor kesihatan swasta berdasarkan lima teras utama. Lima teras utama ini atau singkatannya RESET ini telah dibentang dan dipersetujui di Majlis Tindakan Sara Hidup Negara (NACCOL). Lima teras utama di bawah inisiatif RESET adalah seperti berikut:



Sumber : Slide pembentangan BNM dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025

RESET adalah penting untuk meletakkan negara pada landasan yang lebih mampan dalam memenuhi keperluan penjagaan kesihatan masyarakat di Malaysia. Pelaksanaan inisiatif RESET telah pun bermula dan kemajuan pelaksanaan inisiatif-inisiatif ini akan dilaporkan kepada jawatankuasa bersama peringkat Menteri dari masa ke semasa serta melibatkan sesi libat urus dengan pihak-pihak berkepentingan. Tujuan utama inisiatif RESET adalah seperti berikut:



Sumber : Slide pembentangan BNM dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025

"Dato' Seri Abdul Rasheed Ghaffour [Bank Negara Malaysia (BNM)]: *... Seperti mana yang Ahli-ahli Yang Berhormat sedia maklum, Bank Negara Malaysia, Kementerian Kesihatan, Kementerian Kewangan dan juga pihak berkepentingan lain telah pun bersetuju untuk melaksanakan inisiatif pembaharuan sektor kesihatan swasta berdasarkan lima teras utama. Lima teras utama ini atau singkatannya dalam bahasa Inggeris, RESET adalah penting untuk meletakkan negara pada landasan yang lebih mampan dalam memenuhi keperluan penjagaan kesihatan masyarakat di Malaysia.*

Inisiatif RESET ini akan menangani beberapa cabaran utama dari segi pembiayaan kesihatan, penyedia perkhidmatan kesihatan serta struktur pasaran yang telah menyumbang kepada peningkatan kos perubatan. Saya akan mengulas lebih lanjut mengenai perkara ini di slaid seterusnya.

Untuk makluman Ahli Yang Berhormat, inisiatif RESET ini telah pun dibentang dan dipersetujui di Majlis Tindakan Sara Hidup Negara (NACCOL). Selain itu, seperti yang telah diumumkan oleh Yang Amat Berhormat Perdana Menteri pada hari Selasa yang lalu ketika perasmian Sasana Symposium 2025, sebuah jawatankuasa bersama peringkat Menteri mengenai kos penjagaan kesihatan swasta yang diterajui oleh Yang Berhormat Menteri Kesihatan dan juga Yang Berhormat Menteri Kewangan II telah ditubuhkan bagi menggerak dan memantau pelaksanaan inisiatif RESET ini.

Oleh itu, sukacita ingin saya maklumkan bahawa pelaksanaan inisiatif RESET telah pun bermula dan kemajuan pelaksanaan inisiatif-inisiatif ini akan dilaporkan kepada jawatankuasa bersama peringkat Menteri tersebut dari masa ke semasa.

Pelaksanaan inisiatif RESET ini juga turut melibatkan sesi libat urus dengan pihak-pihak berkepentingan.

Susulan daripada perbincangan yang diadakan, dua inisiatif telah ditambah kepada sembilan inisiatif asal. Dua yang baru itu adalah pertamanya, untuk membantu pengguna menentukan keperluan dan pilihan MHIT, inisiatif nombor dua dan juga, pengumpulan data mengenai kos penjagaan kesihatan swasta, inisiatif nombor tujuh.

Sebelum ini pada bulan Februari, bila kami bentangkan, ada sembilan sahaja inisiatif. Pada masa ini, ada 11 semuanya setelah kita ambil maklum pandangan dan juga cadangan daripada pihak berkepentingan [Tidak jelas].

Inisiatif RESET juga bertujuan untuk menangani beberapa cabaran utama dalam sistem penjagaan kesihatan di Malaysia. Antaranya termasuk inflasi perubatan yang tinggi yang didorong oleh reka bentuk produk MHIT telah menggalakkan penggunaan perkhidmatan kesihatan secara berlebihan. Sebagai contoh, had manfaat yang tinggi di bawah pelan MHIT memberi kesan dari segi tingkah laku yang mendorong penggunaan dan pengenaan caj yang tinggi bagi perkhidmatan kesihatan. Maklumat harga perubatan dan juga caj kesihatan yang kurang telus juga telah menyebabkan kesulitan bagi pelbagai pihak untuk membuat perbandingan harga serta jangkaan kos dalam penggunaan perkhidmatan kesihatan.

Tahap perlindungan dan simpanan yang rendah di kalangan rakyat untuk tujuan kesihatan juga telah menyumbang kepada kesesakan dan juga tekanan kapasiti dalam sektor kesihatan awam. Peranan penjagaan primer (primary care) dan pesakit luar yang terhad dalam pelbagai peringkat penjagaan kesihatan juga telah menyumbang kepada perkara ini serta model pembayaran fee for service di sektor swasta yang tidak mampan. Melalui inisiatif RESET ini, cabaran-cabaran ini akan diberi perhatian untuk memastikan ekosistem penjagaan kesihatan di Malaysia kekal mampan. Oleh itu, keutamaan kami pada masa ini di bawah inisiatif RESET ini adalah untuk membangunkan produk asas MHIT yang seragam, yang akan menjadi asas kepada penawaran produk MHIT pada masa hadapan oleh ITO.

Pembangunan produk asas MHIT ini adalah penting untuk pertamanya, membantu lebih ramai rakyat Malaysia untuk mendapatkan perlindungan kewangan untuk menghadapi kos rawatan perubatan yang lebih tinggi. Kedua, memastikan perbelanjaan penjagaan kesihatan swasta digunakan dengan lebih cekap dan juga berkesan serta ketiga, mendorong penambahbaikan penjagaan kesihatan yang memberi tumpuan kepada nilai keseluruhan kepada pesakit. Kami menyasarkan reka bentuk produk asas ini akan dimuktamadkan menjelang akhir tahun 2025.

Seterusnya, produk ini akan melalui fasa rintis pada separuh pertama tahun 2026 dan akan dilancarkan dengan lebih meluas pada separuh kedua tahun 2026. Produk asas MHIT ini bertujuan untuk menyusun semula pasaran insurans kesihatan swasta. Ia juga akan membuka jalan kepada sistem penjagaan kesihatan yang lebih bersepadu dan mampan demi kesejahteraan rakyat Malaysia.

Produk asas MHIT juga akan berfungsi sebagai lapisan teras yang seragam yang ditawarkan oleh semua ITO yang menjalankan perniagaan MHIT. Melalui produk ini, pengguna yang berkemampuan termasuklah golongan M40 boleh mendapatkan

perlindungan bagi menampung perbelanjaan perkhidmatan kesihatan yang asas (essential services). Pada masa yang sama, golongan yang memerlukan perlindungan tambahan boleh mendapatkan produk MHIT tambah ataupun base plus. Produk ini boleh ditawarkan secara kompetitif oleh ITO di pasaran untuk memenuhi keperluan pemegang polisi yang berbeza.

Perlindungan asas yang seragam ini juga akan membolehkan pengumpulan risiko yang lebih luas. Ini seterusnya akan mendorong beberapa perubahan penting kepada ekosistem kesihatan seperti pertamanya, premium produk asas yang lebih mampan serta mekanisme pengumpulan risiko yang lebih saksama.

Kedua, peralihan kepada model pembayaran berasaskan nilai seperti diagnosis-related group bagi kesihatan swasta melalui produk asas sebagai pembayar utama.

Ketiga, peningkatan peranan penjagaan primary care sebagai tempat rujukan pertama dan kesinambungan rawatan yang tidak memerlukan penjagaan di hospital.

Keempat, menggalakkan simpanan kesihatan individu dengan jangkaan yang lebih baik untuk menampung bayaran out of pocket serta premium pada masa hadapan.

Dengan pengambilan produk asas MHIT secara lebih meluas yang memberi akses kepada hospital swasta, perkhidmatan kesihatan awam akan kekal sebagai jaringan keselamatan sosial (social safety net) untuk orang ramai khususnya bagi mereka yang tidak mampu untuk membeli insurans..."

[Muka surat 2 - 4, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

Selain itu, **Dato' Seri Abdul Rasheed Ghaffour** turut menjelaskan bahawa sebanyak 11 inisiatif di bawah lima teras utama telah dipersetujui hasil kerjasama menyeluruh antara BNM, KKM, MOF, industri insurans, dan pihak hospital swasta (APHM). Perunding bebas telah pun dilantik untuk merangka pelaksanaan inisiatif tersebut. Selain itu, penyelarasan ini diperkukuhkan lagi dengan penubuhan jawatankuasa peringkat menteri, jawatankuasa pemandu, serta majlis perundingan yang melibatkan pihak luar seperti NGO dan persatuan pengguna bagi memastikan keberkesanan pelaksanaan setiap inisiatif.

***"Dato' Seri Abdul Rasheed Ghaffour [BNM]:** Thank you Yang Berhormat for the question. In fact, if I can, saya boleh jelaskan. Pertamanya, all the inisiatif, yang 11 ini with the lima teras yang kita terangkan tadi itu, it is inisiatif yang telah dipersetujui oleh Bank Negara Malaysia, industri insurans, Kementerian Kesihatan, Kementerian Kewangan dan semua pihak-pihak berkepentingan termasuklah APHM, hospital swasta. Kita telah bermesyuarat berkali-kali dan kita semua telah bersetuju. So, these are the five teras that we want to do and these are the 11 initiatives.*

Initially, pada [Tidak jelas] Februari, bila kita bentangkan kepada PAC, kita ada sembilan inisiatif sahaja. Setelah kita berbincang dengan pihak hospital dan sebagainya, mereka mencadangkan dua lagi. Jadi sekarang kita ada 11 inisiatif. So, all initiatives ini is part and parcel of one initiative actually, pertama.

Kedua, memang terdapat koordinasi yang menyeluruh di antara Bank Negara, Kementerian Kesihatan, industri insurans dan juga pihak hospital. So, that is where we have come out with all these recommendations.

Ketiga, dari segi konsultan, kita telah pun melantik konsultan baru-baru ini, ia telah pun dilantik dan mereka akan bermula dari segi kerja-kerja mereka untuk mengeluarkan rangka kerja dari segi pelaksanaan inisiatif-inisiatif yang telah kita identify-kan ini.

Dari segi 11 inisiatif ini pun, contohnya, salah satu daripada inisiatif itu, nombor sembilan, Rakan KKM telah pun diluluskan oleh Kabinet pada hari Rabu, semalam. Jadi untuk makluman Yang Berhormat, perkara ini sebenarnya adalah satu koordinasi yang kukuh di antara pihak-pihak terbabit, Bank Negara, KKM, syarikat insurans dan juga syarikat hospital. Kita juga telah menubuhkan jawatankuasa peringkat Menteri itu, termasuklah yang akan dipengerusikan oleh Menteri Kewangan dan Menteri Kesihatan dan kita akan ada steering committee yang dipengerusikan oleh penasihat teknikal kami Datuk Jessica dan juga dengan wakil daripada Kementerian Kesihatan Dr. Yap. Steering committee ini akan merangkumi pihak-pihak yang terlibat, yang tertentu termasuklah industri insurans, Kementerian Kesihatan, Bank Negara dan sebagainya.

Selain daripada itu, kita juga akan menubuhkan consultative committee (council) yang akan melibatkan pihak-pihak terbabit yang lain. Contohnya ITO, consumer association, persatuan hospital dan sebagainya untuk memberi pandangan dan juga komen ke atas perlaksanaan 11 inisiatif ini. So, perkara ini telah pun sedang dilaksanakan, Yang Berhormat."

[Muka surat 9, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

ii. <u>Penjelasan Penasihat Teknikal BNM</u>

Datuk Jessica Chew Cheng Lian [Penasihat Teknikal BNM] dalam Prosiding Bil. 5(q)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa peranan perunding bebas yang dilantik adalah untuk memperincikan pakej manfaat dan kadar premium agar lebih mampu milik, sekali gus membolehkan lebih ramai golongan masyarakat mendapat akses kepada perlindungan insurans.

"Datuk Jesicca Chew Cheng Lian [BNM]: *... Jadi, yang appointment of consultant ini Yang Berhormat Pengerusi, is really to memperincikan benefit package dengan pricing, the premium rate. Jadi bila kita buat itu, kita akan mengambil kira juga affordability. So, we will look at the demographic of society yang sekarang ini tidak*

dapat, cannot afford insurance dan kita akan menentukan apa tahap premium yang boleh, yang sesuai. Jadi, kita boleh meliputi lebih ramai orang dalam pakej ini. Terima kasih."

[Muka surat 7 - 9, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

iii. Penjelasan KPE LIAM

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(p) bertarikh 19 Jun 2025 menjelaskan mengenai perkembangan terkini 12 inisiatif industri dan sembilan (9) komitmen reformasi untuk menangani cabaran inflasi tuntutan perubatan seperti berikut:

BIL.	INISIATIF INDUSTRI	STATUS TERKINI
1.	Melantik perunding bebas untuk menganalisis dan mengesyorkan tindakan pihak berkepentingan bagi mengurangkan inflasi tuntutan	Pelantikan perunding bagi membangunkan produk "Basic MHIT" (Insurans/Takaful Kesihatan dan Perubatan Asas) dalam pelaksanaan. Inisiatif ini juga bertujuan untuk mengkaji langkah-langkah yang diambil oleh pihak atau negara lain dalam menangani masalah inflasi tuntutan
2.	Langkah sementara**:** Menawarkan bantuan kepada pelanggan berisiko kehilangan perlindungan kewangan, serta memperkukuh amalan pendedahan jualan dan meningkatkan komunikasi serta ketelusan mengenai penentuan harga semula.	Langkah-langkah sementara BNM telah dilaksanakan. Format pendedahan Baharu menunjukkan kesan inflasi 7% dan 10% ke atas premium sepanjang 20 tahun untuk ketelusan yang lebih baik, bermula pada bulan September.
3.	Bayaran bersama (*co-payments*) pemegang polisi diperlukan untuk menyelaraskan kepentingan dan mengurangkan penggunaan berlebihan perkhidmatan kesihatan	Kadar pengambilan sejak September 2024 adalah antara 11% hingga 99% jualan baharu. Kebanyakan syarikat insurans mencatatkan kadar melebihi 50%, dengan beberapa syarikat besar melebihi 90%. Deduktibel RM500 kurang berkesan selepas seseorang dimasukkan ke hospital. Negara-negara seperti Singapura dan Indonesia mewajibkan *co-insurance* minimum 5%.
4.	Menggalakkan dan memberi insentif kepada gaya hidup sihat melalui bonus tanpa tuntutan.	50% syarikat insurans LIAM kini menawarkan beberapa bentuk insentif seperti bonus tanpa tuntutan, insentif kesihatan atau penetapan harga berasaskan tuntutan. LIAM akan menjalankan kempen literasi kesihatan dua tahun bermula 2025.

BIL.	INISIATIF INDUSTRI	STATUS TERKINI
5.	Penubuhan pangkalan data tuntutan seluruh industri untuk analisis tuntutan yang lebih baik dan mengurangkan penyalahgunaan, serta ketelusan yang lebih besar dengan menerbitkan purata kos prosedur/rawatan biasa dan inflasi kos perubatan tahunan di hospital swasta.	Pangkalan data tuntutan telah ditubuhkan dan sedang mengesahkan data 2024. Penerbitan kadar inflasi disasarkan pada Q3, manakala penerbitan kos prosedur biasa di seluruh hospital swasta disasarkan pada akhir 2025 untuk meningkatkan ketelusan dan membantu pemegang polisi membuat keputusan dalam penjagaan kesihatan. Mengemas kini panduan klinikal dan amalan audit untuk keperluan perubatan, penerbitan kos prosedur biasa, ujian diagnostik, data nasional mengenai rawatan/prosedur, serta kadar inflasi tuntutan perubatan akan meningkatkan ketelusan.
6.	Membangunkan produk perubatan asas yang mampan jangka panjang bersama BNM, dan membenarkan Pengendali Insurans/Takaful (ITOs) untuk menginsuranskan skim tambah nilai bagi mereka yang mampu.	Jawatankuasa telah dibentuk bersama BNM, MOF, MOH, EPF, dan industri. Permintaan untuk Cadangan (RFP) bagi pembangunan produk Basic MHIT telah diterima dan pemilihan/ penganugerahan akan dilakukan pada Jun 2025. Fasa pembangunan tiga bulan akan diikuti dengan maklum balas dan kumpulan fokus. Projek rintis dan pelancaran disasarkan pada 2026. Kenaikan kadar disebabkan oleh umur bukanlah penetapan harga semula perubatan. Penilaian komuniti dengan subsidi silang merentasi kumpulan umur memerlukan produk Basic MHIT kebangsaan yang dibiayai oleh hasil cukai atau kadar pengambilan yang sangat tinggi disokong oleh subsidi dan insentif cukai.
7.	Mengecualikan insurans kumpulan daripada 8% SST (Cukai Jualan dan Perkhidmatan) untuk menggalakkan lebih ramai majikan mengambilnya.	Permintaan telah ditolak oleh pihak Kastam. Meminta pengecualian daripada SST bagi menggalakkan majikan menyediakan perlindungan insurans kesihatan swasta kepada pekerja, sama seperti penjagaan kesihatan swasta yang tidak tertakluk kepada SST.
8.	Syarikat insurans mempertimbangkan untuk membangunkan rangka kerja penentuan harga semula (penentuan harga semula tahunan) yang sesuai dan diperkemas untuk mengurangkan kejutan kenaikan kadar.	Langkah-langkah sementara BNM telah dilaksanakan. Syarikat ahli digalakkan untuk melakukan penentuan harga semula yang lebih kerap tetapi kuantum yang lebih kecil sejajar dengan inflasi perubatan tahunan.

BIL.	INISIATIF INDUSTRI	STATUS TERKINI
9.	Penyedia dan syarikat insurans/TPA perlu menyelaraskan dengan lebih baik mengenai kos dan penggunaan perkhidmatan penjagaan kesihatan, dan industri menyokong penggunaan penetapan harga DRG (*Diagnostic-Related Group*).	Jawatankuasa DRG akan menumpukan pada hospital awam, pengajaran, dan tentera dahulu, untuk dilancarkan pada 2027. Penggunaan di hospital swasta tidak dirancang untuk diwajibkan. Pengendali Insurans/Takaful (ITOs) amat bimbang dengan kemajuan dan cita-cita ini. Mereka ingin merayu kepada MOH untuk mempercepatkan pembangunan dan peralihan kepada mekanisme pembayaran yang berkesan ini.
10.	Bekerjasama dengan MOH untuk mewajibkan penggunaan ubat generik dan mengawal harga semua ubat. Laporan APHM (Persatuan Hospital Swasta Malaysia) menyatakan bahawa 48% keuntungan hospital swasta datang daripada farmaseutikal.	Memerhatikan kesan ketelusan harga ubat sebelum melobi untuk kawalan harga ubat. Pengawasan kawal selia yang lebih kukuh diperlukan, serta panduan penggunaan generik. Sebagai contoh, MOH Singapura telah menerbitkan senarai ubat kanser yang dilindungi oleh MediShield.
11.	Meminta hospital swasta untuk membekukan kos untuk tempoh yang sama syarikat insurans/pengendali takaful diminta untuk mengehadkan kenaikan premium.	Walaupun syarikat insurans telah melaksanakan langkah-langkah sementara BNM (walaupun dalam keadaan kerugian), APHM secara terbuka telah menolak, menunjukkan keperluan untuk bentuk peraturan/kawalan yang sesuai jika penjagaan kesihatan swasta dianggap sebagai perkhidmatan penting.
12.	Rakan KKM (Kementerian Kesihatan Malaysia) boleh membantu berfungsi sebagai penanda aras harga untuk DRG penjagaan swasta.	Industri menyokong. Pelancaran disasarkan pada Q3 2025 di 5 hospital. Perlu bergerak lebih pantas.

Semua pihak berkepentingan, termasuk syarikat insurans/pengendali takaful, hospital swasta, doktor, pengawal selia, dan pemegang polisi, harus bekerjasama dalam pendekatan seluruh negara untuk menangani cabaran yang menyumbang kepada peningkatan kos dan premium.

[Berdasarkan Slide pembentangan LIAM dalam Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

Selain itu, **Encik Mark Steven O'dell** turut merumuskan sembilan inisiatif pembaharuan di bawah rangka kerja RESET Bank Negara, seperti berikut:

BIL.	TERAS	INISIATIF
1.	**Ketelusan Harga yang Lebih Besar**	● Terbitkan kadar inflasi kos tuntutan setiap tahun (disasarkan Q3 2025). ● Terbitkan kos prosedur biasa di seluruh hospital swasta (disasarkan sebelum akhir 2025). Bersama dengan penerbitan kos ubat-ubatan, ini akan memudahkan pelaksanaan caj yang munasabah dan lazim. Mengukuhkan pengawasan kawal selia ke atas hospital swasta.
2.	**Mekanisme Pembayaran Pembekal yang Lebih Baik**	● Melaksanakan Penetapan Harga Kumpulan Berkaitan Diagnostik (DRG) untuk menggantikan bayaran-untuk-perkhidmatan (*fee-for-service*). Ini akan menggalakkan kecekapan pembekal yang lebih besar. Mempunyai rancangan yang lebih bercita-cita tinggi dan mempercepatkan pembangunan.
3.	**Transformasi MHIT**	● Pembangunan pelan MHIT asas yang lebih berpatutan dan mampan, bekerjasama dengan BNM, MTA, MOF dan EPF. Projek rintis dan pelaksanaan disasarkan pada 2026. ● Semak semula reka bentuk pelan untuk mengurangkan kemasukan dan ujian yang tidak perlu bagi memacu diagnosis dan rawatan yang betul di tempat yang sesuai. ● Lebih banyak pelan untuk menawarkan bonus/diskaun tanpa tuntutan, insentif kesihatan. ● Rasionalisasi dan penggredan rangkaian atau penyedia atau doktor.
4.	**Pilihan Kos Efektif**	● Menyokong Rakan KKM dan pengenalan pembayaran tuntutan berasaskan DRG.

"Tuan Mark Steven O'dell [LIAM]: *… As we have to finally wrap it up, you know we need an all-of-nation approach to this. We don't see a lot of changes at the hospital's side. There is a lot of initiatives that are ongoing on the insurance and regulatory side. I would like to then just finish with the summary of the reform initiatives that we have agreed or are undertaking. There are nine of them and categorised them into the thrusts that Bank Negara earlier had issued five thrusts. Now — they've rearranged it. Now, they call it RESET, so they just rearranged to the thrust but they're the same as in what they covered.*

So, Thrust 1 greater price transparency, publish annually the claims costs, inflation rate. Dated to be targeted it Q3. This is of concern we always get is that there is no authority for what is the claims inflation. So, here we are hoping to be able to educate the public on the cost of care and the cost of claims or the rate of inflation on claims, each year. Next bullet is publish the costs of common procedures across all private hospitals. We hope to do that before the end 2025. We have a work group formed for that together with publishing cost of drugs. These will facilitate the implementation of reasonable and customary charges.

This is another area that we face. Zee Wang was — if you look at that. Even though the policy is may often cover as charged but there is another provision that says up to the reasonable customary fee. But there is no authority for a reasonable customary fee and so each insurer left on their own to negotiate those with the hospital. We are hoping that this would provide some benchmarking of the cost across to the private hospitals sector.

As was alluded to with Zee Wang with the slides, we need to strengthen the regulatory oversight over… [Masalah teknikal – tiada rakaman hilang] ...private hospitals.

Thrust 2, improve provider payment mechanisms. Implement Diagnostic-Related Group pricing to replace fee-for-service. This will promote greater provider efficiencies, and the support we need there is we need a more ambitious plan and expedite development of this DRGs. In my own desktop research, the Scandinavia countries, I read report from Boston Consulting that it takes about three years, two to three years an average to implement some form of Diagnostic-Related Group pricing.

Thrust 3, development of basic MHIT product that is more affordable and sustainable, collaborating together with other ministries and EPF. Target pilot and implementation is next year. Review planned design to reduce unnecessary admissions and tests to drive right diagnosis and treatment at the right setting. More plans to offer, no-claim bonus or discounts and wellness incentives. Rationalizing and tiering networks or providers or doctors. This is ongoing.

Thrust 4, support Rakan KKM and the introduction of DRG-based claims payment. Finally, it's not written here but we're working together with BNM reviewing insurance data on managing closed blocks of business and whether greater pooling would be beneficial to policyholders. So, with that, I end my presentation Madam Chair. "

[Muka surat 10 - 11, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

Seterusnya, **Encik Mark Steven O'dell** juga berpendapat bahawa inisiatif RESET akan memberi impak jika dilaksanakan mengikut reka bentuk asalnya, namun mengakui terdapat banyak pemboleh ubah yang mencabar. Beliau menekankan bahawa tiada jaminan pelan perubatan asas yang sedang dibangunkan akan benar-benar mampu milik atau menarik minat pengguna.

***"Tuan Mark Steven O'Dell [LIAM]:** Maybe I'll take this first. I think if it is executed as designed, I think it will have an impact. But you know, there is a lot of variables. Number one is, let's take the basic plan. There is no guarantee yet, you know, that we can design a basic plan that is affordable and adequate. So, this is what we are going to be working through with the consultant in the next three months and that is attractive, you know? So, it's a big challenge but it also a big variable. And things like DRG is another one that we think is something that is — will make a big*

difference. But we need the will of MOH to actually make it mandatory in order for it to have its greatest effect. So, I think the short of it is if implemented as outlined, I think it will make a difference. The devil is in the implementation."

[Muka surat 26, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

iv. <u>Penjelasan Pengerusi, Allianz Malaysia Berhad</u>

Tuan Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad] dalam Prosiding Bil. 5(p) bertarikh 19 Jun 2025 memaklumkan bahawa beliau menyokong inisiatif RESET tetapi meragui kadar pengambilan (*take-up rate*) oleh orang awam.

Berdasarkan pengalaman lepas seperti program i-Lindung dan polisi khas penyakit kronik, beliau mendapati sambutan pengguna tetap rendah walaupun produk tersebut murah. Bagi beliau, cabaran terbesar bukanlah penyediaan produk, tetapi kegagalan mengawal tingkah laku manusia yang sering tidak mahu mengikut rejim kesihatan atau komited terhadap perlindungan insurans.

"Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *YB, just a perspective of an individual company. The RESET is good but like Mark said, are people going to buy? Even if you make it cheap, will they buy? This is the other issue. We really don't know. We have done in the past, if you remember, I think EPF came out with i-Lindung, was it? And what happened? No take-up, right? Ya, very low take-up. So, we are talking about human behaviour, we are talking about restructuring the medical, there's a lot of factors.*

So, we say we will do it, we'll try and we'll see how far we can actually go with this particular aspect but don't expect the 100 percent, it will be somewhere in between. Hopefully higher than what we have previously experienced but we cannot control human behaviour. Like I said, we come out with Type 1, with all this diabetes policy, if you got hypertension, you can still buy a policy. No take-up. People — not that they don't want to take up; they don't want to follow the regime. They said, "Oh got regime? I don't want", you know? So, it depends also on human behaviour as well."

[Muka surat 26, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

v. <u>Penjelasan Ketua Pegawai Penjagaan Kesihatan, AIA Berhad</u>

Tuan Heng Zee Wang [Ketua Pegawai Penjagaan Kesihatan, AIA Berhad] dalam Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa RESET memerlukan pendekatan seluruh negara (*whole-of-nation*) untuk berjaya, terutamanya dalam aspek ketelusan harga prosedur dan kos. Beliau

melahirkan kebimbangan kerana langkah sedia ada hanyalah penyelesaian sementara sedangkan kos di pihak hospital terus meningkat tanpa kawalan.

Beliau mencadangkan agar pembaziran sumber perubatan di sektor swasta dikurangkan dan kapasiti tersebut digunakan untuk menyokong kekurangan di hospital kerajaan. Beliau turut menekankan kepentingan audit terhadap kewajaran perubatan (*medical necessity*) kerana setakat ini tiada kawal selia atau audit yang jelas dilakukan oleh pihak berkuasa terhadap amalan di hospital swasta.

> ***"Tuan Heng Zee Wang [AIA Berhad]:*** *So, YB. Sim, maybe just to supplement, I think you know, question on we said that we were all there yesterday. I think what Mark shared earlier the 13 items, if you were to regroup them, it all fall under the RESET, different buckets of RESET. Like for the example the first one on the revamp MHIT, Mark talked about the base plan. This is actually currently you know going on. The second one on enhanced price transparency. We spoke a lot about price transparency and procedure transparency and cost transparency. That one is very essential. So, this will work if you really take a whole-of-nation approach like everyone has to participate in making this possible.*
>
> *Why we are so concerned today is because Bank Negara actually announced yesterday to say interim measure is a plaster, it's a temporary fix, hence we bring down the price. But if we see the price at the other side continue to go up, it's not sustainable and hence that's why it's very important for everyone to say, look, this is what we can do you know, to control the cost. Right? It's not about making profits, who makes more profits. It's about reducing the wastage, you know? Medical resources are very valuable. The public side have insufficient amount of screenings and you know, but yet in the private side you know, we use this excessively. Maybe you can use the spare capacity to support some of the shortfall we have in the government's facility and at the right price which is what you know Datuk Seri Dzul talked about funneling some of the B40 patients, at the right price, to the private hospital.*
>
> *So, this really requires everyone working together. One side, insurance or Bank Negara work alone. It's insufficient, I have got to say, coming out from yesterday's session, we are quite worried that it becomes quite clear that there's no appetite to introduce any form of regulations or control. If there isn't any regulation or control on private healthcare, which we now deem as essential, then the transparency part becomes very important. The benchmarking part becomes very important. The audit on what's medically necessary is becoming very, very critical because today, that is not part of the scope. As far as we understand the hospitals, maybe they do their own audit. We are not aware that KKM actually do medical-necessary or appropriate audit on private healthcare, for example."*
>
> [Muka surat 25 - 27, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

Penjelasan TKSU KKM dan KPE Pejabat Transformasi Kesihatan

Dato' Sri Zahrul Hakim bin Abdullah [TKSU KKM] dan **Dr. Yap Wei Aun [KPE HTO] dalam Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025** telah membuat pembentangan bagi memaklumkan kemajuan pelaksanaan strategi seluruh negara bagi membendung inflasi perubatan swasta.

Kerajaan telah mengambil pendekatan menyeluruh untuk menangani isu inflasi perubatan swasta dengan membentuk **Jawatankuasa Bersama Peringkat Menteri Mengenai Kos Penjagaan Kesihatan Swasta (JBMKKS)** pada 24 Jun 2025. JBMKKS disokong oleh satu jawatankuasa pemandu yang dipengerusikan bersama di peringkat Bank Negara Malaysia (BNM) dan Kementerian Kesihatan Malaysia (KKM). Suatu majlis perundingan yang terdiri daripada pemegang kepentingan daripada sektor swasta, universiti dan NGO turut bersama dalam Jawatankuasa ini.

Tujuan Utama (*Term of Reference*) JBMKKS adalah termasuk:

- Memastikan pelaksanaan dan pemantauan langkah segera yang tepat pada masanya dan berkesan untuk menangani kenaikan kos penjagaan kesihatan swasta.
- Memupuk kerjasama jangka panjang dan konsensus di kalangan pemegang kepentingan dan agensi kerajaan.
- Menyokong pembangunan ekosistem penjagaan kesihatan swasta yang efektif, mampan, dan mampu milik, selaras dengan perkhidmatan penjagaan kesihatan berasaskan nilai (*value-based healthcare services*).

"Dato' Sri Zahrul Hakim bin Abdullah [Timbalan Ketua Setiausaha (Kewangan) Kementerian Kesihatan]: *... Untuk makluman Datuk Wira Pengerusi dan Ahli-ahli PAC sekalian, isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impaknya terhadap kesihatan awam melibatkan pelbagai pihak yang berkepentingan bukan sahaja di peringkat Kementerian Kesihatan Malaysia, bahkan tentunya melibatkan juga Kementerian Kewangan dan Bank Negara Malaysia (BNM).*
KKM sangat komited dan memandang serius berkaitan dengan isu ini kerana ia memberikan impak yang langsung kepada kemampuan rakyat bagi mendapatkan rawatan dan keberlanjutan daripada sistem kesihatan negara sedia ada.
Jika harga perkhidmatan penjagaan kesihatan di sektor swasta terlalu tinggi, kita khuatir rakyat akan lebih bergantung kepada fasiliti kesihatan kerajaan di mana ini tentunya akan memberikan tekanan terhadap fasiliti-fasiliti sedia ada dan juga para petugas kesihatan.[AB1]

Untuk makluman Datuk Wira Pengerusi serta Ahli-ahli PAC, pada 24 Jun 2025 yang lalu, satu jawatankuasa bersama peringkat Menteri telah dibentuk berkait dengan kos penjagaan kesihatan swasta yang dipengerusikan bersama oleh Menteri Kewangan II dan Menteri Kesihatan Malaysia.

Ini adalah merupakan salah satu daripada inisiatif di bawah strategi reset bagi menangani inflasi kos perubatan yang semakin meningkat...."

[Muka surat 3, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

*"**Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]:** ... Seperti mana yang dimaklumkan, kerajaan mengambil agak serius cabaran inflasi perubatan sektor swasta dan telah mengarahkan pembentukan jawatankuasa bersama peringkat Menteri mengenai kos penjagaan kesihatan swasta ataupun JBMKKS. Struktur tadbir urus JBMKKS adalah seperti berikut.*

Jawatankuasa bersama peringkat Menteri yang dipengerusikan bersama oleh Yang Berhormat Menteri Kewangan II dan Yang Berhormat Menteri Kesihatan. Keahlian jawatankuasa ini terdiri daripada Gabenor Bank Negara serta dengan pengurusan tertinggi Kementerian Kewangan dan Kementerian Kesihatan. Jawatankuasa ini disokong oleh satu jawatankuasa pemandu yang dipengerusikan bersama di peringkat Bank Negara Malaysia dan Kementerian Kesihatan dan suatu majlis perundingan yang terdiri daripada pemegang kepentingan daripada sektor swasta, universiti dan NGO turut disertakan.

Beberapa kumpulan kerja juga boleh dibentuk dan telah dibentuk untuk membantu dalam kerja JBMKKS ini. Mesyuarat pertama seperti yang dimaklumkan telah diadakan pada 24 Jun 2025. Boleh saya terus kepada bahasa Inggeris tentang terma rujukan jawatankuasa ini.

Terma rujukan jawatankuasa ini adalah to ensure timely and effective implementation and monitoring of immediate measures to address rising private healthcare cost, to foster long-term collaboration and consensus among stakeholders and relevant ministries, government agencies and private sector representatives in the private healthcare ecosystem and to support the development of a private healthcare ecosystem that is effective, sustainable and affordable in line with value-based healthcare services.

And it lists the three different hearts of this JBMKKS. The first is the ministerial level Joint Ministerial Committee which provide strategic direction and decisions, an oversight on the implementation of RESET. RESET is the name of the framework for implementation which I will elaborate on later. Facilitate communication and coordination among key industry stakeholders and government bodies and to update the Cabinet and public on progress.

The Steering Committee on the other hand is to oversee the implementation and monitoring of initiatives, make recommendations on the implementation of the Joint

Ministerial Committee and to convene and consult the Consultative Council members as and when necessary, in the development and implementation of the initiatives.

The Consultative Council is to represent the members of respective organisations and to provide inputs into the development and implementation of the initiatives and facilitate the implementation of the initiatives amongst the members of respective organisations.

This slide lists down some of the key members of the — the permanent members of Consultative Council which include members representing private hospitals, private healthcare professionals, private insurance and takaful providers as well as other stakeholders who are quite critical representing the interest of consumers and also, we have representatives from expert such as academia..."

[Muka surat 4-5, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

Kerangka Pelaksanaan Strategi Seluruh Negara (RESET)

JBMKKS menyelia pelaksanaan kerangka kerja inisiatif **RESET** bagi menangani isu inflasi kos perubatan. Inisiatif RESET terdiri daripada lima (5) strategi utama seperti berikut:

Strategi	Penerangan
R	***Revamp* MHIT (Insurans dan Takaful Kesihatan Perubatan):** ● Membangunkan produk MHIT asas yang diseragamkan untuk menyokong penjagaan kesihatan berasaskan nilai (*value-based healthcare*). ● Memasukkan liputan kitaran hidup (*life course coverage*) dan laluan untuk individu dengan keadaan sedia ada (*pre-existing condition*) seperti diabetes.
E	***Enhance Price Transparency* (Meningkatkan Ketelusan Harga):** ● Mengukuhkan inisiatif sedia ada untuk memaparkan harga farmaseutikal di klinik dan hospital swasta. ● Mengusahakan penubuhan mekanisme untuk menghasilkan, memantau, dan menerbitkan ukuran inflasi perubatan yang konsisten, melibatkan DOSM dan Bank Negara. ● Menyemak Akta 586 untuk menyokong inisiatif ketelusan harga dan pembangunan DRG.
S	***Strengthening the Digital Health Ecosystem* (Mengukuhkan Ekosistem Kesihatan Digital):** ● Memanfaatkan teknologi untuk membolehkan perkongsian data dan mengelakkan penduaan ujian atau imbasan yang tidak perlu di fasiliti swasta.
E	***Expand Cost-Effective Options*** (Mengembangkan Opsyen Kos-Efektif): ● Mengembangkan peranan Rakan KKM (yang menyediakan perkhidmatan tahap pertengahan/ekonomi premium) dan hospital bukan berasaskan keuntungan. Rakan KKM Sdn. Bhd. dijangka menerima pesakit pertama pada Disember tahun 2025.
T	***Transform Provider Payment Mechanisms* (Transformasi Mekanisme Pembayaran Pembekal):**

Strategi	Penerangan
	● Melaksanakan ***Diagnosis-Related Groups*** **(DRGs)** di sektor swasta secara berfasa, sebagai peralihan daripada sistem pembayaran *fee-for-service* (bayaran mengikut perkhidmatan). ● Pelaksanaan DRG akan dikaitkan dengan produk MHIT asas, dengan perancangan bermula secara berfasa pada tahun hadapan (2026).

"Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]: *... The first thing to notice is that this is the whole-of-nation approach. This RESET framework. Dia bukan sahaja satu inisiatif daripada satu kementerian atau satu agensi atau satu pemegang kepentingan tetapi adalah satu strategi secara menyeluruh untuk menangani ini secara pendekatan seluruh negara.*

The first part of the strategy is R, to revamp MHIT which is basically a transformation of the private healthcare insurance and takaful products. This is really quite an ambitious reform. You can see that there we plan to develop a base MHIT product to support value-based healthcare services. Incorporating global best practices in the design on encouraging for example wellness, prevention, primary care as well sustainable payment models which is one of the key things which I will describe more later on under DRGs. And also, there's a desire to have life course coverage (liputan kitaran hidup) so that it is fairer for people across all stages of life. When they join when they are young and healthy and if they commit to this product, this product should commit to them even past post-retirement.

Also, we need a pathway, actuarially sound pathway for including people with pre-existing condition such as diabetes into this coverage. On the right-hand side on number 10, we see there it's also quite important to create a simple framework for people, for consumers to make informed choices when they select a private health insurance coverage options.

Going to strategy E, which is to enhance price transparency. The overall game of this is to provide more information for consumers to make informed choices. You'll notice that they also includes number two, pre-existing initiatives on the paparan harga pharmaceuticals for private clinics and private hospitals which are already on-going. But it also includes things to clarify some of the confusion regarding let's say medical price inflation numbers where different sources co-different values. But we also want to come out with a standardised methodology for that.

You will see also number four, five and 11 of the strategy E, that we do hope to review some of the legislation, particularly at Act 586 to support initiatives both for price transparency as well as to support the development of DRGs. Leading to the publication of price ranges for common healthcare services, so that people and consumers and the rakyat can make inform choices about where is it going to be expensive or cheaper to get private healthcare. In this number 11 definitely requires some form of a standardised framework collecting this information.

Moving on to strategy S, strengthening the digital health ecosystem. I just want to acknowledge also my colleagues from the rest of ministry from divisions who are here also to help to support and provide answers as need be to including the digital health

division and I think from perubatan side. [Dicelah] We have Dr. Mahesh from Bahagian Kesihatan Digital and also we have colleagues from Bahagian Amalan Perubatan as well.

So the whole game aim of strategy S, is to leverage and to just come out to the stand of technology where we do not need to duplicate tests and scans even though a patient go across different hospitals in a private sector. And this is just a technological element of allowing this interruptibility to happen. So, people can share with the patients consent and agreement information recording their little scans and lab results. So that the relevant to inflation is that we do not need to duplicate unnecessary tests just because a person is going to different facilities.

Strategy E, is really intervention to work on the supply side, to expand cost-effective options and release two. So not only Rakan KKM which provides a mid-tier premium economy services much more affordable than five to six star private hospitals. But we also want just generally expand the role of non-profit hospitals. I think some of you may be aware of them such Tung Shin, Lam Wah Ee, Assunta, et cetera.

The most critical actually from Ministry of Health's perspective is also to get DRGs going and that's under last strategy T, transform provider payment mechanisms."

[Muka surat 6-7, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

7.1.8 Program Bonus Tanpa Tuntutan (NCB) Dalam Polisi Insurans Kesihatan.

Industri perlu beralih daripada insentif token kepada insentif kewangan yang substansial untuk menjadikan NCB relevan.

BNM harus menggalakkan standardisasi struktur NCB yang lebih agresif dalam produk baharu untuk memupuk budaya "jaga kesihatan" dalam kalangan pemegang polisi.

i. <u>Penjelasan KPE CompuMed Services Sdn. Bhd.</u>

Puan Fiona Rebecca Limus [KPE CompuMed Services Sdn. Bhd.] dalam Prosiding Bil. 5(m) bertarikh 17 Jun 2025 menjelaskan bahawa konsep Bonus Tanpa Tuntutan (NCB) seperti insurans kenderaan sememangnya wujud dalam industri insurans kesihatan. Beliau menjelaskan bahawa bagi pemegang polisi yang tidak membuat tuntutan, syarikat insurans menawarkan ganjaran dalam bentuk pemeriksaan kesihatan eksekutif percuma atau potongan premium bagi tahun berikutnya. Beliau turut mengakui pandangan ahli

jawatankuasa bahawa ganjaran yang kecil atau tidak praktikal (seperti baucar diskaun yang memerlukan perbelanjaan tambahan yang tinggi) adalah tidak signifikan dan kurang menarik bagi pengguna.

ii. <u>Penjelasan KPE PMCare Sdn. Bhd.</u>

Tuan Kamal Aryf Baharuddin [KPE PMCare Sdn. Bhd.] dalam Prosiding Bil. 5(m) bertarikh 17 Jun 2025 menjelaskan bahawa semakin banyak syarikat insurans kini memperkenalkan program NCB bagi polisi individu yang diuruskan oleh TPA. Beliau menekankan bahawa program yang diuruskan pihaknya berbeza daripada sistem diskaun kecil yang dikritik, kerana ia menawarkan nilai yang lebih bermakna. Bergantung kepada jenis polisi dan premium yang dibayar, pemegang polisi boleh menebus pakej saringan kesihatan yang lengkap secara tanpa tunai tanpa perlu menambah wang sendiri. Matlamat utama program ini adalah untuk memberi ganjaran kepada pengguna yang kekal sihat melalui penebusan produk atau perkhidmatan berkaitan kesejahteraan kesihatan.

"Puan Teresa Kok Suh Sim [Ahli PAC]: *May I can have a suggestion? You see, we all buy car insurance, right. So, in order to save the what NCB…*

Puan Fiona Rebecca Limus [CompuMed Services]: *NCB, no claim bonus.*

Puan Teresa Kok Suh Sim [Ahli PAC]: *So, when our car got some minus scratch lah here and there, don't pump here and there…*

Puan Fiona Rebecca Limus [CompuMed Services]: *We don't…*

Puan Teresa Kok Suh Sim [Ahli PAC]: *We don't claim, right because we want to simpan you know one day…*

Puan Fiona Rebecca Limus [CompuMed Services]: *Until 55 percent, right?*

Puan Teresa Kok Suh Sim [Ahli PAC]: *Exactly. How come we–you know this healthcare insurance we can't do that?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Actually, they do. In fact, Kamal is managing NCB programme, maybe Kamal you can share.*

Tuan Kamal Aryf Baharuddin [PMCare]: *In fact, quite the number of insurance company now starting to introduce this for the individual policy. So, we are managing one of the insurance company for this NCB programme. Means that if*

there is no claim, what they do, this insurance company will give certain amount of money for those policy holders to redeem or purchase item either for wellness or other things related to healthcare.

Puan Fiona Rebecca Limus [CompuMed Services]: *So, they give like perhaps complimentary wellness, executive health screening or maybe even deduction of next year premium. So, they do have just like NCB for cars.*

Puan Teresa Kok Suh Sim [Ahli PAC]: *Actually, for me you know you offer all that, tak, normally we don't need it also. For example, like Great Eastern, every year come to my birthday, I'll get the RM50 voucher. But I've to go to Gleneagle Hospital which is so far away from my house and then we know that you do a check-up already in many thousand and then you give discount RM50 ya, you know this kind of thing is really useless lah.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Insignificant, right?*

Puan Teresa Kok Suh Sim [Ahli PAC]: *You want–you give… you deduct in all that us see the cash let say come to next year you deduct how many berapa ratus and all that. Then only if you attractive you see.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Ya, so…*

Tuan Kamal Aryf Baharuddin [PMCare]: *Sorry. For the company that insurance company that we are managing totally different from what you just mentioned just now. So, this is where that depending on the policy the premium paid, so the amount also quite significant that covers certain packages of screening. So, you just go and redeem and enjoy it cashless as well. So, it is not that they just give discount or rebate of RM20 or RM50, RM100 but you need to top up your own money to do that. No, this one is depending on the policy, the premium that you paid, and that you can enjoy with the providers that funding under this programme."*

[Muka surat 12 - 13, Laporan Prosiding Bil 5(m)/2025 bertarikh 17 Jun 2025]

7.2 *Cost of Insurance* (COI)

Struktur ILP menyembunyikan kenaikan kos sebenar sehingga ia menjadi krisis. Justeru itu, ketelusan mengenai jadual kenaikan COI hendaklah diperbaiki.

Penjelasan NAMLIFA

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa dalam polisi *investment-linked*,

premium yang dibayar oleh pemegang polisi merangkumi beberapa komponen, termasuk:

a. *Cost of Insurance* (COI) – meningkat mengikut umur dan risiko kematian.
b. Kos pengurusan dan pengambilan polisi (*acquisition cost*)
c. Simpanan syarikat (*reserves*)
d. Yuran pelaburan (*investment fees*)

Walaupun COI meningkat setiap tahun, premium biasanya kekal, kerana sebahagian premium dilaburkan dan pulangannya digunakan untuk menampung kenaikan COI. Namun, jika pulangan pelaburan tidak mencukupi (contohnya semasa krisis ekonomi), pelanggan mungkin perlu membuat bayaran tambahan bagi mengekalkan perlindungan. Masalah menjadi lebih ketara apabila polisi mengandungi *rider* perubatan, kerana ia menambah kos tinggi yang menjadikan polisi tidak mampan dalam jangka panjang.

> *"**Encik G Saseedaran Gengadharan [NAMLIFA]:** Dia panggil cost of insurance. Sebenarnya perkiraan ini adalah ciri-ciri investment-linked product. Cost of insurance. Kos perlindungan dia akan naik setiap tahun mengikut umur kita. Kos insurans adalah sebahagian daripada premium insurans yang dicaj. Dalam satu premium insurans itu ada pelbagai elements. Satu, cost of insurance. Satu lagi, dia punya acquisition cost. Satu lagi, dia punya reserve. Satu lagi, investment cost. Macam-macam dia campur semuanya dia jadikan premium ataupun sumbangan in takaful.*
>
> *At the back cost of insurance (COI) is determined by your age. Tetapi adakah ini bermaksud premium akan naik tiap-tiap tahun? Tidak, sebab mekanisme untuk investment-linked product ialah walaupun di belakangnya at the back end kos insurans naik tetapi premium akan kekal kerana jumlah yang dilabur (fund invested) itu pulangan dia itu digunakan untuk membayar kos yang naik setiap tahun. Di situlah dia punya sampai satu tahap mungkin bila terlalu tinggi dan pulangan pelaburan memang katalah iklim pelaburan agak mundur. Very bad economic crisis di mana all the funds are not doing well dalam produk sebegini.*
>
> *Masa itu cost of insurance sudah tinggi dan premium yang pelanggan itu bayar, tak boleh menampung lagi. Masa itu syarikat insurans akan minta dia top up untuk cover. Maybe it is an interim or temporary top up ataupun continuous. Perkara ini berlaku hanya banyak kali apabila kita sertakan rider medical di dalam investment-linked policy. Kalau produk ini hanya cover untuk live coverage sahaja dan untuk dapatkan force savings lah, simpanan. Dia tak akan burst. Dia boleh sustain very well. Tapi bila sertakan rider medical ini it is very heavy because of the costing. That's what we are seeing now. Cost of insurance is bursting. So, tak boleh sustain, reprice. Kalau tuan nak tahu lebih, kami ada banyak kursus yang bertauliah."*
> [Muka surat 22 - 23, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

7.3 Peningkatan Premium Insurans Kesihatan

7.3.1 Penetapan Had Kenaikan Premium Oleh BNM

Had kenaikan premium merupakan langkah penstabilan sementara bagi memberi ruang kepada kerajaan dan pihak berkepentingan untuk melaksanakan reformasi struktur yang lebih menyeluruh dalam sistem pembiayaan kesihatan.

i. <u>Penjelasan Pengerusi Allianz Malaysia Berhad</u>

Encik Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa arahan yang dikeluarkan oleh Bank Negara Malaysia adalah untuk menetapkan had kenaikan premium insurans kesihatan kepada maksimum 10% setahun selama tiga tahun, dan bukannya melarang kenaikan premium sepenuhnya. Beliau turut menyatakan bahawa tanpa arahan moratorium ini, kenaikan premium pasti akan berlaku disebabkan oleh inflasi kos perubatan yang semakin meningkat dan sukar dielakkan.

> ***"Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]:*** *Yang Berhormat Pengerusi, sedikit. Mohon respons, antara objektif PAC kita membuat prosiding kenaikan premium ialah kita nampak tidak ada konsisten persetujuan awal di pihak ITO. Dalam jawapan oleh Timbalan Menteri Kewangan kepada Parlimen pada Disember tahun lepas, beliau sebut bahawa syarikat insurans dan takaful telah bersetuju untuk menyemak kembali harga premium supaya tidak ada kenaikan. Itu janji disebut oleh Timbalan Menteri Kewangan. Maknanya sudah pasti saya lihat ada perbincangan dan persetujuan di pihak ITO dengan kerajaan.*
>
> *Namun, apabila tahun ini Januari nampak sudah tidak ada komitmen itu dan peningkatan sehingga disebut capped tadi sampai 10 percent. Jadi, sebenarnya apa yang mungkin dijawab kita kepada public sendiri dan juga kepada— walaupun ada juga disebut soal kos di hospital. Tapi persoalan besarnya itu maknanya komitmen kita sendiri di pihak ITO itu untuk kita ini juga protect hal dengan public ini. Terima kasih.*
>
> ***Encik Zakri Mohd Khir [Allianz]:*** *Ya, YB memang dari Bank Negara arahannya kita kena cap kata 10 peratus untuk tiga tahun. Itu memang setiap tahun, selama tiga tahun. That means moratorium 10 percent increase only untuk tiga tahun.*
>
> ***Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]:*** *Kalaulah kalau dia tak ada moratorium, adakah akan ada kenaikan?*

Encik Zakri Mohd Khir [Allianz]: *Oh, mesti. Terus terang saya cakap mesti. Fasal memang ada inflasi perubatannya. Memang naik.*

[Muka surat 54 - 55, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. Penjelasan Ketua Pegawai Eksekutif, Great Eastern Life Assurance (Malaysia) Berhad

Dato Koh Yaw Hui [Ketua Pegawai Eksekutif, Great Eastern Life Assurance (Malaysia) Berhad] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan beberapa langkah yang telah diambil syarikat dalam menangani isu kenaikan premium insurans kesihatan. Bagi tahun 2024, Great Eastern secara automatik akan mengurangkan kenaikan premium kepada 10% bagi semua pemegang polisi yang terkesan, tanpa perlu sebarang permintaan daripada mereka.

Selain itu, syarikat turut melaksanakan moratorium untuk individu berusia 60 tahun ke atas yang berada dalam pelan asas (RM100 sehari), melibatkan kira-kira 50% pemegang polisi, selaras dengan arahan Bank Negara Malaysia. Bagi kes pemulihan polisi (*restore*), ia hanya dipertimbangkan jika pemegang polisi menyatakan bahawa mereka berhenti kerana tidak mampu membayar selepas kenaikan premium; ia tidak dilaksanakan secara automatik kerana ada juga yang menghentikan polisi atas pilihan sendiri.

Beliau turut menjelaskan bahawa polisi bernilai RM5–10 juta hanyalah *rider* tambahan yang dibeli secara pilihan oleh individu tertentu dan tidak menjejaskan struktur kos kumpulan yang memiliki polisi asas. Tambahnya lagi, rawatan penyakit kritikal seperti kanser boleh menelan kos jutaan ringgit, maka perlindungan tambahan ini adalah relevan bagi sesetengah pihak.

Namun begitu, beliau mengakui terdapat cabaran apabila pemegang polisi yang sihat berpindah ke pelan lain atau ke syarikat insurans lain, menyebabkan ketidakseimbangan dalam kumpulan asal dan seterusnya membawa kepada keperluan menaikkan premium.

"Dato Koh Yaw Hui [Great Eastern Life Assurance]: *…So, on your question on whether or not you enjoy 10 percent, you say that you received the letter last year in*

2024 October ya. So, in 2024 for Great Eastern, there will be two batches of increase. One is starting effective July 1st, and the other one effective October 1st. I think you will be in this two.

So, according to Bank Negara yes, you enjoy the 10 percent. You enjoy the 10 percent going forward. So…

Tuan Sim Tze Tzin [Ahli PAC]: *July also. July batch also? [Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Yes, yes. So, starting from 2025 automatically whatever you pay the 50 percent it will be reduced 10 percent that you are paying. So, for the Great Eastern I do not want to commit on other people. For Great Eastern we make it automatic. Anybody who has bought, who's policy actually experience an increase in 2024 will automatically be reduced to 10 percent.*

…

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *I think YB— YB sorry. Bank Negara instruction is clear that for any repricing happened in 2024 you can— insurance company can decide to approve as and when you receive the request from the policyholders. So, it's up the individual completely to make a decision.*

Like for instance as I'd mentioned to you YB for Great Eastern we have taken the stand to give all. Meaning that we don't wait for people to come in because we also like what you have mentioned it could be probably for people who does not hear about it if they don't come in subsequently if they come in to us, I think it is easy for us to match by giving to everybody. So, we are. As I said I'm only speaking on behalf of Great Eastern.

Tuan Sim Tze Tzin [Ahli PAC]: *The issue on lower band and also the— what you call surrender, not surrender one, yes the people who surrender recontinue.*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *People who surrender YB, this is a little bit tricky where sometimes when people surrender it is not because they are not, they can't afford it. Sometimes they— they just think that they do not want it anymore.*

So, we just want to make sure that the person who come back actually come back and say I surrender because of the increase and I can't afford it. For this group of people, we will immediately reinstate. Not an issue.

But there are people who are actually that every year they were people who come and surrender and said I don't need. I prefer self-insured. I don't mind to go to general hospital. The price again it is a reason why they surrender. So, we just want to clarify that instead of immediately reinstate them and then they say I do not want it, you know. Why are you reinstating me? So, we are making it very clear. So, for us with the policyholders our communication has to be very clear. That is actually

very upfront from Bank Negara to ask as well. Most importantly is communication to them.

Tuan Sim Tze Tzin [Ahli PAC]: *60 years old, 60 years old lowest band. [Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Yes, 60 years old I think if I'm not wrong there is Bank Negara is also talking about lowest band. Again, this is for Great Eastern.*

Great Eastern for 60 years and above we have checked you know. Actually 50 or 50 percent of 60 years and above actually enjoy that one-year waiver which means you know 60 percent, 50 percent of whole block of 60 years old are actually in the lowest. It's not the lowest plan.

It's actually in one plan which is at the lowest category that like room and board which RM100 room and board. So, 50 percent of them do enjoy.

Tuan Sim Tze Tzin [Ahli PAC]: *I think the issue here is that the Prime Minister announced it in the Parliament and it doesn't look good if the people out there and see there is a discrepancy okay, of only the lowest band is being given. I think that has to be addressed.*

It looks very, very bad. Of course, I don't know the final ruling by Bank Negara but I think that is not right. If let's say 60 percent moratorium them moratorium-lah. Only one year what? Right. Okay.

Okay another issue I want to raise is about these new plans of RM10 millions, big new plans which I think most of the people only claim up to RM100,000. If let's say people who are— you need RM5 million, RM10 million, unlimited claim I think it's unrepairable that person, okay.

So, mostly we go into hospital less than 100 percent. I would say 95, 99 percentile. So, why are insurance companies still giving that kind of thing? Then, this has actually added to the cost inflation.

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *YB, can I just explain a bit on this. In fact, every year we are scanning the market and do a lot of survey on consumer needs for instance. I think today, just over the last few months…*

...

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Oh sorry. Ya, it's on. Can you hear me? Over the last few months, when we have this more than, let's say five million, eight million, it's additional rider to what the plan, the basic plan that you have. So, we don't actually just put into the basic plan, which means we created another rider for those people who really needed it, would buy that plan. So, whatever claim experience that is experience, it's only for that group of people who decide to buy more.*

Just I'd like to let you know YB today, I tell you it's very sad to see where cancer claims for instance, over the last few months. I've seen a lot of cases where the claims come in per admission is over a million dollar. Particularly, cancer. So, they're in the ICU for 60 days, you can calculate and I've to sign it you know, over— and to be fair, we received a lot of appreciation from this type of policyholders to come in and tell us it is insurance company that give them a chance to live, you see.

So, there are people who needed these things and going— you know, from now onwards you can see, the treatment cost it's going to up a lot. In order for them to get good treatment, yeah if you have only RM300,000, RM200,000, it is insufficient YB. So, we are saying that it's only for those who truly needed it. So, we don't force into one plan, you know. So, they have to that add on a rider and the claims experience would be calculated based on that group of people. So, it's don't affect the basic plan group.

So, again we are reviewing this every year and the treatment has becoming very sophisticated and there's a lot of new needs from the policyholders.

...

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *YB, this is again you are perfectly right. This is one of the issues where a pool become unsustainable because the healthy life are moving away. Something this healthy life don't move away from my company, there're actually move away to other company.*

So, it is something that is happening which I always say that it becomes the right of the healthy policyholder. Then, they have a choice to then shop around for the best policy they think— may not be in the same company.

If we look it into our experience, each time when we do repricing, there're only about two to three percent of them actually leave the pool and these two to three percent of them, though it is not much but as you have rightly mentioned, small number are actually people who does not want buy anymore but larger amount of people are healthy life and say "hey, I have a choice, I will shop around" and there's where in Mark's presentation the repricing cycle actually makes a lot of different.

Meaning that, you see the Great Eastern reprice today and another company does not reprice. They thought it is cheaper over there and they buy. But, when their repricing cycle happens, they would say, how come mine also increase. So, one of the things which we experience today is repricing cycle. So, how do we then be able to let the policyholders know to compare what are they're paying when compare to other insurance company."

[Muka surat 49 - 54, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

iii. Penjelasan KPE Prudential Assurance Malaysia Berhad

Encik Lim Eng Seong [KPE Prudential Assurance Malaysia Berhad] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan syarikatnya belum melaksanakan sebarang kenaikan premium bagi tahun 2024. Beliau turut memaklumkan bahawa dasar kenaikan maksimum 10% seperti yang ditetapkan oleh BNM hanya akan dilaksanakan secara prospektif, iaitu bermula pada Mac 2025.

> ***"Encik Lim Eng Seong [Prudential Assurance Malaysia Berhad]:*** *YB, I can go first. I think for us we have yet to implement it but in short yes, we are applying it forward not backwards. So, we have not…*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *Only January 15th and onwards? [Bercakap tanpa menggunakan pembesar suara]*
>
> ***Encik Lim Eng Seong [Prudential Assurance Malaysia Berhad]:*** *Yes.*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *On 1st March onwards?*
>
> ***Encik Lim Eng Seong [Prudential Assurance Malaysia Berhad]:*** *Yes, because we have not done a repricing for medical inflation in 2024. So, we are applying the 10 percent January 2015 onwards. In fact, to be precise is March 2015 onwards.."*
>
> [Muka surat 49, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

iv. Penjelasan KPE Allianz Malaysia Berhad

Encik Charles Ong [KPE Allianz Malaysia Berhad] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa bagi Allianz Malaysia Berhad, semua polisi bermula Januari 2025 akan tertakluk kepada kenaikan 10 peratus. *Repricing* telah dilakukan pada 2024, dan syarikat memberi peluang kepada semua pelanggan untuk memohon pengurangan. Langkah ini diumumkan secara terbuka supaya semua pemegang polisi mengetahui dan tiada yang tertinggal.

> ***"Encik Charles Ong [Allianz Malaysia Berhad]:*** *YB, for Alliance we are also prospective. So. All the 2025 January onwards, it will be all subject to 10 percent increase.*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *Did you do a reprising in 2024? [Bercakap tanpa menggunakan pembesar suara]*

Encik Charles Ong [Allianz Malaysia Berhad]: *Yes, we do a reprising in 2024. For those blocks, all customers they can actually come back and apply and then we will actually grant them the…*

Tuan Sim Tze Tzin [Ahli PAC]: *That is not fair to the people who didn't come back to you.*

Encik Charles Ong [Allianz Malaysia Berhad]: *No, we make it public, we make to all. They know that this is…"*

[Muka surat 50, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.3.2 Mekanisme Penetapan Premium

Mekanisme pasaran bebas gagal menyediakan harga yang stabil dalam sektor kesihatan kerana sifat inflasi perubatan yang sentiasa melebihi inflasi umum. Oleh yang demikian perlu ada mekanisme penstabilan harga seperti dana penyamaan risiko atau kawalan harga input iaitu caj hospital untuk memutuskan rantaian kenaikan premium yang tidak terkawal.

i. <u>Penjelasan Pengerusi, Allianz Malaysia Berhad</u>

Encik Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa premium insurans dipengaruhi oleh kos tuntutan (*cost of claims*) dan inflasi perubatan, justeru ia lazimnya meningkat. Kenaikan premium bukan kerana kehendak syarikat, tetapi merupakan hakikat industri insurans secara global. Beliau menegaskan bahawa walaupun terdapat isu kenaikan premium, permintaan orang ramai untuk membeli insurans tidak terjejas.

"Encik Zakri Mohd Khir [Allianz]: *Banyak soalan itu. Saya buat satu-satulah. Macam mana kita calculate premium. Kita— ia punya influence dia cost of claim. Maknanya kalau peningkatan insurans kesihatan inflation, then premium akan naik lazimnya. Kecuali ada golongan-golongan nyawa yang baharu masuk dalam kita punya pool of life, then mungkin dia akan ini— Ss, memang merata dunia sama macam itu. Itu memang hakikatnya insurans premium akan naik. Bukan kita nak tapi memang hakikat ia macam itu. Okey.*

...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Based on the current situations, what is the response like among the people yang nak beli*

insurans ni? Sebab dah dengar macam-macam isu kenaikan ini, ada apa-apa kesan terjejas tak?

Encik Zakri Mohd Khir [Allianz]: *Demand tak terjejas.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Tak terjejas?*

Encik Zakri Mohd Khir [Allianz]: *Tak terjejas."*

[Muka surat 55 - 57, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. <u>Penjelasan Ketua Jabatan, Jabatan Penyelidikan, Pembangunan dan Inovasi Universiti Malaya]</u>

Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya] dalam Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025 menjelaskan bahawa kenaikan premium insurans kesihatan adalah kebimbangan global dan bukan hanya di Malaysia. Jumlah premium yang dibayar penting kerana ia mempengaruhi kebolehmampuan (*affordability*), kebolehcapaian (*accessibility*), dan perlindungan kewangan untuk mendapatkan perkhidmatan kesihatan. Oleh itu, pembaharuan diperlukan untuk memastikan perlindungan kesihatan yang mampan. Faktor penyebab kenaikan premium adalah seperti berikut:

a. Peningkatan Kos Perubatan dan Inflasi
   Ini disebabkan oleh kenaikan kos ubat-ubatan, kemajuan teknologi rawatan, dan peningkatan permintaan untuk perkhidmatan kesihatan.
b. Peningkatan Penyakit:
   Pertambahan populasi yang menua dan peningkatan bilangan kes penyakit kronik yang disebabkan gaya hidup tidak sihat, penyakit tidak berjangkit yang tinggi seperti kanser dan kesihatan mental serta lain-lain penyakit berjangkit.
c. Perbelanjaan Pentadbiran dan Operasi
   Syarikat insurans kesihatan menanggung kos operasi dan pentadbiran yang besar.
d. Ketidakcekapan Pengumpulan Risiko (*Risk-Pooling Inefficiencies*) dalam Insurans Swasta

Premium insurans swasta ditentukan berdasarkan risiko individu di mana lebih tinggi jika individu mempunyai penyakit, berbeza dengan insurans sosial yang menggunakan penarafan komuniti (*community rating*) di mana sumber dan beban penyakit dikongsi.

"Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya]: *... We understand that there is rising of health insurance premiums. A global concern, this is not an isolated case yang berlaku di Malaysia tetapi juga di merata dunialah. And then— and adalah satu perkara yang penting berkenaan dengan health insurance premium ini kerana harga ataupun bayaran jumlah premium yang kita bayar adalah merupakan satu faktor yang akan melibatkan affordability, accessibility dan juga financial protection especially to the people when they need healthcare services. And therefore, there is a need for us to reform in order for us to ensure sustainable have coverage.*

Next, please. So, what are the factors that increase the health insurance premium? Okay, we understand on the rising medical cost and inflation and the rise in medical cost is of so many cases ataupun reasons, among which is the increase in the cost of drugs, okay. The advancement in technology for treatment and of course, the increase in the demand for healthcare services especially for ageing population and kita tahu that the prevalence of chronic diseases semakin meningkat di negara kita disebabkan tabiat ataupun cara hidup yang tidak sihat. And you have also to understand negara kita sebenarnya masih lagi struggling dengan penyakit-berjangkit. Okey sekarang ditambah pula dengan prevalence penyakit tidak berjangkit yang sangat tinggi especially with regards to cancer dan juga mental health, okay.

Premium ini pun terpaksa dinaikkan oleh para health insurance company ataupun pemberi because of administrative and operational expenses. We know that there is a huge administrative and operational expense incurred for them to run their business ataupun to offer health insurance.

And most importantly, there is risk-pooling inefficiencies in private insurance because private insurance ini dia premiumnya adalah berdasarkan kepada individual risk rather than community rating. Bermakna jika you ada penyakit ataupun ada masalah kesihatan, premium insurans yang you perlu bayar adalah lebih tinggi. Sedangkan kalau community rating seperti di dalam social insurance, kita share the resources and kita share the burden of diseases…"

[Muka surat 5 - 6, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

7.3.3 *Risk Pooling*

Penyatuan kumpulan risiko adalah kunci kelestarian. Segmentasi risiko yang berlebihan pada masa kini hanya menguntungkan syarikat dalam jangka pendek tetapi merosakkan pasaran jangka panjang.

BNM perlu memandatkan penyertaan dalam kumpulan risiko nasional untuk produk asas sebagai syarat lesen operasi, demi kepentingan nasional.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor Bank Negara Malaysia] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa BNM akan menambah baik sistem *risk pooling* insurans bagi mengatasi masalah kenaikan premium yang tidak seimbang. Beliau menyatakan bahawa majoriti pemegang polisi mengalami kenaikan premium di bawah 40%, dan hanya sebilangan kecil melebihi angka itu. Sekiranya ada aduan, beliau menyeru agar individu terbabit tampil kepada BNM untuk siasatan dan penyelesaian. Contohnya, kes pesakit kanser yang mengadu kepada BNM telah berjaya diselesaikan.

Beliau juga menegaskan bahawa BNM akan menyemak lebih teliti semua data yang dibekalkan oleh syarikat insurans dan tidak akan membenarkan ketidakadilan berlaku. BNM berhasrat menjadikan sistem insurans lebih inklusif supaya mampu dinikmati oleh semua rakyat Malaysia dan pada masa yang sama menggalakkan golongan muda membeli insurans, bagi mengurangkan tekanan kepada sistem kesihatan awam.

> ***"Tuan Sim Tze Tzin [Ahli PAC]:*** *Kalau boleh saya nak buat sedikit soalan tambahan. Contohnya saya nampak dekat sini, saya dalam kategori 40 hingga 49. You see that is still quite flat on that score. Tetapi pengalaman saya adalah saya dikenakan 50 peratus my premium naik sebanyak 50 peratus. Is it fair?*
>
> *I don't think it's fair to me because I feel that based on your graph, it's still quite flat. The worse is the people who are 60 and above. They're pesara. Saya rasa adalah insurance company is forcing them out to surrender because they don't want to take that kind of cases. Okay.*

Satu lagi ialah isu pooling. Pool mereka. Saya difahamkan syarikat-syarikat insurans ia banyak pool. They're created the new product; they're create one pool. So, pool yang lama itu ia tak ada orang baru masuk. Maka premium mereka akan naik.

Jadi isu adalah the structure of their product dan mereka ini sebab mereka nak bersaing, dia nak market shares dan sebagainya dia create all kinds of new product to get market share.

Saya rasa itu adalah sesuatu yang tidak sihat. Maka apakah mekanisme atau intervensi daripada Bank Negara to consolidate those pools sebab saya rasa ini adalah satu ketidakadilan. It's a great injustice to those people who have been loyal to the company for so long and they're just let them— they just want to kick them out.

What kind of company is this? [Dicelah] It's the heartless. To me, it's heartless ya. Jadi minta pandangan.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Terima kasih Yang Berhormat. I think atas pandangan tersebut apabila kita kaji semula dari segi risk pooling, so that is one of the area di mana kita akan menambahbaikkan. Saya ambil maklum, data yang dikongsi oleh Yang Berhormat tadi in terms of seorang yang berumur atas 49 hingga 50 tahun, so saya rasa dengan kajian semula di atas risk pooling ini kita akan dapat menangani masalah-masalah sebegini, pertama.*

Keduanya Yang Berhormat, saya juga ingin menyentuh tadi dari segi kenaikan sebenarnya premium oleh pemegang-pemegang polisi ini kebanyakan daripada mereka mengalami kenaikan di bawah 40 peratus sebenarnya. Kalau ada yang lebih 40 peratus adalah mungkin merupakan golongan minoriti. Di sini, saya ingin menyarankan kalau boleh mereka datang ke Bank Negara Malaysia to our LINK dan kita akan melihat secara rapi apakah masalah yang dihadapi and then kenapa mereka dikenakan premium yang melebihi apa yang sepatutnya.

Kalau kita tengok Yang Berhormat tadi dari segi peratusan peningkatan lebih 90 peratus mengalami tuntutan tidak lebih daripada 40 peratus. Lebih daripada 60 peratus ataupun 61 peratus mengalami kenaikan kurang daripada 20 peratus. Sekiranya ada yang lebih daripada itu mungkin daripada golongan minoriti tersebut dan mungkin ada sebab-sebab tertentu. Di sini kalau kita ada maklumat yang penuh kita akan dapat melihat dengan sebenarnya.

Contohnya, Yang Berhormat mentioned tadi ada cancer patient itu. Dia pun telah datang berjumpa dengan Bank Negara dan kami telah berjaya menyelesaikan masalah pesakit tersebut. Di sini kita perlukan kerjasama dan juga bantuan daripada Ahli Yang Berhormat sekalian sekiranya ada mana-mana pihak yang rasa tertindas ataupun tidak adil, kami memang mengalu-alukan supaya mereka datang dan kita dapat tahu apakah masalahnya dan kita akan cari jalan penyelesaian. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: *Minta maaf ya Dato'. Saya rasa data yang diberikan oleh syarikat insurans, they are giving you a general view which I think is*

may not be the real case sebabnya kita tahu semuanya bell curve yang extreme cases manning ada. Tetapi generally, saya rasa katakan— tadi saya katakan because apa yang pengalaman saya adalah dia bagi satu chart, very clear chart umur berapa, increase how many percent, umur berapa increase how many percent dan saya masih ada chart tersebut. Nanti saya boleh hantar. Tetapi generally 30 peratus hingga 70 peratus the increase.

For a normal— saya di tengah-tengahlah ya, 40 to 49 dia naik 50 percent. Saya rasa bukan minority, actually its majority. This is a big demographic who is paying for this. So, I think the insurance company is not telling the truth to Bank Negara ya. Saya haraplah Bank Negara go deep into this because we cannot allow them to tell you one thing and do another ya.

How about the pool itu? Bagaimana Bank Negara boleh reformasikan pool supaya dia tidak menindas orang-orang yang susah dan loyal kepada syarikat?

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Okey, pertamanya dari segi maklumat berkenaan dengan minoriti tadi itu, kami akan lihat, kami akan pastikan kami akan lebih lagi— kami telah pun, kami akan lebih lagi meneliti segala data yang diberikan oleh ITO kepada kami. Pada masa ini, memang kita validate all the data that is given by the insurance company, dengan izin dan kami akan teruskan usaha ini. Biar saya jemput Datuk Jessica untuk menambah sikit lagi berkenaan dengan cara bagaimana kita hendak mengkaji semula risk pooling.*

...

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Kita juga ingin mencapai matlamat being inclusive supaya produk insurans ini dapat dinikmati oleh semua rakyat di Malaysia ini. Kita ingin juga menggalakkan golongan yang muda untuk mula membeli insurans, kerana apa? Kerana kita tidak mahu memberi pressure ataupun tekanan ke atas kesihatan kerajaan, awam."*

[Muka surat 13 - 16, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

ii. <u>Penjelasan Timbalan Gabenor BNM</u>

Datuk Jessica Chew Cheng Lian [Timbalan Gabenor] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa premium insurans ditentukan berdasarkan konsep *risk-pooling*, iaitu kutipan premium digunakan untuk membayar tuntutan semasa dan bukan untuk mendahulukan tuntutan masa depan. Oleh itu, apabila umur meningkat, tuntutan kesihatan turut meningkat dengan ketara, menyebabkan premium juga naik.

Beliau turut menyentuh cadangan penggunaan sistem *community rating* (kadar rata bagi semua), namun menjelaskan ia hanya boleh dilaksanakan jika

terdapat skala yang besar. Jika tidak, individu muda dan sihat akan dikenakan premium tinggi, sekali gus mendorong mereka menjauhi pembelian insurans. Justeru, produk MHIT asas yang dirancang akan memberi skala lebih besar dan membantu mengimbangi pelarasan premium agar lebih mampan dan adil untuk semua.

> ***"Datuk Jessica Chew Cheng Lian [Bank Negara Malaysia]:*** *... Izinkan saya untuk menjelaskan serba sedikit mengenai penetapan premium berdasarkan umur itu Yang Berhormat tanya tadi.*
>
> *Jadi kalau kita tengok slaid ini. [Merujuk kepada pembentangan slaid]. Yang sebelah kanan ini kamu boleh perhatikan itu trend tuntutan mengikut umur. Jadi bagi jurang-jurang umur yang lebih tinggi memang nampak trend itu ketara. Ia nak secara ketara.*
>
> *So, berdasarkan konsep risk-pooling ini sebenarnya premium yang dikumpulkan adalah untuk membayar tuntutan bukan untuk pre-fund, future claims. Ia bagi membayar tuntutan pengalaman sekarang, masa kini untuk risk pool itu. Jadi bila kita ikut trend ini kalau umur naik memang tuntutan makin tinggi. Jadi ini akan menyebabkan premium yang dikumpulkan itu pelarasan akan dinaikkan sedikit juga.*
>
> *Ada opsyen juga seperti yang ada pihak telah ketengahkan opsyen untuk apa dipanggil community rating jadi flat rate untuk semua. Ini memerlukan skala yang besar. Itu yang sebab itu kita nak pursue produk asas ini. Sebab kalau ada skala mungkin boleh moderate premium kepada semua pemegang polisi. Kalau tidak, kalau kita menetapkan premium yang rata untuk semua pemegang polisi, ada kemungkinan yang muda yang sihat juga akan mengalami premium yang sangat tinggi.*
>
> *Kalau macam itu kita akan mengelakkan daripada membeli insurans pula. Itu juga menjadi masalah. Jadi itu yang masalah yang kita nak tangani sekarang ini untuk mengkaji semula risk-pooling ini dan penting itu produk asas yang akan memberi skala yang besar yang boleh membuka opsyen untuk kita moderate pelarasan premium. Terima kasih."*
>
> [Muka surat 12 - 13, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

Selain itu beliau turut menjelaskan bahawa penyelesaian utama kepada isu kenaikan premium adalah melalui pelaksanaan produk asas insurans kesihatan, yang sedang dibangunkan oleh BNM. Produk asas ini penting untuk mencapai skala besar yang membolehkan risiko diagihkan secara lebih meluas (*risk pooling*), sekaligus mengurangkan lonjakan premium.

Beliau turut memaklumkan bahawa BNM sedang meneliti data sedia ada untuk melihat bagaimana *risk pooling* dapat diperluas lagi dalam kalangan penanggung insurans dan takaful. BNM pernah melaksanakan perluasan parameter risk pooling sebelum ini dan akan cuba lagi melaksanakannya dengan cara yang adil, termasuk mempertimbangkan beban yang ditanggung oleh pemegang polisi muda yang baru memasuki pasaran insurans.

> ***"Datuk Jessica Chew Cheng Lian [BNM]:*** *Terima kasih Gabenor. So, pertama sekali dengan pooling ini kita akan— sebelum itu saya ingin menekankan lagi yang penyelesaian isu ini sebenarnya kita hendaklah melaksanakan itu produk asas yang sedang dibangunkan ini. Itu penting sebab kalau tidak, kita tidak dapat mencapai skala yang besar susah. Macam mana pun kita nak memperluaskan risk pooling, akibatnya kalau kita tengok satu-satu penanggung insurans memang susah nak flatten to curve tadi itu. Jadi pembangunan produk asas itu memang penting.*
>
> *Tetapi bagi risk pooling yang sedia ada sekarang ini dengan penanggung insurans dan takaful, kita akan memperhati— tengok macam mana kita boleh memperluaskan lagi pool itu juga kita boleh spread the risk to more and dampen the premium increase. Itu yang kami sedang melaksanakan sekarang, sedang meneliti data yang Gabenor mentioned tadi. Kita akan tengok— sebenarnya kita sebelum ini pun telah melaksanakan satu kali kita telah memperluaskan risk pooling, parameter risk pooling. So, kita akan cuba sekali lagi tengok macam mana kita boleh membuat ini secara adil. Sebab yang penting juga kita kena adil juga kepada pemegang polisi yang lebih muda yang baru masuk kerja, baru nak beli produk insurans kan. So, itu pun penting. Terima kasih."*
>
> [Muka surat 15, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

Manakala **dalam Prosiding Bil. 5(q)/2025 bertarikh 19 Jun 2025 Datuk Jessica Chew Cheng Lian** turut memaklumkan bahawa "produk asas" akan membolehkan perkongsian risiko (*risk pooling*) dilakukan merentas semua syarikat insurans dan takaful (ITO), berbanding amalan sekarang yang terhad di dalam syarikat masing-masing, bagi mengurangkan tekanan kenaikan premium.

Sementara menunggu produk tersebut dilancarkan, BNM telah melonggarkan peraturan untuk membolehkan syarikat insurans menggabungkan lebih banyak kumpulan risiko bagi meningkatkan fleksibiliti. Aspek keadilan turut diberi perhatian terutamanya bagi pemegang polisi yang memiliki reka bentuk produk yang berbeza.

"Datuk Jesicca Chew Cheng Lian [BNM]: *Kalau saya boleh tambah, YB. Jadi, the base product juga akan membolehkan risk pooling itu merentas syarikat ITO. Itu yang penting sebab sekarang ini all the risk pooling is within the ITO. So, it is a limited pool. So, with the standardized base product, kita boleh risk pool for the whole system and that will really bring down the premium pressure.*

Satu lagi. I think sementara itu— sebab base product belum keluar lagi. Sementara itu, kami juga telah melonggarkan kebolehan untuk syarikat ITO boleh increase the flexibility for them to risk pool sebab kita ada peraturan risk pooling ini sebab also for fairness. Kalau risk pool itu kita campurkan produk-produk yang memang berbeza dari segi design itu, memang it won't be fair for some of those who bought different product. Contohnya, with higher deductibles, sebab mereka akan dikenakan premium yang jauh lebih tinggi.

So, kita ada beberapa peraturan yang cuba ensure fairness across the policy holders. Tapi sekarang kami juga telah melonggarkan itu bagi membolehkan syarikat- ITO boleh pool across- lebih banyak daripada pemegang polisi ini. Terima kasih."

[Muka surat 14, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

7.3.4 Penetapan Premium Mengikut Kumpulan (*Cohort*)

Penetapan premium mengikut kumpulan (*cohort*) membolehkan syarikat memindahkan risiko sepenuhnya kepada kumpulan rentan sambil menawarkan harga murah kepada pelanggan baharu.

BNM perlu mengkaji semula etika penetapan premium mengikut kumpulan dan mungkin mewajibkan *community rating* atau subsidi silang antara *cohort* dalam syarikat yang sama untuk melindungi pemegang polisi lama.

i. <u>Penjelasan KPE Allianz Malaysia Berhad</u>

Encik Charles Ong [KPE Allianz Malaysia Berhad] **dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025** menjelaskan bahawa premium ditentukan berdasarkan kumpulan pelanggan (*cohort*) yang dibentuk mengikut tahun dan manfaat polisi. Kumpulan pelanggan lama menunjukkan peningkatan tuntutan akibat faktor usia dan kekerapan rawatan. Pada tahun 2024, sekitar 20–30% pelanggan perubatan Allianz terlibat dalam pelarasan semula harga (*repricing*).

"Encik Charles Ong [Allianz]: *...Then I'll also want to explain about cohort, okay. Sometimes you ask the industry. Industry will take all the companies 14 conventional players, 11 takaful players they average it out. Then if you see look at Allianz, we actually say that 19.6 percent latter 19.1 percent. 19.6 percent is all my blocks. 19.1 percent was for that particular block, cohort by cohort, okay.*

Those cohort for example, in fact your first question YB Sim, Yang Berhormat, you know you look at 20 years ago I sell this medical then after that the cohorts will go into the new blocks with a better benefit is another cohort.

So, the first cohort it will be close, new cohort. Then of course it continues to have a new cohort because we continue to sell new business, okay. Some cohort can be three, four years depending on the benefits that you want to provide, the group of people you want to put them together.

Of course, the older block of the cohort, 20 years ago, these people are aging, getting older. But they are already in one cohort that they share, okay. This are the claims experience increase in terms of frequency, they go hospital more. The treatment also more expensive.

…

Encik Charles Ong [Allianz]: *Yes, sure. We also want to share is how we price it is based on that particular cohort. In the…*

..

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Can you all of you tell us, Allianz how many percent you increase recently? Great Eastern how many percent you increase recently and all of you. I want to see whether it's consistent or different. That's all.*

...

Encik Charles Ong [Allianz]: *So, in 2024, okay on average, I think is about 20 to 30 percent of my total customer in medical business, they are subject to repricing."*

[Muka surat 67 - 68, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. <u>Penjelasan KPE AIA</u>

Encik Ben Ng Kee Heng [KPE AIA] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa kenaikan premium insurans adalah berbeza mengikut kumpulan, iaitu 25% dan 40%, bergantung kepada tempoh semakan harga. Syarikat insurans memerlukan masa dan modal rizab besar sebelum menjana keuntungan. Beliau juga menyeru kerjasama antara

kerajaan, industri, majikan dan individu dalam memperkukuh perlindungan kesihatan, serta pentingnya pendidikan kewangan dan simpanan peribadi untuk menampung kos perubatan masa depan.

"Encik Ben Ng Kee Heng [AIA]: *Yes. So, for AIA YB, last year we have some cohort again. The quantum is different by cohort. One cohort is at 25 percent and another cohort is at 40 percent. The reason the core at 40 percent is because the product was launched five years ago. So, its hasn't been adjusted the price for a long time. But, its respective right now we all follow Bank Negara interim measure guidelines right now. So of course, the one of the things you know, may I take the opportunity to also talk about 60 years old because many of us here either 60 or going to cross 60 very soon including myself.*

… So, I'll be quite uncomfortable if doctors and hospitals are compromised care because of profit. I hear about the investment that to make into technology and all that, actually not very well known by everyone. Actually, insurance company in January, we don't make money in the first year when we sell a policy. I think the policy, January depending on product could take three to seven years to start to make money for life insurance. Actually, that one actually takes time. These are investments.

The other thing is YB, is all the insurance company have to set aside what we called required capital, reserved and required capital. So, its not like premium is higher than claims, we can straight away take the profit. We…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What is the required capital for AIA?*

Encik Ben Ng Kee Heng [AIA]: *The required capital like in company like AIA is in the billions. So, we have set aside these billions of required capitals. So that one I think is important I thought to be fair to the industry. Actually, we have a long period to you know, to invest as well and we also have to set aside required capital. I just want too also just comment on the OH. Actually recently I because I think insurance product is only one part.*

Actually, I like what EPF did recently. What they tell Malaysian, at ages 55, you need to have RM240,000 savings to retire because you probably going to live another 20 years. So, but RM240,000 is obviously not enough based on the discussion we had and that's how we know even not enough just to cover for the medical costs. So, I think I will say maybe together the industry and the government can look at how we can first, improve on the education…"

[Muka surat 64 - 74, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

iii. Penjelasan KPE Great Eastern Life Assurance (Malaysia) Berhad

Dato Koh Yaw Hui [KPE Great Eastern Life Assurance (Malaysia) Berhad] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa kadar kenaikan premium insurans bagi Great Eastern adalah antara 30% hingga 50% bagi tempoh tiga tahun, bergantung kepada kumpulan (*cohort*) pelanggan dan *claim experience* semasa. Beliau menerangkan bahawa andaian kenaikan ini dibuat berdasarkan kadar tuntutan sedia ada, dan jika kadar tuntutan berjaya dikurangkan melalui rundingan yang lebih berkesan dengan hospital, tempoh kestabilan premium boleh dilanjutkan kepada empat atau lima tahun tanpa perlu penetapan semula harga (*reprice*). Secara purata, kadar kenaikan tahunan dianggarkan sekitar 15% setahun, selaras dengan kadar inflasi semasa dalam sektor kesihatan.

"Dato Koh Yaw Hui [GE]: *For Great Eastern is between 30 to 50 percent. In fact, it depends on different cohorts. If fact for us ya…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The average out the cohort-lah. [Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [GE]: *No, no. It's between 30 to 50 percent as I've said. What is more important here is we have make the assumption on the claims. Yes, on the claim experience.*

If the claim experience over the next three years is able to reduced, then we will— yes, YB. The 30 to 50 percent for us is for the next— when we look at the claim experience that we are experiencing. We are saying that by increase 30 to 50 percent in the next three years I don't need reprice anymore.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [GE]: *So, if today if our negotiation with the hospital for instant is effective. If we are able to bring the claim experience down then we be able to extend the three years to four years and five years.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, is not...*

Dato Koh Yaw Hui [GE]: *The next five years you don't need to reprice.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *It is not per year-lah, not per year-lah.*

Dato Koh Yaw Hui [GE]: *No, no, no. This is stable for year.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What about AIA, AIA?*

Dato Koh Yaw Hui [GE]: *It's stable for a year. Is 30 to 50 percent.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Is two three years.*

Dato Koh Yaw Hui [GE]: *For three years and that depends very much because we have made the claim experience assumption.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, about 15 percent per year average.*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Ya, it's about 15 percent. There about— close to the which is very close to our current inflation.*

[Muka surat 64 - 74, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.3.5 Kenaikan Premium Bersifat Multi-Tahun

Model penetapan harga berkala (*cyclical repricing*) mencipta kejutan kewangan kepada pengguna.

Peralihan kepada pelarasan tahunan yang lebih kecil dan stabil (*incremental annual repricing*) adalah lebih mesra pengguna dan mengurangkan kejutan kewangan.

i. <u>Penjelasan KPE LIAM</u>

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa subsidi silang dalam insurans berlaku di peringkat dana pemegang saham, bukan antara dana insurans secara langsung, kerana setiap dana perlu kekal mampan menurut Akta Perkhidmatan Kewangan 2013 (FSA). Walaupun komitmen telah dibuat bersama Bank Negara Malaysia untuk mengehadkan kenaikan premium tidak melebihi 10%, inflasi perubatan dijangka kekal tinggi disebabkan kos rawatan, pergantungan luar negara, dan penuaan penduduk. Justeru, kenaikan premium yang tinggi (sehingga 40–50%) sebenarnya mencerminkan pelarasan untuk beberapa tahun, bukan setiap tahun. Namun begitu, tiada jaminan kadar premium akan menurun sekiranya inflasi berkurang pada masa hadapan.

"Encik Mark Steven O'dell [LIAM]: *Thank you, YB. On the issue of the cross-subsidy, actually all the profits from all the funds there are all aggregated together in the shareholders fund. So, when the cross-subsidies the money that I just mentioned the RM45 billion all come from shareholders, they come from the shareholders' fund.*

That fund is an aggregated of the profit that comes from each of the individual funds. What I meant to say maybe I didn't say it clearly is that each of the fund themselves have to be sustainable on their own. That is part of the FSA. But the subsidy and it has come and companies, they have come up and make commitments and have agreed with Bank Negara to put up, to hold the increases to not more than 10 percent and that adds up to sizeable amount of money.

When you talk about inflation, when things go up, when things go down. I was told and I believe that basically medical inflation I don't think we are ever going to see it go down, honestly. You know when you look at the investment and treatment, you look at the way the Malaysians have to buy overseas. When you look at the health of the population, the aging population, I think there will always be a core medical inflation rate that we are going to have to deal with. It's just my opinion.

Tuan Sim Tze Tzin [Ahli PAC]: *No, what I mean is that now the medical inflation, according to Bank Negara is about 10 percent, okay. Then, but your insurance premium goes up 40, 50 percent, alright. So, one day it might go down to eight percent or seven percent inflation. So, will you revise your 50 percent down to 20 percent, maybe 10?*

Encik Mark Steven O'dell [LIAM]: *Of course, the insurance will make their judgement on what the inflation trend is. When we talk about 40 percent this is also a little bit of misunderstood. Those are almost always multiyear increases you know, in insurance company will— and the practice varies. Some of them may raise their premium every year, some may raise their premium every three to four years. If somebody is coming up with the 40 percent increases not for one year, is for multiple years looking ahead and they hope they can keep that premium at that level for several years going forward."*

[Muka surat 26 - 28, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. <u>Penjelasan NAMLIFA</u>

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa kenaikan premium insurans perubatan bukan perkara baru, bermula pada 2020 tetapi ditangguhkan setahun akibat pandemik dan bermula semula pada 2021. Pelbagai perbincangan telah dijalankan dengan BNM dan LIAM untuk memastikan kenaikan premium lebih lestari. BNM juga mengeluarkan polisi pada 2024 yang mewajibkan ciri *co-payment* dalam produk insurans baru, menyebabkan

kenaikan premium berterusan sejak 2021 hingga kini. Terdapat langkah interim *capping* kenaikan maksimum 10% setahun sehingga 2026, namun ketidakpastian tetap wujud selepas 2026, memberi kesan kepada pengguna dan syarikat insurans yang sukar meramal keadaan masa depan.

"Encik G Saseedaran Gengadharan [NAMLIFA]: *Dalam kami punya pembentangan ini yang kami kongsi dengan semua. [Sambil menunjukkan senaskhah dokumen] Memang dia telah cerita perkara ini. Tetapi, biar saya recap balik di sini ya.*

Cerita repricing ataupun kenaikan premium ini bukan baharu. Ia bermula pada tahun sepatutnya kenaikan asal dia pada 2020 dan disebabkan pandemik, Bank Negara memutuskan untuk menangguhkan kenaikan ini selama setahun iaitu dia hanya boleh tangguh selama setahun. Dia bermula pada 2021 dan sebelum itu, kami sudah pun ada banyak siri-siri engagement dengan Bank Negara dan juga Persatuan Insurans Hayat iaitu LIAM berkenaan dengan kenaikan ini dan sudah pun menyuarakan apa yang kami sedang suarakan di sini masa itu pun. Di mana, sustainability untuk premium insurans itu dia kena pastikan tidak akan berulang lagi lah dia punya kenaikan itu.

Tetapi selepas itu, Bank Negara mengeluarkan satu polisi dokumen. Polisi dokumen for medical health insurance dan takaful. So, di dalam polisi dokumen itu, banyak perkara yang telah dijelaskan dan juga Bank Negara sarankan bermula 1 September 2024, produk-produk medical yang baharu itu mesti ada ciri-ciri perkongsian ataupun co-payment. Co-sharing bermaksud syarikat insurans akan membayar satu jumlah dan baki yang ada satu had yang kurang lah, pelanggan kena bayar. Dia kena tanggung. Co-sharing. So, sudah melaksanakan langkah ini, syarikat-syarikat insurans takaful terus menaikkan premium sekali lagi pada tahun 2024 hari itu dan kenaikan ini bukan bermula pada 2024. Dia bermula sejak 2021. Dia 2021 dia naik sikit. 2022 dia naik sikit. Lepas itu, 2023 kenaikan dia mungkin dia tunggu sebentar. 2024 naik balik.

Jadi, bila kita kata tentang ketidakpastian ini, baik sekarang ini sudah ada langkah-langkah interim yang bagi orang kata capping sebanyak 10 peratus satu kenaikan setiap tahun sehingga 2026. Okey, jadi sekarang ini maklum balas yang kita terima daripada kami punya pelanggan-pelanggan kami. Bayangkan 120,000 orang kalau seorang itu ada 10 pelanggan macam mana? [Ketawa] So, daripada pelbagai lapisan.

Ketidakpastian dia ialah baik, sekarang saya boleh tahan sehingga 2026, bagaimana pula 2027? Jadi, ketidakpastian ini sebenarnya oleh semua pihak dan syarikat-syarikat insurans juga tidak boleh memberikan sebarang unjuran apakah yang akan berlaku 2027 ke atas itu.

Jadi, ini satu feedback yang kita kena bagi tahu di sini akan the uncertainty ataupun ketidakpastian yang sedang dialami oleh rakyat di luar sana."

[Muka surat 6 - 7, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

iii. <u>Penjelasan Ketua Serantau Kesihatan Asia Tenggara Munich Reinsurance Company</u>

Puan Catherine Love Soper [Ketua Serantau Kesihatan Asia Tenggara, Munich Reinsurance Company] dalam Prosiding Bil. 5(s) bertarikh 14 Ogos 2025 menjelaskan bahawa kenaikan mendadak tersebut bukanlah satu tindakan mengambil keuntungan, sebaliknya ia berpunca daripada kegagalan menyelaraskan kadar premium semasa tempoh COVID-19. Menurut beliau, kelewatan pelarasan selama satu atau dua tahun menyebabkan magnitud kenaikan terkumpul menjadi sangat besar pada tahun ketiga (mencapai 75 hingga 78 peratus) bagi menampung margin bersih yang negatif. Beliau menegaskan bahawa pihak Munich Re sendiri mengalami kerugian margin bersih yang besar bagi tahun 2022 hingga 2024, yang membuktikan bahawa syarikat tidak mengambil kesempatan daripada situasi tersebut.

> ***"Tuan Sim Tze Tzin [Ahli PAC]:*** *So, does it mean that it is fair for us 75 percent because of 2023 percent. So, my question is insurance company taking advantage of this repricing to make their profit?*
>
> ***Puan Catherine Love Soper [Munich Re]:*** *It's a very good question. The answer is not, hopefully this table will address your question which is that in year one, the net negative margin was small and a small rate rise would have done the job. However, during COVID-19, people tend not to reprice, very understandable reason. And if you can see from the table, if you miss one or two years of rate rises, there's 75 or 78 in year three.*
>
> *So, that magnitude of rate rise is in line with my calculation here and is in line with a kind of experience we're seeing. So again, going back to path the graph on slide 15, if that so, okay. This again hopefully demonstrates that we won't be taking advantage, we, ourselves experience negative, pretty large negative net margins in those — in fact all three years 22, 23 and 24."*
>
> [Muka surat 13, Laporan Prosiding Bil 5(s)/2025 bertarikh 14 Ogos 2025]

7.4 Struktur Kos Hospital Swasta

Sektor hospital swasta mempertahankan kedudukan mereka sebagai entiti perniagaan yang berhadapan dengan kos operasi tinggi dan margin keuntungan yang sederhana.

Penjelasan Setiausaha APHM

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(h)/2025 bertarikh 10 Mac 2025 menjelaskan bahawa margin keuntungan sebelum cukai (PBT) hospital swasta adalah tipis dan munasabah, iaitu sekitar 14% daripada hasil, yang mana lebih rendah berbanding purata industri penjagaan kesihatan Malaysia (16%) dan sektor sokongan berkaitan seperti insurans, farmasi, dan syarikat teknologi perubatan.

Struktur kos hospital sangat didominasi oleh perbelanjaan operasi, di mana lebih 60% daripada hasil digunakan untuk kos langsung (bahan habis pakai, ubat-ubatan) dan kos kakitangan (gaji). Selain itu, hospital swasta mempunyai tahap pelaburan semula yang sangat tinggi iaitu hampir 9.5% daripada hasil akan dilaburkan semula kerana sifat industri penjagaan kesihatan memerlukan perbelanjaan modal yang besar dan berterusan.

Oleh itu, APHM berpendapat bahawa hospital swasta sebenarnya berada di tahap keuntungan yang lebih rendah dalam ekosistem penjagaan kesihatan Malaysia, kerana sebahagian besar keuntungan selepas cukai mereka digunakan untuk menampung kos operasi yang tinggi dan keperluan pelaburan semula kritikal ini.

> ***"Encik Anwar Anis bin Anis Ahmad [The Association of Private Hospitals of Malaysia (APHM)]: ...*** *So, perhaps the first item that we would like to share is about the levels of profitability in the private hospitals because sometimes, I think our understanding of what profit is could be very different and we are not saying either one is right or wrong but we certainly would like to explain and share what is a profitability in private hospitals.*
>
> *So, from our study that we've done among the members hospitals and this study was undertaken by a third party is that our profit margin is actually quite slim and reasonable if you can say. Of course that can be argued whether it is [Tidak jelas] but 60 plus percent of the cost actually is direct cost and staff cost.*
>
> *So, if you look at the chart itself, the waterfall chart. [Merujuk pada pembentangan slaid] It starts from the left-hand. For every RM1,000 of revenue generated in the hospital, firstly we deduct the discounts that are already been given. So, on average based on our study, discounts from hospitals are about 10 percent. These are discounts to insurers, TPAs and others. And this discount is from hospital chargers. Typically, the discount is not from doctors' fees.*

And then the next item in the waterfall chart is the doctors or the consultant fees. So, that is about 155. So, once we take away discount and the doctors' fees, we arrive at let's say a revenue unit of 1000. So, we are using the 1000 units to explain to you what the other cost structure between the hospitals.

Firstly, is direct cost. What we do mean by direct cost? That mean the patient is admitted and use sutures, you use consumables and operating theater, medication, all of this are direct cost. These are costs that we have to buy and we have to pay to the suppliers as we provide care to the patient. So that about 318.

Next is staff cost at an average of about 312. So, both of this is where we say over 60 percent of our cost is direct cost. Next is administrative and other expanses which is about 79 units. Then utilities, rent and maintenance another 74 units. Depreciation and amortisation that's 81 units.

Finance cost, we take an average of five units out of the 1,000 and we finally arrive at our operating profit. So, operating profit here we say is 130 out of 1,000, or we can also say it's 13 percent. This excludes expenses related to bad debt write-off and so on ya. *Then from the operating profit, there is some other income. Again, we are being transparent and the hospital sometimes we have rental of space, revenue from carpark. I mean non-healthcare revenue* ya. *So that is about 10 percent and that brings our profit before tax to about 140 out of 1,000, of 14 percent.*

We would like to highlight how that compares to the profit before tax across selected healthcare industries and this is based on 2023 numbers. So, among the participating hospitals, where this study was undertaken by IQVIA, the profit level among participating hospitals in the study was about 14 percent or 13 percent. But private hospital groups, we find that consistent. So, whether it was a study or we look at listed companies and so on, is about 14 percent as well.

So that gives you that consistency between the hospitals that participated in the study, as well as available data publicly among listed entities. However, if you compare that to the industry average in Malaysia for industries in healthcare, that's about 16 percent. So, we are already lower than the average. And then if you compare to other industries which are supporting or part of healthcare in Malaysia, insurance is about 17 percent on average, pharma is about 19 percent.

However, if you only consider the originator companies, right, those who provide high-end original drugs, innovative drugs, their profit before tax is certainly higher between 30 to 40 percent. And then the MedTech or the medical technology companies are about 20 percent. So, what we would like to highlight to the PAC here is really within the various entities who's provide healthcare in Malaysia, hospitals are actually the lower end of profitability. Like we said, we can still argue, masih boleh dipertikaikan sama ada 13 ataupun 14 peratus itu adalah munasabah. *But the reality is, we are the lower end.*

And then the bottom part of the table actually shows you the profit after tax, right. We again, we are between nine to 11 for participating hospitals or 12 percent for private hospital groups. Allow me to elaborate further on the next slide. At the next slide where you can see is that the profit margins have actually— our study shows that is

normalized after COVID-19, right, at about 11 percent and the direct cost is still maintained at about over 60 percent, 63 percent of revenue.

So, this is the same waterfall chart if you include the consultant fee, the direct revenue but what we are spending here is we ended just now, whether the profit before tax was at 140 out of 1,000. Now, after paying the taxes and so on, our profit after tax is close to 11 percent, just shy of 11 percent. But the key important matter here is that from the study itself it shows that our reinvestment level is extremely high in providing private healthcare.

Providing healthcare itself, I think that the same experience within the government hospitals, when you need a lot of investment to ensure that the hospital remains relevant, remains safe, equipments are up to date, ya. So, almost 95 units out of 1,000 is reinvestment. This is a very significant amount that is reinvested. Meaning that on average hospitals retained a small amount of their profit because of the nature of healthcare, where reinvestments are important ya. That does not mean that it is an industry that is not viable but it just shows that the nature of the industry requires reinvestment and we can talk about reinvestment in the latest slides, so if there is a question from PAC itself.

But the reason for reinvestment YB is that, irrespective of when you started your hospital. Of course, when you start a hospital, you incur a lot of capital costs. But in seven or eight years, you do need to refresh your technology. You need to put in additional new technology. You also need to put in a new patient safety initiative. You also need to upkeep your facility, whether it's your medical guests and all this. So that is a lot of reinvestments that need to take place..."

[Muka surat 3 - 6, Laporan Prosiding Bil 5(h)/2025 bertarikh 10 Mac 2025]

7.4.1 Struktur Pengebilan dan Subsidi Silang

Struktur pengebilan hospital swasta di Malaysia pada masa ini disifatkan sebagai kurang ideal kerana gagal mencerminkan kos sebenar perkhidmatan secara telus. Fenomena harga ubat-ubatan yang tinggi hanyalah merupakan manifestasi kepada isu struktur yang lebih besar, iaitu keperluan mendesak untuk menampung kos operasi yang tinggi serta pematuhan terhadap mandat perundangan yang mewajibkan ketersediaan perkhidmatan 24 jam tanpa sebarang subsidi kerajaan. Justeru, selagi model subsidi silang ini dipraktikkan, kekeliruan dalam kalangan masyarakat mengenai ketidaktelusan harga item perubatan akan terus berlarutan.

Penjelasan Setiausaha APHM

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(h)/2025 bertarikh 10 Mac 2025 menjelaskan bahawa struktur pengebilan

hospital swasta di Malaysia adalah tidak ideal tetapi terpaksa wujud sedemikian rupa kerana ia dipengaruhi oleh bagaimana produk insurans dijual dan keperluan hospital untuk melaksanakan subsidi silang (*cross-subsidisation*).

Hospital tidak menyalahkan orang ramai yang mempersoalkan mengapa beberapa item kelihatan mahal, tetapi menegaskan bahawa harga yang tinggi pada item tertentu adalah perlu untuk menampung kos besar yang tidak boleh dicaj secara langsung kepada pesakit. Kos ini termasuk perkhidmatan yang disubsidi (caj wad, ICU dan kejururawatan), kos operasi wajib yang tidak dicaj sama sekali (gaji kakitangan bukan kejururawatan), kos bangunan/sewa dan bil utiliti komersial yang mencecah jutaan ringgit, kos keselamatan siber, serta kos wajib untuk menyediakan perkhidmatan ambulans dan Jabatan Kecemasan 24 jam.

Oleh itu, subsidi silang ini menyebabkan caj item yang boleh dituntut seperti ubat-ubatan dan bekalan perubatan di-*mark-up* bagi memulihkan kerugian daripada item yang disubsidi, yang kemudiannya menimbulkan kekeliruan dalam kalangan pesakit.

> ***"Encik Anwar Anis bin Anis Ahmad [The Association of Private Hospitals of Malaysia (APHM)]:*** *... And what we hoping today is really to share the fact that this is the nature of the healthcare industry. Maybe we move on to the next item. Like I said, we can come back to reinvestment and the need for it. But we want to also share some of the nature of how billing and cost structure is in private hospitals because— and we don't blame anyone, we don't blame the public and others to sometimes asked question as to why certain items or perhaps more expensive than what they can buy themselves, let's say in the pharmacy.*
>
> *But the reason for reinvestment YB is that, irrespective of when you started your hospital. Of course, when you start a hospital, you incur a lot of capital costs. But in seven or eight years, you do need to refresh your technology. You need to put in additional new technology. You also need to put in a new patient safety initiative. You also need to upkeep your facility, whether it's your medical guests and all this. So that is a lot of reinvestments that need to take place.*
>
> *And what we hoping today is really to share the fact that this is the nature of the healthcare industry. Maybe we move on to the next item. Like I said, we can come back to reinvestment and the need for it. But we want to also share some of the nature of how billing and cost structure is in private hospitals because— and we don't blame anyone, we don't blame the public and others to sometimes asked question as to why certain items or perhaps more expensive than what they can buy themselves, let's say in the pharmacy.*

The reality is, the billing and cost structure and private hospitals in Malaysia, which has matured and developed over many years, is perhaps not— is not ideal but has developed in this way because partly of how insurance products are sold and how we need to cross subsidise and we will elaborate on this further. But if you just look at the chart here, what we want to share is, there are three buckets. One is items that appear in the patient's bill and examples of this are the drugs has given medical supplies, rehab, physio charges, operating theatre charges, medical officer fees, doctors' fees.

So, those are things that appear in the patient's bill. The next one in orange, are item that appears in the bill but are actually at the subsidised rate. What it means is we are not charging the actual of full amount for these items, which are in the patient's bills. So, one is ward charges and we'll get into an example for that. ICU, nursing charges and we will give you an example similarly for nursing care and charges that emergency departments and emergency equipment's. So, although these are in the bill, it is not the actual charge or is below the actual cost to us.

But it also a huge amount of items that's not in the bill and these are non-nursing staff costs. We cannot charge for our finance, our IT and so on those, those costs. Allied health staff cost. Again, we cannot charge for the pharmacist, the radiographer. These are the risks we don't reflect in the bill. Building cost and rentals, again, that's not reflected in the bill. Some hospital owns their buildings, some hospitals rent their buildings and again, there's obviously a significant cost to that. But again, that's not reflected in the bill.

General plan and equipment. Hospitals are 24/7 365-day facilities. We have to run our chillers, we have to make sure our operating theatres are at the right humidity, right temperature. All this equipment again, we have to maintain it, we have to make sure it is always available at up and up times is high, while this also not charge, right. Land cost when we developed the place, maintenance and general plan equipment, like I said, not only do we have to have those chillers, humidifiers and so on, but we have to maintain it.

There's also a growing cost for IT and cybersecurity. The PAC may not be aware but actually most hospitals we also received cyber attacks, one thing to get into our electronic medical records and so on. So, over the last five years, we had to invest a lot more into cybersecurity costs because we have to protect our patients' data and so these are again, not reflected in patient's bill. And then utilities, for them are packed. Actually, for a private hospital, we do not receive any concessions whether from TNB or others, we pay the full commercial rates.

And for a large hospital, our utility bill on a monthly basis is RM600,000 to RM700,000 per month or even close to a million for hospitals which are 400 to 500 beds, right. So it's very significant, a million Ringgit a month just on electricity cost alone. So, those items are not in the bill. There's also another list of items which is not in the bills is where we have to provide redundancies and preparedness, and what do we mean by that?

By law, by regulation, hospitals must provide ambulance services whether their own or they have to contract someone. And for every hospital to provide whether small or big,

it is a cost. Our ambulances don't run as regularly as perhaps, ambulance is from KKM or another's but we must provide ambulances. We must provide 24/7, three shifts and those staff costs as well. And also, the equipment and maintenance of both not just ambulance but also other equipment in the emergency department.

So then if we go to the emergency department itself, like I said is 24/7, we have to provide treatment rooms, emergency OT. Again, 24/7, 365, three shifts on staff, staff on call and it is perspective of the volume. This is again dictated by law, it is not by choice. We cannot say that because there are five hospitals in one area. Let's say you know in the middle of KL, we cannot say there only two hospitals provide emergency departments and the rest don't. It is a requirement of KKM and CKAPS requirement that we must provide an emergency department. But does that mean that all emergency departments are busy, all emergency are running that is not the case but we have to, for patient safety and because of regulations.

So, this like we said are redundancies and preparedness costs which is also not reflected in the bill..."

[Muka surat 6 - 8, Laporan Prosiding Bil 5(h)/2025 bertarikh 10 Mac 2025]

7.4.2 Cabaran Pelaksanaan Inisiatif Kesihatan Swasta

Dasar kerajaan yang tidak selaras iaitu mengenakan cukai sambil meminta pengurangan kos telah memberi impak kepada inflasi perubatan.

Pengecualian cukai (SST) untuk sektor kesihatan dan pemudahcara proses pelesenan adalah langkah segera yang boleh diambil kerajaan untuk menurunkan kos operasi hospital.

Penjelasan Setiausaha APHM

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(l)/2025 bertarikh 17 Jun 2025 menjelaskan mengenai cabaran dan kebimbangan sektor kesihatan swasta terhadap pelaksanaan dasar serta kos operasi baharu yang diperkenalkan oleh kerajaan iaitu :

a. Pelaksanaan Produk Insurans MHIT Asas

APHM menekankan cadangan untuk mewujudkan produk insurans kesihatan asas dengan harga siling (*fixed price*). Matlamatnya adalah untuk menjadikan insurans lebih mampu milik, namun beliau memberi amaran agar

penetapan harga murah tidak menjejaskan kualiti rawatan atau pemilihan implan perubatan yang berkualiti rendah.

b. Ketelusan Harga Ubat (*Medicine Price Display*)

Walaupun APHM menyokong paparan harga ubat untuk pesakit luar, terdapat kebimbangan besar mengenai pelaksanaannya bagi pesakit dalam (*inpatient*).

c. Beban Cukai SST dan Impak Kos Operasi

Kebimbangan terhadap pelaksanaan Cukai Jualan dan Perkhidmatan (SST) bagi pesakit asing dan kos operasi hospital yang dijadualkan pada 1 Julai 2025. Tempoh pelaksanaan tersebut terlalu singkat kerana hospital memerlukan masa untuk menaik taraf sistem kewangan yang kompleks. Selain itu, perkara ini juga akan menjejaskan daya saing pelancongan perubatan negara. Pengenaan SST ke atas sewa premis dan kos pembinaan hospital dikhuatiri akan meningkatkan inflasi kos kesihatan yang akhirnya terpaksa ditanggung oleh pesakit.

d. Kerjasama Awam-Industri (*Public-Industry Cooperation*)

Kekurangan sokongan kerajaan dalam memacu penyelidikan dan penggunaan teknologi seperti kecerdasan buatan (AI) dan pengurusan data DRG bersama pihak swasta.

"Encik Anwar Anis bin Anis Ahmad [APHM]:..*These are other initiatives from APHM where we have put in effort and supported the government in 2025 but we also— where we also face some challenges, all right. Here is again where we hope that we can outline some key concerns, where we hope the PAC will be able to take those concerns and help us address it as well.*

So, the first one, basic MHIT at fixed prices. I don't know whether you are aware, it is actually APHM who suggested that we have a basic MHIT product when we met Bank Negara in October last year. So, the suggestion came from APHM because we recognise that the current design of the private insurance, health insurance, does not support us and our doctors in pushing certain decisions and doing certain things.

So, MOH has already started developing the basic MHIT product and we understand that Bank Negara is in fact going to be hiring a consultant to do this work together with MOH and BNM. But we want to clarify that when we launched MHIT, which I think the government has said that they want to launch it, latest by

the middle of next year. That's what we understand in our discussions is that this is not DRG.

Basic MHIT means if we want to have some fixed price or fixed cost or ceiling cost in terms of let's take an example, total new replacement and we want to say that under MHIT, total new replacement is a certain price maximum with of course enough conditions so that we don't compromise patient care. Kita pun tak nak kita bagi harga katakan RM30,000 untuk TKR tapi ada pula doktor dan hospital yang masukkan implan yang sangat murah dalam lima tahun menjadi masalah kepada pesakit. So, we also need the quality to be balanced. This is where we say APHM and the doctors must play a role. Because if we only want to go for the cheapest or set the price, we cannot compromise on quality.

So, this one we need to be part of it but we have not seen any— a lot of discussion between the insurers and us. So, the ITO seems to be reluctant because if you do one product across the whole country and the same for all the insurers and to make it affordable, we must be able to find a way of selling this product in a very efficient way where the cost of selling it is not through expensive agency fees. Because of this, I think there is some discomfort but we need BNM and MoF to really encourage our insurers to push ahead and force to design this MHIT product. So that's number one.

Number two, medicine price display. Even when we came to the PAC the last time, we had said that APHM is committed to maximum price display and we specified that we are supportive to do it in the outpatient setting. And since the announcement by MOH, APHM members, APHM encourage all members to start immediately and we believe that all our members started on the 1st May, displaying outpatient.

There is a three-month grace period. During this grace period, we hope that we can engage MOH to discuss how to really do the inpatient display because we are still very concerned in terms of displaying inpatient pricing. Because this could result to medical legal issues or poor decision making. If a patient decides I don't want a particular drug. Because if you even read the guidelines from MOH is really about giving the patient choice.

For outpatient, very clear. I don't want a medicine from this hospital, I want to buy from the pharmacy, no issues. I don't want medicine A, I can discuss take medicine B but in an inpatient setting, in an emergency, in the ICU, how does the patient decide, "I want that choice"? And these are the things that we've said, we need clear guidelines. We need clear guidelines so that we can protect the doctor. Because the patient says, "Saya tak nak ambil ubat ini", how does a doctor in a hospital protect themselves from a medical legal perspective? How do we make sure the patient has good clinical outcomes? And we are waiting for the government to come back to us in terms of discussing the issues related to the inpatient medicine price display.

The fourth one— the third one, sorry. Sales and Service Tax. This has come to us as a surprise because we've not really had a lot engagement who we had one engagement with customs in December last year, where it was an open discussion. There was no direction given in terms of what the sales tax would be. But this was

announced last week and the implementation timeline or effective date is 1st July. I hope the members of PAC understand that hospitals have not been subject to SST. We do not have the system in place. It is not that we were subject to SST and now we just turn it on or we increase the SST rate. We have not been subject to SST. So, we do not have it in place in our finance, in our billing and in our structures.

To be announced last week and to start on 1st July, it is almost impossible for us. It is also difficult and I give you an example. We are told that we have until 31 December, so before that is we have to show best effort. Tapi saya bagi contohlah. Kalau hospital A dengan B ia mungkin tidak berjauhan and this SST is on foreign patient. So, katakan di Pulau Pinang where it is a major economic contributor to our country, right? Foreign patients coming to Penang is a huge contributor to the state and also to the country. Penang is one example but certainly in KL, in Johor, in Malacca, you know it's a big contributor because they fly to us, they stay in our hotel, they shop, they consume but they also seek healthcare.

So, I come back to the example, Hospital A, Hospital B are close by. Hospital B, the systems are now ready and they said maybe they can start on 1st September. Hospital A is still in progress because the systems are more complex. Why would Hospital B start charging SST? It will make healthcare in the hospital automatically six percent more expensive. Why would they want to start first? So, I think for healthcare and for foreign patients, for the imposition of SST, it cannot be different people starting at different times because the patient will decide why I would go to the hospital. I am going to pay six percent more. If my bill is RM50,000, it means RM3,000 more. This is going to create a lot of disruption. So, we hope that this will be looked into. The day after it was announced, we already wrote in to the Ministry of Finance, we've written in MK2 asking for a discussion and for a clear deadline to start. So, I hope that one example gives you some colour.

The other is Sales and Service Tax imposed on foreign patients or non-Malaysian, rather, we understand the government's objective. It is to increase our revenue and not to burden Malaysians but foreign patients who are coming here because they feel Malaysia is very affordable. Another six percent to them and this is the logic from what we understand, because Malaysia is affordable private healthcare. Adding another six percent, they will continue to come to Malaysia. So, I hope the government also listen to itself, right. The reason the government is saying I can impose six percent is because healthcare in Malaysia is affordable. Okay, so that's number one.

So, that six percent to foreign patients. However, we are also subject to SST for the hospital in terms of operating costs. Cost of rental and maybe Mr. Ching can explain because a various structures, some hospitals are renting their premise. Some hospitals and groups on writ, so on and so forth. So, SST on rental will increase healthcare costs and here we are asking to reduce inflation and yet rental is going to have an impact on our operating cost immediately. Number one.

Number two, SST on construction. Hospital and healthcare if we considered to be a critical asset, we are now imposing SST on construction costs even to hospitals.

Again, our projects even small hospitals are RM200 million, RM300 million in terms of cost. Imagine another six percent SST on hospital construction? Who is going to bear this cost YBs? Right? So, on one hand we are having all these discussions on reducing healthcare cost and inflation but we are ourselves imposing additional costs on healthcare which the patients will have to bear ultimately. So, we hope that we can have discussions with Ministry of Finance and others as well as soon as possible because otherwise this will cause a lot of disruption.

And the fourth one is really about public-industry outreach. Right? So, we mentioned this in earlier slides. I think our contribution is we've been investing our own association money and all that to look at research, look at data, understand DRG, understand different models, look at AI, look at where and how we can make healthcare more efficient.

So, we've been doing this. However, we do hope that we can have support from the government in terms of doing this together with us as well because APHM on its own, will not be able to drive this public-industry outreach…"

[Muka surat 10 - 14, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

7.4.3 Kelestarian dan Ketelusan Kos Perubatan Swasta

Perselisihan kepentingan antara pihak hospital dan syarikat insurans kini memberi kesan negatif kepada pengalaman dan akses pesakit kepada penjagaan kesihatan.

Terdapat keperluan mendesak untuk mewujudkan kod etika industri yang komprehensif. Selain itu, pelibatan Suruhanjaya Persaingan Malaysia (MyCC) diperlukan bagi memantau amalan persaingan untuk memastikan proses rundingan harga adalah adil, telus, dan sentiasa mengutamakan kepentingan akses pesakit.

Penjelasan Setiausaha APHM

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan mengenai perkara utama dalam menangani kos dan kelestarian hospital swasta:

a. Keperluan menyemak semula struktur pengebilan hospital. Ini kerana kadar bayaran insurans sedia ada bagi kos kejururawatan dan bilik adalah jauh lebih rendah daripada kos sebenar, sehingga memaksa hospital melakukan subsidi silang yang menjejaskan ketelusan bil.

b. Ketidakadilan dalam keuntungan portfolio insurans, di mana syarikat insurans menuntut diskaun berlebihan (sehingga 30%) daripada hospital meskipun margin keuntungan hospital hanya sekitar 9 hingga 11 peratus.

c. Tindakan mengugut untuk mengeluarkan hospital daripada panel jika diskaun tidak diberikan bukan sahaja mengancam kelestarian hospital swasta, malah mengehadkan pilihan pesakit. APHM turut menggesa kerajaan mewujudkan sistem penanda aras bagi memantau ketelusan syarikat insurans, terutama dalam aspek penolakan tuntutan yang sering mengecewakan doktor dan pesakit.

d. Keperluan terhadap sokongan institusi yang kukuh untuk mengurangkan beban kawal selia yang kosnya mencecah jutaan ringgit. APHM mencadangkan agar tempoh pelesenan hospital dipanjangkan dari dua kepada lima tahun dan beralih ke arah kawal selia kendiri bagi mengatasi masalah kekurangan kakitangan di kementerian yang menyebabkan kelewatan teknikal.

e. Kepentingan integrasi penjagaan primer dan sokongan pasca-rawatan, di mana polisi insurans sedia ada perlu ditambah baik untuk melindungi kos rawatan susulan bagi memastikan hasil klinikal yang lebih baik.

f. Proses pendaftaran pemegang polisi diperketatkan bagi mengurangkan isu pengisytiharan maklumat yang tidak tepat, sekali gus membantu mengurangkan beban kos kesihatan kepada rakyat dalam jangka masa panjang.

"Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay. So, already many request to PAC but three key areas YB, really. Right? This to summarise what we have perhaps said earlier. So, one is issue of insurance rates and why our bills, people find it's unfair, right? It's because insurance is only willing to pay for certain things at certain price. We said it earlier room and board for example. Nursing charges. In our first PAC session we showed you that actual nursing cost is three times, four times what the insurance is willing to pay. Because of that we have to push the cost to other areas.*

So, we really need to fix this issue so that we can be objective and may look at the hospital bill and if the hospital bill is then reflective of the actual cost, then we can have those discussions with those hospitals who are not charging fairly. Because right now, all of us can say "Sorry, our bill is not transparent." We give you the bills but it's mixed up. Right? We're having to do cross subsidisation and everything else. So, it's very difficult to have that discussion. But if you can fix the bill, then we can talk to any hospital who's not doing the right thing, we can have more productive discussions with them. So, we need to review and revise billing structures.

Then, of course there's an issue of the underfunded segments, right? Yang Berhormat, for most of whether is KPJ, IHH, A1H, most of our hospital groups, healthcare is the only thing that we do. We do not generate income from other businesses. But we keep hearing that the insurance saying their healthcare portfolio is not profitable or very slim margin. But they are very profitable all the other areas.

So, we hope that there is a transparency in insurance premiums because we know that selling health insurance is the way to open the door to selling other insurance. I sell health, then I sell life and I sell others.

But, if we expect for medical insurance to stand alone and be as profitable as other segments in the insurance portfolio, how is that fair to providers? Because our margins are already very slim. This is the only thing that we do but we are asked to give a lot more discount at the detriment of our future in terms of private healthcare.

So really, unlike private hospitals and other certain line of business, ITOs do not cross-subsidise. We don't know whether there is a law, whether there is a regulation, but this is the argument that is being put forward to say, "Healthcare portfolio must stand alone."

So, this issue certainly has got long-term impact. We can see that what is happening the last six months to 12 months. I think do look at financials from hospitals in the next quarter. It'll likely will see no growth or even negative. But, look at the financials. I encourage you to look at the financials from the insurers after this. So, that's number one.

Number two, we do need protective guidelines, policies and regulations. Just because we are at the most visible— in healthcare so you've got— everybody else when we talk about construction, people who construct hospitals, supply the hospital, putting in the systems, medical technologies, Phamar, the payers. But to the public what they can see is the provider, it's us because we are the one that's most visible. Because of that, all the pressures are being put on the providers.

So, already for many years, hospitals have been giving discount, generally up to 10 percent to insurers. But, now because of the moratorium put on the insurers, the demand to the hospitals is unsustainable. We are now being asked for 20, 25, 30 percent discount.

We have shared before, public listed companies in Malaysia, public listed hospitals, our profit margin is nine to 11 percent. We can give this discount for a short period.

But, for a long— if you ask to do this for a long term it will certainly threaten our existence.

So, two issues. One is asking for excessive discounts; and two removing hospitals who don't give discounts from the panel. This limits patient's choice and this is not going to be sustainable for us.

While we don't want to mention it and we did mention that last time, I think it's important to note that many of our hospitals really are under GLICs and government-owned, right? They can see what our profitability is. What this means in terms of return back to our own people, to the rakyat in terms of EPF, Tabung Haji and everything else, KWAP and so on and so forth. So, again those impacts to be felt down the line if it's not already felt already.

So, implementing a benchmarking system for ITOs would certainly make it better and make it more transparent and we are urging. Again, we may have to ask for donation among APHM members to do a study. But, in Singapore for example there's already a study right— to look at different payors. How are they behaving, how much of the claims that they reject. I think the government also need to look at it between different insurers, how many claims are they rejecting.

One of the issues that we have today is to frustrate the doctor. The insurance just asks more and more questions. They will say it's deferment, please clarify, deferment, please clarify until the doctor will decide okay never mind, I don't want to charge. I will remove my fee or part of my fee out of frustration so that the guarantee letter is approved and finally the doctor and the hospital get paid.

So, we need transparency. Which insurance are doing this? Who are better and who's performing better and who's been a fair payor to both the doctor and a hospital. So, at the bottom level, we urge the PAC and the government to really address the detrimental impact on patient care and healthcare cost which is the result of this excessive discount demands and the depanelment threats that hospitals are facing.

Third and last, is we really need strong institutional support for industry-led initiatives. We have mentioned this and just like to recap it, right? A national medico-legal committee. We really need this because this impacts not just private hospitals but the government as well. So, we hope that such a committee can be established and we can contribute towards it.

Regulatory burden we've mentioned, it costs us millions and millions of ringgit. Today we understand that— and we are not blaming CKAPS. We know they are also understaffed for the work that they do. The engineering department MOH is understaffed.

They are not able to visit the hospitals in time. They are not able to review our plans and time. Because of that, it becomes a delay. The people, who we know the people in CKAPS they are working very hard. I mean we salute them. Sometimes even weekends they work but there is only a handful of them. But, because of this, the regulatory burden and the delays to us is significant. That is why our

recommendations are to move relicensing to a longer period from two to five, is to split licensing and also move towards self-regulation to reduce that burden on the government and to reduce that regulatory burden cost on the hospitals.

Third is primary healthcare expansion. We've mentioned it and we really are committed to do this together and many of our hospitals have already started doing this. It may not be known to you but some of the insurance wording, some of the policy wording actually says that reimbursement is only for specialist care.

So, they have to go back to Bank Negara, they have to go back and redo their legal framework because their current policy wording says that what they pay is for specialist care. So, even you want to include primary care it cannot be done overnight. It requires BNM intervention and it requires legal intervention. So, that's one.

But certainly, we need all the government effort to look at what happens to a patient before they come to the hospital, also what happens to a patient after they leave the hospital. So, in countries where healthcare is more integrated, patients can leave the hospital earlier because you've got support when you go back home. You got clinical support, rehab support.

Today in Malaysia once you leave the hospital, if you are talking from the insurance perspective, once you leave the hospital, we cannot charge the patient if we do a home visit for physio. Already some insurances have said that even the follow up visit post-procedure is out of pocket. You pay first and claim. We are now seeing that patients who had a procedure are not doing the two follow-ups that they need to do because they have to pay first and claim for it. That will result in poor outcome as well.

And lastly, is really improving policy holder enrollment. We mentioned this before. We need to have some screening when we have policy holders buy insurance. We wish that you know we were society that was 100 percent honest. But we have to recognise that that's not the case. People are always under declaring when they buy and that's creating a lot of other issues.

So, those are the four institutional support that we feel that the PAC can certainly play a role besides all the other things that we've mentioned. But if you can focus on these four. It will have some medium-term and long-term impact in terms of reducing the healthcare cost and hence, the healthcare burden to the rakyat…"

[Muka surat 14 - 17, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

7.4.4 Strategi dan Cabaran Dalam Pengurangan Kos Hospital Swasta

Hospital sedang berusaha mengurangkan kos melalui perolehan berpusat dan penggunaan peralatan alternatif. Namun, komponen kos terbesar iaitu tenaga kerja

seperti gaji pakar dan jururawat terus meningkat akibat persaingan global dan kekurangan tenaga kerja.

Ruang untuk penjimatan kos dalaman hospital adalah terhad. Penjimatan hanya boleh dicapai melalui kecekapan proses dan pengurangan pembaziran klinikal, bukan pemotongan kos input asas.

Penjelasan Ahli Lembaga Pengarah APHM

Dr Tan Hui Ling [Ahli Lembaga Pengarah APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa hospital swasta sedang melaksanakan inisiatif proaktif untuk mengurangkan kos dan meningkatkan ketelusan, bermula dengan penstrukturan semula model pengebilan bagi mengelakkan kekeliruan orang awam. Hospital kini memperkasakan perolehan berpusat dan mengetatkan pematuhan garis panduan klinikal bagi mengelakkan pembaziran sumber perubatan.

Walaupun berdepan kenaikan kos tenaga kerja yang tidak boleh dikurangkan, hospital beralih kepada peralatan perubatan yang lebih kompetitif dari Asia khususnya China sebagai alternatif kepada produk Eropah yang mahal, meskipun berdepan kekangan kelulusan Medical Device Authority (MDA). Selain itu, doktor kini lebih cenderung menguruskan kes sebagai pesakit luar bagi mengurangkan kemasukan ke wad yang tidak perlu.

Walau bagaimanapun, terdapat cabaran daripada syarikat insurans yang menuntut diskaun melampau sehingga 40 peratus bagi semua klien mereka. Syarikat insurans juga menggunakan taktik pengguguran hospital daripada senarai kemudahan tanpa tunai (*cashless*) sebagai ancaman untuk memaksa pemberian diskaun, satu amalan yang sangat menekan hospital kecil dan dianggap tidak mampan bagi sektor swasta.

> ***"Dr Tan Hui Ling [APHM]:*** *YB, the very first initiative it is what we supposed to do. Number one, we had to restructure our billing model which is often give rise to a lot of arguments from public. Why are you charging me gauze and all that.*
>
> *So that's number one. We will do that. We undertaking to do that but we can't do alone when the insurance company telling us you cannot reprice like that because I do not design the product to reimburse. So, we are striving from that.*

Number two, we are also working on our procurement and cost savings. That part has been going on and on and on in our industry. It just that now we have to re-intensify our efforts. To work even closer with the doctors. How do we strictly follow clinical practice guidelines to take treatment? To reduce so-called overused of medical resources. That part absolutely we are committed to do. After this whole discussion and arrangement absolutely, I think KPJ, Asia One, us, even Dr. Tan and Stanley. This is what we do every day so, maybe KPJ can share with you how much they have actually done into the pool procurement to reduce the cost and the cost saving is back to the patient. It's not like cost saving, we still keep in our pocket and then we all earn more money. It does so, right? We will not do nine percent profit after tax. We should be earning more. I mean let's get real.

…

Dr Tan Hui Ling [APHM]: *Okay, I think since end of last year all the private hospitals have panic and really, really started cost saving measures. Things that we don't shout about for example, we can only focus on things that we can reduce the cost. There are a lot of elements we can't reduce the cost. Manpower is one of the biggest chunks we cannot reduce. If we reduce by not increasing salary, we know that we are lose all our staffs, okay. Anything else I think the cost has just going up for us in recruiting staff because of market competition and etcetera.*

Those that we can control would be equipment that we can invest in. Now all of us now last time we hardly consider China brands. I can tell you now China vendors are our favourite. Please bring in more okay but we need those that have MDA approved which is a challenge. Most of the China products or even Taiwan products or even Japan products, medical equipment etcetera do not have MDA yet okay. So, that's our biggest problem whereas the European products are all MDA approved. But we know that they are more expensive.

Okay, so we are working on that as an industry which is why APHM exhibition recently, we have two halls just for China vendors. So, we are sourcing. We sourcing cheaper products and hopefully as good quality, okay? Things that beyond our control are imported drugs. Imported drugs that beyond our control. With this US tariff, our biggest fear is the cost for importing these drugs would be higher because it will be more expensive to be made in US and other countries as well.

So, those that we can convert to generic some we can but some we really cannot. Because generics theoretically they work the same but they don't honestly. Efficiency, side effects are different. I mean, I myself use— even as simple, Panadol or Paracetamol. Paracetamol is generic. The drug name Paracetamol for different brands give me different side effect. I get gastric discomfort for the generic brand. What more or a lot of other cardio hard drug etcetera. All doctors have also tried to work with the insurance. Those that really do not need admission, we really see them cutting down those admission cases, okay? Those can be managed as outpatient they tried as much as possible, discuss with the patient go for outpatient option.

Okay so these are all on going that we never shout about but the truth is ongoing and the biggest so-called cost cutting is actually giving in to the insurance by offering them

more discounts. We have insurance asking for 25 percent discount, 40 percent discount even. But it's impossible for us to give 40 percent discount. Giving 40 percent discount means I am subsidising your client. It doesn't make sense in a private sector. Even a charity hospital cannot run with 40 percent discount.

Tuan Sim Tze Tzin [Ahli PAC]: *I just point to this insurance— discount to insurance, 25 percent to 40 percent. How many cases they ask for this kind of discount? Out of like 100 cases, I am sure it is not everything.*

…

Dr Tan Hui Ling [APHM]: *All their clients.*

…

Dr Tan Hui Ling [APHM]: *All clients of theirs. Otherwise, you might be removed from being the cashless facility. In fact, I have one insurance that come to both of my hospital which when we had catch up with them every year, we do reviews with them every year. To us your bill size very reasonable. Suddenly in February we receive a notice, your hospital is being removed from cashless facility. I say "don't come and talk to me anymore. I don't even want to negotiate with you", and that's how they deal with us. Now they use these two to go to the bigger groups and negotiate. If you don't give me more discount this what will happen to you. Look at the small flies, we are the small fly okay. Small hospitals, small fly. We can just de-list you like that. And that's how the insurers deal with us."*

[Muka surat 35 - 37, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

7.5 Inflasi Perubatan

7.5.1 Status Kadar Inflasi Perubatan Semasa

Secara keseluruhannya, kemelut inflasi perubatan di Malaysia tidak harus dilihat sebagai isu kenaikan kos barang atau teknologi semata-mata, sebaliknya ia berpunca daripada kegagalan sistemik dan kelemahan kawal selia yang mendalam. Wujudnya jurang maklumat yang ketara dan masalah ketidaktelusan; di mana walaupun pihak hospital dan syarikat insurans mencatatkan keuntungan berbilion ringgit, beban kos operasi tetap dipindahkan sepenuhnya kepada rakyat melalui kenaikan premium serta caj rawatan.

i. <u>Penjelasan KPE LIAM</u>

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa kadar inflasi industri (tidak diaudit)

bagi tahun 2021–2023 ialah 16.1%. Menjelaskan bahawa kadar ini berdasarkan *database* tuntutan perubatan yang baru ditubuhkan. Menyatakan sokongan terhadap penubuhan suruhanjaya atau badan bebas untuk menyelesaikan isu penentuan kadar inflasi bersama pihak hospital, syarikat insurans, dan kerajaan.

"Encik Mark Steven O'dell [LIAM]: *YB let me comment on that. We had expect negara as a result of our studies from 2019 to tell us to set up a medical claims database. And one of the deliverables of this medical claims database is to come out with an annual rate of inflation every year.*

Inflation is made up as were said I think by Allianz comments colleague is made up of the cost of care and the number of people who claimed, right. So, we just stood up this database actually, and it'll get more granular as the years go by. But right now, we have an unaudited number. We are waiting for the audit to come but the unaudited number for the inflation rate for 2021, 2022, 2023 is 16.1 percent.

So, there is another number I can't throw out there. [Ketawa] There are so many numbers going out there. I think Allianz number is specific to Allianz. The number I just quoted is the entire industry.

Every company would have something a little bit different. But what we trying to get at is, if there is a number let's say it's 16.1 for instances, and we're satisfied with the methodology then we would like to see company's be able to adjust their premium in some fashion with some relevance to the annual inflation rate.

Tuan Sim Tze Tzin [Ahli PAC]: *And 16 percent is scary.*

Encik Mark Steven O'dell [LIAM]: *It is scary.*

Tuan Sim Tze Tzin [Ahli PAC]: *I mean, what on earth things go up 16 percent per year, if you compile it five years is going 100 percent.*

Encik Mark Steven O'dell [LIAM]: *Yes, yes.*

...
Encik Mark Steven O'dell [LIAM]: *Can I add a little bit to especially to what YB Sim was asking earlier, I didn't get the chance to respond. You talk about the commission. We've tried on our own actually. We try to get the doctors and the hospitals together with MOH and Bank Negara and the association and we realised that we had no authority, you know. We can't come together and decide on something to do together because that is anti-competition.*

So, depending on how this sort of commission thing might be set up, it could be quite useful to settle grievances between parties. I just want to say also we thought a lot from time to time about national health insurance or national health

insurance scheme. Generally speaking, I think the industry is in favour of a national health insurance scheme. Also, where if any part the private sector could play on that.

Lastly, I just want to comment that I'm glad it came out that the price increase is a multiyear because there is a misconception that if somebody raises their premium 40 percent is just for that year. It is usually for two years; three years could be for four years. Every company is on the different schedule or scheme in terms of how often they reprice. Thak you.

[Muka surat 64 - 74, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. <u>Penjelasan Presiden Federation of Private Medical Practitioners' Associations Malaysia (FPMPAM)</u>

Dr. Shanmuganathan Ganeson [Presiden FPMPAM] dalam Prosiding Bil. 5(g) bertarikh 4 Mac 2025 menjelaskan bahawa Malaysia sedang mendepani cabaran besar dengan kadar inflasi perubatan mencecah 12.6 peratus pada tahun 2023. Angka ini adalah lebih dua kali ganda berbanding purata global iaitu 5.6 peratus, menunjukkan lonjakan yang signifikan berbanding kadar 12 peratus pada tahun sebelumnya. Selain daripada peratusan inflasi, beliau turut mengetengahkan data keuntungan luar biasa syarikat insurans dan rangkaian hospital swasta yang meningkat sehingga ratusan peratus (seperti lonjakan keuntungan IHH Healthcare kepada RM4.05 bilion). Data ini digunakan untuk mempersoalkan naratif industri yang mendakwa kenaikan harga premium dan kos rawatan adalah tindakan luar kawalan bagi menyerap inflasi, sedangkan laporan kewangan menunjukkan pertumbuhan keuntungan yang sangat kukuh bagi entiti-entiti terlibat.

"Dr. Shanmuganathan Ganeson [Presiden Federation of Private Medical Practitioners' Associations Malaysia (FPMPAM)]: *... So just an introduction. We are facing the medical cost inflation rate. That is a significant challenge for both the doctors and patients and that is the reason we are here today, I guess. Look at the statistics on the inflation rate. 12.6 percent in 2023, more than double the global average which is 5.6 percent and it increase by 12 percent in 2022.*

So, what does the insurance say, they say that price adjustment is inevitable but Chia Chu Hang of the EMIR Research, he is an assistant researcher. He came up with these figures. Allianz in 2019, profit before tax RM365 million. In 2023, went up to RM577 million. Prudential Assurance Malaysia, RM573 million. In 2023, it was RM1.42 billion. 147 percent increased.

Now for the hospitals, the Association of Private Hospitals in Malaysia explained that private hospitals are by design business entities. That allows patients to make voluntary choices regarding the treatment.

The rising costs are too great for private hospitals to absorb unless they increase their prices. But again, Chair points out look at what the financial report suggests. IHH Health Care, which operates 18 private hospitals, made RM1.04 billion in 2019 and went up to RM4.05 billion in 2024. KPJ Health Care's profit before tax 2019 RM217 million, in 2023, they went up to RM370 million. So, these are big figures."

[Muka surat 2 - 3, Laporan Prosiding Bil 5(g)/2025 bertarikh 4 Mac 2025]

7.5.2 Faktor Pendorong Inflasi Perubatan

Inflasi perubatan di Malaysia adalah simptom daripada kegagalan sistemik:

a. Kegagalan Kawal Selia kerana Akta 586 tidak mengawal caj non-profesional.
b. Kegagalan Struktur kerana sistem insurans mendorong kemasukan wad.
c. Kegagalan Ekonomi kerana ketergantungan melampau kepada teknologi dan ubat import.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa kadar inflasi perubatan yang tinggi di Malaysia didorong oleh dinamika pasaran yang kompleks antara penyedia perkhidmatan, syarikat insurans, dan tingkah laku pengguna. Berasaskan data tuntutan dan kajian dalaman BNM, beliau menggariskan enam (6) faktor utama:

a. Peningkatan penggunaan hospital swasta oleh rakyat yang memiliki insurans atau takaful.
b. Kenaikan harga rawatan, ubat-ubatan, dan ujian perubatan oleh hospital swasta.
c. Wujudnya amalan caj lebih tinggi kepada pelanggan yang memiliki insurans berbanding mereka yang membayar sendiri.
d. Kenaikan kos ubat dan alat perubatan seperti mesin x-ray.

e. Ketiadaan kawalan harga dalam sektor hospital swasta menyumbang kepada lonjakan kos rawatan, dan kerajaan merancang meminda Akta 586 untuk memberi kuasa kawal selia kepada Kementerian Kesihatan.
f. Peningkatan permintaan selepas pandemik kerana pesakit menangguhkan rawatan semasa tempoh krisis turut menyebabkan lonjakan kos sehingga 25% pada tahun 2023.

"Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Terima kasih Yang Berhormat. Ada beberapa faktor yang mendorong kepada tingginya kadar inflasi perubatan di Malaysia. Pertamanya, dari segi peningkatan penggunaan perkhidmatan hospital swasta. Sebab pada masa ini kita lihat lebih ramai orang mempunyai produk insurans dan takaful dan juga apabila mereka mempunyai produk insurans dan takaful ini, mereka lebih menggunakan perkhidmatan hospital swasta. Jadi ini telah meningkatkan penggunaan.*

Kedua, dari segi peningkatan harga oleh penyedia hospital swasta. Peningkatan harga dari segi pertamanya rawatan. Kedua dari segi perubatan. Ketiga dari segi kos membuat segala ujian dan test dan sebagainya.

Ketiga, apa yang kita perhatikan juga Yang Berhormat adalah terdapat juga situasi di mana apabila seseorang itu mempunyai insurans, harga yang dikenakan adalah lebih tinggi berbanding dengan seseorang yang membayar sendiri ataupun dia bayar dulu then dia claim selepas ini. Ini adalah hasil daripada kajian kami berasaskan kepada data-data yang diberi melalui tuntutan yang diterima oleh insurans. Itu juga mendorong kepada peningkatan kadar inflasi perubatan di Malaysia.

Keempat, ada juga disebabkan oleh kenaikan harga ubat dan juga alat-alat ujian. Contohnya, mesin-mesin x-ray dan sebagainya, mereka perlu invest dan ini telah di-translate-kan kepada kos kepada mereka.

Kelima adalah disebabkan pada masa ini tiada kawalan harga dari segi perubatan dan juga dari segi caj sektor hospital swasta. Di sinilah kerajaan telah menyatakan hasrat untuk to amend Akta 586 untuk memberi kuasa kepada KKM supaya boleh mengawal selia kenaikan harga oleh hospital swasta. Itulah pendorong-pendorong utama kepada meningkatnya kadar inflasi perubatan di Malaysia.

Faktor terakhir adalah kita perhatikan selepas daripada pandemik, lebih banyak orang telah menggunakan perkhidmatan hospital swasta. Inilah kerana pada masa tempoh pandemik itu mereka mungkin delay tidak nak pergi buat certain-certain treatment yang mungkin tidak terlampau meruncing sangat, dia tunggu, lepas pandemik baru dia buat. Itu kita nampak kenaikan yang agak ketara kadar 25 peratus pada tahun 2023 Yang Berhormat.

[Muka surat 16 - 17, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

ii. Penjelasan KPE Allianz Malaysia Berhad

Encik Charles Ong [KPE Allianz Malaysia Berhad] **dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025** menjelaskan bahawa Inflasi perubatan dalam rekod Allianz merupakan gabungan antara peningkatan kos rawatan 5.9% dan kadar penggunaan 12.9%, menjadikan jumlah keseluruhan sekitar 18% hingga 19%.

Peningkatan ini didorong terutamanya oleh kekerapan penggunaan kemudahan hospital (*utilization*), bukannya semata-mata kenaikan harga perubatan asas (kos purata). Berdasarkan tren semasa, tempoh dua (2) hingga tiga (3) tahun kebelakangan ini, terdapat lonjakan ketara dalam kadar kemasukan ke hospital, termasuk bagi kes-kes yang mungkin tidak memerlukan rawatan inap yang intensif.

> ***"Encik Charles Ong [Ketua Pegawai Eksekutif, Allianz Malaysia Berhad]:*** *YB, if I may say something-lah. I think number one we have to talk about utilisation, okay. For example, in the past, they hospitalise you when necessary.*
>
> *Over the last two three years what we have seen is the hospitalisation has actually increased a lot. For example, if you have a gastro, is it necessary to go for hospitalisation? I think we heard some examples.*
>
> *So, if they actually increase in the hospitalisation means the utilisation, also means the frequency. That is part of the inflation rate. So, not only the price per glove, nursing rates, those are one thing, those are average cost. But utilisation we have seen in our in Allianz experience that has actually been increase in the utilisation.*
>
> ***Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:*** *The cost should be per person, per capita.*
>
> ***Encik Charles Ong [Allianz]:*** *Per person correct. So, the overall claiming population…*
>
> ***Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:*** *Yes. How can more the cost be higher. The more the cost should be lower.*
>
> ***Encik Charles Ong [Allianz]:*** *…Has actually increase. In our slide, we actually show that the average, cost per person has actually increased. Almost from— yes…*
>
> ***Encik Zakri Mohd Khir [Allianz]:*** *Five points…*

Encik Charles Ong [Allianz]: *Yes. Average cost 5.9, utilisation is actually 12.9, add up to be about you know for here 18, 19 percent, okay..."*

[Muka surat 66 - 67, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

iii. <u>Penjelasan Pengasas Federation of Private Medical Practitioners' Associations, Malaysia (FPMPAM)</u>

Dr. Steven Chow (Pengasas FPMPAM] dalam Prosiding Bil. 5(g) bertarikh 4 Mac 2025 menjelaskan bahawa kos penjagaan kesihatan meningkat dalam tempoh 20–30 tahun, namun punca kenaikan adalah kompleks dan pelbagai faktor, bukan sekadar inflasi perubatan atau isu caj doktor. Langkah seperti DRG atau memaparkan harga ubat di klinik bukanlah suatu penyelesaian mudah, kerana standard rawatan masa kini jauh lebih tinggi berbanding dahulu. Kenaikan kos juga berpunca daripada pertumbuhan populasi dan peningkatan jangkaan pesakit, masyarakat dan mahkamah.

Selain itu, syarikat insurans memainkan peranan besar sebagai orang tengah yang mengawal aliran pesakit dan hospital, mengenakan pelbagai potongan serta mempengaruhi kos industri, namun jarang mengambil tanggungjawab terhadap inflasi perubatan. Masalah sebenar adalah berpunca daripada kekurangan regulasi menyeluruh terhadap keseluruhan ekosistem perubatan, bukan hanya doktor dan hospital. Justeru itu, FPMPAM telah meminta Kerajaan menggubal peraturan bagi mengawal perniagaan perubatan.

"Dr. Steven Chow Kim Weng [Federation of Private Medical Practitioners' Associations, Malaysia (FPMPAM)]: *Thank you Dr. Shan, YB Puan Pengerusi; YB Dr. Lee Boon Chye. I was the President of the Federation. We just short term calls it, ya for at least 20 over years. I'm not a GP. I'm a dermatologist in private practice in a private hospital. I think it's important we be all on the same page. Otherwise, it will be an argument looks like cows come home.*

Has the cost of health care gone up over these past 20, 30 years? The simple answer, yes. The absolute cost has gone up. The absolute cost. Number two, why is this so? Okay. We talk about medical inflation in a very simplistic way the total cost divided by the number of years, okay. That's the simplistic way. But if you look at the cost of medical care or going up, there are many factors. It is not a simplistic thing, you know. I totally disagree with the Minister of Health's recent comment that to control this issue, alright DRG is the answer, okay. Display of a medicine cost in the GP's clinic is the answer. It's too simplistic. It's more complex than that.

Why has our budget for health care gone up? It's very simple. The population has grown. Dulu, what 25,000 on million people. Now, we have 30 over million people, alright. The standard or the benchmark of medical health care has gone up. Simple example, a head injury. A head injury in 1970's, when Dr. Lim Kuan Joo was practicing and Dr. Lee Boon Chye was practicing in the hospital system. You admit the patient, keep them for 24 hours, do what they call a head chart. The head chart is where the nurse waking you up every 15 minutes and record. Is the patient conscious bla, bla, bla, bla, alright. 24 hours later, alright, he is okay, you go home. At most, you will do a skull X-ray. Am I correct? Same page, isn't it?

But today, in 2025 if someone comes in with a head injury, if you do not admit him and they do not have a CT scan, at least, then you are in deep trouble. If this case ever goes to the court. Likewise, a child with a fever and a rash. Okay, the GP will say, "Oh, this is a viral rash, measles perhaps". But can you let this go today? No man, you better investigate this child for dengue, it's a little joke lah. Maybe for leprosy also, okay. Or else we will be in deep trouble. So, the standard of care expected by the patient, expected by the public, expected by the Members of Parliament here, they are quite different and definitely, expected by the court, okay. And, this produces increased medical legal litigation cost which are more apparent right now.

Now, insurance blame doctors. When they fail to blame doctors, then they blame the hospitals for increased cost, okay. Alright, and they will give all sorts of reasons, all sorts of data to prove that this is cause for the medical inflation, okey. Hardly ever blame themselves. Today, the insurance control the flow of patients to doctors and hospitals. Private hospitals I'm talking about. Public hospitals are not being controlled yet. These are simple terms. The middleman of the industry. The middleman of the industry decides. You want to see a doctor, please go to the middleman. Doctor, you want to see this patient, please go through the middleman. Am I correct? The middleman does not work for free. He works for a fee and this fee can easily mount year by year.

What has insurance done over the years? Over the past 10 to 15 years? I'll share you the story of a company called ING. In the year 2010, they were B-I-G. In that year, they tried to arm-twist the doctors. "Doctors, we want 30 percent of your professional fees. Otherwise, you will be taken out of the panel". True story. The doctors fought back. Not a big number of them but in various hospitals, they fought back and the insurance gave up. Now, insurance they tell private hospitals, "If you want 40 percent cut from this, 50 percent cut from this or we will take you off the panel". Why they do this and how do they manage to acquire this process? It's very simple They now control the industry.

They bought in cheap. They sold their policies very cheap. Companies bought in and now, they control the industry. It's time to harvest. They are not here for the charity or prize. They are not here for charity. They are here to make money and when they are done with their bidding, they will leave. They will sell off. Company has sold off before leaving unpaid bills, you know. This is on record. Companies—insurance, and then sales have sold off leaving unpaid bills. So, where is this cost of our medical inflation? Not the doctors, not just the medicine costs, okay. The whole

system needs regulations. Proper regulations of the industry, so that the cost can be controlled.

You can't just say regulate the doctor, regulate the hospital but not regulate the other middleman business. We have asked for the open letter to the PM in 2023, "Please enact regulations to regulate the business of medicine". Okay, this open letter was sent to PM and then followed by a petition by more than 2,000 over private doctors. Okey, we'd like to know is this measure correct or wrong? Are we barking up the wrong tree? And this particularly message is not just new you know. We have been bugging this for the past 20 years since a year that 1998 when the Private Health Care Facilities and Services Act was passed. I think I will reserve further comment on this but the bottom line is the doctors are not to be blamed. It's a multi-factorial issue, okay. The DRG is not the magic bullet. If you follow the history of the DRGs, in America, around the world okey, you will clearly see that DRG is not the answer, it's not a silver bullet, okey.

Countries that have gone to risk phase, now we are entering that phase, alright. From that phase is now next step is value-added health care. This is a well-trodden commercial process. We have an excellent system in Malaysia, we should nurture it, okay. Where do we go wrong? I think reforms are needed. Definitely, reforms are needed. But in the process during the reform, we must bark up the right tree, okay. The GP's is definitely not the right tree. Our system is in danger. We are at the eye of a perfect storm. Why do I say that?

The healthcare system in Malaysia is like a stool, a three-foot stool. Bangku tiga kaki. The health of the entire population sits on this stool. The public health system is breaking down. COVID-19 accelerated it. So, you see resurgence of leprosy. TB, malaria. Something is going on you know. It shouldn't be there, alright. The hospital services which are our secondary care, also got problem.

He got brain drain issue. He got inequality system, mild disputation of manpower resources. That system will break down. Then the primary care which is the third leg is also being sawn off. GPs are not able to survive. The GP system the solo practitioner 40 percent looking over 60 percent of patients were longer be tenable. Then that breaks the whole system will collapse. Whatever we do please do not deform the system Yang Berhormat Pengerusi. Thank you."

[Muka surat 3 - 6, Laporan Prosiding Bil 5(g)/2025 bertarikh 4 Mac 2025]

iv. <u>Penjelasan Setiausaha APHM</u>

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(h)/2025 bertarikh 10 Mac 2025 menjelaskan bahawa empat faktor utama yang menyumbang kepada inflasi perubatan iaitu:

i. Kenaikan harga farmaseutikal didorong oleh inovasi ubat-ubatan baharu dan lebih maju, seperti biologik dan perubatan individu, bukan kerana kenaikan harga barangan sedia ada yang sama.

ii. Peningkatan nilai import bagi farmaseutikal (meningkat 63%) dan peranti perubatan (meningkat 88%), yang dipengaruhi oleh kadar pertukaran asing dan tarif global (seperti tarif 25% untuk komponen yang dipasang di luar negara) yang dijangka akan melonjakkan lagi kos ini.

iii. Kenaikan kos kakitangan perubatan; hospital perlu menaikkan gaji (gaji asas jururawat dan staf lain meningkat hampir 10% setahun) kerana permintaan tinggi dan pengambilan aktif kakitangan Malaysia oleh negara-negara seperti UK, Timur Tengah, dan Amerika Syarikat.

iv. Kelewatan pematuhan regulatori iaitu kelulusan lesen memakan masa 1 hingga 3.5 bulan atau lebih yang disebabkan oleh beban kerja berlebihan di bahagian CKAPS (Pusat Kompentensi dan Pematuhan Amalan Kesihatan Swasta) KKM, yang secara tidak langsung menyumbang kepada kenaikan kos operasi.

"Encik Anwar Anis bin Anis Ahmad [APHM]: *...Allow me then to touch a little bit about what has contributed to the medical inflation. So, there are four key factors and of course others as well and I won't spend too much of time on this. I will touch on the main topic where suddenly increase in pharma prices due to the innovation of drugs such as biologics in the market and all these drugs and you know individualised medicine and so on.*

These have certainly contributed to drug prices increasing because they are more advanced. Not because of the same item, not because the Panadol which was RM1 becomes RM1.12, but because there are now better drugs and better products in the market. Secondly, is that there's a 63 percent increase in import value for pharma and 88 percent increase for medical devices.

So, these import values are for various factors. It could be our exchange rate and so on so forth. With what is going on now, with changes in tariff and all that, we could expect because if certain items or parts are coming from China going to U.S for an assembly of an advanced medical equipment and the tariff is another 25 percent. This could again have an impact to us. If you buy something next year and those tariff impacts come back, this is where the increase in the import value of this pharma or medical devices will jump again. Can we control it? Unfortunately, we cannot.

Third is the medical staff increase. As we mentioned, our nurses including our other staff, radiographers, our health line staff are very much in demand. Whether it's down south across the causeway, whether it's in the Middle East, now UK, even U.S, they actively recruit our staff. We need to obviously pay them better. But, to pay them better, we also need to increase our bills.

However, in the last three years, we've been trying to not increase our charges but increase salaries and on average, basic salaries have increased by seven percent. When I say basic salaries which means allowances which have increased but a lot more are not covered, benefits have also increased by a lot more. If you include those, our nursing salaries have actually increased per annum but at least close to 10 percent.

Finally, one of the factors in terms of rising medical costs is delays in regulatory compliance where approvals are between at least one to 3.5 months. What we are seeing now, I think with the pressure that KKM is facing, we actually feel bad for the staff in CKAPS. They are stretched and they can only count to us and visit us for licensing maybe in three to four months after we apply. Then, it takes them about another three to four months to revert back. It is because they are overwhelmed with the amount of work that they have to do..."

[Muka surat 15 - 16, Laporan Prosiding Bil 5(h)/2025 bertarikh 10 Mac 2025]

Selain itu **dalam Prosiding Bil. 5(l)/2025 bertarikh 17 Jun 2025, Encik Anwar Anis bin Anis Ahmad** turut menjelaskan bahawa kadar inflasi perubatan sebanyak 15 peratus yang sering dilaporkan sebenarnya terdiri daripada dua komponen utama yang berbeza. Komponen terbesar, iaitu sekitar 60 hingga 70 peratus (bersamaan 8 hingga 9 peratus daripada keseluruhan kadar tersebut), berpunca daripada peningkatan jumlah tuntutan dan penggunaan kemudahan kesihatan akibat faktor seperti penuaan masyarakat. Sebaliknya, peningkatan kos sebenar bagi setiap item perubatan hanyalah sekitar 6 hingga 7 peratus, malah data daripada pihak insurans sendiri menunjukkan inflasi per item hanyalah sekitar 4 peratus sekiranya faktor volum dikecualikan. Peningkatan saiz bil hospital juga dipengaruhi oleh pengenalan prosedur perubatan baharu yang lebih canggih, namun secara keseluruhannya, inflasi kos item perubatan masih selari dengan Indeks Harga Pengguna (IPI) iaitu sekitar 4 hingga 5 peratus.

***"Encik Anwar Anis bin Anis Ahmad [APHM]:** Okey, terima kasih YB Sim atas soalan itu. So firstly, you're very correct YB Sim. Right, dalam data yang biasa diumumkan dan sebagainya, the 15 percent ada dua komponen. And I think during our first PAC, we tried to explain. Laporan-laporan seperti yang daripada Aon*

Hewitt, laporannya. Bila angka 15 peratus itu ada dua komponen. Satu komponen adalah peningkatan dalam penggunaan kemudahan kesihatan (increase in access, increase in number of claims). Dan, kedua adalah peningkatan dalam kos.

So, secara umumnya kalau kita lihat, at the different reports— some reports say 15, some say 12. But what we know is 60 to 70 percent of that is increase in claims. So, YB Sim you are very correct and that's why we try to show right, that the increase in the number of people coming to healthcare. Because of aging society and so on and so forth has increased. Even if you take the 15 percent number and if you say, 60 to 70 percent is increase in number of claims, that is already eight to nine percent.

That means eight to nine percent of the 15 percent is because is increase in volume. Then, the other component is increase in cost. So, increase in cost is between six to seven percent. If you talk about that 15 percent number. Our own data shows that inflation for and we explained before inflation for per item is really close to CPI— it's four to five percent. So, where is that— how the bills getting bigger, right? We explained before over the years of course, if you look at the last five years— introduction of new procedures, laparoscopic, all that because there's more consumables and so on are also increases the cost.

But if you take all of that into account, kita ambil semua faktor-faktor ini, actual cost inflation is six to seven percent and the balance is increase in claims volume. I do not have the specific article but even— and this was in one of the national articles. Even the data from Prudential shows that medical inflation per item— if you exclude volume increase, was actually four percent. So, even from the ITOs own data."

[Muka surat 19 - 20, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

v. Penjelasan Presiden & *Managing Director*, KPJ Healthcare Berhad

Encik Chin Keat Chyuan [Presiden & *Managing Director* (KPJ Healthcare Berhad)] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa angka inflasi perubatan yang tinggi (12 hingga 15 peratus) adalah berdasarkan kadar aliran perubatan (*medical trend rate*), yang merangkumi elemen jangkaan peningkatan tuntutan pada masa hadapan dan bukannya sekadar kos semasa.

Semasa tempoh pandemik, syarikat insurans (ITO) memperoleh keuntungan besar kerana pesakit tidak dapat menjalankan prosedur elektif, namun permintaan melonjak mendadak selepas tahun 2022 apabila orang ramai mula menyedari kepentingan perlindungan kesihatan. Statistik menunjukkan peningkatan pembelian polisi melebihi 100 peratus, yang secara langsung

meningkatkan volum penggunaan hospital. Sekiranya faktor lonjakan tuntutan dan jangkaan masa hadapan ini diasingkan, inflasi perubatan sebenar berdasarkan Indeks Harga Pengguna (IPI) hanyalah sekitar 4 hingga 6 peratus, iaitu kadar yang hampir sama dengan sektor-sektor lain.

> **"*Mr. Chin Keat Chyuan [APHM]:*** *Ya, I just want to build on that. Like what Mr. Anwar mentioned, the earlier numbers that we have actually seen that is actually using medical trend rate. The medical trend rate it has the element of anticipating what happen in the future also. So, it is not really based on that current actual medical inflation— built on anticipating future berapa lagi yang akan increase and that increase including of the anticipation of the claim.*
>
> *And truly like what YB Sim mention because of the delayed during that two, three years it was haven for the ITO. Everybody hanya bayar premium sahajakan tak ada orang dapat pergi hospital kerana hospital memang kan MCO memang tak boleh pergi hospital. Hospital have almost zero elective procedures private hospital tak adakan hanya COVID, COVID and COVID.*
>
> *And because of that the delayed, when it comes everybody start actually going after that elective procedures as one I think after 2022 second half of the year, the premium of insurance also actually gone up in terms of people buying a healthcare policies because people start realize that without healthcare policy it is so vulnerable.*
>
> *So 2022 until 2024, there was a clear case if you check with LIAM data statistic showing their update in terms of policy was actually increase by more than 100 percent. So, because more people buying – people want to also use dia punya polisi. So, the update the delayed in terms of the procedures together with all the things there have actually added. So if you minus that out like what Encik Anwar rightly said ya the actual CPI index for us in terms medical inflation it is around 4 to 6 percent which is no different compare to others.*
>
> *But the moment when you combine the increase in terms of asses and the claim rates that's how the whole thing double up from 12 to 15 percent and that's stand-up Malaysia because there are using medical trend rates. There are many methodology for us to actually look at how you are anticipate for all this but that methodology was actually being use lah. Sorry YB Sim."*
>
> [Muka surat 20 - 21, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

vi. <u>Penjelasan Pharmaceutical Association of Malaysia (PhAMA)</u>

Puan Deepti Saraf [Naib Presiden PhAMA] dalam Prosiding Bil. 5(i)/2025 bertarikh 6 Mac 2025 menjelaskan bahawa kos ubat-ubatan hanya menyumbang sebahagian kecil (12% hingga 16%) daripada keseluruhan kos

rawatan pesakit, dan penyelesaian inflasi kos penjagaan kesihatan Malaysia tidak boleh hanya memfokuskan kepada harga ubat. Inflasi perubatan didorong oleh pelbagai faktor makro, termasuk demografi penduduk yang menua, kos R&D ubat inovatif, kelemahan Ringgit Malaysia, dan kenaikan kos pengeluaran seperti utiliti dan logistik. Walaupun terdapat cabaran ini, kenaikan harga produk syarikat inovator adalah munasabah iaitu disekitar 3.5% hingga 4.7% dan ia sejajar dengan kadar inflasi.

Namun, isu utama yang menyumbang kepada kos tinggi pesakit adalah mark-up median yang tinggi di mana kadangkala sehingga 300% yang dikenakan pada pelbagai peringkat rantaian bekalan, termasuk hospital swasta, klinik, dan farmasi komuniti. PhAMA juga komited untuk bekerjasama dengan kerajaan dan KKM dalam usaha mencari penyelesaian bagi mengurangkan kos untuk pesakit.

> ***"Puan Deepti Saraf [Pharmaceutical Association of Malaysia (PhAMA)]:*** *… You will again see that medicine only accounts for 12 percent of the entire cost of the entire hospital structure. So, what we are trying to say is that medicine only contributes to a fraction of the entire cost of treatment. If you go to the next slide, you will also see that over the years, the cost of the expenditure from the Ministry of Health has been relatively flat, as can be seen in that orange line on the graph. Of course, that has been some increments in the private sector but largely in the public sector, expenditure has been quite flat when it comes to medicine.*
>
> *Not just that, you will also see, this is a 2022 report from the ministry and from Malaysia's statistics on medicine. It again says that only 10 percent of the MOH's expenditure was allocated to pharmaceuticals as such. So, with these two slides, what I'm trying to summarise is that medicine is just a fraction of the entire treatment cost and only solving for medicine price, will not solve for the entire inflation challenges that we see in Malaysia today.*
>
> *There are many reasons why we see inflation in prices and overall healthcare costs. We, of course see that on the left-hand side in my chart you can see that we have a social demographic of the country where we see more aging people, which of course need much more care and treatment as aging brings a lot of chronic diseases with it, the lifestyle of the population which also contribute to metabolic disorders such as diabetes as well as cardio metabolic problems. We there, foresee a rising prevalence of these conditions in the population as a whole that NCDs.*
>
> *We also know that, in addition to this as science is advancing across the world and new innovative medicine are getting launched. This, of course, brings with it better care, better outcomes but with the R&D costs, it also brings some more expensive medicine into the population but it helps the population to be more productive to become better faster. Some of the other reasons also include the weakening of the*

Ringgit Malaysia and the reason past. Of course, there are lots of rising costs in doing business as well as in production.

As you can see on the right-hand side, with all the micro indicators, energy and utilities, transportation and logistics, commodities. All these costs and the recent past have increased within the range of one and a half to three percent. If you put all that together, it adds to the cost of medicines and the cost of manufacturing products.

If you go to the next slide, you will also see that not just all these inflations parameters, the social economic parameter but we also in Malaysia and in the pharmaceutical industry have a complex supply chain and there are multiple partners and agents from the pharmaceutical industry who manufactures by the time it reaches the patients. There are multiple layers in the middle, which we have to ensure that this enables the patients to have access to the medicine with the large geography.

From the suppliers, both the MNC as well as the generic manufactures, we have distributors at one level which then goes to the hospitals, sometimes directly. When it goes to the public sector, we also have agents and suppliers who then further supply to hospitals and clinics. So, there's a complex supply chain which is needed in this industry but it also adds to the cost of the medicine. But having said that, despite all these inflations of producing medicines of the weakening RM of the population, we see that in the recent past and I'm talking from 2022 to 2023 and also from 2023 to 2024, we have used IQVIA data and we have looked at the top PhaMA members. So, the MNC companies and their products and we have seen that our price increases have been quite reasonable in line of the inflation, in facts sometimes even lower than the inflation. So, you will see from 2022 to 2023, there was a price increase overall of about 3.5 percent and from 2023 to 2024, a price increase 4.7 percent.
I hope the room feels this has been a reasonable price increase given all the inflation cost. This also includes launches of new innovative product that already been incorporated in that price increase 3.5 and 4.7. In addition to this, Malaysia has a lot of laws that makes sure that no company make unreasonable profit. So, under the Malaysia Price Control and Antiprofiteering Act 2011 under KPDN, there are laws in place to ensure that companies such as ours do not make unreasonable profits. So, I hope this also tell the room that you know there has been a reasonable price increase at least from PhAMA's member in the recent past.

In addition to that, innovator companies and innovator product also added lots of societal benefits to the patient. As you can see from the left-hand side chart of the blue graph, you will see that almost RM9 billion we were able to save with innovator launches. This is actually added to the quality of life of patients worth RM9 billion. You will also seen some of the launches in the recent past and again you will see that actually with the addition of these new products, while they bring some— you know, you make all of them expensive but they are actually extend the quality of life of diabetes patient almost three percent. Another product here which extends the quality of life by almost 18 percent. Again, while the price increase has been quite reasonable, we are also adding more people in the society to be more productive over the years.

In line with our Prime Minister's vision and also our policies in place, generics first policy. You will see from both these graphs that not only in terms of doctor's prescriptions where over the recent years, it has largely gone to generic drugs— almost about 55 percent of the prescriptions were actually given to generic drugs. As you can see in this graph and this is the latest data from 2023 and 2024. All the volumes even on the private channels, 66 percent actually is contributed by generics. So, this is in line with our vision that generics are actually taking the main prescriptions, the main volumes when it comes to private hospitals too.

Having say that, this graph is also shows us that there is a challenge in terms of the median markups that are happening at different levels. So, once we as a manufacturer sell to the hospital or sell to the distributor, there are markups that are put at the hospital level. You would see that in the first block, innovators versus generic, you will see the markups that have been implied or have been put by the inpatient setting in the private setting. You will say that the markups has been quite high. Both the innovator and generics but even more in generics than the innovators. This trend is consistent through different channel. So, whether it is a private hospital, private clinic, community pharmacies, you will see that sometimes margins and markups have gone up 300 percent by these providers. I'm sure for good reasons but this of course adds to the cost of the patients pricing and then the inflation cost that we see in Malaysia.

In summary, what I would like to end with saying is that overall medicine does not contribute to the major amount. We are in the range of 12 to 16 percent of the total cost. There are multiple factors that have increased the production cost in the recent past. However, PhAMA members price increased has been in line with that inflation or even lower with that inflation considering all the new products that we have launched in Malaysia.

There are multiple other factors such as markups that have been adding to the inflation in Malaysia and we are committed to work with the government and the Ministry of Health to come out with solutions that enable all of us to reduce the cost for patient."

[Muka surat 6 - 10, Laporan Prosiding Bil 5(i)/2025 bertarikh 6 Mac 2025]

vii. <u>Penjelasan Malaysian Organisation of Pharmaceutical Industries (MOPI)</u>

Encik Ch'ng Kien Peng [Presiden, Malaysian Organisation of Pharmaceutical Industries (MOPI)] dalam Prosiding Bil. 5(i)/2025 bertarikh 6 Mac 2025 menjelaskan bahawa kos ubat bukanlah faktor utama yang mendorong peningkatan premium insurans kesihatan atau caj perubatan. Walaupun pasaran swasta mendominasi dari segi nilai (73% atau RM9.36 bilion), MOPI menunjukkan bahawa sumbangan ubat generik keluaran tempatan kepada jumlah nilai pasaran hospital swasta adalah sangat kecil, iaitu

hanya 6%. Sebaliknya, 94% nilai pasaran hospital swasta masih dikuasai oleh ubat import.

Walaupun menghadapi cabaran seperti kejatuhan Ringgit, inflasi, dan kenaikan tarif elektrik, kenaikan harga ubat ahli MOPI adalah rendah iatu disekitar 4%, malah ada yang menurunkan harga bagi ubat biasa. Oleh itu, isu inflasi kos penjagaan kesihatan bukan berpunca daripada ubat generik tempatan, sebaliknya industri tempatan adalah penting untuk menjamin keselamatan bekalan ubat jangka panjang negara.

"Encik Ch'ng Kien Peng [Presiden, Malaysian Organisation of Pharmaceutical Industries (MOPI)]: *Yang Berhormat Berbahagia Puan Pengerusi, Ahli-ahli Jawatankuasa PAC, tetamu kehormat, rakan-rakan industri serta hadiran yang dihormati sekalian. Selamat petang dan terima kasih atas peluang ini untuk kami Malaysia Organisation of Pharmaceutical Industries (MOPI) berkongsi pandangan kita.*

Kami ingin menegaskan bahawa kos ubat bukanlah faktor utama dalam peningkatan premium insurans kesihatan dan caj perubatan. Sebaliknya, industri pengeluar farmaseutikal tempatan telah memainkan peranan dalam memastikan akses kepada ubat melalui persaingan dalam pasaran generik dan mengukuhkan kapasiti pengelolaan tempatan demi kepentingan rakyat Malaysia.

Slaid kedua. Industri pengeluar farmaseutikal tempatan diiktirafkan sebagai industri strategik dan kritikal untuk negara kita. Sebab-sebab, diberikutnya. Satu daripada dua rakyat Malaysia mengambil ubat yang dikeluarkan oleh pengeluar tempatan. 64 peratus daripada jumlah ubat generik di pasaran Malaysia dihasilkan oleh syarikat tempatan. 47 peratus ubat daripada senarai Ubat-ubat Penting Kebangsaan (NEML) hasil daripada industri tempatan. Industri ini melaburkan RM623 juta pada tahun 2023 dan menyediakan lebih daripada 15,500 pekerjaan di Malaysia.

...

Pecahan daripada pasaran sektor kerajaan dan swasta 2024. Ini data yang latest sekali. Slaid ini menunjukkan pecahan pasaran sektor kerajaan dan swasta. Pada tahun 2024 berdasarkan kepada nilai dan kuantiti keseluruhannya sebanyak 12.81 bilion dari segi value atau nilai sektor swasta menguasai 73 peratus, RM9.36 bilion manakala sektor kerajaan menyumbangkan 27 peratus, RM3.45 bilion.

Dari segi kuantiti volum, sektor kerajaan membekalkan 57 peratus. Manakala, sektor swasta menyumbangkan 43 peratus. Walaupun sektor swasta mendominasi dari segi nilai tetapi sektor kerajaan masih merupakan penyumbang utama dalam jumlah unit yang dibekalkan. Saya meneruskan kepada slaid yang next.

Pecahan pasaran sektor swasta pada tahun 2024, 9.36 bilion dibahagikan kepada pharmacy sector, hospital dan klinik. Hospital lebih kurang 29 peratus. Saya narrow-kan lagi next slide.

Sumbangan ahli MOPI nilai dan kuantiti bekalan ubat generik kepada hospital swasta hanya enam peratus daripada jumlah nilai pasaran hospital swasta datang daripada ubat generik yang dihasilkan oleh ahli MOPI dengan nilai 1.75 juta. Sebaliknya, 94 peratus daripada nilai pasaran hospital swasta masih dikuasai oleh ubat import dengan jumlah keseluruhan 2.54 bilion.

Dari segi kuantiti, 81 peratus daripada jumlah unit ubat yang dibekalkan ke hospital swasta adalah ubat generik keluaran ahli MOPI bersama dengan nilai yang 4.84 juta. Next slide.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Can I ask when you say unit mean?*

Encik Ch'ng Kien Peng [MOPI]: *Unit maksudnya counting unit, maksudnya ubat-ubat katakan tablet, satu tablet sebiji, sebiji. Sorry.*

Slaid yang seterusnya menunjukkan pembahagian daripada segi ubat kanser, ubat antibiotik suntikan dan also contoh-contoh seperti ubat antibiotik tablet. Slaid ini menunjukkan lebih kurang empat peratus (percent) harga kenaikan bagi ahli MOPI dan ubat antibiotik suntikan yang biasa digunakan di hospital, MOPI ahli kebanyakannya mengurangkan ubat.

Contohnya, katakan ubat daripada rakan saya daripada Duopharma dia punya gentamicin untuk suntikan. Dia turunkan dua sen per suntikan. Sebagai contohnyalah.

Punca-punca peningkatan harga di Malaysia kebanyakannya adalah contoh-contoh seperti yang berikut. Deflasi daripada ringgit, kadar inflasi, kos bahan mentah, kenaikan harga siling, kerja lebih masa untuk pekerja di kilang, kenaikan tarif elektrik– kebanyakannya.

Sebagai kesimpulan apa yang saya nak menegaskan di sini ialah kos ubat bukan faktor dalam peningkatan premium insurans kesihatan atau caj hospital swasta sebagai faktor yang saya tunjukkan. Pengilangan tempatan penting untuk keselamatan bekalan ubat dalam jangka panjang. Industri pengeluar farmaseutikal tempatan komited untuk mengkaji bagaimana keupayaan pengilang ubat-ubat yang penting kini 100 peratus diimport boleh dikeluarkan atau dihasilkan daripada di Malaysia. Sebagai peranan yang strategi untuk meningkatkan sistem kesihatan Malaysia..."

[Muka surat 30 - 33, Laporan Prosiding Bil 5(i)/2025 bertarikh 6 Mac 2025]

viii. <u>Penjelasan KPE PMCare Sdn. Bhd.</u>

Tuan Kamal Aryf Baharuddin [KPE PMCare Sdn. Bhd.] dalam Prosiding Bil. 5(m) bertarikh 17 Jun 2025 menjelaskan bahawa kadar inflasi perubatan di Malaysia yang dianggarkan mencecah 15 peratus serta faktor-faktor yang

menyumbang kepada trend peningkatan kos tersebut. Beliau mengenal pasti bahawa punca utama kenaikan ini meliputi penularan pengurusan penyakit kronik, keadaan kesihatan berkaitan faktor usia, gaya hidup tidak aktif, serta peningkatan tuntutan manfaat perubatan daripada kesatuan sekerja. Selain itu, beliau mendedahkan realiti yang membimbangkan mengenai ketidakberkesanan program saringan kesihatan eksekutif yang disediakan oleh majikan. Walaupun pemeriksaan kesihatan diberikan secara percuma kepada pekerja berumur 40 tahun ke atas, hanya 20 peratus pekerja yang memanfaatkan peluang tersebut sekiranya ia tidak diwajibkan oleh syarikat. Hal ini kerana ramai pekerja bersikap takut atau enggan mengetahui status kesihatan sebenar mereka, sekali gus menyumbang kepada kegagalan langkah pencegahan awal penyakit.

> ***"Tuan Kamal Aryf Baharuddin [PMCare]:*** *...Next slide. Baik. Lagi. Okey. Then, I think this more interesting topic because kami dipanggil pun untuk membincangkan mengenai kenaikan kos perubatan. Ini adalah that yang menunjukkan as far as a report yang telah dikeluarkan oleh few mengatakan inflasi negara untuk perubatan di Malaysia lebih kurang 15 peratus.*
>
> *Next slide. Untuk makluman, ini adalah makluman awam yang di mana mengatakan mengapakah, apakah punca-punca kenaikan kos perubatan. So, itu, seperti dimaklumkan juga, prevalence of chronic diseases management, chronic diseases, age-related condition, inactive lifestyle, demand of more in pay benefit termasuk tuntutan-tuntutan sama ada daripada persatuan kesatuan pekerja dan juga kebanyakan juga underutilize the executive screening yang diberikan oleh syarikat.*
>
> *Menurut data yang kami ada, walaupun syarikat-syarikat memberikan kemudahan screening untuk pemeriksaan kesihatan kepada yang berumur lebih daripada 40 tahun, tetapi mana-mana syarikat yang tidak mengenakan syarat sebagai mandatori, hanya 20 peratus pekerja sahaja yang mengambil peluang ini. Ini realitinya.*
>
> *Realitinya, ramai pekerja tidak mahu tahu kedudukan status kesihatan mereka, tidak mahu membuat pemeriksaan, walaupun syarikat memberikan coverage secara percuma."*
>
> [Muka surat 18 - 19, Laporan Prosiding Bil 5(m)/2025 bertarikh 17 Jun 2025]

ix. <u>Penjelasan Presiden FPMPAM</u>

Dr. Shanmuganathan Ganeson [Presiden FPMPAM] dalam Prosiding Bil. 5(g) bertarikh 4 Mac 2025 menjelaskan bahawa punca peningkatan inflasi

perubatan adalah pelbagai dan saling berkaitan. Pandemik COVID-19 mencetuskan kekangan logistik, permintaan melebihi bekalan serta peningkatan kos asas perubatan dan bukan perubatan, termasuk kesan kejatuhan nilai ringgit.

Penjagaan kesihatan primer sangat menjimatkan kos. Namun, dasar daripada kementerian, syarikat insurans, serta perspektif umum kini cenderung memintas (mengabaikan) peranan GP.

Polisi tuntutan insurans yang hanya membenarkan tuntutan melalui kemasukan wad turut meningkatkan kos kerana prosedur yang boleh dibuat sebagai rawatan harian atau di klinik GP menjadi lebih mahal apabila perlu dimasukkan ke hospital. Pada masa sama, premium insurans meningkat akibat peluasan perlindungan seperti rawatan pandemik, sindrom pasca COVID dan penyakit kritikal.

Selain itu, amalan *"defensive medicine"*, di mana lebih ramai pakar dilibatkan secara berlebihan bagi mengelak risiko perundangan tetapi akhirnya menaikkan kos rawatan. Selain itu, isu *moral hazard* dalam kalangan penyedia perkhidmatan dan pesakit perlu diberi perhatian melalui mekanisme kawal selia yang lebih kukuh.

> ***"Dr. Shanmuganathan Ganeson [FPMPAM]:*** *These are the causes of the medical inflation. Dr. Steven Chow has actually given his point of view on all the issues talked about the stools, the three legs, all three legs and danger of breaking.*
>
> *Let's quickly go through this next slide. Number one, pandemic we learnt a lot lessons there. Lot of logistic challenges during COVID-19. Demand outstrips supply during the time. So, hysteria— because we couldn't getting like masks for example. How to approach the patients. Doctors saw patients from a distance and so on. The next one is higher over cost. Put medical, non-medical and also the currency with the ringgit being low.*
>
> *Underutilisation of primary care. Luckily during COVID there was a public-private partnership. For the first time the government worked with the GPs to do both the detection of COVID-19 and also subsequently the vaccination. Primary healthcare is very cost effective. But what we see policies from the ministry, policies from the insurance, public perspective itself and all these that now tend to bypass the GP.*
>
> *Look at insurance claims policies. They only allow claims with admission. Even the simplest of thing need to be admitted. That's a cost. Outpatient or daycare*

procedures actually reduce cost. We should go for that. Procedures at the GP lower the cost. They make use of the one great asset in Malaysia, the GP. They are not being used. They also look at the rising premiums due to other things. Extended coverage, pandemic coverage, post COVID syndrome, critical illness and so on. These also give rise to increase in insurance premiums.

Practice of defensive medicine. This is too much of a good practice. Then for every patient they bring in too many sub specialties and specialties to look at them and increase the cost. Moral hazards. Now in public health moral hazard is an issue we need to quickly put in all the checks and balances to overcome these hazards whether it is on the doctor side, whether on the patients themselves…"

[Muka surat 6 - 7, Laporan Prosiding Bil 5(g)/2025 bertarikh 4 Mac 2025]

x. Penjelasan Ahli Lembaga Pengarah APHM

Dr Tan Hui Ling [Ahli Lembaga Pengarah APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa walaupun fi profesional doktor tidak berubah selama 13 tahun, kos operasi hospital swasta tetap meningkat secara mendadak disebabkan oleh beberapa faktor luaran.
Oleh kerana 90% peralatan perubatan adalah diimport, prestasi Ringgit yang lemah menyebabkan kos perolehan aset hospital melonjak naik. Penggunaan ubat-ubatan baharu yang lebih inovatif turut menyumbang kepada kenaikan kos rawatan. Hospital swasta bersaing untuk menyediakan teknologi terkini kerana pesakit menuntut kualiti yang lebih baik. Selain itu, kos perubatan turut didorong oleh amalan "perubatan defensif" oleh doktor bagi mengelakkan risiko liabiliti perundangan (*medico-legal*) yang semakin mencabar.

Gabungan antara kemajuan teknologi, peningkatan kos sara hidup, dan amalan klinikal yang lebih berhati-hati ini secara tidak langsung menjadi punca utama yang menolak kos rawatan di sektor swasta ke paras yang lebih tinggi.

***"Dr Tan Hui Ling [APHM]:** Ya, YB. Just to summarise from all of them. Yes, doctors' fees have not changed for the last 13 years but you and I all of us living in Malaysia, we do face the cost of living is increasing. So, when the cost of living is increasing like exactly what summarising what my colleagues are saying. Operating costs have increased because some costs have increased tremendously. Then we are talking about the currency Ringgit Malaysia has not been performing very well in the past few years. I think we mentioned it in the last PAC. 90 percent of the medical equipment is all imported. When it's imported, we are talking subject to currency exchange. We are talking about innovation into drugs. So, as in the private as you can hear all of us are competing in private. So, the patients are demanding*

better drugs, better innovation, higher technology. All these will drive the technology, will drive the cost going up, So, you wouldn't be able to have somebody to come in to a hospital to say, "I'm okay to have a non-digital X-ray. I still want to see a film". I think nowadays in KL no more. They want in a thumb drive, emailed to them and all that. So, does it mean a film is— definitely film is cheaper in a way but nobody would want it anymore. So, indirectly, the technology advancement is pushing the cost to go up then couple with all other things that we talked about.

So, basically in summary according to all our colleagues. Of course, medical legal definitely is driving up the cost because the doctors have to practice a little bit more defensive medicine to make sure they don't get sue easily. Yes, thanks."

[Muka surat 26, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

xi. <u>Penjelasan Timbalan Pengarah Kanan I, KKM</u>

Dr. Davis Johnraj (Timbalan Pengarah Kanan I, KKM) dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa antara punca utama kos rawatan yang tinggi di sektor swasta adalah kecenderungan penggunaan ubat inovatif walaupun versi generik tersedia dan mempunyai keberkesanan yang sama. Di hospital swasta, terdapat amalan menggunakan ubat atau antibiotik mahal yang sepatutnya hanya digunakan untuk kes kritikal seperti di ICU. Ini telah menyumbang kepada inflasi kos kesihatan. Terdapat beberapa syarikat insurans kini hanya membayar bagi ubat generik dan ini merupakan satu langkah yang positif.

"Dr. Davis Johnraj [Timbalan Pengarah Kanan I (Bahagian Perancangan), Kementerian Kesihatan Malaysia]: *Datuk Seri can I just… [Dicelah] Ya. One of the reasons also why the private sector medicine fee is very high is a tendency for all drugs to be innovator even though the generic version is available. That is one.*

The second is there is a tendency when compared per cabin pattern of government specialists. The private specialist turns always go for a higher version of the same drug rather than— So, we have seen the private insurance companies told us, one of the most commonly prescribed antibiotics is a really strong antibiotic which in the KKM, we're only prescribed in eye for ICU patient. It's very expensive. One dose is like something like RM300. So, all this drives up the cost. Because I think the tendency for the private sector to feel or we want to give the best to the patients because they pay a lot.

So, I think this is something that is driving up the cost but I was told today morning that some of the insurance companies actually telling the private hospital that we will only be paying generic. So, I think that is a good way ahead because the effectiveness is almost the same. If the patient chooses innovator, they can

probably choose to pay themselves or buy from the pharmacy. But I think it shouldn't be imposed on the patients and increase, drive the healthcare inflation.

[Muka surat 39 - 47, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

xii. Penjelasan MMA

Dr. Kuharaj Balasubramaniam [Ahli MMA] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa caj doktor bukanlah punca utama inflasi kos kesihatan swasta, kerana yuran perkhidmatan doktor adalah tetap dan tidak berubah selama lebih daripada sepuluh tahun. Kenaikan kos adalah didorong oleh caj hospital dan pelbagai peraturan baharu serta *mark-up* kos yang berlaku dalam rantaian bekalan. Secara keseluruhannya, beliau menegaskan bahawa isu kenaikan caj hospital perlu dilihat secara holistik, dengan menilai kesan pelbagai peraturan dan *mark-up* rantaian bekalan, dan bukannya menyalahkan caj doktor.

"Dr. Kuharaj Balasubramaniam [MMA]: *Dr. Kuharaj, O&G specialist private sector. There is one quoting. We are independent contractor most of the time, working in the private hospital.*

We do not have access to what the billing is finally given to the patient. Many of time I only know my chargers. So finally, the bill is given to the patient then the patient comes to me sometime and are like, "Doctor, what are these chargers? We are okay with your chargers because it has been fixed by the law for the last 10 years or more. What are these chargers?" To be honest, I also don't know because there are actually coded in certain ways.

Now, to the analogy of the glove, everybody keeps talking about this glove. It come in the newspaper as well. There are SOPs that required one patient has one box of disposal glove to themselves. We cannot take one patient's glove and go and use it in another.

In KKM we do it all the time because you know, we need to cut cost. The nurse will scold us and say "Look, you jangan buang, bazir". But their gloves are different quality as well. There are different ranking and certain times we use slightly more expensive gloves for certain procedure because the quality of the glove is important for the kind of procedure that we are doing including sometimes radiation blockage.

But there is another essence of it is that we are only one part of the medical healthcare provision. Medical devices, drug prices all are different, disposable items. I give you an example of laparoscopic myomectomy where we actually do keyhole surgery, we take out a big fibroid, we have a machine that cuts it up. That machine alone is single-used. It used to be useable but SOP and regulations

demand now and that is disposable. The use of that machine is double the cost of my surgical fees. Include my patient will tell me is double your charge, I said what to do, my charge is fixed by law, they can mark it up whatever they want.

So, I think looking at it as a whole is more important, the multiple regulations that actually involving the private healthcare but just private healthcare, Medical Devices Act now is coming into force but we have to have a local distributor. Previously, we can go to overseas and buy certain equipment and use it for a cheaper price. But when we have regulations that insist, that we have a local distributor there is markup there also. At every step, there's a markup, so it the supply chain is just not with us."

[Muka surat 19 - 20, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

7.5.3 Punca Kenaikan Kos Perubatan di Hospital Swasta

7.5.3.1 Caj Hospital

Caj Hospital membuktikan bahawa punca utama inflasi perubatan bukan terletak pada yuran profesional doktor, tetapi pada kebebasan hospital swasta menentukan harga bagi komponen bil seperti ubat, bekalan, dan ujian. Perbandingan dengan Jepun (0.9% inflasi) menunjukkan bahawa intervensi kerajaan melalui pindaan Akta 586 dan pelaksanaan sistem DRG adalah satu-satunya jalan untuk memecahkan kitaran kenaikan premium insurans yang kini telah mencecah tahap tidak mampan.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa bayaran kepada pakar perubatan *(specialists*) sebenarnya dikawal oleh KKM dan tidak meningkat sejak sekian lama. Oleh itu, kenaikan kos rawatan perubatan bukan disebabkan oleh bayaran kepada pakar, sebaliknya berpunca daripada komponen caj hospital yang tidak dikawal, seperti:

a. Bekalan dan perkhidmatan hospital,
b. Penggunaan peralatan perubatan seperti X-ray dan CT scan; serta
c. Kos ubat-ubatan dan bahan pembedahan.

Produk dan caj hospital swasta ini tidak tertakluk kepada sebarang kawal selia, menyebabkan ia menjadi penyumbang utama kepada inflasi kos

perubatan. Bank Negara Malaysia bersama KKM sedang berusaha menangani isu ini melalui inisiatif kawalan kos, termasuk pelaksanaan sistem *Diagnosis Related Group* (DRG) bagi meningkatkan ketelusan dan kawalan harga.

"Dr. Hajah Halimah Ali [Ahli PAC]: *Kejap, kejap. Saya nak sambung apa yang disebut tadi, okey. Dalam public hearing yang lepas, hari Jumaat yang lepas yang mana the specialists are telling us, you pergi hospital swasta kah apa, the rates— consultation rate itu, bayaran bagi kepada pakar-pakar ini, perubatan ini tidak meningkat langsung, dah berpuluh tahun mungkin. So, yang meningkat ini apa the business part of it kah what because the specialists yang susah-susah nak belajar ini, nak training ini tak cukup tidur and all that, all the work-life balance tak ini, they don't benefit from it, it's the other people— kalaulah, ikut lah that why you just saying yang saya faham itu kan, is benefitting from it.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Yang Berhormat...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Buat duit.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Memang betul dari segi bayaran kepada specialists memang dikawal oleh pihak Kementerian Kesihatan. Yang tidak dikawal oleh Kementerian Kesihatan adalah bayaran hospital swasta. Tapi memang kita dapati dari segi fi kepada specialists dan konsultan memang tidak naik. Memang terkawal. Memang tidak menyumbang kepada peningkatan inflasi.*

Yang menyumbang kepada peningkatan inflasi ini adalah kalau kita tengok tadi about 70 percent, 60 to 70 percent daripada jumlah komponen bil adalah merupakan caj bekalan dan perkhidmatan hospital yang tinggi. Contohnya, penggunaan alatan x-ray dan sebagainya, CT scan dan sebagainya, kedua ubat-ubat dan juga ketiga, contohnya bila ada surgery, penggunaan barang-barang untuk surgery tersebut. Itu yang meningkat dengan lebih tinggi Yang Berhormat, bukan specialists di hospital.

Dr. Hajah Halimah Ali [Ahli PAC]: *So, who is the controlling body? Is it the Kementerian Kesihatan or who?*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Pada masa ini untuk produk-produk hospital tidak ada pengawalseliaan.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Tidak ada? Okey, sebab yang the blame goes to— I am a medical doctor. So, I kesian lah I punya colleagues itu tau, okey. Bila sakit you pergi ke hospital, you kena habis duit and all that, who gets blamed? Itulah doktor ini, apa ini, nak makan duit orang, getting money out of people illnesses. So, the doctor gets the blame. Better set apa dia punya ini betulkan dia punya situations ini.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *YB, we are with you Yang Berhormat on these issues. So, that's why kita membangkitkan isu-isu ini di*

mana kita nyatakan about 70 percent daripada komponen di hospital adalah caj bekalan dan perkhidmatan. So, di sini merupakan faktor utama dan tumpuan harus diberi kepada faktor ini dan di sinilah kita dapat sekarang ini usaha dengan pihak Kementerian Kesihatan di antara enam inisiatif yang kita identify tadi, salah satunya adalah untuk memastikan kita dapat kawal kos-kos berikut melalui DRG dan sebagainya.

[Muka surat 17 - 18, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

Dato' Seri Abdul Rasheed Ghaffour turut menjelaskan bahawa BNM mengiktiraf isu kenaikan kos perubatan sebagai serius. Justeru itu BNM telah bekerjasama dengan Kementerian Kesihatan, hospital swasta, dan pengendali insurans untuk melaksanakan 9 inisiatif (kini 11 inisiatif) utama bagi menangani inflasi kos perubatan secara menyeluruh. Antaranya termasuk menggalakkan ketelusan caj hospital supaya pesakit dapat membuat perbandingan dan meningkatkan persaingan, serta memperkenalkan sistem DRG (*Diagnosis-Related Group*) yang menetapkan kadar tarif tetap bagi rawatan tertentu untuk mengawal caj berlebihan. Bagaimanapun, pelaksanaan DRG memerlukan persiapan data yang rapi. BNM menegaskan bahawa pengawalseliaan kos perubatan dan farmaseutikal adalah penting dan akan dilakukan bersama KKM untuk memastikan kos terkawal dan sistem insurans lebih adil.

"Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Terima kasih Yang Berhormat Pengerusi. Pertama, saya nak ucap tahniah Dato' Seri Gabenor Bank Negara kerana memberikan taklimat yang begitu menyeluruh, I am sure you put a very deep thought into this before you come up with the presentation.*

Pertama, saya nak minta pencerahan Dato' Seri mengenai lima teras untuk membendung kadar inflasi. Satu benda yang saya tengok itu ialah pelaksanaan DRG ataupun diagnosis-related group. Boleh Dato' Seri berikan lebih banyak sikit maklumat atau pencerahan? Itu pertama.

Keduanya, banyak diperkatakan bahawa kenaikan insurans premium ini adalah disebabkan oleh kenaikan kos perubatan oleh hospital swasta. I think that is what people have been saying. So, ada juga kebenarannya kalau kita dengar banyak daripada public hearing yang diberitahu kepada kita ada kebenaran tapi kita have to be fair to both sides, we have to listen to both sides and see how do we rationalise all these things. Perlu ada satu ketelusan daripada pihak hospital swasta mengenai kos perubatan ini sebab dia punya charges pun it varies from one hospital to another hospital. I don't know how insurance can come out with what kind certain percentage of premium insurance yang berbeza-beza.

Just sebenarnya kesan terhadap kenaikan premium insurans ini, dia akan memberikan kesan lain yang lebih besar iaitu kesan di mana orang yang tidak mampu lagi untuk membayar premium insurans yang kian meningkat sehingga begitu tinggi. Umpamanya daripada 2014 hingga 2024, 10 years kenaikan more than 143 percent, that is an average of 14 over percent per year, that is too high, much higher than inflation of yearly inflation. That is very high dan kesan besar sekali yang kita nampak sedang berlaku dan akan bertambah teruk lagi ialah orang yang tidak mampu bayar kenaikan ini akan pergi ke hospital kerajaan yang kita sedia maklum hospital-hospital kerajaan ini memang dah very crowded, orang sakit kena tunggu dulu dua hari, duduk katil tak keluar, sebelum masuk ICU dan sebagainya. This is a very serious matter sebab itu PAC mengambil inisiatif ini untuk mencari penyelesaian yang terbaik bagi isu kenaikan insurans ini.

Dalam sistem kita hari ini Dato' Seri dan juga Datuk Perbendaharaan, kita ada— I mean specialists public hospital tadi disebut, dia it's regulated, it's regulated. Dia punya gaji dia, dia punya elaun dia regulated by body, so dia tak boleh naik ikut suka dia. Umpamanya saya bagi contoh seorang doktor specialist bagi tahu saya, kos total perubatan bagi hospital swasta RM110,000, hospital pakar ini dapat RM10,000 je, not even 10 percent and this pakar ini dia yang akan menentukan live and death of pesakit itu.

Ini satu perkara yang perlu dilihat, fine kita boleh regulate specialist hospital punya pay, but at the same time kita tak ada regulations or not regulated hospital swasta tidak di regulated, ia tidak ada ketelusan dan insurans juga kita tak regulate sebab itu dia naik sesuka hati even though Bank Negara ada juga control here and there but at the end of the day, they just naik saja lepas itu orang dapat surat yang sakit yang teruk-teruk ini, kanser, jantung, kalau dia tak tahan tengok itu dia terkejut, dia boleh mati yang sakit jantung ini dia terkejut, mati pasal terkejut itu je. Betul tak, YB? So, this is something very serious lah, mungkin ini patut dilihat oleh kerajaan, maybe not the Kementerian Kewangan, Bank Negara tapi something related. Kerajaan as a whole must look into this to regulate hospital swasta and also insurance supaya ketiga-tiga ini to be regulated barulah mungkin kita akan dapat suatu kesan yang lebih baik dan positiflah. Itu buat sementara, terima kasih Dato' Seri, terima kasih Datuk.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Terima kasih Yang Berhormat. Kami sebenarnya bersetuju dengan apa yang dikatakan oleh Yang Berhormat. Memang isu ini merupakan isu yang serius dan kami mengalu-alukan langkah PAC untuk memanggil kesemua pihak berkepentingan untuk membincangkan perkara ini dan juga untuk mencari jalan penyelesaian yang baik.*

Sebagaimana saya katakan tadi untuk menangani isu ini, kita memang memerlukan pendekatan whole of nation dan juga semua pihak berkepentingan perlu sama-sama berganding bahu untuk menangani masalah ini. Kos perubatan yang meningkat memang satu yang memang yang kita akui dan kita perlu tangani dan inilah sebabnya kita telah menggariskan sembilan inisiatif-inisiatif ini untuk menangani isu peningkatan kos perubatan ini secara holistik. Ia melibatkan bukan saja Bank Negara juga KKM, hospital swasta, pihak ITOs dan sebagainya.

Untuk makluman Yang Berhormat sekalian, kami juga telah mengadakan mesyuarat dengan kesemua pihak. Kami telah berjumpa dengan pihak KKM dan bersetuju on beberapa perkara. Kami juga telah berjumpa dengan pihak ITO dan mengarahkan mereka melakukan beberapa perkara. Kami juga telah berjumpa dengan pihak hospital, APHM dan berbincang dengan mereka dan mereka juga bersetuju dengan langkah-langkah yang kita telah identify dan kita akan ambil untuk tempoh tiga tahun ini supaya kita dapat bersama-sama mengurangkan inflasi kos perubatan.

Kedua dari segi ketelusan. Memang kita telah pun menggalakkan dan mengarahkan pihak ITOs dan juga hospital untuk lebih telus dari segi caj mereka. Hospital contohnya, apabila kita dapat pada dua, tiga tahun yang lalu kurang sikit sambutan daripada pihak hospital untuk memberi bil yang lebih telus. Kita telah menggunakan pihak ITO untuk mereka mengeluarkan maklumat tersebut, menzahirkan maklumat tersebut, jadi pihak pesakit boleh melihat hospital ini macam ini charges dia, hospital ini macam ini charges dia.

Jadi ia juga bertujuan untuk menggalakkan persaingan di antara mereka supaya mereka tidak come together dan meningkatkan harga kos hospital, itu telah dilakukan oleh Bank Negara Malaysia. Tapi di bawah spesifikasi inisiatif yang sembilan ini kita akan dapat sama-sama menangani isu ini. Ketiga, memang dari segi regulation adalah amat penting. Dari segi mengawal selia peningkatan harga kos perubatan adalah amat penting dan juga dari segi ubat itself, dari segi farmaseutikal juga perlu pengawalseliaan. Di sinilah pihak KKM akan memainkan peranan di bawah inisiatif yang kita ambilkan melalui sembilan inisiatif utama ini.

Dan ketiga dari segi soalan Yang Berhormat berhubung dengan DRG, DRG ini dia akan memperkenalkan kadar tarif tetap untuk setiap kumpulan berkaitan diagnosa masing-masing. Contohnya kadar diagnosis untuk penyakit yang A contohnya di mana ia tidak melibatkan sebarang kerumitan ataupun kompleksiti, lebih kurang harganya sedemikian. Jadi ia boleh jadi macam benchmark kepada semua orang dan semua hospital. Mereka tidak boleh mengecaj lebih tinggi daripada harga yang dia telah tetapkan di bawah inisiatif DRG ini.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okey lah contohnya macam appendix semua lah, SLE, penyakit SLE dan sebagainya.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Ya betul. Betul, betul.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Sekarang ini dia different hospital caj.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Ya exactly, exactly. Tapi memang DRG ini memerlukan banyak data dan banyak juga pre-condition yang perlu diadakan terlebih dahulu sebelum kita boleh melaksanakan DRG dengan jayanya.*

[Muka surat 18 - 22, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

ii. Penjelasan Persatuan Insurans Am Malaysia (PIAM)

Encik Ng Kok Kheng [Pengerusi PIAM] **dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025** menjelaskan bahawa kenaikan premium adalah akibat kenaikan kos perubatan yang lebih besar, bukan disebabkan industri insurans semata-mata. Sebagai contoh negara Jepun berjaya mengekalkan inflasi perubatan rendah pada kadar 0.9% kerana kawalan ketat kerajaan Jepun terhadap harga rawatan dan ubat-ubatan.

"Encik Ng Kok Kheng [PIAM]: *YB, sorry. I know I haven't been speaking at all. I think all this additional information like you want to find out from the insurance company, individually, what their increases has been and how they do their pricing. That there is a discipline and there is a structure to it. There are pricing policies that insurance company have to come out. So, they do follow a very strict guideline in accordance to regulations that Bank Negara provide.*

I just wanted to— I mean I just thought that maybe we should also come to look at what really is the basic problem why we are having this meeting here today. Because as an insurance company, I think we are just the consequence of something that has happened. The consequence is that they need to price their premium up and what cause the price of the premium to go up. Its basically the other things that's happening. One of them is medical costs inflation.

I was very interested when we look at the statistic that Mark O'dell provided earlier of course, from the industry. When I look at Japan, their inflation— medical costs inflation is 0.9 percent, Australia is advanced country five over percent, but all the rest are close to the 10 and maybe even more than 10 percent. I think we don't even have to talk about the US, probably the highest in the world. I think if you all know what happen there is people have to find the job to get insurance cover. If you don't have a job, they cannot afford insurance. The insurance companies have to control the costs.

Therefore, they imposed these things like you know, maybe even controlling the hospitals and even the treatments to the extend that we have this recent incident why the United Health CEO got shot you know. Because he was trying to control the cost as well. Its for profiteering basis. But I think the important issue is the medical costs is still going up. We are part of you know, the entire chain. So, I think the information that you want I think, we can provide to you. But just an interesting thing is that how do Japan keep it at 0.9 percent?

Interesting is this morning we had discussion with a group of Japanese insurers came to visit. As you know, I asked them this question you know. They said that in Japan, they whole medical thing, is actually with a lot of effort there is done by the government. The government is very much in control. The ministry is managing because they even determine how price of certain treatments and drugs and so on are managed you know. They said that medical insurance

premium increased all this are not an issue for them. When I explained to them our issue that we are currently facing, they were quite surprised you know. So, we did talk to them and perhaps, there is something that maybe in our future you know, engagement with them will could find out from them what they do.
But, it's not from insurance industry. I think is the whole ecosystem including the way the government manage it— I put that as priority, that national health scheme. Having a national health scheme may not solve our problem. Because your national health scheme costs can also go up. Because it's related to medical costs, right? So, if you have a national health scheme, somebody's got to pay for it too whether it's a sharing basis or whatever. But if you don't manage that part of the costs, the costs will still go up.

I remember in Australia when I was there, they have Medicare for the last 30 over years. Everybody pays a premium from their salary. I think its automatically deducted. That has also gone up, you know. I think from when they started, it was like one or two percent from everyone's salary. I am not sure what the increase to— I think its… [Dicelah] Ya. So, but they manage it as a whole country system. So, I think this an area we really have to pay attention to as well. Otherwise, each one will be having their own you know, agenda and its going to be very difficult. That's what I thought. Ya, thank you.

[Muka surat 64 - 74, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.5.3.2 Caj Berlapis */ Double/Triple Charging*

<u>Penjelasan KPE HTO KKM</u>

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM menyedari isu caj berlapis (*double/triple charging*), namun setakat ini data yang ada belum mencukupi untuk membuat perbandingan yang adil antara kes rawatan yang serupa. Perbezaan caj mungkin dipengaruhi oleh tahap keparahan penyakit, kerumitan prosedur, serta faktor individu pesakit seperti umur dan penyakit sampingan. Untuk menangani isu ini secara menyeluruh, KKM kini bekerjasama dengan BNM dan pihak industri untuk membangunkan pangkalan data yang lebih lengkap dan sistematik. Pangkalan data ini akan merangkumi maklumat penting seperti diagnosis, rawatan, hasil discaj dan lain-lain untuk menyokong sistem klasifikasi klinikal dan pengebilan yang setara. Selain itu, KKM juga mempertimbangkan penggunaan atau pindaan Akta 586 untuk memperkukuh pelaksanaan inisiatif ini.

"Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, kalau saya boleh tanya tentang isu cases yang double charges ya, three time charges. Contohnya, apa yang berlaku kepada denggi dan juga pneumonia di mana ada multi— saya difahamkan ada five tiers of charging oleh private hospital. The first tier is of course the medical tourism. Medical tourist come to Malaysia, they have a charged katakan RM10,000. On top of it, they have agent fees of about 25 to 30 percent. Whoever refer to them, they get another extra 30 percent. So, it goes up RM13,000, contohnya. Okay, some kickback dan sebagainya. Itu tier pertama. Tier kedua adalah guarantee letter. Guarantee letter of course, dia akan menjadi mahal. Tier ketiga adalah contohnya kita yang pay and claim. Okay. Tier keempat adalah yang tidak– pay sendiri, yang bayar sendiri tanpa— bukan pay and claim tetapi yang bayar sendirilah macam YB Kubang Pasu. Okey.*

...

Tuan Sim Tze Tzin [Ahli PAC]: *Dan last sekali ada yang tidak dapat bayar, mereka bagilah charity dan sebagainya. Contohnya, yang tak mampu langsung, okey. They give some you know maybe they heavily subsidised. So, that's five tiers. Jadi, benda ini berlaku, apakah kerajaan ada apa-apa— sebab to me some of the— saya rasa amat tidak berpatutanlah dengan guarantee letter versus the pay and claim. Dia contohnya denggi empat kali ganda, then untuk pneumonia tiga kali ganda. Itu belum kira lagi yang Dato' Kubang Pasu punya kes lah, mungkin lagi rendah ya, dia punya perbezaan lagi besar. What are we going to do about this? Because it's clearly— Sorry to say, it's abusing the insurance and causing the insurance price to go up.*

...

Dr. Yap Wei Aun [KKM]: *Kami sedar dan telah melihat pelbagai analisis oleh pihak industri, ITO dan hospital swasta yang menunjukkan perbezaan harga dalam bil hospital bagi episod kes yang serupa. Analisis ini menggunakan pelbagai metodologi dan tidak berasaskan maklumat yang mencukupi dan lengkap untuk membolehkan perbandingan setara yang sah bagi episod rawatan klinikal itu. Perbezaan tersebut mungkin dan boleh mencerminkan perbezaan dalam tahap keparahan penyakit, perbezaan dalam kerumitan prosedur yang diperlukan untuk merawat penyakit, faktor pesakit seperti comorbidities, umur dan jantina dan sebagainya.*

Bagi menambah baik analisis ini, Kementerian Kesihatan memerlukan data yang lebih lengkap dan sistematik untuk merangkumi keseluruhan sistem hospital swasta khususnya diperlukan lebih banyak maklumat mengenai diagnosis primer dan sekunder, prosedur yang dilakukan, hasil rawatan semasa discaj, berat lahir, umur, jantina dan sebagainya. Data yang diperoleh akan digunakan untuk mengkategorikan episod klinikal ini kepada kumpulan yang setara, apples to apples comparison, dari segi klinikal dan penggunaan sumber.

Kumpulan sedemikian juga merupakan asas kepada sistem pembayaran DRG. So, it's related to DRG in that way. KKM, Bank Negara dan rakan industri sedang bekerjasama untuk membangunkan pangkalan data discaj hospital swasta termasuk data minimum yang diperlukan untuk menyokong pengkategorian ini

dan maklumat pengebilan yang berkaitan. Ini akan membolehkan ketelusan harga. So that you will be aware of the prices and can make an informed consumer choice dan perbandingan harga yang lebih setara antara hospital. So, you are allow apples to apples comparison. So, we don't know whether the GL or the tunai really reflects a comparable episode of care or is it just because the population are systematically different, the severity different et cetera.

Kuasa di bawah Akta 586 dalam bentuk sedia ada ataupun dengan pindaan yang diperlukan dijangka diperlukan untuk inisiatif ini. Then, berdasarkan perbincangan awal dengan pihak berkepentingan hospital swasta, telah wujud persetujuan awal mengenai perkara ini. So, just to let you know that at least from the Bank Negara, ITO, private hospital, some of the major changes, they are more or less on board with the understanding that really rather than just argue, "Oh, methodologies and you say mine is three times, four times and the other person say it's actually seven percent cheaper". Let us focus on the future and the future is let's sort out our data, let's get enough data to allow an apples to apples comparison between conditions. So, that's just not industry-driven analysis and we fitting whatever narratives that they might be comfortable with. But, it's just something we just based on real comparable clinical episodes including the severity and comorbidities, patient factors, the complexity of the procedures and that's really much in the card for what we are working on together as a seluruh negara... "

[Muka surat 17 - 19, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

7.5.3.3 Diskaun Kepada Syarikat Insurans

Isu diskaun ini merupakan "perang" tuntutan antara dua pihak yang akhirnya memberi kesan kepada rakyat. Syarikat insurans mendakwa mereka perlu meminta diskaun bagi mengawal kos rawatan yang tidak terkawal kerana hospital mengamalkan sistem caj mengikut satu-persatu item (*ala carte*). Mereka mahukan "harga yang adil" bagi membendung amalan sesetengah hospital yang didakwa sengaja mengenakan rawatan berlebihan semata-mata untuk memulangkan modal pembelian mesin perubatan yang mahal dengan cepat.

Sebaliknya, pihak hospital pula merasa tertekan kerana diminta memberikan diskaun yang terlalu tinggi, iaitu antara 25% hingga 40% bagi setiap bil pesakit. Hospital mendakwa mereka sering diugut akan dikeluarkan daripada senarai panel rawatan tanpa tunai (*cashless*) sekiranya enggan memberi diskaun tersebut. Keadaan ini dianggap tidak adil memandangkan

keuntungan bersih hospital swasta sebenarnya tidaklah setinggi yang disangka, iaitu sekitar 9% hingga 11% sahaja.

Kesannya kepada orang awam, penjimatan kos yang dibuat oleh hospital tidak sampai kepada pesakit kerana dana tersebut habis digunakan untuk memberi diskaun kepada syarikat insurans. Bagi menutup kerugian tersebut, hospital terpaksa menaikkan harga ubat-ubatan dan peralatan perubatan dengan sangat tinggi, kadangkala sehingga 300%. Ini menyebabkan struktur bil hospital menjadi mengelirukan dan tidak telus.

i. <u>Penjelasan KPE LIAM</u>

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa permintaan syarikat insurans untuk mendapatkan diskaun daripada hospital adalah perlu bagi mengawal kos rawatan dan memastikan dana perubatan kekal mampan bagi pemegang polisi. Beliau berpendapat bahawa hospital swasta pada masa ini tidak mempunyai insentif untuk mengawal kos kerana mereka beroperasi atas dasar harga per item (*ala carte pricing*). Keadaan ini, menurutnya, hampir tidak meninggalkan pilihan lain kepada syarikat insurans selain terus mendesak untuk diskaun bagi mengurangkan jumlah bil keseluruhan.

Tindakan mengeluarkan hospital daripada panel bukanlah bermakna pelanggan tidak boleh menggunakan hospital tersebut dan membuat tuntutan, tetapi ia bermaksud kemudahan tanpa tunai (*cashless facility*) akan ditarik balik. Semakan panel hospital adalah proses berkala di mana hospital ditambah atau dikeluarkan berdasarkan kriteria yang ditetapkan oleh setiap syarikat insurans.

Beliau turut bersetuju bahawa terdapat masalah yang perlu diperbaiki dalam sistem penjagaan kesihatan swasta dan LIAM komited untuk bekerjasama dengan pihak berkuasa bagi mencari penyelesaian.

> ***"Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:*** *The discount 10 percent? Insurance company asking for discount 10 percent from…*

Encik Mark Steven O'dell [LIAM]: *Oh, oh, ya. Well, you know, the hospitals, they really have like I say, they really have no incentives to control costs. They are on per item ala carte pricing basis. Its really left the insurers almost no choice, but to keep pressing for discounts and all to get the total bill down in order to keep the fund, the medical fund as sustainable as possible. When it comes to— when you say remove them, it's not like the customers cannot go to their hospital and claims, it's just the cashless facility which is I know it's not just— but I mean, it's the cashless facility that is removed if somebody is coming of the panel. But I do want to say that reviewing of the panel is a regular exercise and companies hospital are added or subtracted from the panel based on criteria put forth by each insurer.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Mark, I just want to make this clear. As far as PAC is concerned, we are not taking side. We are not taking the side of private hospitals or taking side on the insurance companies, which is want to get information…*

Encik Mark Steven O'dell [LIAM]: *Understand.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *To see where we can go from here. What I know is few private hospitals that I talk to, their profit is very low. Even without that 10 percent discount, five percent compared to insurance, their profit is low. They have to spend a lot of money on expansion of hospital, adding more hospital because the great demand and all that. So, this is the information we get and we see how to resolve all this issue.*

Encik Mark Steven O'dell [LIAM]: *Ya. I think we can definitely agree on the need to be something fixed, that is broken. We are committed to work with the authorities to do the best we can to do that."*

[Muka surat 25 - 26, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. <u>Penjelasan Ketua Pegawai Penjagaan Kesihatan, AIA Berhad</u>

Tuan Heng Zee Wang [Ketua Pegawai Penjagaan Kesihatan, AIA Berhad] dalam Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa diskaun hospital sering menjadi tidak berkesan kerana hospital akan menaikkan harga item lain untuk menutup potongan tersebut. Isu utama bukanlah diskaun, tetapi "pembaziran perubatan" seperti penggunaan mesin MRI atau prosedur teropong (*scope*) yang berlebihan dan tidak perlu, yang akhirnya meningkatkan kos keseluruhan bagi semua pemegang polisi.

"Tuan Heng Zee Wang [AIA Berhad]: *… On the second point of a hospital discount, as I shared earlier, actually the discount is very ineffective today.*

Personally, you know I see from our own experience for our company. It's because every time we see there's a discount being negotiated, the price was actually being passed through in the increase because there's no control. As I indicated, yes, you know true enough for this quarter, maybe a lot of the insurer, because of interim measure, has gone to the provider to request for discounts. But we also see that, look you know the price actually already almost immediately moved up.

Now, I can speak on maybe for my company or maybe on behalf the industry that, look, if the private hospital says that, "Look, insurance asked for discount". If it says, "Look, we are happy to remove the 10, 20 percent discount", will the price come down by 10-20 percent? Will the provider be committed to say, "Look, if insurance don't ask for discount, the price of the cost will come down". That means they will adjust all the price to come down. Will that happen? For example.

...

***Tuan Heng Zee Wang [*AIA Berhad*]:** So YB, just to add, it's not about questioning whether hospital make how much margin or who makes so much. So, as an insurer we're responsible you know for the fair chargers, we are payor. So, we are responsible for fair charges for our customers, for our patients and that the consequence of that is basically the increase in premium right? And the worst thing is if one person over-utilise or if one person being overcharged, is the nine others who is actually in the insurance pool that will have to pay for? That's the whole concept of insurance right? Like each one pay USD1 and if somebody — something happens to somebody, he takes the USD10. If the person decided to take USD20 when he needs, then everyone has to pay USD2, that's the most simple, basic fundamental of pooling of risk in insurance. So, our job is to make sure that we pay a fair price.*

Hence Mark just now talked about the need of a reasonable and customary price. DRG is aimed to address that but DRG will take a very, very long time and that's where our concern is. Hence our question is; in the meantime, are we able to say why one hospital charged RM5,000 for an MRI? Why another hospital charged RM3,000 for MRI? Why another hospital charged RM1,500 for MRI? Why do we need to use MRI of a certain accuracy of a high definition for a mild symptom cases, for example. So, all these are what we call medical wastages. Just like the scopes, it's not about wanting a discount for the scopes. Actually, we don't need the discount if you say, "Look, upper lower scope is done sparingly and it's not 65 percent upper lower scope but it's 20 percent". The whole cost will come down and there's no need for discount on that because it's used in appropriate manner."

[Muka surat 17 - 19, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

iii. Penjelasan Pengerusi, Allianz Malaysia Berhad

Tuan Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad] dalam Prosiding Bil. 5(p) bertarikh 19 Jun 2025 memaklumkan bahawa syarikat insurans sebenarnya tidak mengejar diskaun, sebaliknya menuntut "harga yang adil" (*fair pricing*). Beliau mendakwa hospital swasta sering mengenakan caj berlebihan untuk memulangkan modal pelaburan mesin perubatan mahal secara pantas dengan cara menggalakkan penggunaan berlebihan (*over-utilisation*).

Beliau menggesa agar hospital menerbitkan harga mereka secara telus dan menggunakan sistem DRG untuk memberikan kejelasan kos bagi setiap prosedur, daripada terus mendakwa mereka ditekan oleh syarikat insurans.

> ***"Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]:*** *Tuan Pengerusi, saya nak masuk campurlah dari segi Allianz. YB, why should there be a discount in the first instance? They should be charging fair pricing and clearly there's evidence to show that they have not being doing that. There are many issues, the hospital are private institutions, some are listed. You know, they buy a piece of machinery, they want to recover that piece of machinery in six years and make six times profit from that particular machinery. This is what happening in — us. So, we are asking for fair pricing, we are not asking for discount. So, why you call it discount? Because we realised that they are charging us more than what they should be charging, and this is the reality. So, let's stop talking about discount, we want fair pricing. We want fair pricing. Publish your price, we can see.*
>
> *Use the DRG that will show more clarity in respect to procedures — cost of procedure. Why don't we do this? But they come to you and say, "Oh insurance companies are whacking us, asking for a discount." It's not discount, we are asking for fair pricing. So, this is the reality.*
>
> ***Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]:*** *That means, in your view, the private hospitals maybe per patient they make more than 30 percent of the profit. That's why you demand, you know they give the insurance companies clients a 25 percent discount. So that they make less profit. I mean, is that how you view?*
>
> ***Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]:*** *I think YB, they are making more than 30 percent. Okay, you buy a lithotripter machine, for example. It's a tank that you put to diagnose, to break up your stones in your kidney. So, let's say it's a USD1 million, for example. The hospital will want six times that amount, they want six times that. So, they put everybody to utilisation. So, the only way to*

recoup, to get that six percent is to charge higher. So, it's not fair pricing. The way they behave as well in terms of utilisation of the machine. They buy a new machine, "Oh, we have to utilise". They send an email to all of the doctors, "Please utilise this machine as much as possible", and this is what's happening. So, fair pricing, over-utilisation, trying to recoup back their fixed cost is basically causing the prices to go up. I'm not throwing them under the bus. They are behaving like any other private entity, they want to make money.

But a certain landing page has to come. We have to get to a point of fair pricing. What is fair?"

[Muka surat 18 - 19, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

iv. <u>Penjelasan Bendahari APHM</u>

Puan Erica Lam [Bendahari APHM] dalam Prosiding Bil. 5(l)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa penjimatan kos yang dilaksanakan oleh pihak hospital yang memperoleh penjimatan 3 peratus sebenarnya tidak dinikmati oleh pesakit atau hospital, sebaliknya dana penjimatan tersebut terpaksa digunakan sepenuhnya hanya untuk menampung atau menyubsidi kadar diskaun yang dituntut oleh syarikat insurans.

***"Puan Erica Lam [Bendahari APHM]:** But I'll give you a statistic. Last year my discount to the PHKL because I am very familiar PHKL numbers but now Hospital Kuala Lumpur numbers. The discount I'm giving to the insurance and all like it's about three percent of my revenue. But because last year we have gone for one round negotiation already. Last year was nothing about this whole era, it's just pure business negotiation. I give you more, you give me more discount. Immediately we see impact of increase by 1.5 percent. So this year 4.5. Now coming soon in April, January, April all the hospital group already strike many, many deals, market forces discount negotiation. We expect our discount rate will go up another three more percent, six to seven percent.*

So, as a country why I choose Malaysia? We are talking about a cost savings to get three percent. Why we do three percent cost saving? Because to save the money to subsidise the discount. As simple as it is. Initially we'll be just leave it at it. The patient has got savings we got savings. Saving is actually go back to the discount. So, we have to give three percent discount then we save money from three percent, put the money back together. So that is as it is I can give it to you."

[Muka surat 37 - 38, Laporan Prosiding Bil 5(l)/2025 bertarikh 17 Jun 2025]

v. Penjelasan Ahli Lembaga Pengarah APHM

Dr Tan Hui Ling [Ahli Lembaga Pengarah APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa hospital swasta kini berhadapan dengan tekanan besar daripada syarikat insurans yang menuntut kadar diskaun yang tidak munasabah, mencecah antara 25 peratus hingga 40 peratus bagi semua bil pelanggan mereka. Syarikat insurans menggunakan taktik tekanan dengan mengancam untuk mengeluarkan hospital daripada senarai panel kemudahan tanpa tunai sekiranya tuntutan diskaun tersebut tidak dipenuhi. Situasi ini meletakkan hospital kecil dalam kedudukan yang sukar kerana mereka dianggap sebagai pihak yang lemah dan mudah disingkirkan oleh penanggung insurans jika enggan berunding mengikut syarat yang ditetapkan.

> ***"Dr Tan Hui Ling [APHM]:*** *…Okay so these are all on going that we never shout about but the truth is ongoing and the biggest so-called cost cutting is actually giving in to the insurance by offering them more discounts. We have insurance asking for 25 percent discount, 40 percent discount even. But it's impossible for us to give 40 percent discount. Giving 40 percent discount means I am subsidising your client. It doesn't make sense in a private sector. Even a charity hospital cannot run with 40 percent discount.*
>
> ***Puan Erica Lam [APHM]:*** *YB, I got the number already. The IHH Malaysia cost saving percentage is about two to three percent but our discount to insurance is five percent. How can? That's what this is now, in real life.*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *I just point to this insurance— discount to insurance, 25 percent to 40 percent. How many cases they ask for this kind of discount? Out of like 100 cases, I am sure it is not everything.*
>
> ***Dr Tan Hui Ling [APHM]:*** *All their clients.*
>
> ***Puan Erica Lam [APHM]:*** *Every, everything, everything in the bill YB. [Ketawa]*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *All cases?*
>
> ***Puan Erica Lam [APHM]:*** *Everything. All. Yes.*
>
> ***Dr Tan Hui Ling [APHM]:*** *All clients of theirs. Otherwise, you might be removed from being the cashless facility. In fact, I have one insurance that come to both of my hospital which when we had catch up with them every year, we do reviews with them every year. To us your bill size very reasonable. Suddenly in February we receive a notice, your hospital is being removed from cashless facility. I say "don't come and talk to me anymore. I don't even want to negotiate with you",*

and that's how they deal with us. Now they use these two to go to the bigger groups and negotiate. If you don't give me more discount this what will happen to you. Look at the small flies, we are the small fly okay. Small hospitals, small fly. We can just de-list you like that. And that's how the insurers deal with us."

[Muka surat 35 - 37, Laporan Prosiding Bil 5(l)/2025 bertarikh 17 Jun 2025]

vi. Penjelasan Gabenor BNM

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025 memaklumkan bahawa permintaan diskaun oleh syarikat insurans merupakan salah satu langkah kawalan untuk mengekang inflasi kos perubatan dan mengawal kenaikan premium insurans. Menurut beliau, tindakan ini bertujuan untuk memastikan kos prosedur dan bekalan perubatan tidak melampau. Walau bagaimanapun, BNM komited untuk bertindak sebagai pemudah cara dalam perundingan antara kedua-dua pihak bagi memastikan sebarang diskaun yang dipersetujui adalah adil dan saksama tanpa menjejaskan kepentingan mana-mana pihak.

"Dato' Seri Abdul Rasheed Ghaffour [BNM]: *...First is that, langkah-langkah ini adalah di antara langkah-langkah untuk mengawal kenaikan kos inflasi perubatan sebab kita dapat lihat dari segi penggunaan berlebihan dan juga kos-kos yang tinggi terutamanya dari segi surplus dan sebagainya. Jadi, untuk mengekang atau menahan kenaikan inflasi ini, salah satu langkah yang kita ambil adalah untuk memastikan pihak insurans menetapkan beberapa langkah ataupun inisiatif bagi mengurangkan kos dari segi perubatan ini supaya ini dapat mengurangkan kenaikan dari segi premium mereka.*

One of the measures that taken by the industry is to actually ask the hospital to reduce the cost, to provide discount. Walau bagaimanapun, memang kita tahu terdapat sedikit perundingan di antara pihak insurans dan juga pihak hospital di mana kami pihak Bank Negara telah pun memberi pandangan kami dan juga cuba membantu untuk mereka memastikan sebarang diskaun yang dikenakan atau diperuntukkan adalah fair kepada kedua-dua pihak, kepada pihak insurans dan juga kepada pihak hospital. Kami juga telah beberapa kali berjumpa dengan kedua-dua pihak untuk menangani isu ini..."

[Muka surat 9 - 10, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

vii. Penjelasan Penasihat Teknikal BNM

Datuk Jessica Chew Cheng Lian [Penasihat Teknikal BNM] dalam Prosiding Bil. 5(q)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa langkah pembendungan kos *(cost containment*) perlu diteruskan kerana portfolio insurans perubatan kini sedang mengalami kerugian. BNM memantau rundingan diskaun tersebut dan meminta syarikat insurans serta hospital memberikan data sokongan untuk mencapai kata sepakat.

Selain itu, BNM juga sedang berusaha mengaktifkan semula "mekanisme aduan" (*grievances mechanism*) bagi menyelesaikan pertikaian kos dan membuka saluran terus kepada hospital untuk melaporkan kes-kes spesifik yang dianggap tidak adil.

> ***"Datuk Jesicca Chew Cheng Lian [BNM]:*** *Ya, kami memang memantau cost containment measures yang diambil oleh pihak ITO sebab dengan— sebelum, even before kita implement interim measures ini, memang dah wujud the pressure on the performance macam kita tunjuk tadi pun portfolio itu memang loss-making sekarang. Jadi, dengan implementation of the interim measures, tekanan ke atas syarikat ITO memang akan berterusan sampai 2027. Jadi, salah satu daripada respons syarikat insurans adalah untuk berunding dengan pihak hospital swasta. Jadi, sama-sama kita kena control cost sikit sepanjang tempoh ini sehingga produk asas ini boleh dikeluarkan.*
>
> *Jadi, itu rundingan dan kami pun sudah pun dah memantau langkah-langkah yang diambil oleh syarikat insurans. Yang paling removal, macam diskaun ini memang will continue YB Pengerusi because it is important to contain cost. Everybody needs to play a part, right? If not, the pressure on the insurance companies, the premium, will remain. Although it will be interim for three years, it will be limited to 10 percent. After that, you will see this big jump. So, all need to cooperate, to try and bring the cost down.*
>
> *We understand sometimes this discount terlalu tinggi. Jadi in those cases, we will ask the insurances companies to explain the basis and they will show us the data that they used to negotiate with the hospital and we invite the hospitals to do the same, to present their data, then they can come to agreement on this.*
>
> *We also Yang Berhormat Pengerusi, we also have something called a grievances mechanism actually, that was setup dua, tiga tahun yang lalu to allow private hospitals, doctors ke who have complaints about such action by ITO, to bring to this body. This body has medical professionals. It will have independent people who will look at cases and then will recommend what would be appropriate course of action but that has been suspended temporarily. Sambil kita menjelaskan dengan Competition Commission because there could be some*

concern over collusion and all that. So, we wanted to make sure that it is not an issue tapi we intend to reactivate this mechanism to allow them to resolve such disputes between private hospital dengan insurans.

Lagipun kita dah— also we offered, yang mana hospital yang ada masalah macam ini boleh, can approach Bank negara and we have opened a channel for them to do so. We said yang kita boleh address ini, we need specific cases. Susah kata, yang kita speak generally, kan? So, if you give us specific cases, our team will look into it, will get the insurances companies to explain their action and we have done so in the number of cases. Cuma you know, the— we have not seen many its specific cases brought forward to us but we have opened the avenue for the hospitals to come forward."

[Muka surat 10 - 11, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

viii. PenjelasanTimbalan Gabenor BNM

Encik Aznan Abdul Aziz [Timbalan Gabenor BNM] dalam Prosiding Bil. 5(q)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa permintaan diskaun oleh syarikat insurans tidak dilakukan secara menyeluruh (*across the board*), sebaliknya berdasarkan perbandingan statistik antara hospital. Syarikat insurans akan meminta diskaun yang lebih tinggi daripada hospital yang dikesan mengenakan kos rawatan yang jauh lebih mahal berbanding hospital lain sebagai langkah penyelarasan kos. Beliau menyarankan mana-mana hospital yang merasa terbeban dengan permintaan diskaun yang tidak munasabah untuk tampil membuat laporan kepada BNM dengan justifikasi yang jelas.

"Encik Aznan Abdul Aziz [Bank Negara Malaysia (BNM)]: *Yang Berhormat, maybe if I want to add to that. Kami juga ada melakukan perbincangan dengan beberapa syarikat insurans dan diskaun ini adalah berdasarkan satu rundingan dan lagi satu, statistik. So, maknanya dia bukan across the board, let's say 20, 25, 30 percent. It depends on the hospital. So, dia buat perbandingan kos hospital A, hospital B, hospital C. So, hospital mana yang kosnya tinggi, yang itu akan diminta diskaun untuk menyelaraskan kos supaya tidak berlebihanlah.*

So, mungkin yang kompelin itu adalah hospital yang kos dia agak tinggi berbanding dengan hospital-hospital lain. So, syarikat insurans akan memberi justifikasi kenapa diskaun tersebut diminta. Like Datuk Jessica said, kalau ada yang bukan seperti itu, then bolehlah laporkan kepada kami. Then, we can take a look into it."

[Muka surat 11, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

7.5.3.4 Surat Jaminan (GL) dan *Pay and Claim*

Fenomena ketidaksetaraan caj antara instrumen Surat Jaminan (GL), *Pay and Claim*, serta pembayaran tunai mencerminkan kelemahan sistemik dalam model operasi dan jurang regulatori yang kritikal dalam ekosistem kesihatan swasta. Wujud asimetri maklumat yang ketara antara harga pasaran terbuka dengan struktur harga kontrak yang dirundingkan secara tertutup antara pihak hospital dan syarikat insurans. Walaupun hospital menyatakan pemberian diskaun kepada penanggung insurans, namun ketiadaan ketelusan menyebabkan penggunaan insurans tetap dianggap oleh masyarakat sebagai pemacu utama kepada lonjakan kos rawatan. Masalah ini diburukkan lagi dengan ketiadaan pangkalan data harga yang bersepadu, sekali gus mengehadkan keupayaan pihak berkuasa iaitu BNM dan KKM untuk memantau dan mengesahkan amalan diskriminasi harga secara efektif.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa terdapat perbezaan caj rawatan bergantung kepada cara bayaran pesakit sama ada menggunakan GL (*Guarantee Letter*), membayar dahulu kemudian tuntut insurans, atau bayar sendiri. Caj rawatan menggunakan GL adalah yang tertinggi, diikuti bayar kemudian, dan bayar sendiri. Namun, data yang ada agak terhad dan hanya dari pihak insurans.

Beliau menegaskan kepentingan kemampanan kos perubatan supaya industri insurans kesihatan dapat terus beroperasi dengan baik, serta mendorong pengenalan produk asas yang mampu dimiliki ramai rakyat. Ini juga membantu mengurangkan tekanan ke atas hospital kerajaan.

Mengenai cadangan rebate untuk pemegang polisi yang tidak membuat tuntutan *(No Claim Discount*), beliau menjelaskan bahawa walaupun rebat ada kebaikan, ia juga boleh membawa kesan negatif seperti pesakit menangguh rawatan bagi mengelakkan kehilangan rebate, yang akhirnya meningkatkan kos dan risiko kesihatan.

Beliau memaklumkan bahawa banyak syarikat insurans kini memberi insentif kepada pelanggan yang mengamalkan gaya hidup sihat seperti bersenam dan pemakanan seimbang, dan BNM akan terus menggalakkan usaha ini.

"Tuan Haji Azli bin Yusof [Ahli PAC]: *Terima kasih Yang Berhormat Timbalan Pengerusi, Datuk KSP dan juga Dato' Rasheed. Saya tertarik dengan sebab kenaikan kos perubatan yang antaranya menyatakan tentang perbezaan jumlah kos rawatan antara pesakit GL dan juga yang pay and claim.*

Saya rasa ada satu lagi kategori yang juga terkaitlah dengan perbezaan kos ini iaitu yang mendapatkan rawatan perubatan, tetapi yang tidak claim pun. Maknanya dia memang bayar sendirilah. Itu kadang-kadang saya termasuk dalam kategori itu juga walaupun ada insurans, tapi kadang-kadang contoh macam isteri kah anak, dia pergi, dia tak nak masuk dalam— tak nak warded-lah so to speak kan. So, I have to pay-lah. Warded itu leceh lagi, macam-macam sebab duduk dalam dan sebagainya. Tapi, rate dia itu memang berbeza.

Hari itu bila ada pembentangan daripada— no, bukan pembentangan, taklimatlah daripada Persatuan Perubatan hospital, mereka menyatakan dia kata yang kadar rendah yang diberikan kepada penerima rawatan yang membayar sendiri ini adalah macam dia orang kata macam bagi sort of charity-lah. But the charity should not be obtained or taken from those who are paying the insurance. Makna if you want to make charity, you should contribute from your profit or whatsoever, CSR lah kan. So dalam hal ini, macam mana Bank Negara dalam inisiatif yang dicadangkan tadi boleh meng-regulate-lah, so make sure that the kadar itu tidak terlalu jauh berbezalah antara satu sama lain.

Dan yang mendapatkan rawatan perkhidmatan secara membayar sendiri ini, tidak claim ini pun dapat juga pembelaan sebab mereka juga membantu hospital kerajaan because dia mengurangkan kebergantungan orang ramai pergi ke hospital kerajaan.

Keduanya, berkenaan dengan rebate. Ada juga cadangan dari orang ramai yang hadir pada masa public hearing itu juga mencadangkan supaya ada sort of macam rebate kepada pembeli insurans ini yang memang tidak pernah claim for at least 25, 30 years. Saya antara yang tak pernah claim lah, alhamdulillah. Tak claim itu maknanya baguslah, sihatlah kan kita. Kita tak nak claim because bila kita claim kita tak sihat. So...

Tapi bila kita tidak claim itu actually there is a cost to it. Number one, either you maintain your healthy lifestyle meaning you pergi gym, you beli alatan sukan dan sebagainya, so that is a cost to it to maintain a good health kan. Akan tetapi dalam masa yang sama, you still want the protection. So, you still continue to buy the insurance and pay the premium.

Nombor dua, kalau you have been prescribed by the doctor, ada lah darah tinggi, macam-macam lagilah kan, so, you pun nak maintain your health, so you buy drugs and macam-macam lagilah.

Contoh sayalah, I maintain about— I, myself and my wife, I maintain about RM500 a month to maintain a good life lah dengan pressure, dengan Parlimen dan jumpa rakyat dan sebagainya memang lepas itu bila jumpa rakyat ini dia dengan jamu satu hari dengan 10 kali makan ini, memang tak boleh kontrollah, gula makan kan. So, I have to buy drugs prescribed by the doctor, so I maintain that lifestyle. So, dua bayar, bayar premium bayar this one.

Akan tetapi at the end of the day, nanti kalau dah umur katakan dah gaji Parlimen pun dah tak ada, I have to— how do I continue kalau premium itu dinaikkan because of the aging factor tadi itu kan, and the pool is getting lesser and the cost of tuntutan itu bertambah. So, bagaimana cadangan itu yang rebate itu? Sekurang-kurangnya mereka yang tidak membuat claim for a certain period of time at least boleh top-up lah maksudnya at the later age something like that. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Terima kasih Yang Berhormat. Ada dua perkara, pertama dari segi perbezaan caj itu. Memang saya bersetuju malah dari segi penelitian kami pun dengan menggunakan data-data daripada claims punya data from the ITO dan juga from a few studies undertaken memang ada perbezaan dari segi sekiranya seorang itu pergi dengan GL ataupun pergi bayar dahulu claim kemudian ataupun bayar sendiri, memang ada perbezaan. Akan tetapi data kami adalah agak terhad, kami terima daripada pihak insurans sahaja. Memang ada pihak juga yang question our database. Akan tetapi secara kasarnya, memang kita perhatikan terdapat perbezaan. Jika kita pergi dengan GL harga lebih tinggi dari segi kalau bukan setakat dari segi caj kalau masuk hospital, caj penggunaan peralatan pun sama, berbeza harganya.*

Kalau bayar sendiri dulu and claim kemudian, kurang sikit. Kalau bayar sendiri memang lagi kurang. Saya bersetuju dengan apa Yang Berhormat sebut tadi sekiranya mereka nak buat CSR, tidak bolehlah juga membebankan pihak yang mempunyai insurans.

Kedua, kenapa kita amat menekankan kemampanan dari segi kos perubatan? Ini adalah kerana kita nak pastikan supaya insurans dapat terus beroperasi dan kedua, kita menggalakkan mereka untuk memperkenalkan produk asas kerana kita nak memperluaskan inclusivity of orang ramai atau rakyat yang mempunyai insurans-insurans perubatan dan juga boleh mendapat perkhidmatan hospital swasta dengan mudah. Jadi ini juga akan mengurangkan bebanan ke atas hospital kerajaan. Memang selaras dengan apa Yang Berhormat sebut tadi.

Kedua, dari segi rebate, memang ada banyak cadangan dari segi rebate. Rebate ini ada dia punya positive side dan juga ada dia punya downside. Downside dia kadang-kadang bila kita nak pertahankan, nak dapatkan rebate atau NCD itu kita akan cuba elak daripada pergi hospital. Kadang-kadang apabila kita pergi hospital, mungkin dah terlewat dan kos lebih tinggi kepada patient tersebut dan juga kepada insurance company dan juga sebagainya. Itu yang kedua.

Akan tetapi kita telah menggalakkan malah ada banyak insurance company telah mula pun membuat— contohnya, incentivize provide insentif for people yang goes to the gym atau mengamalkan pemakanan yang sihat dan sebagainya, mereka memang ada insentif-insentif yang diberikan kepada pemegang polisi insurans yang menuju ke arah tersebutlah. That is something that I think memang dah ada dan kita akan lebih galakkan perkara-perkara inilah."

[Muka surat 26 - 29, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

ii. Penjelasan NAMLIFA

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa terdapat perbezaan ketara antara dua kaedah pembayaran insurans perubatan:

1. *Guarantee Letter* (GL):
   Syarikat insurans memberikan surat jaminan kepada hospital untuk menanggung kos rawatan. Hospital mengenakan caj maksimum yang telah digazetkan kerana mereka tahu bayaran akan datang daripada syarikat insurans dan menjadikan kos rawatan melalui GL biasanya jauh lebih tinggi**.**

2. *Pay-and-Claim*:
   Pesakit membayar dahulu kos rawatan dan kemudian menuntut balik *(reimburse)* daripada syarikat insurans. Caj rawatan adalah lebih rendah, kerana pesakit adalah "*paying patient*" dan berunding terus dengan hospital. Perbezaan kos antara GL dan *pay-and-claim* boleh mencecah sehingga 40%.

Perbezaan ini menunjukkan keperluan untuk ketelusan dan kawalan terhadap caj hospital, serta pembaharuan dalam sistem insurans kesihatan agar adil kepada semua pihak.

***"Tuan Sim Tze Tzin [Ahli PAC]:** Pengerusi, terima kasih. Saya nak tanya tentang very technical lah ya. Number one, what's the difference between guarantee letter and pay-and-claim? Sebab tadi from your case, dia tidak dapat guarantee letter tetapi lepas itu, dia boleh pay-and-claim. Sama juga datang daripada syarikat insurans. So, what is the difference? Kenapa ada perbezaan*

sebab kita nampak Bank Negara pun katakan ada perbezaan. Contohnya, pneumonia. Pay-and-claim, bayar RM1,200. Tapi guarantee letter hospital swasta charge RM5,000. That's a difference four times. Kenapa?

Encik G Saseedaran Gengadharan [NAMLIFA]: *Ya. True. When insurance company provides guarantee letter, the charges as we are told yang kita faham, dia bagi maximum charges that hospital itu sudah pun they gazetted maximum rate. So, patient don't pay, insurance company will pay later. So, mungkin dia ambil kira tempoh masa yang dia menunggu untuk dapatkan duit dari syarikat insurans kah apa, sebab itu dia charge maksimum.*

Tapi pada masa yang serupa, kalau paying patient. Patient itu bayar dari poket dia, sudah tentu kos dia lebih rendah daripada apa yang syarikat insurans yang akan bayar. So, RM1,200 sahaja. Pay-and-claim. So, ada situasi di mana syarikat insurans tidak memberikan guarantee letter tetapi kata pay-and-claim disebabkan kemungkinan ianya adalah pre-existing iaitu penyakit yang sedia ada ataupun dia tidak memberikan maklumat yang jelas tentang penyakit dia apabila dia mengambil insurans masa itu.

Jadi, dia dilindungi tetapi dia diminta untuk bayar dahulu, kemudian claim dari syarikat insurans. So, ada bezanya. As I mentioned just now, dekat 40 percent ada beza. Biasanyalah."

[Muka surat 18 - 19, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

iii. <u>Penjelasan Setiausaha APHM</u>

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(h)/2025 bertarikh 10 Mac 2025 menjelaskan bahawa APHM membantah dakwaan perbezaan kos rawatan yang besar (300%-400%) antara pesakit insurans yang menggunakan GL / *cashless* dan pesakit bayar sendiri (*self-pay*) di hospital swasta.

Berdasarkan data APHM, yang membandingkan kes kemasukan denggi dan pneumonia yang setara, menunjukkan perbezaan kos yang kecil, iaitu hanya 7% hingga 14%. Perbezaan kos yang kecil ini didorong terutamanya oleh hospital yang memberi diskaun purata 10% kepada syarikat insurans sebagai syarat untuk berada dalam panel *cashless* mereka, serta insurans menolak untuk membayar caj item kecil seperti yuran pendaftaran.

Sementara itu, perbezaan kos yang besar dalam kes tertentu (di mana pesakit tunai membayar kurang) adalah didorong oleh faktor kemanusiaan

dan kemampuan pesakit (*affordability*), bukannya caj harga yang berbeza. Ini berlaku apabila pesakit tunai memilih untuk menolak kemasukan atau menolak ujian mahal atas sebab kewangan, atau apabila doktor mengurangkan yuran perundingan walaupun dibenarkan untuk mengenakan caj yang lebih tinggi atas dasar simpati terhadap pesakit yang kurang berkemampuan.

"Encik Anwar Anis bin Anis Ahmad [APHM]: *... When we say GL patient and pay and claim over this both admitted patients or was one a daycare and one an admission case. Was the length of stay the same? Was the dengue patient somebody who had complications who stayed for five to six days? Was the pay and claim being somebody who came for daycare, admitted and discharged on the same day as a daycare patient? So, these are questions which are important because the variable is too big and we cannot understand where it came from.*

We also have to share with you that pay and claim is a very small number. Most patients do not want to pay and claim. So, we also are not sure what is the data set that was used. Although there's a number of sample size of 33,000 and 53,000, but how many of these were pay and claim? In our hospital, our experience is it is a very-very small number. A patient is either self-pay out-of-pocket or they are from insurance. Because if they have an insurance, they will want to go to a hospital where it is cashless.

YB Teresa, we will come to about the discount and cashless later because that is something that is important to understand. So, parking that aside. Like I said, pay and claim is a very small volume. So, our concern with this data is there is no indication of whether this comparison is for admission, patients with or without complication and so on.

Now, allow me to move on to the right-hand side and the data that APHM itself collected based on dengue and pneumonia cases in 2024. Our data shows that the variable is very small.

So, the multiple that you see which means is only seven or 14 percent of the difference. It's very small, right? It could be that the insurance patient pays a little bit less than a cash patient or in some hospitals, it could be that the insurance pays slightly more and the cash pays slightly less. It could be either way.

But the variable, what we are trying to say is, the variable is very small. It is not 400 percent or 300 percent but it is rather seven or 14 percent. These are based on 10,000 cases of dengue and pneumonia collected from various hospitals. But what is important is that this all admitted cases. So, we make sure that the comparison of all cases were having admission and for admission of between three to five days.

So, it is important that we compare apples to apples. Now, why is it in our data that the insurance patient is paying slightly less? Now, the insurance product

when they sell it to the public, the agents when they sell it, one, the key benefits that they say is," Oh, you can go to the hospital, you can use your card. You do not have to pay." They say is cashless. Now, cashless is not a policy or part of the agreement. Cashless is a benefit, which means— and we hope that doesn't happen. Which means if tomorrow all the insurance decides that they no longer want to allow cashless benefit, everybody must pay and claim. That could happen. Because that is not in the agreement when you buy the insurance. But that is a benefit.

So, when the agents sell it, they say, "Okay. You can use your cashless card. You can go to the hospital and you can claim." But for insurance to put a hospital on a cashless panel, they will negotiate with us. And that is why in the earlier profitability study, you saw that on average, you give a 10 percent discount to the insurer. It is because the insurance will come to us and say, "Do you want to be on the cashless panel? If you do, you must give us a discount. If you do not give us a discount, by and large, they will not put us on the panel."

There are exceptions. We are not saying that this is 100 percent the case. If in a place, let's say in a rural place like— not rural-lah, a less developed place in Sungai Petani whether few new hospitals, they may say I need to put all the hospitals because there are less options. However, in most areas, especially major cities, they will require that you provide a discount to be on the panel. And that is why YB, the cost of the insurance is lower. Another example which you find on most bills, insurance will say that I will not pay for registration costs. Now, most hospitals will charge RM10 or RM15 for registration. Even if we go to KKM, there is a registration fee.

So, registration is only to facilitate the paperwork, documenting the patient, getting their details, putting it into the system, putting the patient profile into our EMR and so on. But insurance in their agreement will say you cannot charge for a registration fee. Already in the first line item, as the patient comes and registers, a self-pay patient is paying RM10 to RM15 to register, insurance patient is paying zero or rather, the charge to the insurance is zero. Because they insist that we cannot charge registration. Some insurance also says that we cannot collect deposits and so on and so forth.

So, what is driving that difference? If you look at our actual bills, it is really the insurance patients or the insurance bills has a discount on most light items but the cash-paying patient does not. So, that's the reality. Of course, if you come back to the data from the government, what drove this difference and what drives that difference? Why is the public saying that when I pay out of my own pocket is less but when it is insurance is more? Let's take one example. An insurance patient who comes with dengue who went to a GP before that, the GP tried to manage but the dengue has not resolved, the patient is now feeling quite ill, the white blood count is low and so on and they come to the hospital. They are seen by the doctor and the doctor decides they need to be admitted.

It is not so low that it is critical but it is low enough that the patient requires to be admitted based on clinical guidelines. If it's an insured patient, so the patient says, "Okay doctor, if you think I need to be admitted, please admit me." So, I'm

admitted, the patient is monitored for the next few days until based on clinical guidelines, his fit enough to be discharged. So that bill is RM4,000 to RM5,000 for three days. Unless, take a patient who paying out of pocket and he comes to the hospital. And this is the patient who maybe is from the lower part of the M40 category, katakan. Again, the doctor looks at his blood test and all that and he says that actually, you need admission. But this patient says, "I cannot afford. Actually, I have to work." Maybe he is a Grab driver, or whatever. He cannot afford to be away from work or he has his own business or he has got kids to look after at home or she's got a kid to look after at home and she said, "I really cannot be admitted or I cannot afford it and I don't want to be admitted." And doctors, out of their goodwill, may say, "Okay, never mind. You don't get admitted. Tomorrow, you come back and we will monitor again." So, that could be one difference.

The other difference is again, I am a self-pay patient and the doctors explain that look they are a good blood test. There is a blood test, for example, the advanced blood test, that can show you that actually yes, you have dengue. And we can start the treatment straight away but that blood test is expensive. And again, most hospital doctors will explain especially for cash-paying patients.

"We need to do this blood test."
"Berapa ya doktor blood test ini?".
"Oh, RM300."
"Oh, mahallah doktor. Blood test biasa tak boleh?".
"Okay, we can do but the result will come a bit later. It takes a bit more time.".
"Tak apa doktor. Saya sanggup."

So, that difference now starts to drive— it is not because the same item in the hospital is RM300 to the insurance patient and RM200 to the self-paying patient. It is not because of that. It is because of humanitarian grounds. It is because of patient affordability that drives the variable. Doctor's fees are set at the maximum in this schedule of fees. We also have to agree that this dengue patient— okay, when the doctor consults him, the doctor will feel, "Okay, it is an insured patient, I have a right to charge RM230 and he will charge RM200." That is already from the schedule of fees.

But if it's a self-pay patient and the patient says, "Doktor, tolonglah saya. Saya kurang kemampuan." And the doctor out of goodwill and humanity, charges him only RM100 because he is self-pay. Does that make it wrong? The RM230 is what the doctor deserves to charge. It is the right charge. But the RM150 or RM100 is out of humanitarian grounds. So, these things are what drive the variable between self-pay and insured patients.

[Muka surat 18- 21, Laporan Prosiding Bil 5(h)/2025 bertarikh 10 Mac 2025]

iv. Penjelasan MMA

Dr. Gunalan @ Arumugam Palari [Ahli MMA] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa perbezaan bayaran pesakit tunai mungkin membayar lebih tinggi daripada pesakit insurans kadangkala berlaku kerana syarikat insurans telah merundingkan diskaun 10% hingga 20% dengan hospital, diskaun yang tidak diberikan kepada pesakit tunai. Diskaun lain yang diberikan adalah atas muhibah sukarela doktor dan hospital untuk pesakit yang tidak mampu.

Mengenai dakwaan menahan rawatan, Dr. Gunalan menegaskan bahawa hospital swasta tidak akan meminta kad insurans sebelum memulakan rawatan kecemasan (zon merah); sebaliknya, mereka diwajibkan oleh Akta Penjagaan Kesihatan Swasta untuk merawat pesakit dahulu. Kaedah pembayaran hanya dibuat untuk kes yang tidak kritikal (zon kuning/hijau) dan ia adalah soalan pentadbiran semata-mata, bukan bermaksud rawatan akan dihentikan. Walaupun pesakit tidak mampu membayar, rawatan masih diteruskan sehingga pesakit stabil dan boleh dipindahkan ke kemudahan awam dengan persetujuan mereka, dan doktor akan terus menguruskan penjagaan tersebut.

> ***"Dr Gunalan@Arumugam Palari [Malaysian Medical Association (MMA)]: …*** *Now, some of the anecdotal views that have been put up in public which I think I would like to take this opportunity to actually correct it. This thing about cash patients paying more and sometimes more than the insurance and whatnot because sometimes insurance companies have certain arrangements with the hospitals where we are supposed to give a 10 to 20 percent discount. Whereas this particular extension is not actually given to the cash patients. So, at times there are sometimes the same surgeries the patients may actually end up paying more compared to what is insured.*
>
> *There are also times when certain procedures are done as a package so where the package was concerned certain discounts but this is at the goodwill of the doctor and the hospital. There is a certain cost element to the procedure but doctors take it upon themselves to set the look this particular patient may not afford it, we give a substantial discount of the fees. That is actually purely a volunteering thing. So, sometimes again, why certain patients are paying cash and why certain insurance procedures are charged more, these are some of the reasons behind it. But again, I think to break it down in detail I think these are things that we actually have to highlight and move forward.*

The second thing is in any department we do not actually ask for your card before starting treatment. That's actually a very wrong thing to actually assume. A lot of times people come in a collapse state or a near cardiac arrest state kind of thing, treatment in a private hospital is always treated first, ask about the money later. Only the yellow and the green zone type of cases where the patients come in with cold or fever and cough that potentially where they are actually waiting to be seen by the doctor is when the finance team will ask what is the method of your payment. Would you like to pay using cash or with the— That is purely an administrative question. Not because we are going to stop treating you because of whether you have a card or not.

For all red zone cases where the patient comes in collapse, we are mandated by the Private Healthcare Act to actually proceed to start the treatment first. Once we stabilise and the patient is back to some form of stability, that is when we actually ask the question. This is more of a financial discussion and not so much of medical treatment. Treatment is still going on. We will ask the patient, "Do you want to continue care here and this is the estimate or do you want to continue your care at the public hospital if you find that you do not have the means to kind like pay for this treatment."

Most of the time, doctors are still involved in the care of the patient. Just because they cannot pay, it doesn't mean that we have signed off. We will still continue managing the patient until the care of the patient is handed over to a team that is willing to take over. Like most of the time, the private hospital in Klang Valley, we'll actually call our colleagues from HKL or Serdang or Ampang or even UMMC, UKM to actually see whether they are willing to take over the hand management of the patient. But, while the patient is still housed in the hospital, they will care— it's not to say you are stopping the care, the medications are stopped, the ventilators are stopped. Nothing of that stop. The typical thing that you see in a Hindi movie and Tamil movie, it doesn't happen in Malaysia. We are all bound by the laws of the government. So, we need to actually clearly emphasize that fact lah..."

[Muka surat 5 - 6, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

7.5.4 Kawal Selia & *Regulatory Gap*

Regulatory Gap membuktikan bahawa punca inflasi perubatan bukanlah yuran doktor, sebaliknya ia adalah hasil daripada kegagalan Akta 586 untuk berkembang mengikut peredaran zaman. Akta ini membiarkan hospital beroperasi sebagai entiti korporat yang mengejar keuntungan tanpa mekanisme audit harga yang setara dengan kawal selia profesionalisme doktor. Akibatnya, rakyat terpaksa menanggung bil yang dimanipulasi melalui caj-caj kreatif yang sah di sisi undang-undang tetapi tidak munasabah dari sudut moral dan ekonomi.

i. Penjelasan Ketua Pengarah (KP) Kesihatan / Malaysian Medical Council (MMC)

Datuk Dr. Mahathar bin Abd Wahab [KP Kesihatan / MMC] dalam Prosiding Bil. 5(n)/ 2025 bertarikh 21 Julai 2025 menjelaskan mengenai had kuasa kawal selia terhadap kos perubatan swasta seperti berikut:

a. Pelanggaran Etika dan *Overcharging*:
Beliau menjelaskan bahawa pengamal perubatan yang melakukan rawatan tidak mengikut keperluan klinikal sehingga menyebabkan caj berlebihan (*overcharging*) boleh dianggap melanggar *Code of Professional Conduct*. Beliau menegaskan MMC mempunyai jawatankuasa penyiasatan untuk menilai fakta aduan sedemikian, namun setakat ini MMC belum pernah menerima sebarang aduan rasmi berkaitan *overcharging*.

b. Had Kuasa di bawah Jadual 13 (Akta 586):
Beliau mengesahkan bahawa bidang kuasa kementerian di bawah Jadual 13 Akta 586 adalah terhad kepada kawalan fi perundingan dan fi prosedur profesional sahaja. Kadar fi perundingan pakar ini telah pegun dan tidak berubah sejak tahun 2013.

c. Item Pengebilan di Luar Kawal Selia KKM:
Beliau mendedahkan secara jujur bahawa dalam pengebilan terperinci (*itemised billing*) hospital swasta, terdapat komponen seperti caj bilik, caj penggunaan bilik air, dan pelbagai caj lain yang bukan di bawah kawal selia Akta 586. Beliau menegaskan kos-kos yang meningkat ini berada di luar bidang kuasa Kementerian Kesihatan untuk dikawal.

d. Dilema Semakan Fi Pengamal Perubatan Umum (GP):
Beliau memaklumkan terdapat permohonan daripada pihak GP untuk menyemak semula kadar perundingan (RM10-RM35) yang tidak berubah selama hampir 30 tahun. Walau bagaimanapun, beliau menjelaskan sebarang keputusan untuk meningkatkan kadar tersebut

perlu dikaji mendalam kerana ia akan memberi implikasi besar terhadap perbelanjaan luar poket (*out-of-pocket*) rakyat.

e. <u>Skop Tugas MMC vs Perundangan Kementerian:</u>

Beliau menyatakan pandangan peribadi bahawa isu kawalan caj perubatan secara menyeluruh adalah di luar skop tugas MMC. Sebaliknya, beliau mencadangkan isu kawalan kos ini lebih sesuai ditangani melalui penambahbaikan komponen dalam Akta 586 di peringkat kementerian, yang kini sedang dalam usaha untuk dikaji semula bagi menangani aspek peningkatan kos rawatan.

*"**Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]:** … Saya nak bertanya berbalik kepada isu yang kita sedang bincangkan ini iaitu kenaikan kos perubatan ini.*

Dalam prosiding sebelum ini, ada yang ditimbulkan iaitu terdapat amalan overtreatment ataupun upcoding di hospital swasta ini ya, yang menyebabkan caj yang dituntut itu melebihi yang kadar biasalah ya. Dalam Akta Perubatan 1971 atau 1950 itu, yang MMC tu, disebut adalah salah satunya mengawal etika profesional dan amalan pengamal perubatan ya.

Jadi, dalam akta ini bagaimana mechanisme atau kaedah yang digunakan oleh MMC sebagai satu pemantauan ataupun audit etika yang dilaksanakan secara praktisnya kepada pengamal-pengamal perubatan ini? Terima kasih.

***Datuk Dr. Mahathar bin Abd Wahab [MMC]:** Terima kasih soalan tersebut YB. Soalan yang baik sekali. Sebarang ataupun any — sebarang pengamal-pengamal perubatan yang melakukan rawatan tidak menuruti keperluan perawatan tersebut dan menyebabkan overcharging dan sebagainya, mereka boleh melaporkan terus kepada MMC untuk tindakan dan memungkinkan pelanggaran kepada Code of Professional Conduct. Itu jelas. Boleh buat pelaporan dan di pihak MMC, akan ada satu jawatankuasa penyiasatan jika aduan tersebut naik dan jawatankuasa penyiasatan tersebut akan menilai aduan tersebut secara fakta.*

***Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]:** Dalam tempoh mungkin untuk beberapa tahun ini, adakah ada kes-kes yang dirujuk oleh MMC seperti ini?*

***Dr. Mohamed Anas bin Mohamed Hussain [MMC]:** YB, kita belum ada terima aduan yang sedemikian. Tak pernah. Overcharging tak pernah ada.*

***Datuk Dr. Mahathar bin Abd Wahab [MMC]:** Tapi kami tiada halangan untuk ini because pada asasnya, kalau mereka membuat satu perawatan yang tidak sepatutnya, itu salah satu bentuk pelanggaran etika."*

(Muka surat 25-26, Laporan Prosiding Bil. 5(n)/ 2025 bertarikh 21 Julai 2025)

*"**Dato' Adnan bin Abu Hassan [Kuala Pilah]:** … Yang Berbahagia Datuk, sebenarnya kita PAC ni telah memanggil ramailah dan banyak pihaklah stakeholders yang terlibat dalam isu kenaikan harga insurans ini.*

Dan, saya lihat daripada beberapa saksi atau stakeholders yang kita panggil ini, saya boleh buat kesimpulan bahawa 70 peratus, contohnya daripada billings. Saya balik, balik kepada kita punya tajuk ni. 70 peratus daripada caj yang dikenakan kepada pesakit itu sebenarnya datang daripada perkara lain yang di luar caj melibatkan servis diberikan oleh doktor tersebut. Okey.

Jadi, saya lihat banyak kepada medical supplies contohnyalah, 70 percent daripada findings kita dapatlah. Jadi, saya ingin bertanya kepada Yang Berbahagia Datuk, adakah Yang Berbahagia Datuk bersetujulah, bersetuju? Saya ingin mohon pandangan sahaja. Mungkin kita boleh buat satu usul juga di pihak PAC agar semua perkara yang melibatkan billing ini, caj kepada pesakit ini diletakkan di bawah MMC. Seperti mana Bar Council meletakkan semua perkara melibatkan peguam di bawah Bar Council termasuklah sehingga ke dia punya scale professional fee dia, remunerasi (remuneration) semuanya diletakkan di bawah Bar Council dan ia bercakap tentang diskaun, contohnyalah.

Fasal saya lihat tadi dan saya bersetuju dengan Yang Berbahagia Datuk bahawa saya nak tanya tadi tetapi soalannya telah ditanya oleh jawatankuasa yang lain iaitu ada tidak aduan berkaitan dengan over charge ini dan apakah tindakan. Saya lihat tadi mungkin daripada seperti tadi Yang Berbahagia Datuk tadi, Datuk pun sebenarnya MMC sendiri pun terikat tangannya. Bukan semuanya MMC boleh masuk. Contoh tadi, saya dengar ucapan Yang Berbahagia Datuk tadi yang melibatkan mungkin hospital swasta apa semua ini, kita pun tidak boleh masuk, contohnya. Betulkan saya kalau saya silap.

Jadi, benda-benda macam itulah yang saya rasa — fasal tajuk kita ini ialah tajuk macam mana kita nak address isu kenaikan ini, harga-harga caj kepada pesakit ini yang melambung tinggi inilah. Ini saya hanya memohon pandangan dengan Datuk atau mungkin kita dipihak PAC ini boleh membantu dalam konteks tersebutlah.

...

***Datuk Dr. Mahathar bin Abd Wahab [MMC]:** Untuk kawalan caj itu. Untuk MMC, saya rasa – personal opinion sebagai Yang Dipertua MMC, dia agak terkeluar daripada skop sebenarnya MMC tersebut. Tetapi, apa yang kita boleh laksanakan — dia melibatkan kementerian lain. Saya tak pasti sama ada PAC dah panggil kementerian lain berkaitan dengan kawalan harga dan sebagainya. Jadi yang untuk...*

***Dato' Adnan bin Abu Hassan [Ahli PAC]:** Yang Berbahagia Datuk, sebenarnya saya yang kita risau ini banyak yang kita panggil dah ini. Ya lah, kalau di konteks biasanya kita boleh cakap profiteering. Kita boleh cakap.*

***Datuk Dr. Mahathar bin Abd Wahab [MMC]:** Ya.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Kita boleh address isu-isu itu. Tetapi, dalam konteks medical ini, tak boleh, siapa kita nak apa kan mereka. Jadi, itu saya tengok tidak ada parti, tidak ada body, agensi yang mungkin boleh letakkan isu ini di bawah mereka. Jadi, sebab itu saya cadanglah tadi kepada Datuk kalau mungkin ia nya suitable-lah. Terima kasih.*

Datuk Dr. Mahathar bin Abd Wahab [MMC]*: Salah satu perkara yang mungkin kita boleh bincang dekat kementerian di bawah Akta 586 sebenarnya. Itu adalah — saya rasa adalah lebih sesuai untuk kawalan kawal selia dan sebagainya caj-caj tersebut. Itu pun dalam peringkat perbincangan sebenarnya untuk perkara tersebut berkaitan dengan — tetapi bukan bawah MMC lah ya YB."*

(Muka surat 27-30, Laporan Prosiding Bil. 5(n)/ 2025 bertarikh 21 Julai 2025)

"Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *… Berbalik kepada prosiding kita untuk melihat kenaikan kos perubatan dan premium insurans ini. Saya ingin bertanya kepada Yang Berbahagia Datuk Ketua Pengarah. Dalam Akta Kemudahan Perkhidmatan Jagaan Kesihatan Swasta 1998 itu. Disebut Yang Berhormat Menteri Kesihatan mempunyai kuasa menetap struktur caj dan yuran hospital swasta. Namun kita lihat dari segi kronologinya kajian schedule of fee itu last nya 2013. Sudah lebih hampir 10 tahun tidak dibuat semakan. Ada pembentangan 2019 tapi tidak dilaksanakan lagi. Di pihak Datuk sendiri bagaimana? Maknanya, proses ini mungkin agak panjang masa dia. Walaupun ya lah Datuk baru menjawat bulan Mei hari itu.*

Mungkin ya lah, maksudnya, apa kekangan di pihak kementerian sendiri dari segi kita kata sebut schedule of fee itu sebab kita lihat dalam prosiding-prosiding sebelum ini maknanya bila kita tidak ada penetapan soal kos itu jadi diambil ruang oleh pihak yang ada kepentingan, pihak swasta ini, pihak hospital dan juga insurans itu sendiri. Dia mengenakan caj yang sangat ketara sehingga ada peningkatan sampai 15 peratus dalam laporan itu.

Jadi, bagaimana Datuk melihat, kementerian sendiri dengan kuasa yang ada di bawah akta itu untuk segera memuktamadkan schedule of fees itu? Baik, terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Terima kasih, YB. Soalan itu adalah soalan cepumas sebenarnya. Kita, saya, kami secara jujurnya kalau kita melihat kepada Akta 586 yang di bawah Jadual 13 yang di bawah kawal selia adalah lebih kepada fi perundingan, free perundingan, free fi perundingan tersebut.*

Jadi, dalam kalau kita melihat daripada segi charged billing dan sebagainya yang dilaksanakan oleh hospital-hospital swasta, bila seseorang itu — saya pasti many of us masuk hospital swasta. Kalau kita melihat kepada itemised billing tersebut yang dikemukakan, yang dikeluarkan tersebut, dia ada caj bilik, caj bilik air, caj macam-macamlah dalam itu semua yang dimasukkan dan perkara-perkara tersebut bukan di bawah kawal selia Akta 586 sebenarnya. Itu [Tidak jelas].

That's why bila berlaku escalation cost di situ, itu yang caj yang diberikan, tetapi pada kadar perundingan tersebut pada pakar-pakar yang melihat dan prosedur-prosedur yang dilakukan yang — contoh dia sebagai seorang pakar bedah. Jika dia membuat sesuatu prosedur, caj untuk prosedur tersebut dia memang tak berubah untuk daripada, semenjak daripada 2013 yang lalulah. Kita pun maklum kalau melihat daripada kos semasa dan inflasi dan sebagainya, sepatutnya kadar tersebut akan meningkat. Tetapi kita pun maklum kalau kita tingkatkan perkara tersebut, dia akan dapat kita panggil implikasi lebih besar kepada apa yang perlu dibayar dari segi out of pocket as supposed to daripada insurans dan sebagainya.

Yang caj itu kita — saya rasa semua maklum kita tak ada buat — even sampai sekarang pun kita tak ada kita panggil dalam perancangan untuk meningkatkan kadar perundingan tersebut. Tetapi apa yang berlaku sekarang yang kenaikan tersebut, caj-caj lain yang bukan di bawah kawal selia dan ada lebih — saya sebutkan secara jujur, yang caj lain-lain itu bukan di bawah kawalan Akta 586 dan bukan Kementerian Kesihatan yang boleh mengawal perkara tersebut. Itu pun sebenarnya satu perkara yang agak sukar.

Saya rasa YB pun maklum baru-baru ini, saya sebutkan di sini berkaitan dengan yang di luar sana adalah kita panggil permohonan daripada kita punya general practitioners (GPs) kita berkaitan dengan untuk menilai semula kadar perundingan yang RM10 ke RM35 yang sudah hampir 30 tahun yang tidak di-review. Jadi, sebenarnya untuk kita — kita pun maklum sebagai contoh, sebagai contoh ya, sebagai contoh, kalau kita tingkatkan kadar minimum tersebut, implikasinya adalah pada kita punya rakyat, daripada out of pocket yang mereka boleh bayar untuk mendapatkan perundingan tersebut.

Jadi, that's why untuk membuat keputusan sedemikian pun, kita perlu mengangkat, kita perlu kaji dengan lebih mendalam dan mendapatkan kita panggil input daripada pelbagai pihak dan seterusnya, mengangkat ke Kabinet untuk membuat keputusan. Jadi, itu yang kita risaukan sebenarnya.

Dari kos semasa, kami di pihak Kementerian Kesihatan Malaysia, dari segi kawalan itu yang apa yang di bawah bidang kami, memang kami cuba — bukan kami cuba, memang tak pernah dinaikkan pun untuk sekian lama. Macam YB lah, bayar RM1 kan, dan rakan-rakan. Yang kena bayar sekarang RM1, kita memang takkan usik yang itu sebab kita tahu isu-isu semasa. Tetapi kalau kita berbalik kepada soalan YB tadi, kos-kos yang menaik itu adalah bukan di bawah kawal selia kami.

***Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]:** Sedikit soalan tambahan. Jadi, adakah Yang Berbahagia Datuk setuju bahawa Akta 586 ini ada nampak ada kelonggaran sedikit...*

***Datuk Dr. Mahathar bin Abd Wahab [MMC]:** Ya,*

***Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]:** ...Ya dan perlu ada penambahbaikan yang maksudnya di-review oleh pihak maknanya kementerian*

sendirilah untuk mungkin di apa itu, ditambah lagi item-item penting untuk nak mengelakkan apa yang sedang berlaku itu. Maksudnya, sebagai kawalan kepada kos-kos itu maknanya dapat disenarai dengan penuh ya dan tidak ada celahan oleh pihak ada kepentingan ini untuk dia nak elak daripada dia kena tindakan dan sebagainya. Adakah Datuk bersetuju dengan mungkin pindaan maksud saya, kepada akta ini sendiri?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Ya, ya, ya, ya. Yang — betul Yang Berhormat. Ini dari segi skop Akta 586 itu, pihak kami perlu berbincang semula untuk memastikan komponen-komponen mana yang perlu ditambah baik terutamanya daripada melihat dari segi aspek peningkatan kos terhadap apa ini, untuk mendapatkan rawatan dan sebagainya. YB cakap itu perkara yang memang kita sedang usahakan. Terima kasih."*

(Muka surat 10-13, Laporan Prosiding Bil. 5(n)/ 2025 bertarikh 21 Julai 2025)

ii. <u>Penjelasan NAMLIFA</u>

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa ketiadaan kawalan harga terhadap caj bukan profesional (ubat dan fasiliti) serta amalan "diagnosis komprehensif" telah menyebabkan kos rawatan melambung, dengan contoh bil mencecah RM19,000 bagi tempoh dua hari sahaja. Beliau menegaskan bahawa tanpa mekanisme audit yang ketat, kenaikan caj hospital yang melampau ini tidak akan dapat dibendung.

"Encik G Saseedaran Gengadharan [NAMLIFA]: *Yang kita faham, terdapat dua jenis caj. Satu ialah caj profesional iaitu caj-caj doktor yang dia memang regulate. Tetapi caj non-professional fee iaitu caj hospital dan perubatan, ubat, ia tak dapat di-regulate. So... [Ketawa] Jadi, kita faham masalahnya lebih cenderung kepada dari mana.*

So, pihak hospital dia nak justify dia punya sebab kenapa kenaikan begitu tinggi sekali. Dia kata, kalau dibandingkan bil-bil ataupun caj hospital swasta di Malaysia dengan caj-caj hospital di serantau Asia di sini, kita antara yang masih bagus lagilah. Masih rendah, dia kata. Sebab itu kita punya medical tourism pun sedang naik. Jadi, itu justifikasi dia.

Satu lagi ialah iaitu approach yang dia kata comprehensive treatment. Bila seseorang itu pergi ke hospital untuk dapatkan rawatan, maka hospital dia kata dia nak check semua sebab kadang-kadang sekarang ini very complicated punya era di mana banyak jenis virus yang kita tak kenal pun masih sudah ada dan pihak hospital akan melakukan comprehensive punya diagnosis. So, di mana mungkin si pesakit itu pun mahukan yang sebegitu.

Jadi, disebabkan semua sebab ini, bilnya akan naik. Kadang-kadang dua hari sahaja sudah capai RM19,000. Jadi, kita lihat di sini kalaulah kos-kos yang dikatakan sekarang ini tidak diaudit, jadi saya rasa tidak ada kesudahan lah tentang kenaikan caj hospital yang melambung tinggi selalu. Itu maksud kami di sini. Caj-caj ini harus diaudit.

[Muka surat 10, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

iii. <u>Penjelasan Ketua Penolong Pengarah Kanan, Bahagian Amalan Perubatan</u>

Dr. Harshinderjeet Singh [Ketua Penolong Pengarah Kanan, Bahagian Amalan Perubatan] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM hanya mengawal caj profesional doktor di hospital swasta, iaitu caj konsultasi dan prosedur perubatan, berdasarkan Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 (Akta 586).

Manakala bagi warga asing, hospital swasta boleh mengenakan surcharge tambahan 25% daripada caj maksimum yang dibenarkan dalam senarai yuran profesional. Kos lain seperti ubat, makmal, bilik, kemudahan hospital (contoh: lounge, akuarium, piano dsb) tidak dikawal oleh KKM. Caj ini ditentukan sepenuhnya oleh pihak hospital. Perkara ini menyebabkan perbezaan kos rawatan antara hospital, termasuk faktor kemewahan yang boleh meningkatkan bil pesakit secara signifikan.

Beliau turut menerangkan bahawa Jadual Ketujuh di bawah Akta 586 merujuk kepada struktur bayaran bagi doktor am (*General Practitioners* – GP) yang berkhidmat di klinik swasta. Kadar bayaran semasa adalah antara RM10 hingga RM25 dan tidak pernah disemak sejak tahun 2006. Pada Disember tahun lalu, KKM telah mengadakan perbincangan bersama Persatuan Perubatan Malaysia (MMA) dan kumpulan GP bagi tujuan semakan semula kadar bayaran ini. Susulan itu, pada 7 Februari, KKM bersama Jabatan Perangkaan Malaysia telah menjalankan simulasi untuk menentukan kadar bayaran baharu yang lebih munasabah, dan kini sedang menunggu hasil simulasi tersebut.

Bagi Jadual Ketiga Belas, sebanyak 1,300 prosedur baharu telah dimasukkan ke dalam draf pindaan jadual tersebut. Prosedur-prosedur ini termasuk teknologi rawatan terkini seperti penggunaan robotik. Draf pindaan tersebut kini sedang disemak oleh penasihat undang-undang KKM sebelum dihantar ke Jabatan Peguam Negara untuk tindakan selanjutnya.

"Dr. Hajah Halimah Ali [Ahli PAC]: *Boleh tak kami PAC tahu the category of health tourism hospitals and the non-tourism hospital? Do you have that kind of category in place or is it just by the mungkin by the iklan so, orang Indonesia datang, orang daripada luar datang for surgery and all that. Do you have that? Is it in your radar?*

...

Dr. Harshinderjeet Singh [KKM]: *Okey, selamat sejahtera YB Puan Teresa Kok sebagai Pengerusi Jawatankuasa Kira-kira Wang Negara dan Ahli-ahli Yang Berhormat yang lain. Okay, the fee schedule. Bagi saya bahas dalam bahasa Inggeris ya. For foreigners, the fee schedule is applied to 13 fee schedules but for foreigners, there is a surcharge or additional charge of 25 percent of the maximum charger field of the maximum for the foreigners.*

For our rakyat is the maximum chargearble which is currently in the fee schedule. But again, I repeat, in our— for foreigners coming in, we have to charge 25 percent.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Are you talking about public hospital or private hospital?*

Dr. Harshinderjeet Singh [KKM]: *It's private hospital.*

Tuan Sim Tze Tzin [Ahli PAC]: Public... [Bercakap tanpa menggunakan pembesar suara]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Private— public right?*

Dr. Harshinderjeet Singh [KKM]: *No, private.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Private...*

Dr. Harshinderjeet Singh [KKM]: *Private hospital. For private hospital for foreigners, there is an additional charge for 25 percent of the maximum chargable fee.*

Dr. Hajah Halimah Ali [Ahli PAC]: *And, is it in the KKM's— MOH registry or something that you know, when you heard this, we heard— we heard Friday, when we had this public hearing because some of the hospitals, they said, okay. You go, hospitalisation, doctors' fees, medicine and all that, but the exorbitant*

fees, he was suprised that hospital got aquarium three— tiga tingkat? Tiga tingkat, big aquarium, apa lagi?

Tuan Sim Tze Tzin [Ahli PAC]: *Piano. [Bercakap tanpa menggunakan pembesar suara]*

Dr. Hajah Halimah Ali [Ahli PAC]: *Piano. You know, in front of the lobby and all that. This kinds of six, seven star hospitals. So, is the cost of operation [Ketawa], you know, being or were shared to the patients? That means, the patient has got to pay that kind of, you know, luxury. That kind of six-star hotels and things like that.*

So, we were wondering the insurance thing, you know. Whether they are paying for what they want to have be treated with or is it the luxurious, ambience, atmosphere and all that? Is that— are you considering that? Are you aware of that? Because, we had that in the public hearing.

...

Dr. Harshinderjeet Singh [KKM]: *Okay. This one, because as what Kementerian Kesihatan or MOH, they regulates only the professional fees. That means, the consultation and also, the procedure. So, this be regulated in the [Tidak jelas] schedule of the Private Healthcare Facilities and Services Act.*

However, as what Dr. Wei Aun has mentioned just now, the other charges as, you know, lab charges, medication, your operational, your bed, your lounge, whatever, it's not being regulated. So, that may differ from one hospital to another hospital and some hospital categorised it.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry. When you say stop being regulated...*

Dr. Harshinderjeet Singh [KKM]: *No, we are— we don't develop...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Not regulated?*

Dr. Harshinderjeet Singh [KKM]: *Not regulated. So, we only regulate the consultation and also, procedure fee."*

[Muka surat 19 - 21, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

"Dr. Harshinderjeet Singh [KKM]: *Okay thank you YB. For Seventh Fee Schedule— again, may I speak in English. It's for the GPs who were practicing in the GP clinic outside. So in the— since the fees has not been increased since 2006, okay that is RM10 to RM25. So lately, in the December last year, we have engagement with Malaysian Medical Association and GP group that to increase the GP fees.*

So recently on 7th of February, we actually held a discussion with DOSM, Department of Statistic Prime Minister Office to run a simulation to see what is the appropriate fee to increase for the GPs. So, we are waiting for their reply. So

that we can go on with the exercise to actually see what are the appropriate fees to increase for the GPs. That's for the Seventh Fee Schedule.

For the Thirteenth Fee Schedule, we have completed 1,300 new procedures to be added into the new fee schedule. Not the mean the new, in the amendment of Thirteenth Fee Schedule. The draft of the new procedures, approximately 1,300 is including robotic or the latest technology will be added in. So, at that draft now is with our legal advisor for the revision or to untuk disemakkan sebelum diangkat pada AG Chamber. Thanks."

[Muka surat 25 - 26, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

iv. Penjelasan Menteri Kesihatan

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [Menteri Kesihatan, Kementerian Kesihatan Malaysia] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa beliau telah lama membangkitkan isu semakan semula Jadual Ketiga Belas (bayaran konsultasi doktor di hospital swasta) dan Jadual Ketujuh (untuk klinik swasta) di bawah Akta 586. Jadual Ketujuh tidak pernah disemak selama beberapa dekad dan pengamal klinik swasta kini mendesak perubahan. KKM telah bersedia untuk membuat semakan, tetapi sedang menunggu pandangan dan masa yang sesuai daripada Majlis Tindakan Sara Hidup Negara (NACCOL) sebelum melaksanakan perubahan tersebut.

"Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: ... *Dalam penggal pertama saya mengemudi KKM lagi saya telah mengangkat isu revision of Jadual Ketiga Belas 586, bayaran ataupun renumeration kepada MOs. Dalam fasiliti, itu satu. Mungkin beza sedikit, yang ini consultation. Pokoknya consultation. The Thirteenth Schedule is meant for those doctors in private hospital. Jadual Tujuh, Dr. Harshinder— adalah kepada klinik-klinik swasta. Klinik swasta, Jadual Tujuh ini lagi berdekad lamanya tidak pernah dinaikkan, revised. Mereka mengasak saya hari ini untuk tidak— silap-silap nanti dia orang nak demonstrasi depan Parlimen ini. Tetapi yang Schedule Tiga Belas ini adalah schedule yang konsultasi itu. Jadi kalau dapat sikit— kami memang sudah bersedia untuk membuat revision ini. Kami sudah mengangkat perkara ini bukan sekali dua dan kita menunggu waktu yang sesuai atas NACCOL punya pandangan supaya dapat kami laksanakan. Dr. Harshinderjeet, would you have to say something.*

[Muka surat 25, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

v. Penjelasan Ahli Jawatankuasa FPMPAM

Dr. Chang Chee Seong (Ahli Jawatankuasa FPMPAM) dalam Prosiding Bil. 5(g) bertarikh 4 Mac 2025 menjelaskan bahawa kenaikan kos kesihatan bukan berpunca daripada yuran doktor. Ini kerana jadual yuran GP tidak berubah bagi tempoh 33 tahun dimana pakar mempunyai had fi yang dikuatkuasakan. Perubahan kos bekalan semasa pandemik seperti sarung tangan nitril menunjukkan kos bukan perubatan naik dengan ketara.

> ***"Dr. Chang Chee Seong [FPMPAM]:*** *Hi good afternoon everyone. My name is Dr. Chang. I am general practitioner. I would like to just share my experience as a GP. I've also experienced working in a private hospital in an emergency department. You see for healthcare cost when we talked about cost of healthcare there's a lot of other things rather than just professional fees.*
>
> *During pandemic a box nitrile gloves that cost RM15 in 2019. In 2020 the cost is RM45. At one point it went up to RM60. After pandemic we know that when price goes up it hardly comes down. Now the box of same nitrile glove compared to four years or five years ago is about RM28. Almost a hundred times increase in price. When we talk about healthcare cost it always was— people always think of doctors are charging a lot. Professional fees getting more. But if you check your facts the GP fees schedule has not changed for 33 years. Even the specialist price they are all regulated. There is a maximum charge for the specialist as well.*
>
> *If we can be one very sure about one thing, medical inflation is not caused by professional fees. That is very sure. I think the specialist and any other doctors here can attest to it. Even in the public sector if you talk about professional wages, public servants' wages has not gone up that much. It is definitely not comparable to inflation. I just want to say that if you want to look at what is the cause of rising healthcare cost, I think you will have to look at the bigger picture and investigate more clearly."*
>
> [Muka surat 7, Laporan Prosiding Bil 5(g)/2025 bertarikh 4 Mac 2025]

vi. Penjelasan MMA

Dr. Gunalan @ Arumugam Palari [Ahli MMA] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa walaupun kos keseluruhan hospital swasta meningkat secara mendadak, yuran/fi doktor kekal tidak berubah. Sumbangan yuran doktor kepada jumlah bil keseluruhan hospital kini semakin berkurangan (dahulunya 30%, kini sekitar 25% dan dijangka menurun lagi), membuktikan bahawa kenaikan kos

rawatan bukanlah berpunca daripada yuran doktor, tetapi daripada peningkatan kos teknologi dan peralatan.

Cadangan pindaan jadual ke-13 yang merangkumi prosedur dan teknologi baharu seperti pembedahan robotik, telah dirunding bersama Kementerian Kesihatan sejak tahun 2020 dan ia masih belum diwartakan.

> ***"Dr Gunalan@Arumugam Palari [MMA]:*** *Alright. So, I think the next slide we all agree that the inflation has gone up. But the most important thing is that the 13 schedule that was started in 2014. Previously, the earliest schedule was 1998. There was no revision until 2014, where there was a 14.4 percent increase in our fees. There was an initial bump in the doctors' contribution to the fees from 2015 onwards. But from 2016, 2017 onwards, our fees are fixed all the way. Whatever contribution that you see for the total bill now is actually to be honest it is not a component because of the doctor fee.*
>
> *Just for example, laparoscopic appendectomy, our fees are probably, say, RM4,000 for anesthetic and surgeon. Total hospital bill saying in 2015 was about RM20,000. The same RM4,000 we are still charging for patients but it is now RM30,000 for example because of the use of certain technologies and equipment and what not that has gone up. Our fee is still they are very similar. In fact, the percentage of the doctors' contribution to the overall bill is actually much lower. It used to be 30 percent. Now, I think most of the time we see at about 25 percent. At the rate the inflation is going, maybe by 2030 if it has no adjustment to our fees will probably around 20 percent. That's the likelihood that we are looking at the moment.*
>
> *The amended fee schedule. This has been something that the doctors have actually sat together with the Ministry of Health officials. We have gone through from 2020 onwards. There are certain procedures that are not captured in the original 13 schedule that was released in 2013. This is because new procedures have come up. New technology has been used. For example, in robotics surgery, these are not captured in the fee schedule. We have sat together with the Ministry of Health Bahagian Amalan and gave our reasons in terms of what is appropriate fee.*
>
> *At this present moment in time, these are still not gazetted as yet. We haven't gone into the details when it will be gazzeted or whatever but this is actually the amended schedule that is still being waiting for approval. That is still under the Bahagian Amalan and Auditor-General Office…"*
>
> [Muka surat 11 - 12, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

vii. Penjelasan NAMLIFA

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa hospital swasta mengenakan caj berlebihan terutamanya ke atas caj bukan profesional (*non-professional fees*), seperti peralatan perubatan asas. Perbezaan kos antara pesakit yang membayar sendiri dan pengguna insurans boleh mencecah 40%, dengan pesakit yang membayar sendiri sering perlu berunding untuk mengurangkan bil. Untuk membendung amalan ini, kawalan baharu telah diperkenalkan: syarikat insurans kini menuntut doktor membuktikan keperluan sebarang ujian tambahan sebelum perlindungan diberikan, dan mereka juga melaksanakan anggaran tempoh tinggal (*estimated length of stay*), di mana tempoh tinggal pesakit di wad melebihi jangkaan memerlukan justifikasi dan kebenaran daripada insurans. Beliau menekankan bahawa caj-caj bukan profesional ini mesti diaudit dan mengharapkan KKM memainkan peranan dalam mencari keseimbangan antara keuntungan hospital dan manfaat yang sewajarnya diterima oleh pengguna.

> ***"Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]:*** *Datuk Wira Pengerusi, saya ingin minta pandanganlah, what is your views fasal naratif hospital swasta ini yang dikatakan overcharge lah?*
>
> *Seperti yang kita sedia maklum bahawa this private hospital is business entity lah. Of course, their priority number one is to make money. Number two is to provide medical service. Am I correct or not? So, oleh sebab itu, maka dia punya top management akan menyediakan satu sales target. Maybe daily sales target or monthly or annually. Therefore, you must— today you must achieve this kind of sales target, contohnya. Therefore, all these medical providers yang berkhidmat di sana akan memastikan supaya that to achieve a certain target per day.*
>
> *Naratif di luar sana mengatakan bahawa mereka akan melakukan pelbagai non-medical chargers ataupun some medical tests, procedures dan sebagainya yang mungkin tidak perlu tetapi terpaksa dilakukan untuk mencapai sales target harian ataupun bulanan tersebut. Jadi oleh sebab itu, bila kita lihat dia punya itemised bill itu tadi memanglah kita tahu bahawa profesional ataupun chargers by that specialist memang tak banyak because that one is dipantau tapi yang lain-lain itu memang tidak ada dihadkan.*
>
> *So, that is where they charge even di [Tidak jelas] syringes, they can charge up to RM20 whereby one box is almost RM20. You know gauze also, is talking about RM20 this kind of thing tapi harga satu bungkus itu mungkin RM20. Even*

gloves, they charged one pair is about RM20 tapi sekotak glove itu hanya RM14. So, these kinds of chargers. What is your pandangan dan view you see? True or not this kind of thing happened?

Encik G Saseedaran Gengadharan [NAMLIFA]: *Pandangan kami memang konsisten iaitu caj-caj non-professional fees ini, must be audited. Exact example yang tuan berikan tadi ya. Macam kalaulah mereka itu adalah paying patient iaitu mereka yang membayar sendiri, mereka punya bil itu adalah rendah kalau dibandingkan dengan mereka yang menggunakan insurans perubatan. Ada juga perbezaan sehingga sampai 40 peratus beza dia.*

So apabila mereka yang membayar itu secara terus, kami pernah ada experience pengalaman ini di mana mereka kena pergi bargain dengan pihak hospital untuk mengurangkan ataupun mengeluarkan caj untuk membatalkan caj itu macam seperti yang tuan kata tadi, gauze lah. Sekarang ada nursing charges pun yang akan berjalan setiap hari. Nursing chargers. Kita tahu sebab memang manpower pun dekat hospital, kepakaran manpower dari segi nurses punya kapasiti pun dah kurang jumlah dia. So, we understand the problem tetapi mesti ada imbanganlah iaitu your socialist approach and the capitalism approach lah kan.

So, pihak hospital itu macam tuan kata tadi dia ada bagi sales target. It is very difficult to speak and accuse kan. Tapi memang kita tahu kalau doktor itu, kalau boleh dia nak buat banyak test. Tapi pada masa ini, ada satu perkara yang baik juga sedang berlaku sekarang ini. Sebarang test yang dia nak buat, kalaulah untuk yang menggunakan kad medical, dia kena buktikan kepada syarikat insurans dengan maklumat yang secukupnya bahawa test itu perlu. Kalau tidak, insurans takkan cover. Perkara ini sedang berlaku.

Bukan itu sahaja, pada masa ini, syarikat-syarikat insurans selepas banyak yang kita bising-bising sekarang ini, syarikat insurans sudah mula melaksanakan satu lagi iaitu dia buat estimated length of stay iaitu dia jangkakan, dia profesional ataupun specialist itu harus memberitahu syarikat insurans, kalau untuk penyakit dan rawatan yang sebegini, lazimnya berapa hari patient itu harus duduk dalam wad. Kalau lebih daripada itu, dia kena dapatkan permission daripada syarikat insurans dulu. Dia kena buktikan pada syarikat insurans yang patient itu harus duduk lama lagi. So, controls sebegini sudah mula sebenarnya. Tetapi it should've been done long ago.

Tapi yang kita nak balance itu ialah consumer itu not— dia tak dapat dia punya benefit. Hanya kerana syarikat insurans terlalu konservatif, konsumer tak dapat benefit dia. hanya kerana hospital mungkin keuntungan dia, dia lebih peka kepada keuntungan dia, insurance is overcharge. Jadi di sinilah kita lihat bagaimana peranan yang boleh dimainkan oleh MOH. Memang kita harap MOH boleh buat benda ini. So, tidak menafikan dan juga memberitahu apakah langkah-langkah yang mereka sedang lakukan sekarang untuk membendung perkara ini."

[Muka surat 15 - 17, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

viii. Penjelasan Ketua Pegawai Penjagaan Kesihatan AIA Berhad

Tuan Heng Zee Wang [Ketua Pegawai Penjagaan Kesihatan] dalam prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa dalam tempoh empat bulan pertama, lebih 3,000 item bil perubatan menunjukkan kenaikan harga, termasuk ubat dan peralatan asas yang meningkat tanpa kawalan walaupun Ringgit mengukuh. Beliau menunjukkan contoh caj yang tidak munasabah dan tidak berbundel, seperti pelupusan sisa, sarung bantal, penggunaan peralatan bilik, serta prosedur asas seperti pemasangan IV yang dicaj secara berasingan bagi setiap langkah. Malah, caj tambahan seperti *operating theatre table* dikenakan walaupun bilik pembedahan sudah dibayar. Keadaan ini menyebabkan bil hospital mengandungi ratusan item, menyukarkan tuntutan insurans dan akhirnya membuatkan pesakit perlu membayar sendiri banyak item, sekali gus menimbulkan aduan bahawa perlindungan insurans tidak menampung kos sebenar.

> ***"Tuan Heng Zee Wang [*AIA Berhad*]:*** *Thanks Mark. So, again in the brief [Tidak jelas]. these first four months alone you know, we've actually observed on our medical bills, more than 3,000 unit line items, price has actually increased. So, here is the sample of hospitals that've got 32 items, price increased. Quite a few items are related to drugs. For example, the first item has increased more than two times, two and half times. Interesting to hear like last year when the price increased, we say the Ringgit had weakened significantly and some of this cost has increased. But this year, actually the Ringgit has actually strengthened quite a fair bit but yet we have seen some of this been translated.*
>
> *Second item on GTP load. This is like orthopaedic, you know, pillow and you can see again with a significant price increase and we look across the board it's not only drug price increase. But item three like probe cover, ThermoScan, is actually this is the thermometer that you out in the ear and that plastic cover costs RM3. So again, that question — put question on what is, you know, what is reasonable charges on all these items. Where we see today that the price increase appears to be fully at the discretion of the provider, you know, without any control, it's like that.*
>
> *And then, you look further if we were to say not only that item price can increase, there can also be new item being added into the bills. So, here's one of the examples. You know, most of the time the customer would pay for room and board when you know they are hospitalized. But it's very not uncommon to see you know in the bill, things like clinical waste disposal, bedsheet being charged, pillow case being charged. So, this is similar to you checking into a hotel, you pay for the room, for the hotel but you know you have to pay a separate cost for sleeping on the pillow and the bedsheet and also throwing rubbish.*

So, next slide you know is another one. So, every single item in the room being used, for example, some of you who may had visited friends or had experience of being in hospital you know, the beeping item at the side of the bed. We call the bedside monitor. The usage of it, in this example is RM158 and then there's a whole other layering of charges. Somebody come in to read the blood pressure every four hours. The central team monitoring, just in case, that costs RM172. Somebody come and take a reading of the vital sign is RM49 and then additional pulse oximeter is RM94. That, you know it's per time used or per day used and if three days, you have to pay for three times. Likewise, the thermometer being used as well. So, all these very clear layered charges that's added you know to the room and board.

Next, you know this is another example of operating theatre. You know we pay for the operating. The usage of the operating theatre by hours. So, in this case it's one and a half hours RM800 per hour. But on top of that, there's a line item called operating theatre table, which cost RM1,000. That means you pay for the operating theatre but if you want to sleep on the operating theatre bed you have got to pay RM1,000 for sleeping on the bed.

Next slide, so this is another very good example of unbundled charges. So, very typically when you're hospitalised there are SOPs to put what we call the IV drips on the hand. We're actually being charged for nursing fee and again it's not untypical because of the comment that nursing fee has increased. So, this is a very good example that you pay for that and then you pay for the blood taking then you pay for putting in the needle then you pay for pulling out the needle and then you pay for stuff like putting the alcohol swab on this. So, each of every one of the items is costed differently.

So, hence you know these are the kind of challenges that the industry is actually facing. So, for us you know we need to serve our customer within a very short period of time that they're in hospital, approving them for the claims and wanting them to go home fast you know to rest and recover. Within that time we need to go through the 100 of lines in the bills to find items like that. The worse thing is if the insurer decided not to pay for these items, these items will be have to be paid out-of-pocket by the consumers or by the customers because they have already consumed this item while they're in the hospital.

So, as a result that what we often hear as complaint is that you know we pay insurance premium for many years. This is the first time I used it and I have got to pay for a lot of things or quite a lot of things are not covered. That is a very common complaint that we often hear. So, that's the challenges that you know we face as an industry here."
[Muka surat 8 - 10, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

7.5.5 Langkah Menangani Kenaikan Kos Perubatan

Kelestarian sistem penjagaan kesihatan swasta di Malaysia harus beralih daripada kebergantungan mutlak kepada kenaikan premium, kepada satu ekosistem yang

berpaksikan kecekapan kos, ketelusan data yang radikal, serta perlindungan pengguna yang adil melalui kolaborasi sistemik antara semua pemegang taruh.

i. <u>Penjelasan KPE HTO KKM</u>

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM sedang menerajui kolaborasi bersepadu bersama pelbagai agensi utama seperti BNM, KWSP, dan MOF untuk menangani isu inflasi perubatan secara sistemik. Beliau menjelaskan bahawa usaha ini bukanlah tindak balas mengejut, sebaliknya merupakan strategi proaktif yang telah dilaksanakan sejak setahun lalu melalui mekanisme sedia ada seperti RMK-13 dan inisiatif Rakan KKM. Bagi memperkukuh penyelarasan ini di peringkat pengguna, kerajaan sedang mewujudkan pusat sehenti (*one-stop centre*) sebagai platform rujukan yang lebih efisien bagi menangani aduan berkaitan kos kesihatan yang melibatkan pelbagai agensi.

> ***"Dr. Yap Wei Aun [KKM]:*** *May I respond? I think it's very important to correct the narrative on this. I think that's why very clearly which we mentioned that on the 2nd April 2024, it's recorded in the proceeding of Parliament, YB already informed PSSC for health that there was an issue with medical price inflation. Then in 27th August, issues presented to the same Jawantakuasa Pilihan Khas Kesihatan on solutions to do with inflation issues and even from that time we already indicated that we are working together with Bank Negara.*
>
> *Actually you may not be aware because we are not actively posting in social media. For the last few months, even prior to the inflation issue, we've been working on these solutions including the transformation of private health insurance together with KWSP. These are issues which way predated the public blowup of the inflation issue. We have been using normal government mechanisms to be working together as multiple agencies.*
>
> *So, it's really important to correct your perception that is not that because of the inflation issue that only now we realised there is an inflation and only now we are working together. We have been doing this months, we really have been doing so. When I first started this appointment in March last year, by April of that same year, I have already requested DG Chair. I think this corporation has been going on for almost a year. We have been working with the Ministry of Finance, so on things like Rakan KKM, all these are happening behind the scenes.*
>
> *So, I think really there are a lot of pre-existing government structures to do if inter-ministry of coordination like Kementerian Ekonomi which we also have been working on together RMK-13 process, MTEN process. This is not just because*

there is this issue that suddenly decided we need to talk to each other. It's totally a wrong perception. Yes. Even for Rakan KKM, we set up an appropriate governance structure with two ministries for intervention-based issue. But that is on the policy setting. But you are also asking a question on the consumer side, who do they go to, when it's a issue with multiple agencies?

So, I think, just to reaffirm what my Sec-Gen was mentioning, that basically one of the— because it's urgent. The fastest thing we can do, let's create a one-stop centre. So that people know where to redirect their issues. Given that there's already a pre-existing prevent mechanisms which exist.

[Muka surat 56 - 57, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

ii. Penjelasan Gabenor BNM

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025 menggariskan beberapa langkah strategik BNM untuk menstabilkan kos perubatan dan premium insurans agar kekal mampu milik bagi rakyat:

i. Penyelarasan Data (Inisiatif RESET):
BNM bekerjasama dengan KKM dan Bank Dunia untuk mewujudkan pangkalan data tunggal bagi memastikan kadar inflasi perubatan diukur secara telus dan tepat.

ii. Pengenalan "Produk Asas":
Memperkenalkan pelan insurans dengan manfaat standard pada harga lebih mampu milik bagi mengelakkan rakyat dibebankan oleh reka bentuk produk yang kompleks dan mahal.

iii. Kawalan Harga Hospital:
Menyokong pindaan Akta 586 bagi memberi kuasa kepada KKM mengawal selia caj hospital swasta, sekali gus menangani amalan caj lebih mahal terhadap pesakit insurans (*differential pricing*).

iv. Pemantauan Trend Tuntutan:
Menguruskan kesan lonjakan penggunaan hospital pasca-pandemik (meningkat 25% pada 2023) melalui reka bentuk produk dengan premium yang lebih mampan untuk jangka panjang.

***"Dato' Seri Abdul Rasheed Ghaffour [BNM]:** Thank you Yang Berhormat on the two issues itu. First on inflation. In fact, we have agreed between Bank*

Negara, KKM, APHM. Basically, we know that the inflation data that we are using are all based on different sources. Jadi, memang betullah, it could be different dari segi angkanya. That is why one of the recommendations is to work dengan World Bank to come out with a method to really measure through inflation for medical services.

At the moment, ada banyak cara untuk mengukur inflasi. Contohnya, pertama, dari segi medical cost inflation yang mengambil kira keseluruhan kos perubatan termasuklah test dan sebagainya.

Kedua, medical claims insurance. Data ini daripada insurance company sebab banyak claim meningkat dari tahun ke tahun. That's how they measure the inflation. Pada yang hospital tadi, dia kira dari segi berapa kos perubatan yang kita perlu bayar.

Ketiga, dari segi medical services. Dia ambil satu atau dua services sahaja, berapa banyak yang meningkat medical services tersebut. Jadi, kita bersetuju memang ada banyak indikator dan kita telah pun bersetuju untuk bersama-sama kongsi data. Daripada Bank Negara, KKM, insurans dan juga hospital. Kita combine all the data jadi satu pangkalan data yang komprehensif dan kita boleh dapatkan apakah angka sebenar inflasi. That is one of the initiatives di bawah RESET yang telah dipersetujui oleh ke semua pihak.

Keempat, dari segi secara mata kasar, conclusion yang kita boleh buat dari segi data-data yang kita lihat, Yang Berhormat, secara amnya, kadar inflasi perubatan di Malaysia adalah lebih tinggi daripada negara-negara lain. That is a fact. So, memang kita ada masalah di situ dari segi medical inflation, but we are working on the data, on the numbers.

Kedua, in terms of product design— yes, betul, we agreed. So, that is why we are coming out with the base product. So, the base product will address this product design issue di mana, as what Datuk Jessica mentioned just now, this will be a standardized kind of coverage, standardized kind of benefits di mana sekurang-kurangnya semua orang boleh mendapatkan base product ini pada harga yang berpatutan dan juga pada harga yang pada kos yang mereka mampu milik, contohnya. Kerana dua sebab. Pertama, kita dapat kawal dari segi apakah benefit-benefit-nya. Kedua, pool dia akan jadi besar sebab ramai akan dapat menggunakan produk ini. Jadi, akan berkongsi dengan lebih ramai lagi. Jadi, akan menurunkan harga.

Kedua, apabila kita masukkan the add-ons. Add-ons ini boleh jadi pilihan. Sesiapa yang nak lebih, tambah lagi, mereka boleh beli. Dan ini akan ditetapkan oleh harga pasaranlah. Contohnya demand and supply dan juga dari segi kos sebenar perubatan. So, that is something that will address the issue of the product design.

Betul, Yang Berhormat, kita akui product design was one of the sumber atau faktor yang telah menyumbang kepada peningkatan kos MHIT dan juga premium MHIT ini. Jadi, dengan base product ini, harapan kita adalah kita dapat

menangani kenaikan kos ini dan memberi satu produk di mana premium akan lebih mampan..."

[Muka surat 12 - 13, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

vi. Penjelasan KPE LIAM

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa industri turut mengambil langkah-langkah penting untuk menangani isu inflasi kos perubatan dan memastikan kelestarian sistem. Terdapat beberapa inisiatif yang berada dalam ruang tanggungjawab industri insurans [*Insurance and Takaful Operators* (ITO)] adalah seperti berikut:

a. Menyediakan dana antara RM4 bilion hingga RM5 bilion dalam usaha mengawal inflasi kos rawatan.
b. Menggalakkan gaya hidup sihat melalui insentif seperti *no claim bonus*.
c. Mewujudkan dan menerbitkan pangkalan data kos rawatan perubatan biasa serta kadar inflasi kos perubatan tahunan.
d. Membangunkan produk insurans kesihatan jangka panjang yang mampan bersama BNM.

"Tuan Sim Tze Tzin [Ahli PAC]: *Terima kasih Datuk Wira Pengerusi. Okay, like this. I want to say that this PAC is a neutral platform for you to say your peace, okay. You can give your information et cetera. We might be critical, but we will be critical to everyone as well. We will be fair. But however, I want to see that your slide number 17 and 18. I look through the slide, your twelve recommendations is mostly about you know, other people. Co-pay you know, Rakan KKM, request private hospitals to freeze costs. But I don't see that your industry say that, "Hey, I am going to do this to reduce the cost. What are the reforms I want to do." I don't see that. I hope that when you come here, you tell us and the public because we are with the public that, "Hey, insurance company, we are committed to do reform, to save costs, to safeguard your future." I want to see this, but I am not seeing that. Can you response to this, please?*

Encik Mark Steven O'dell [LIAM]: *Ya. YB, I think there is number of things on the recommendations that are definitely in ITO space. Okay, one is the consultant we can set that aside for now. The interim measures is quite significant that were agreed to Bank Negara. They if we don't get inflation under control and survey that we did with our members and Radzuan was just showing*

me the costs to takaful operators is between RM4 billion and RM5 billion. So I say, you know that, that's quite significant sum of money that the ITO are putting up. Also, encouraging healthier lifestyle with no claim bonuses, establishing our database publishing the average costs of common procedures, publishing the annual medical costs of inflation, try to come up with the long term sustainable medical products together with BNM. I think that all squarely in the ITO space."

[Muka surat 26, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.6 Kerugian Dana Perubatan Oleh Syarikat Insurans

Encik Mark Steven O'dell [KPE LIAM] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa setiap syarikat insurans mempunyai beberapa dana berasingan seperti dana hayat, kebakaran, pelaburan dan perubatan. Beliau menegaskan bahawa kerugian yang dimaksudkan adalah khusus kepada dana perubatan, yang mencatatkan kerugian selama tiga tahun berturut-turut. Manakala keuntungan yang sering dilaporkan datang daripada dana-dana lain, dan undang-undang tidak membenarkan pemindahan keuntungan dari satu dana ke dana lain. Oleh itu, kerugian dana perubatan harus ditanggung oleh pemegang saham, namun ini tidak mampan dalam jangka panjang.

Mengenai margin keuntungan, beliau menyatakan bahawa kebanyakan CEO syarikat insurans menyasarkan keuntungan sekitar 10%, bukan 20-25%. Komponen perbelanjaan dalam polisi pula terdiri daripada komisen (kira-kira 13-15%) dan selebihnya adalah kos pentadbiran seperti pra-kebenaran rawatan, pemprosesan tuntutan dan kos operasi am. Mengenai nisbah tuntutan (*claims ratio*) sebanyak 92.96% bagi tahun 2023, beliau menjelaskan bahawa angka tersebut menunjukkan hampir 93 sen daripada setiap ringgit premium digunakan untuk membayar tuntutan, dan data itu diperoleh daripada laporan anggota LIAM kepada BNM. Angka ini menunjukkan tekanan besar terhadap dana perubatan yang tidak lagi menjana keuntungan.

***"Datuk Ali anak Biju [Ahli PAC]:** Chairman, thank you very much. I got two questions actually. One, is it there— one of the presentations just now said that making loss, insurance company making loss because as far as I know, I don't hear any insurance company making loss. Is it making loss in the premium itself or whatever the overall company making loss? So, which insurance company that is making loss now? I do not know. That's one.*

A second one is, the private hospital loss itself, profit 20 to 25 percent that is excessive, but the insurance company, are you targeting 20-25 percent profit also?

Encik Mark Steven O'dell [LIAM]: *No, sir. No, sir.*

Datuk Ali anak Biju [Ahli PAC]: *And then third one, I see the scenario just like dilemma here between accessibility, affordability and quality. So, insurance plays a very big part of this health issue in this health dilemma cost. So, we want the insurance companies to be more alert, more responsible. I don't say you are not responsible tapi but more responsible. So, to let those who contributed the premium for 10, 20 years, they got a fair deal at the end of the day. So, these another three things what I want you to comment on it.*

Encik Mark Steven O'dell [LIAM]: *Okay, thank you. Maybe if we can go to the first slide. Here is where we talk about loses, right? First, I want to explain that every company has multiple funds. There's a life fund, there's fire fund, that non-fire fund, there's investment-link fund, there's the medical fund and the profit that you are seeing are from fund other than the medical fund. The medical fund is one that is spent as you can see here in this case, this example of standalone, have been losing money for the last three years.*

Now, it spends— say that why if you making so much money on other line of business why can't you suffer losses on this line of business? My answer is that you can become the shareholder pocket. It doesn't come from another fund because that is not legal, it comes when shareholders' pocket and that maybe fine for a period but it's not sustainable, it's absolutely not sustainable, we need to have a sustainable medical fund that works. Sorry, YB you had another question …

Datuk Ali anak Biju [Ahli PAC]: *What is your target of profit?*

Encik Mark Steven O'dell [LIAM]: *Oh.*

Datuk Ali anak Biju [Ahli PAC]: *20, 35 percent?*

Encik Mark Steven O'dell [LIAM]: *No lah. No, I think, I have asked this on many of our members, I do not run the company anymore, so, I cannot say but I think 10 percent is the most common number I hear when I talked to the CEO about profit margin.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry, your 10 percent comes from your which part because this pool is losing money, right. Sorry, it comes from expenses or what?*

Encik Mark Steven O'dell [LIAM]: *No, you see on the right side the expenses distribution commission and profit. It would come from the balance left over after distributing claims, expenses and commission.*

Tuan Sim Tze Tzin [Ahli PAC]: *Expenses of 20 percent something is quite high. What is that expenses for?*

Encik Mark Steven O'dell [LIAM]: *That is— in this case for the standalone insurance, the commission is 15 percent, the average paid by members would be a bit less than that because there are some policies that become orphan than the commissions are not paid anybody. So, maybe about 13 percent or so comes from commissions and the rest comes from administrative expenses to process the pre-authorisation process to claim, overhead, etc.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Where did you get this figure 2023, 92.96 percent, the data? Where did you get— I mean it's very high, very high 92, almost 93 percent, almost 94 percent.*

Encik Mark Steven O'dell [LIAM]: *Right.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Ya, where did you get this figure?*

Encik Mark Steven O'dell [LIAM]: *These are figures that are reported to us and send to Bank Negara that actually comes from each from our members.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Can you please explain more on the claims?*

Encik Mark Steven O'dell [LIAM]: *So, what the claims means 92.6 percent, it simply means that at every dollar, at every ringgit, 92.96 percent goes to pay claims.*

[Muka surat 13 - 15, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.7 Pengawalan Harga dan Pembekalan Ubat di Malaysia

i. <u>Penjelasan KSP MOF</u>

Datuk Johan Mahmood Merican [KSP MOF] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa kawalan ubat adalah di bawah KKM. Semua ubat mesti melalui proses pendaftaran. Beliau juga menerangkan bahawa ubat yang masih di bawah paten memang dikuasai oleh pengeluar asal dari segi harga. Namun begitu, kerajaan mempunyai dasar untuk mengutamakan ubat generik dalam perolehan bagi memastikan kos lebih rendah dan ubat generik ini turut boleh digunakan oleh hospital swasta.

"Dr. Hajah Halimah Ali [Ahli PAC]: *Last sahajalah fasal ubat, kos ubat kan. Do you all regulate the suppliers of ubat or is it the KKM?*

Datuk Johan Mahmood Merican [MoF]: *Yang itu ialah di bawah KKM. Setiap ubat yang boleh dijual di negara Malaysia perlu di— there is a registration process Yang Berhormat untuk setiap ubat yang dibenarkan dijual...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Bukan ada yang big, big pharma industry itu dia apa— dia import all the expensive medicines, dia yang akan supply cause dulu dia ada kecil-kecil dah. There were a lot of competitors. I don't know how, macam mana dia punya apa itu kan. Because that will affect the price of ubat because kalau dia seorang jadi raja, everybody got to pay ambil daripada dia.*

Datuk Johan Mahmood Merican [MoF]: *I think Yang Berhormat— seperti YB sedia maklum, produk yang masih di bawah paten itu memang dia yang dapat kuasai harga dia dan mereka pun akan menetapkan harga yang berbeza mengikut negara berdasarkan dia punya perancangan mereka. Tetapi pada masa yang sama, untuk ubatan yang tiada lagi paten ataupun generik sebab kerajaan ada dasar untuk mengutamakan pembelian ubatan generik.*

So, dengan itu, daripada kontrak perolehan kerajaan, ubatan-ubatan generik tersebut akan juga didaftarkan untuk dibenarkan untuk pasaran tempatan dan hospital-hospital swasta punya boleh juga mengambil kesempatan daripada ubatan generik yang memang dibeli dan dengan itu didaftarkan untuk kegunaan di Malaysia.

[Muka surat 41 - 42, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

7.7.1 *Mark Up* Harga Jualan Ubat

Secara keseluruhannya, kemelut *mark-up* harga ubat ini merupakan manifestasi jelas kepada kegagalan sistemik dan kelemahan kawal selia dalam pasaran farmaseutikal swasta di Malaysia.

Wujud jurang maklumat yang ketara; di mana pesakit tidak mempunyai pilihan selain membayar harga yang telah dinaikkan berkali-kali ganda tanpa mengetahui kos asal ubat tersebut. Walaupun hospital mempunyai kos operasi yang sah, ketiadaan ketelusan menyebabkan margin keuntungan ubat dijadikan alat untuk menutup kos-kos lain.

Langkah yang tuntas diperlukan melalui:

- **Penetapan Had *Mark Up*:** Kerajaan perlu campur tangan dengan menetapkan had *mark-up* yang munasabah bagi memastikan hospital tidak mengambil keuntungan berlebihan daripada ubat-ubatan penting.

- **Penyelarasan dengan APHM:** Cadangan MMA untuk berbincang dengan APHM mengenai kadar *mark-up* yang dipersetujui bersama adalah langkah awal yang baik untuk menstabilkan harga.
- **Pangkalan Data Ketelusan:** Mewajibkan paparan harga jualan ubat supaya pengguna dan syarikat insurans boleh membuat perbandingan harga yang lebih adil.

Tanpa kawalan yang tegas, ubat akan terus menjadi komponen yang membebankan dalam bil perubatan, sekali gus menjejaskan akses rakyat kepada rawatan kritikal seperti kanser.

i. <u>Penjelasan Pharmaceutical Association of Malaysia (PhAMA)</u>

Puan Kam Ai Teng [Presiden PhAMA] dalam Prosiding Bil. 5(i)/2025 bertarikh 6 Mac 2025 menjelaskan bahawa wujud perbezaan ketara antara harga jualan ubat oleh pengeluar farmaseutikal kepada hospital berbanding harga akhir yang dikenakan kepada pesakit. Hospital (sebagai penyedia) mempunyai budi bicara untuk menentukan kadar mark-up, yang mana ini menyumbang kepada peningkatan harga akhir.

Walaupun wujud mark-up yang tinggi ini, PhAMA menegaskan bahawa kos ubat-ubatan masih menyumbang tidak lebih daripada 16 peratus daripada jumlah keseluruhan bil penjagaan kesihatan. Beliau turut bersetuju bahawa jika mark-up yang dikenakan pada peringkat hospital/pengedar ini dapat dikurangkan, sumbangan kos ubat kepada bil keseluruhan secara teknikal akan menjadi lebih rendah, mungkin sekitar lapan hingga sembilan peratus.

> ***"Puan Kam Ai Teng [PhAMA]:*** *So, basically from this data it shows the different range, yes. When we sell to the hospital with X price then it is up to the provider, example the hospital to determine what they want to markup. So, we don't…*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *So, this is where you survey the hospital prices and then you find out that actually…*
>
> ***Puan Kam Ai Teng [PhAMA]:*** *This is from…*
>
> ***Puan Deepti Saraf [PhAMA]:*** *Medicine price monitoring report from Ministry of Health.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, okay.*

Puan Kam Ai Teng [PhAMA]: *So, this is available…*

Tuan Sim Tze Tzin [Ahli PAC]: *So, after selling at this price, the total cost of the hospital bill is only 16 percent. Meaning with this markups.*

Puan Kam Ai Teng [PhAMA]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, meaning actually if we don't have this markup, it would be maybe lower. Maybe eight percent, nine percent. Am I right?*

Puan Kam Ai Teng [PhAMA]: *Technically, yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Technically, yes.*

Puan Kam Ai Teng [PhAMA]: *So yes, medicine contribute not more than 16 percent based on just now what are my colleague have shared to total cost of the bill, the healthcare bill."*

[Muka surat 10 - 11, Laporan Prosiding Bil 5(i)/2025 bertarikh 6 Mac 2025]

ii. <u>Penjelasan MMA</u>

Dr. Gunalan @ Arumugam Palari [Ahli MMA] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa terdapat keperluan untuk memiliki ketelusan kos yang tinggi dalam rawatan perubatan, terutamanya dalam penjagaan kanser, dan memastikan tiada campur tangan daripada pihak insurans yang menentukan apa yang boleh dan tidak boleh dilakukan.

Beliau berpendapat bahawa persatuan-persatuan onkologi yang sepatutnya menentukan pelan rawatan dan protokol, bekerjasama dengan hospital swasta untuk memastikan mereka tidak meletakkan markup harga yang terlalu tinggi. Sebagai contoh, rawatan kanser di mana ubat-ubatan generik boleh didapati dengan murah (dari India dan China), tetapi kualiti biokesamaan (*bioequivalence*) tidak diketahui. Manakala ubat-ubatan asli yang diimport dari negara Barat adalah mahal, dan kosnya semakin melambung akibat markup berganda yang tidak munasabah oleh pengimport, dan sekali lagi oleh hospital, yang boleh menyebabkan kos ubat dinaikkan 200 hingga 300 kali ganda.

Walaupun hospital swasta mempunyai kos tambahan untuk menyediakan perkhidmatan kritikal seperti Penyusunan Semula Ubat Sitotoksik (*Cytotoxic Drug Reconstitution* - CDR), yang memerlukan peralatan dan prosedur yang betul (rantai sejuk, farmasi yang betul), markup yang dikenakan haruslah munasabah.

Dr. Gunalan menyarankan agar perbincangan diadakan dengan Persatuan Hospital Swasta Malaysia (APHM) untuk mencapai persetujuan mengenai markup yang munasabah yang menampung kos mereka. Sekiranya kos dapat dikawal, ia akan membolehkan insurans penjagaan kesihatan sosial dengan premium yang lebih rendah menjadi lebih berdaya maju dan dapat diakses.

> ***"Dr Gunalan@Arumugam Palari [MMA]:*** *Yes. I think as long as there is a great amount in terms of the costings and we can actually to not have any interference for the insurance side of things do dictate what can and cannot be done. But the societies, the oncology society is the one who are actually deciding what is the treatment plan, protocol or whatnot with cooperation from the private hospitals to agree that, look do not markup your prices so much.*
>
> *For example, cancer care. Most of the generic ones are cheap, from India and China you can get cheap. But the bioequivalence nobody knows. But the ones that we be getting original from US and Germany or whatever are expensive. But when they are imported and brought in here, there is a big [Tidak jelas] is actually marked up. And before— even reaches the hospital, there is another mark up as well. So, if you are RM10,000 medication is marked up 200 times of 300 times, it's going blow the budget, okay.*
>
> *So, there has to be some reasonable markup. Because we also understand from the hospital point of view. Chemotherapy, you have to have proper equipment. Cytotoxic, what do you call CDR?*
>
> ***Seorang Ahli:*** *[Bercakap tanpa menggunakan pembesar suara]*
>
> ***Dr Gunalan@Arumugam Palari [MMA]:*** *Cytotoxic drug reconstitution, yes. Cytotoxic drug reconstitution, very toxic drugs, pharmacies has to be properly prepared, cold chain and all the things. They had to be done properly. So, this actually additional cost.*
>
> *So, the private hospitals mark up in order to actually provide this particular service has to be reasonable. I think if you speak to APHM and whether they can agree to a reasonable amount that covers their cost and the markup is not so high maybe that particular social healthcare insurance which is at the lower premium to enter might work."*
> [Muka surat 48 - 49, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

7.7.2 Ubat Generik

Isu ubat generik dan variasi harganya merupakan manifestasi kepada kegagalan sistemik dan kelemahan kawal selia dalam pasaran ubat-ubatan hospital swasta di Malaysia.

Wujud jurang maklumat (*information asymmetry*) yang amat ketara di mana pengguna tidak mempunyai akses mudah untuk membandingkan harga ubat antara hospital. Situasi di mana ubat generik dicaj lebih mahal daripada ubat asal (branded) membuktikan bahawa harga ubat di hospital swasta tidak lagi ditentukan oleh kos perolehan, tetapi oleh margin keuntungan yang ditetapkan secara bersendirian oleh pihak hospital.

Tindakan yang tuntas diperlukan melalui:

- **Penyelarasan Harga:** Mewujudkan mekanisme kawalan atau garis panduan harga yang lebih ketat untuk mengelakkan caj melampau bagi item asas seperti Panadol.
- **Platform Agregator Ketelusan:** Kerajaan atau badan bebas perlu menyediakan platform digital yang membolehkan pesakit menyemak harga ubat secara *real-time* sebelum menerima rawatan.
- **Pendidikan Pengguna:** Menghapuskan stigma terhadap ubat generik melalui data klinikal supaya pesakit lebih yakin untuk memilih pilihan yang lebih murah tetapi sama berkesan.

Tanpa langkah drastik untuk mengawal selia harga ubat, matlamat untuk mengurangkan inflasi perubatan akan sukar dicapai kerana ubat akan terus dijadikan instrumen keuntungan oleh pihak hospital.

i. <u>Penjelasan KPE AIA</u>

Encik Ben Ng Kee Heng [KPE AIA] dalam Prosiding Bil. 5(f) bertarikh 26 Februari 2025 menjelaskan bahawa AIA tidak pernah mengarahkan doktor dalam memberikan rawatan, sebaliknya hanya menyokong penggunaan ubat generik yang telah diluluskan oleh Kementerian Kesihatan Malaysia, selagi ia

sesuai dari segi klinikal. AIA juga menyokong pendekatan penjimatan kos, termasuk rawatan pesakit luar.

Walau bagaimanapun, sekiranya pelanggan benar-benar mahukan ubat berjenama, doktor dan hospital masih boleh mempertimbangkannya bergantung kepada keadaan pesakit.

> ***"Encik Ben Ng Kee Heng [AIA]:*** *Ya hi YB Sim. Since you mentioned about the letter from AIA— so from AIA. So firstly, I think nothing in the letter that says we want to dictate on mandate the practice of the doctors. Like I explained earlier you know obviously things like generic drugs that doesn't mean its cheap drugs is no good. Generics drugs, these are all what we are always stressed is where clinically appropriate and these are all approved by the Ministry of Health. So obviously, what we care the most— given our long term presence in Malaysia. I mean long term reputation looking after customers is our number one priority.*
>
> *So all we're saying is we support Ministry of Health initially in generics drugs, DRG. Of course, we also encourage effective use of the healthcare resources. Healthcare is not luxury is— we are saying some, these simple diseases and maybe you know if you don't need to be hospitalised if it's flu, if its symptoms is not very serious perhaps you know it could be treated on outpatient basis. And some of the treatment if that can be done on the outpatient or daycare like chronoscope. When I used to live in Taipei, I mean I do chronoscope but never once I lived stayed overnight in a hospital.*
>
> *But in Malaysia a lot of scope are still done on the overnight basis. So, this are the kind of the thing that we always stress the importance of where clinically appropriate for them to do that ya.*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *Sorry. But what if because some of the customers they bought your policy insurance is because they want original drugs. So, once you remove this, they have no choice. You see. So how you are going to address this group of people who wanted this.*
>
> ***Encik Ben Ng Kee Heng [AIA]:*** *Ya so like I said YB Sim we are saying that we basically request the hospital to manage on cost efficient. So of course if the customer really insist of using that drugs, then of course then the doctors and hospital are in the position to decide what is best for the patient ya..."*
>
> [Muka surat 39 - 40, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

ii. Penjelasan Ketua Pegawai Penjagaan Kesihatan AIA Berhad

Tuan Heng Zee Wang [Ketua Pegawai Penjagaan Kesihatan, AIA Berhad] dalam prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025 menjelaskan bahawa harga ubat di hospital swasta jauh lebih tinggi dan tidak konsisten berbanding harga runcit. Panadol yang berharga sekitar 40 sen di farmasi boleh meningkat sehingga RM1.52 di hospital swasta. Antibiotik Ceftriaxone juga menunjukkan jurang besar, dengan harga jenama asal antara RM103–RM217, manakala generik antara RM24.79–RM109, malah ada generik lebih mahal daripada jenama asal. Variasi harga yang besar ini menggambarkan ketiadaan kawal selia harga.

Beliau mengalu-alukan penerbitan harga ubat, tetapi mencadangkan satu platform penyelarasan (*aggregator*) bagi memudahkan pengguna membuat semakan dan meningkatkan ketelusan.

> ***"Tuan Heng Zee Wang [AIA Berhad]:*** *Thanks, Mark. So, we're here again, you know, we gained some sample data to show what we observe in you know, in insurance bill. Typically, you know if we go to retail pharmacies, we see the price of a tablet of Panadol for example cost around 40 cents on average but the price that you have to pay in private hospitals. [Merujuk kepada slaid pembentangan] So, the dots represent different hospitals across — and it could range from 59 cents to RM1.52. So, if we just take the average of 40 cent compares to 93 cents, that's more than doubled the cost that we have to pay at private hospitals. It's quite interesting that yesterday, Sasana Symposium organized with Bank Negara talked about rising cost where you know — YB. Datuk Seri Dzul was on the panel together with Prof. Dato' Dr. Adeeba. Dr. Adeeba actually mentioned that — actually question about the reason for this that they've got to pay like RM20 a box for per pax.*
>
> *The next example is a very typical antibiotic widely used, Ceftriaxone, you know. The Rocephin is actually the branded version and then we have a lot of other very, very similar generic version. This actually general so-called potential misconception of generic as inferior drugs. So, you know in pharma terms, a generic actually used the exact molecule or chemical make-up of the drugs. So, they are technically the same. So, right here we can see the price differences for originals there can range for RM103 from one hospital to RM217 to the other hospital. They charge the most. Even generic used, the price ranges can go from RM24.79 to RM109, which actually cost more than the originals in some hospital. So, this huge price variation is a very strong indication when there is no control in price or when there is no reasonable set up of price. This is a consequence that we are seeing today.*

It's good that we see the drug price publication starting today. I think, one step further that we can take to make it easy for customers because today there's still a very long list of drugs that not easy for consumers to find. If there's an aggregator put somewhere that customers can easily have access to, then we make the transparency works even better. Thank you."

[Muka surat 7 - 8, Laporan Prosiding Bil 5(p)/2025 bertarikh 19 Jun 2025]

7.8 Akta 723 (Retail Price Transparency 2011)

Penguatkuasaan Akta 723 bagi pemaparan harga ubat merupakan satu tindakan tuntas untuk mengatasi jurang maklumat antara penyedia perubatan dan pesakit. Ia adalah strategi kerajaan untuk merawat kegagalan sistemik dalam pasaran perubatan swasta di mana pengguna sebelum ini tidak mempunyai kuasa untuk membandingkan harga.

Walau bagaimanapun, kejayaan pelaksanaan ini bergantung kepada bagaimana kerajaan menguruskan sentimen pengamal perubatan am (GP). Kerajaan perlu memastikan bahawa ketelusan harga ini tidak menekan kelestarian klinik-klinik kecil yang merupakan tulang belakang rawatan primer.

Kesimpulannya, langkah ini adalah permulaan kepada reformasi tadbir urus yang lebih besar dalam industri kesihatan Malaysia, di mana ketelusan bukan lagi satu pilihan, tetapi satu kewajipan undang-undang demi melindungi kebajikan rakyat daripada inflasi perubatan yang tidak terkawal.

i. <u>Penjelasan Timbalan Pengarah Program Perkhidmatan Farmasi, KKM</u>

Puan Fatkhiah binti Haji Khalil [Timbalan Pengarah Program Perkhidmatan Farmasi, KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa Akta 723 berada di bawah kawal selia Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup (KPDN). Pelaksanaan berkaitan pemaparan harga ubat dan caj kesihatan memerlukan satu perintah baharu di bawah akta tersebut, yang telahpun diluluskan oleh Jemaah Menteri pada 8 Januari 2025 dan kini sedang dalam proses pewartaan. Perintah ini dibentuk hasil kerjasama strategik antara KKM dan KPDN.

"Puan Fatkhiah binti Haji Khalil [Kementerian Kesihatan Malaysia (KKM)]: *Assalamualaikum warahmatullahi wabarakatuh and selamat petang. Saya Fatkhiah daripada Program Perkhidmatan Farmasi. Akta 723 iaitu Akta Kawalan Harga dan Anti Pencatutan memang di bawah kawal selia Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup.*

Untuk yang price display, retail price, perlu diwujudkan satu perintah baharu di bawah Akta 723 supaya semua fasiliti kesihatan mengkongsikan maklumat harga kepada pengguna. So, baru dibentuklah then akan berkuat kuasa tahun ini.

Berkaitan dengan akta lama, tapi tidak terangkum untuk ubat-ubatan dan caj-caj yang lain sebab bawah KPDN yang ini memang perlu dijawab oleh KPDN sendiri tapi berkaitan dengan ubat-ubatan, perlu buat perintah baru. Itu sahaja yang dimaklumkan oleh KPDN.

Datuk Ali anak Biju [Ahli PAC]: *Itu perintah baru itu apa makna dia? Undang-undang baru ataupun?*

Puan Fatkhiah binti Haji Khalil [KKM]: *Bawah akta yang sama tapi bawah kuasa Menteri KPDN boleh membuat satu perintah bagi kawalan harga ataupun sebarang arahan untuk price display, pemaparan harga ubat.*

Datuk Ali anak Biju [Ahli PAC]: *Siapakah yang menentukan mereka membuat perubahan tersebut daripada pihak MOH? Atau hospital ataupun daripada Parlimen?*

Puan Fatkhiah binti Haji Khalil [KKM]: *Untuk perintah baru yang bagi pemaparan harga ubat, memang telah mendapat keputusan Jemaah Menteri pada 8 Januari 2025 yang mana perintah ini memang— untuk membentuk perintah ini, kerjasama strategik antara KKM dan KPDN bagi mewujudkan satu perintah baru ini dan dapat keputusan sekarang dalam proses untuk pewartaan dalam masa terdekat.*

Datuk Ali anak Biju [Ahli PAC]: *Okey. Thank you. Good answer."*

[Muka surat 36 - 37, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

ii. <u>Penjelasan TKSU KKM</u>

Dato' Sri Zahrul Hakim [TKSU KKM] dalam Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025 menjelaskan isu pemaparan harga ubat di klinik perubatan di bawah Akta 723 (KPDN) telah dikuatkuasakan sejak 1 Mei 2025. Tujuan utama akta ini adalah untuk mencapai ketelusan harga dan memperkasakan pengguna agar rakyat dapat membuat perbandingan dan pilihan yang telus bagi mengelakkan caj tersembunyi atau tidak munasabah. Dalam masa yang sama, KKM kini sedang giat mengadakan libat urus dengan doktor perubatan am (GP) dan KPDN, serta dalam proses

mengkaji untuk meminda Jadual 7 di bawah Akta 586 bagi menangani isu ini secara lebih menyeluruh.

"Dr. Hajah Halimah Ali [Ahli PAC]: *Pengerusi, sikit fasal paparan harga. Price display. So, when you get all the information, inputs from the ground, what establishment where you getting it from? Is it only the hospital swasta or what? Because now you are destabilising the whole GP system.*

Dr. Yap Wei Aun [KKM]: *So, I think there's two initiatives which are slightly different. The first one is initiatives number two which is paparan harga. So, this is the one where we are telling the GP's and private hospitals to papar harga. That's one.*

But what we are talking about in terms of data collection is more on the private hospitals side to get systematic information and billing information so that it can support the generation of the DRG pricelist as well as ultimately some kind of price transparency dashboard so that people can compare different hospitals et cetera in the systematic manner.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry, the hospitals is a different entity? You pay lots to the hospital if you go to the hospital. But if you go to a GP, that one is ciput only and that's the primary care. Hospital is secondary care. So, that's what we— that's what the GPs and now the primary care system is getting angry with KKM because they are not the one who's causing this health inflation.*

And even your health insurance, how do you cater? or how, why is it that you disturbing the primary healthcare system where the real issue is about health insurance is, the hospital bills right? And we are talking about the — what do you call it? TPA ke PTA? TPA eh? TPA, the third party kan? So, that is the big issue now. Right now circulating.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: *Yang Berhormat Kapar, untuk maklum, isu berkaitan dengan pemaparan harga ubat ini, harga ubat yang Yang Berhormat maksudkan untuk GPs, sebenarnya telah pun diluluskan di bawah Akta 723.*

Akta 723 ini kawal selia dia adalah di bawah KPDN. Kita ambil maklum tujuan untuk pemaparan harga ubat ini adalah untuk ketelusan harga dan bagi memperkasakan pengguna supaya mereka boleh membuat perbandingan harga yang lebih telus dan pengguna boleh membuat pilihan dan elakkan daripada caj-caj yang tersembunyi ataupun yang tidak munasabah.

Kita memang mengadakan libat urus dengan GPs serta KPDN berkaitan dengan Akta 723 ini yang telah dikuatkuasakan pada 1 Mei 2025. Dalam masa yang sama

juga, KKM sedang mengkaji untuk meminda Jadual 7 di bawah Akta 586, yang ini juga adalah dalam proses dan akan dibawa kepada Jemaah Menteri.

Jadi, memang ada tindakanlah di peringkat KKM Yang Berhormat."

(Muka surat 14-16, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)

Dato' Sri Zahrul Hakim bin Abdullah selanjutnya memaklumkan bahawa penguatkuasaan Akta 723 adalah di bawah KPDN dan KKM hanya memberi sokongan teknikal.

"Dato' Sri Zahrul Hakim bin Abdullah [KKM*]: ... Kami faham sentimen di luar berkaitan dengan isu bantahan daripada GPs berkaitan dengan penggunaan Akta 723.*

Cuma, dari segi kuat kuasa penggunaan akta itu adalah di bawah KPDN, KKM di peringkat Kementerian Kesihatan, kita memberikan support teknikal dan menjalankan pemeriksaan lapangan juga. Mungkin Dr. Yap boleh maklumkan berkaitan dengan status terkini berkaitan dengan paparan harga ubat.

(Muka surat 17, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)

7.9 *Diagnosis-Related Group* (DRG) sebagai Model Pengawalan Kos Perubatan di Malaysia

Sistem *Diagnosis-Related Group* (DRG) merupakan instrumen sistemik yang mampan bagi menangani isu inflasi perubatan dan meningkatkan ketelusan pengebilan di Malaysia. Melalui sistem ini, orientasi sektor kesihatan dapat dialihkan daripada model berasaskan keuntungan prosedur kepada model yang mengutamakan kecekapan klinikal. Analisis ini menyimpulkan bahawa walaupun DRG bukan merupakan penyelesaian mutlak yang mampu membuahkan hasil secara serta-merta, ia menyediakan kerangka kawal selia yang lebih tersusun bagi sektor swasta. Keberhasilan DRG di Malaysia bergantung sepenuhnya kepada tiga faktor utama:

1. **Ketelusan Data:** Kesediaan hospital swasta untuk berkongsi maklumat kos sebenar secara telus tanpa berlindung di sebalik kerahsiaan komersial.
2. **Kematangan Digital:** Tahap pematuhan terhadap sistem Rekod Perubatan Elektronik (EMR) dan piawaian pengekodan antarabangsa (ICD-10).

3. **Keseimbangan Tarif:** Penetapan harga yang saksama bagi memastikan hospital kekal kompetitif untuk berinovasi, namun pada kadar yang tidak membebankan pengguna melalui kenaikan premium insurans.

Tanpa kawalan yang efektif terhadap asimetri maklumat ini, industri kesihatan Malaysia akan terus berhadapan dengan tekanan kos yang berterusan, yang akhirnya boleh menjejaskan akses rakyat terhadap perkhidmatan rawatan swasta.

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa pelaksanaan *Diagnosis-Related Group* (DRG) telah berjaya diaplikasikan di beberapa negara seperti Indonesia dan Thailand dalam mengawal kos perubatan. Bagaimanapun, untuk memastikan kejayaan DRG di Malaysia, terdapat keperluan penting seperti memiliki pangkalan data kos yang lengkap dari sektor swasta, kerajaan, dan institusi takaful/insurans (ITO). Dengan data yang kukuh, DRG boleh menetapkan kadar tarif yang sesuai mengikut kumpulan diagnosis.

> ***"Dato' Seri Abdul Rasheed Ghaffour [BNM]:*** *Yang Berhormat, saya rasa soalan berhubung dengan DRG, mungkin lebih baik diperjelaskan oleh pihak KKM. Saya difahamkan ada juga sesi dengan KKM, mungkin mereka boleh memberi penerangan yang lebih baik berkenaan dengan pelaksanaan DRG. Tetapi apa yang kita lihat, memang ada negara-negara yang telah pun melaksanakan DRG dan juga memang berjaya.*
>
> *Contohnya di Indonesia dan Thailand. Mereka telah mengamalkan DRG dan kita dapat lihat dari segi keberkesanan dasar DRG tersebut. Jadi, ada banyak contoh yang kita boleh ambil dan banyak pengalaman yang kita boleh belajar daripada negara-negara tersebut, bagaimana kita hendak memastikan DRG ini mencapai matlamat yang kita inginkan.*
>
> *Contohnya, satu precondition yang paling penting pada pandangan pemahaman saya adalah database. Kita perlukan data-data dari segi kos mengikut diagnostic group tertentu dari pihak swasta, pihak government dan juga mungkin pihak ITO juga boleh berkongsi database mereka.*
>
> *Jadi bila ada data berkumpulan sebegini, then that's where we have a very good data point untuk memastikan kita dapat pada kadar yang bersesuaianlah dari segi DRG kita. Mungkin pihak KKM akan dapat memberi penjelasan yang lebih baik akan perkara ini. Terima kasih, Yang Berhormat.*
> [Muka surat 25 - 26, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

Selain itu **dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025 Dato' Seri Abdul Rasheed Ghaffour** menjelaskan bahawa inisiatif seperti DRG dan perkongsian kos bersama pemegang polisi bertujuan untuk mengubah tingkah laku pengguna agar lebih bertanggungjawab dalam memilih rawatan yang munasabah serta ubat-ubatan generik bagi menekan inflasi perubatan. Mengenai pembelian strategik, beliau mencadangkan penggabungan kuasa beli antara sektor awam dan swasta untuk mendapatkan harga peralatan perubatan dan farmaseutikal yang lebih baik.

Beliau bersetuju dengan pendekatan berfasa dalam pelaksanaan DRG, yang mana keutamaan buat masa ini adalah pengumpulan data yang telus bagi menentukan kadar bayaran yang adil dan dipersetujui oleh semua pihak berkepentingan.

> ***"Dato' Seri Abdul Rasheed Ghaffour [BNM]:*** *Yang Berhormat, inisiatif-inisiatif yang telah kita nyatakan di sini ini, termasuklah DRG, telah pun dibincangkan dengan pelbagai pihak. Contohnya, dengan KKM dan juga dengan pihak-pihak lain. Kami juga telah mendapat maklum balas daripada pihak hospital swasta. Memang betul, pada peringkat awal terdapat beberapa isu berkenaan dengan pelaksanaan DRG ini. Walau bagaimanapun, dengan adanya produk asas ini, adalah lebih mudah untuk DRG dimasukkan melalui asas ini. So, this is where kita akan perlu discuss lagi dengan hospital, contohnya untuk memastikan kita dapat melaksanakan DRG ini. Tetapi salah satu perkara utama yang penting untuk DRG ini dilaksanakan adalah data.*
>
> *So, that is where I think, kita perlu sokongan daripada kerajaan dan juga pihak PAC, untuk menggalakkan dan membolehkan perkongsian data. Di mana kita dapat menggunakan data-data tersebut untuk mengeluarkan kadar ataupun tahap DRG yang sesuai, yang boleh dipersetujui oleh pihak KKM dan juga pihak hospital swasta itself. So, that is how kita akan cuba bekerja bersama dengan pihak APHM. Di mana kita akan mengambil pandangan dan pendapat mereka juga dan juga dari segi cara-cara bagaimana untuk kita melaksanakan DRG ini. So, that is number one. Kedua, dari segi cost-sharing itu. Kita telah laksanakan cost-sharing daripada lama dah pun sebab di mana apabila ada cost-sharing ini, ia akan lebih meningkatkan tanggungjawab dari segi pemegang polisi tersebut untuk mengurangkan sebaik mungkin kos perubatan mereka dengan cara memilih untuk pergi ke hospital yang lebih- mungkin caj dia lebih munasabah ataupun lebih baik.*
>
> *Dan juga dari segi menggunakan perubatan ubat-ubatan yang lebih murah daripada ubat-ubatan yang branded dan sebagainya. Ini telah mendorong dari segi perubahan tingkah laku pengguna. Ini secara langsung akan dapat mengurangkan peningkatan cost medical inflation-lah. Dari segi pembelian*

strategik, so this is where perkongsian di mananya, apabila government ataupun swasta untuk membeli alat-alat tertentu, instead of them going alone on their own, so they come together and they purchase together. So, that is where I think we can get a better deal with the syarikat yang menjualkan alat-alat tersebut dan juga dari segi pharmaceutical juga."
[Muka surat 15 - 18, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

ii. <u>Penjelasan Penasihat Teknikal BNM</u>

Datuk Jessica Chew Cheng Lian [Penasihat Teknikal BNM] dalam Prosiding Bil. 5(q)/2025 bertarikh 19 Jun 2025 memaklumkan bahawa keraguan pihak hospital swasta terhadap sistem DRG berpunca daripada cara penetapan harga dan reka bentuk sistem tersebut. Oleh itu, beliau menegaskan kepentingan data yang tepat untuk menentukan harga prosedur perubatan yang berbeza-beza. Beliau turut memaklumkan bahawa pihak hospital kini lebih terbuka untuk menerima DRG setelah diberi jaminan bahawa pelaksanaannya akan dibuat secara teliti, bermula dengan fasa pemantauan prestasi sebelum penetapan harga rasmi dilakukan.

***"Datuk Jessica Chew Cheng Lian [BNM]:** On the DRG. Sebenarnya dalam perbincangan kami dengan syarikat-syarikat hospital swasta, keraguannya itu berpunca daripada cara kita design DRG terutamanya the cost, the price you know, how we set the prices. So, kami pun peka kepada perkara ini. Jadi, data itu yang penting. Kalau kita boleh kumpulkan data that will inform bagaimana kita tentukan harga DRG untuk prosedur-prosedur yang berbeza-beza.*

Dalam hal ini juga, kami pun telah memaklumkan pihak hospital swasta bahawa pelaksanaan DRG ini boleh dilakukan secara berfasa. Jadi, dalam fasa awalnya kita mungkin get data dahulu dan kita boleh monitor dia punya performance and then, baru kita tetapkan harga bagi pelaksanaan pembayaran. So, ini telah— they are more receptive sebab yang assurance yang dia nak ini yang kita tak meragu-ragu melaksanakan DRG tetapi kita buat dengan cara teliti dan dengan makluman yang sesuailah."

[Muka surat 15 - 18, Laporan Prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025]

iii. <u>Penjelasan Menteri Kesihatan</u>

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [Menteri Kesihatan, Kementerian Kesihatan Malaysia] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM sedang beralih ke arah sistem pembayaran bundle payment melalui program *Hospital Services Outsourcing Programme*

(HSOP) sebagai langkah awal ke arah pelaksanaan *Diagnostic-Related Groups* (DRG). Sistem ini menggantikan kaedah *itemised billing*, yang berpotensi menyebabkan peningkatan kos rawatan akibat caj berlebihan. Buat masa ini, 94 hospital telah terlibat dalam program ini merangkumi perkhidmatan kardiotorasik, kardiologi, nefrologi dan radiologi.

Walaupun DRG belum dilaksanakan secara rasmi, pendekatan ke arah sistem ini sedang giat diusahakan bagi membendung inflasi kos perubatan. DRG juga dijangka menjadi langkah awal sebelum pindaan kepada Akta 586 dilakukan bagi membolehkan kawal selia yang lebih menyeluruh terhadap caj perkhidmatan kesihatan swasta. Beliau turut menekankan peralihan daripada sistem pembayaran berasaskan kuantiti prosedur kepada sistem berasaskan hasil rawatan *(value-based)* sebagai matlamat utama reformasi ini.

> ***"Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]:*** *Kalau boleh, saya celah sebelum— poin ini adalah sangat sukar untuk— ramai untuk memahami dan inilah dia kuncinya antara lain. Rather than— di sebalik kita suka menyebutkan tentang kos yang disebutkan oleh beberapa Ahli Yang Berhormat sebentar tadi, sebenar-benarnya pada akhirnya, memperkenalkan satu sistem yang dikatakan remuneration ataupun satu sistem pembayaran, yang akan dapat menggarap kumpulan dan bukannya itemised billings.*
>
> *Kadangkala, kita menuntut sesuatu yang pada akhirnya akan menyusahkan kita dan akan berakibat— mengakibatkan peningkatan dalam kos. Yang ini yang dikatakan unintended consequences. Apa yang kami lakukan— maaf, kalau saya boleh— apa yang kami lakukan dalam outsourcing atau our hospital yang dikatakan HSOP tadi, Hospital Services Outsourcing Programme, di mana kita mengenakan charges kami berdasarkan bundle payment.*
>
> *Kita telah pun memulakan ini. Walaupun DRG itu belum lagi satu amalan atau sistem, tetapi bagaimana kita mengenakan charges kepada hospital-hospital? How many of them now? 94 hospitals are giving services to us berdasarkan empat services. Cardiothoracic, cardiology, nephrology dan juga radiology in imaging. Right? This four.*
>
> *Bagaimana kita mengenakan charges kepada mereka? Kita bundle-kan payment itu. Dengan kata lain, kita tidak izinkan mereka mengenakan setiap satu item, itemised billings but sebaliknya, kita mengenakan kaedah bundle payment. Bundle payment itu adalah sebenar-benarnya ke arah yang dikatakan diagnostic-related groups (DRG).*
>
> *Jadi, kita sebenarnya sudah mula mengambil langkah-langkah permulaan di situ, ya. So, itu yang saya perlu sebutkan dan dalam Akta 586, The Private Healthcare Facilities and Services Act of 586, di situlah kita berpeluang sebenarnya. We will*

come to it. Kita akan pastinya datang untuk membuat amendments tetapi bukan dalam waktu yang terdekat.

Kita perlu meneliti kesemua ini supaya kita hendakkan akhirnya nanti, kita dapat, dalam bahasa kami sekarang ini, we want to nudge. Kita nak asak private health facilites supaya memahami bahawa charges mereka itu seharusnya adalah lebih munasabah. Lebih munasabah, kata Dato' Sri KSU saya. Dengan itu, this escalating medical inflation akan dapat kita tangani. Kita memperkenalkan DRG.

Untuk sehingga kini, private health operators and hospital tidak ada langsung apa juga sistem dalam penentuan harga. Except, apa yang disebutkan oleh Dr. Harshinderjeet sebentar tadi, Akta 586 mengenakan charges— bukan. Mengenakan— menentukan fees untuk konsultasi ataupun rundingan, consultation medical dan juga beberapa procedures. Itu sahaja.

So, we are moving towards a bundle, kind of apa yang dikatakan sebagai DRG. Hari ini, DRG ini bukan rocket science dah. Orang dah lama tinggalkan kita. They are now moving towards CRG, the clinical-related groups. Tetapi, tak apa. Kita akan mengambil langkah-langkah awal ini dan kita akan sampai ke— ke destinasi itu dengan kita meletakkan dan menekankan tentang value-based.

Kita kerap mengingatkan pada hospital swasta supaya jangan pay ataupun jangan charge for services or procedures because the more you do services, the more you do procedures, you charge them.

Tetapi yang kita mahukan adalah pay for outcome. That is the value based. Terima kasih Pengerusi."

[Muka surat 23 - 24, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

Datuk Seri Haji Dr. Dzulkefly bin Ahmad dalam prosiding yang sama turut menjelaskan bahawa DRG bukan penyelesaian mutlak, tetapi memerlukan ekosistem yang lengkap, termasuk rekod kesihatan elektronik kebangsaan (National EMR) dan sistem *"one citizen, one record"* untuk memastikan keputusan berasaskan data yang kukuh. Beliau menyatakan keperluan untuk ketelusan harga dan integrasi sistem kesihatan awam-swasta agar reformasi seperti DRG dapat dilaksanakan dengan berkesan dan adil.

***"Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]:** Ya. Terima kasih. Kalau boleh saya tambah sikit lagi. Sebab itu pada awal-awal kami telah menyebutkan bahawa meskipun DRG akan merupakan satu penyelesaian yang sangat baik ya, satu yang sepatutnya kita telah laksanakan sekian lamanya tapi DRG is not a silver bullet dalam bahasa kami. Dia bukannya senjata yang boleh menyelesaikan semula. Nah, sekarang ini baru kita perasan bahawa important thing to do— actually, be able to supaya kita dapat melaksanakan DRG ini, keperluan kepada data dan this is where the National EMR. Another satu reform yang saya cita-cita untuk bangunkan adalah*

National Lifetime Health Record ataupun Electronic Medical Record (EMR) yang akan mengizinkan that every citizen would have— one citizen one record. They have a master patient index yang meletakkan semua. Insya-Allah, a few years down the road, all our health facilities sama ada klinik, vertikal ataupun horizontal integration, clinics to clinics and then vertical clinic to hospital, public to private.

So, with that, dengan hanya kita dapat— so, this is very important. It almost like a prerequisite, sebagai prasyarat ya perasanan DRG ini adalah wujudnya data yang mengizinkan kita membuat keputusan-keputusan that is truly data-driven. Jadi, dengan itu saya sebutkan sekali lagi the whole ecosystem is so very important. DRG is not the big all and all seperti mana yang YB Bayan Baru sebutkan tadi dan dia perlu kepada the entire ecosystem termasuklah besides the National EMR itu adalah the transparency dan yang lainnya. Itu tambahan daripada saya.

[Muka surat 19, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

iv. <u>Penjelasan KPE, HTO KKM</u>

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa *Diagnosis-Related Group* (DRG) bertujuan untuk meliputi keseluruhan pakej penjagaan klinikal, sambil mengakui kemungkinan penambahan pembayaran untuk komponen bukan klinikal (seperti pilihan bilik wad). Walau bagaimanapun, beliau menegaskan prinsip etika bahawa penjagaan klinikal harus saksama untuk semua rakyat Malaysia, manakala pilihan kemudahan mewah boleh dibenarkan tanpa mengganggu kualiti penjagaan teras. KKM tidak akan menyalin sistem DRG luar secara terus, tetapi akan menyesuaikannya mengikut konteks negara, termasuk epidemiologi tempatan (contohnya, Denggi).

Usaha pelaksanaan DRG sedang dipercepatkan melalui libat urus dengan pelbagai pihak berkepentingan, semakan perundangan, dan bengkel teknikal melibatkan Bank Dunia dan Bank Negara. Selain itu, perbandingan kos perkhidmatan antara sektor awam dan swasta telah dilakukan melalui Kajian *Malaysia Health System Research* (MHSR).

***"Tuan Haji Azli bin Yusof [Ahli PAC]:** Okey, terima kasih Timbalan Pengerusi. Saya ada tiga soalan. Pertama tentang DRG. When you set a single tariff, right— propose a single tariff, the DRG is basically— I mean comparing to other industries— it is similar to activity-based costing I believe where you trace from the beginning of the process until the end and then you set a price for it, right. Then— but across the different ratings of the private sectors then you have a range of*

services. Then, how do you then set a single tariff or would that be a range or like julat for that tariff? That's one.

Number two has KKM or anybody done a comparison between the services provided by the public sector as compared to the private sector for say— for one particular operation or procedures or whatever right? I mean kita selalu kata private sector mahal, mahal, mahal. While actually the public sector is not cheap but because they are getting free. So— subsidies or whatever. So, when you compare, where do public sector fairs with the private sectors— I mean maybe the middle range or something like that. That's number two…

Dr. Yap Wei Aun [KKM]: *Terima kasih atas soalan tentang kelompok berkaitan diagnos ya. Pada permulaan, saya minta you understand info discussing something yang agak teknikal but then sebaliknya anda tanya saya soalan yang even more technical daripada itu. So, maybe I just give more of a principle because these are the things which memang perlu diperincikan di beberapa jawatankuasa teknikal and may you understand further. But, secara am, the best is to see that especially in the context of this based insurance product, the DRG payment is to cover the whole clinical care package.*

Tetapi ada yang sesetengah yang akan meminta— actually I prefer instead of eight bed share, I want one bed share. So, how do you add on to allow that pro— that consumer choice to have a little bit more of the non-clinical care component and then pay for that? So, these are some of the discussions that we had. So, it's possible in experiences done globally. It is possible to link DRGs to additional payments for non-clinical care. But I think it's an ethical choice that we should try to decide on that clinical care is something that it should be equitable. We should not allow that to be the basis by which we discriminate between Malaysians.

So, saya rasa yes, we can allow that some people go to the hospital which maybe they see the three-story fish tank and the grand piano. But we do want that whatever hospital they go to, if they are sick they have the best chance to get the best clinical, the most appropriate clinical care-lah. Itu I think I would suggest that as a policy that would be a good ethical principle that we should apply. Soalan kedua is tentang…

Tuan Haji Azli bin Yusof [Ahli PAC]: *Comparison.*

Dr. Yap Wei Aun [KKM]: *Ha, comparison. Yes. I was actually involved in what's called the MHSR study (Malaysia Health System Research) study and ini melibatkan beberapa kumpulan care work packages. One of the ones was actually looking at the comparison between public costs with private prices. So, I think this study we are trying to push for this to be published then maybe they will put it on our transformasi website at some point then it can be reviewed in general. Thank you."*

[Muka surat 32 – 33, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

"Dr. Yap Wei Aun [KKM]: *I think, I mean, memang kita terima cadangan dan all your suggestions. Pembangunan DRG adalah sesuatu yang melibatkan beberapa*

agensi. I think it's clearly a national priority as well. So, memang kita perlu figure out very carefully how we are going to move this as fast as possible.

Sudah pun kita ada at least the technical level, all the steps that are required, and reviewed all the perundangan yang diperlukan, data requirements, we've been organising town halls to engage with the— untuk buat libat urus dengan semua stakeholders.

I think even just two weeks ago, I think as minister mentioned in his social media posting, kita juga ada melibatkan satu technical capacity building workshop yang melibatkan Bank Dunia, Bank Negara dan kesemua all the stake— pemegang taruh, private hospitals, private ITO, LIAM dan sebagainya. So I think, we're already— even, ya— we're already working as fast as we can on this issue-lah. Itulah. Pagi ini pun ada satu mesyuarat technical advisory committee for national DRG…."

[Muka surat 35, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

"Dr. Hajah Halimah Ali [Ahli PAC]: *Pengerusi, just about this DRG. You ada benchmarking to any— apa, dia mula New Jersey, kan? So, what's the best practice now of this DRG? Or is it just lebih kurang sahaja? Benchmark.*

Dr. Yap Wei Aun [KKM]: *Usually, untuk pembangunan satu DRG, we start with a— the principle of an existing grouping system. Then, kita kena menukar dan adapt dia kepada situasi dekat negara kita khasnya dari segi epidemiology dan cara tata kelola klinikal.*

So, for example, the classic one would be, if you just take something from Australia, then what about dengue? Which is one of our main admissions here. So, kita kena memastikan sistem ini adalah sesuai dengan negara kitalah.
Bukan sahaja dari segi jenis penyakit, tetapi cara perawatan yang digunakan dekat sinilah. So, this is not like we just going to copy some other place. But we necessarily to based the principles on best practice from around the world."

[Muka surat 35 - 36, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

Selain itu **dalam Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025 Dr. Yap Wei Aun** juga menjelaskan perkara-perkara berikut:

DRG dan MHIT Asas:

Pelaksanaan DRG di sektor swasta sangat berkait rapat dengan pembangunan produk MHIT asas. MHIT asas yang dipiawaikan akan menyediakan platform untuk DRG.

Definisi DRG:

Episod penjagaan (termasuk kemasukan hospital, ujian sebelum, dan susulan selepas) diklasifikasikan ke dalam kumpulan yang setanding sumber (*resource comparable*) dan kumpulan klinikal (*clinical group*). Pembayaran dibuat berdasarkan amaun tetap yang telah ditetapkan untuk setiap kumpulan, diselaraskan mengikut tahap keterukan.

*"**Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]:** ...On the top, you see private sector. So, that's a keyword. So, it's not referring to the national DRG intervention which pertains to KKM hospitals, MINDEF hospitals and a public university's hospital as well.*

But, it's a private sector initiative and the other important things — I'm sorry that the formatting is not clear but it says the private sector DRG implementation strategy via base Medical Health Insurance and Takaful (MHIT). So, this private sector DRG implementation is very much linked to that initial thing on top in this slide, where you see the development of this base product — base MHIT product, number one. So, number one and number nine, if you like, are linked to each other. They mutually enable each other.

It's important because a base MHIT being a standardised product with a common benefits package and a common provider network provides that standardised platform for which we can put on a DRG. If we just put DRGs in a fragmented system where there are different benefits, different hospitals, different rules, different ways of paying, it will be a leave it more complicated.

So, let me just also go to the blue box for this, what are DRGs and this is just a very simple definition. I'm sure professors may come up with a more complicated definition but I just want you to think of something simple. So, these are care episodes. So, things like a hospitalisation but not just one of, but just think of it as not just the initial hospitalisation, you may know that you need to go for some test before and some follow-up after. So, just a care episode, classified into resource comparable resource.

That means the amount of resources in terms of staff, time, drugs and otherwise. A comparable clinical group. So, you have to make some sense in terms of the clinical diagnosis and what's going on. And payments are made by a predetermined fixed amount for each of these groups and we typically adjust also for severity. So, if you do appendicitis and a perfectly well and teenager versus doing it in an 80-year-old who has diabetes and obesity, is kind of a different thing in terms of its resource comparability .."

[Muka surat 8-9, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

Tiga (3) Elemen Penting untuk DRG Swasta:

a) **DRG Grouper:** Sistem yang mengklasifikasikan diagnosis dan prosedur ke dalam kumpulan. Strategi keseluruhan adalah menggunakan *grouper* sedia ada termasuk yang dibangunkan KKM dan kemudian disahkan dengan data sektor swasta sebenar.

b) **Kadar Harga (*Price Rates*):** Mengumpul data harga melalui pelbagai strategi untuk menetapkan kadar bayaran balik DRG.

c) **Mandat Pembayaran (*Payment Mandate*):** Dicadangkan untuk dilaksanakan dengan produk MHIT asas.

"Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]: ... *To get this private sector DRG going, we just need three elements, three key elements and I've enlisted there as one, two and three. The first one is a DRG grouper. A grouper is like the system which says that this sort of diagnosis and these sorts of procedures goes into group A. Another sort of diagnosis goes into a group B or C. and their 100, if not 1,000 of groups potentially depending on the grouper. And in between like appendicitis, that might be one, for example.*

And overall strategy is to adopt an existing grouper. They are both open-source groupers available as well as groupers which a ministry already has developed. As I mentioned, there is a long-standing national DRG initiative. And then subsequently to validated based on real private sector data. So, you know whether it works or not and whether it needs a bit of adaptation to local practice, particularly.

But, DRG groupers, if you look on right-hand side, require continuous refinement. The reason why is because healthcare is dynamic. Technologies improved. 20 years ago, your treatment options for cancer are limited. 20 years from now, things are going to be very different as well. So, it moves with technological improvement. It also moves with the way doctors and nurses practice medicine. And it also changes based on the epidemiology of diseases. The spectrums of disease are changing. So, we do need — it does need to be a dynamic system.

Number two is how we get the price rates. So, once you assign something to a group, how much do you actually reimburse for that? So, for this one, we want to really align in terms of standard with all existing national DRG initiatives. I won't bore you but this includes things like coding standards and testing all the variables. I'm sorry if I'm going too technical here but also bailing information.

And then, to collect pricing data using a variety of strategies, both voluntary. You may be aware and I think you've talked to the private sector as well. They have given us their commitment that they are willing to share this data. The reason why

they are willing to share this data is because it is in their interest to do so. They do not want to reimbursement rates to be based on synthetic or data which may not be actually correct. So, I think it's in their interest to give the right data.

But, nevertheless, we are also working on other strategies at the same time, including exploring the changes to 8-5, 8-6 to support the mandatory collection of certain price information, as well as working through insurers and takaful operators to get similar information. But, just like the groupers on top, the price also requires continuous refinement as practices change. And, so this is a dynamic process and we want it to be such as such.

You also realise that collecting this information is not only useful for determine the price rates for the DRGs. it's also useful for providing more price transparency for the rakyat *and consumers and even institutions of purchase, such as insurers, to know which are more expensive or cheaper hospitals. You may recall that in February 1, the hot topic is why is it that people who pay based on insurance seem to have a higher bill than people who pay out of pocket in cash. So, now we want to get more information, so we can answer such questions more definitively.*

Number three is we need a payment mandate. How do we agree or how do we enforce, like if you like the payment based on DRGs? We proposed to link it to the base MHIT product. So, this will most likely be in the form of a contracting process. There is still a lot of ongoing work which is already in progress to explore the legal regulatory and another contracting issues related to that, as well as the development of appropriate systems to support the data collection, validation, all these pricing rates, staff. So, all this is ongoing."

[Muka surat 9-11, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

Garis Masa dan Fasa Pelaksanaan:

DRG dan MHIT asas dijangka akan disegerakan dan dilaksanakan secara berfasa bermula pada tahun 2026. Pelaksanaan akan bermula dengan keadaan yang paling biasa (*common conditions*) dan secara progresif beralih daripada bil *fee-for-service* kepada bil DRG, bertujuan untuk menggalakkan kecekapan dan mengurangkan perbelanjaan yang tidak perlu.

*"**Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]: ...** And, now, I guess you also want to ask when we are going to implement DRGs. So, because the DRGs and MHIT* asas *are linked to each other, so the timeline for DRG implementation and MHIT* asas, *if you like, basically synchronise for that. Approximately sometime next year. And, we plan to phase it in, in phases if you like. Why is this so and how do we do this? Let me just try to explain it in as simple a way as I can. As I mentioned that the DRG groupers you can have 100 if not 1,000 of groups. Some of them will be very obscure conditions and we may not have enough information to say it should be definitely — priced as X ringgit or Y ringgit.*

But there are also if you talk to people, the common conditions for going to hospitals, typically, if we've something to do is gastroenteritis and this can be very, very common. So, we want to start with the most common conditions and we want to progressively shift from the fee-for-service bill in stages towards the DRG bill. So, it's like essentially, we do not need to just go from one day overnight from paying 100 percent based on fee-for-service to which is an itemised bill to 100 percent based on DRG alone.

It's possible to blend in the payments and progressively change that ratio over time so that this will not disrupt the market too much. But nevertheless, we'll start beginning to exert the pressure on hospitals to benefit from efficiency and process improvements and it also disincentivise already at the stage unnecessary— let say, in antibiotic prescribing or unnecessary tests or procedures being done because it already exerts that little pressure on it. So, that's how it happens in phases…."

[Muka surat 11, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

Dr. Yap Wei Aun turut memaklumkan bahawa inisiatif sektor swasta ini adalah tindak balas kepada inflasi di sektor swasta dan tidak bermakna kerajaan hanya memfokuskan kepada penswastaan. Beliau turut memaklumkan bahawa transformasi penjagaan kesihatan sektor awam masih menjadi tumpuan KKM.

"Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]: ... *Now, very often in the public sector, when we mention all these initiatives at the private sector, I'm sure you may also get feedback from a constituency. What about the public sector is basically this government is heading towards just private sector. So, I just want to clarify that these private sector initiatives are a response to the issues of inflation in the private sector and we do need to transform the private sector.*

But, ongoing with this private sector initiatives or how put it maybe Malay, walaupun KKM sedang giat mengusahakan strategi RESET di sektor swasta bersama kementerian dan agensi lain, transformasi perkhidmatan penjagaan kesihatan sektor awam masih adalah tumpuan kita dan inisiatif untuk memperbaiki sektor swasta ke arah perkhidmatan penjagaan kesihatan berasaskan nilai, ini bukannya penswastaan sektor awam. So, just because you see the news that we are announcing things like JBMKKS and we are intervening to correct problems in the private sector to address inflation, it does not mean that, that is all the reforms there are but there are certainly a lot of public sector reforms."

[Muka surat 8, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025]

v. <u>Penjelasan Timbalan Ketua Setiausaha (TKSU) KKM</u>

Dato' Sri Zahrul Hakim bin Abdullah [TKSU KKM] dalam Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025 memaklumkan bahawa inisiatif DRG dan

reformasi kesihatan berkaitan telah dimulakan seawal sebelum Februari 2025. KKM telah menubuhkan Jawatankuasa Bersama dengan Kementerian Kewangan dan Bank Negara Malaysia pada 25 Jun 2025. Matlamat utama adalah untuk menyelaraskan jangka masa pelaksanaan DRG dengan produk MHIT asas (pelan takaful asas mampu milik), dengan sasaran keseluruhan inisiatif dapat dilaksanakan sepenuhnya pada tahun 2026.

Strategi pelaksanaan DRG adalah secara berfasa melibatkan proses peralihan daripada bil *fee-for-service* kepada DRG. Pendekatan ini membolehkan sistem pembayaran menggabungkan kedua-dua kaedah pada peringkat awal, di samping memastikan hospital swasta untuk meningkatkan kecekapan.

Selain itu, inisiatif lain seperti penubuhan Rakan KKM Sdn. Bhd., pembangunan MHIT asas, usaha ketelusan kos rawatan, dan pelaksanaan ekosistem kesihatan digital yang mapan turut giat dijalankan serentak, yang menunjukkan komitmen KKM dalam melaksanakan kerjasama dengan BNM dan Kementerian Kewangan.

*"**Puan Vivian Wong Shir Yee [Ahli PAC]**: So, it started when? Like how long and how long is your prediction on this entire?*

***Dr. Yap Wei Aun [KKM]:** Is your question when we started?*

***Puan Vivian Wong Shir Yee [Ahli PAC]:** Yes.*

***Dr. Yap Wei Aun [KKM]:** I think even when we first met in February, we've already doing the groundwork to figure out the methodologies and talking to stakeholders, talking to people about what needs to be done. So, I think it's really— I mean, PMX announced it in December, right? That he wanted DRGs implemented. So, as executive we are obliged to really accelerate our implementation of that. So, it certainly started some time back.*

***Puan Vivian Wong Shir Yee [Ahli PAC]:** This year? February this year? [Berucap tanpa menggunakan pembesar suara]*

***Dr. Yap Wei Aun [KKM]**: The thinking has— DRGs as a national project, it's been ongoing for a long time. Even the idea of linking it to this is even precedes the PM's announcement. So, it just we have been thinking and trying to do the due diligence to figure out how we can get this going in the private sector for a long time already. But the benefit actually is because of the push on the political side. Because in many countries, they may feel like, "Why we do we want to rock the boat?" The different stakeholders. But now with the clear leadership from the political side to*

say that it is really important to address inflation, I think stakeholders are very much more align. So, I think you all should be appreciated, you all should give yourself a pat on the back for really pushing this issue.

***Dato' Sri Zahrul Hakim bin Abdullah [KKM]**: Yang Berhormat, kalau boleh saya tambah berkaitan dengan timeline untuk inisiatif swasta ini. Sebagaimana yang dimaklumkan, jawatankuasa bersama berkaitan dengan— jawatankuasa bersama yang ditubuhkan pada 25 Jun yang lalu, melibatkan KKM bersama Kementerian Kewangan dan Bank Negara Malaysia dan kita telah mengadakan mesyuarat yang pertama. Matlamatnya ialah untuk menangani inflasi perubatan swasta secara menyeluruh, holistik dan mengukuhkan keseimbangan antara sektor awam dan swasta.*

Dari segi timeline, kita memang ada gerak kerja untuk mengadakan mesyuarat lebih frequent dengan Kementerian Kewangan dan juga Bank Negara Malaysia. Ada beberapa inisiatif yang telah pun dimulakan. Contohnya, berkaitan dengan Rakan KKM, telah pun ditubuhkan pada bulan Jun yang lalu dan berdasarkan kepada perancangan Rakan KKM Sdn. Bhd., kita akan mengeluarkan first patient pada Disember tahun ini.

Inisiatif-inisiatif lain juga sedang dalam pelaksanaan termasuk sebagaimana yang Dr. Yap Wei Aun sebutkan tadi, revamp on MHIT. Ini sedang dibangunkan bersama Bank Negara untuk pelan asas takaful mampu milik. Juga berkaitan dengan pemaparan kos rawatan secara telus melibatkan hospital-hospital swasta.

Di peringkat KKM juga kami sedang giat melaksanakan digital health ecosystem yang lebih mapan menggunakan sistem rekod kesihatan digital, teleperubatan dan interpretability data melibatkan fasiliti-fasiliti kesihatan di bawah KKM. Akan diperluaskan juga di peringkat swasta. Jadi, ini adalah merupakan antara perancangan di peringkat KKM yang kami bekerjasama rapat dengan Bank Negara Malaysia dan Kementerian Kewangan melalui jawatankuasa bersama yang telah pun dimulakan pada 25 Jun yang lalu.

Jadi, kalau Yang Berhormat mohon dari segi timeline ataupun readiness untuk kita melaksanakan, sebenarnya telah pun berlangsung dan kita memang ada perancangan. Tahun hadapan kita akan pastikan semua inisiatif yang kita bincangkan di dalam jawatankuasa ini akan dapat dilaksanakan secara keseluruhan."

(Muka surat 12-13, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)

Dato' Sri Zahrul Hakim memaklumkan jangka masa pelaksanaan inisiatif utama:

a. Pelaksanaan Penuh DRG: Dijangka bermula pada tahun 2027 dan seterusnya, dilaksanakan secara berperingkat;

b. Produk MHIT Asas (Takaful/ Insurans Mampu Milik): Pihak KKM menyasarkan pelancaran produk asas ini pada Disember 2025, dengan sasaran pelaksanaan penuh dapat dicapai pada akhir tahun 2026.

*"**Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:** ... Number two, mengenai DRG ataupun kumpulan berkaitan diagnosis ya. Ini kita berharap ia akan dapat mengurangkan kos perubatan hospital-hospital swasta. Menteri Kesihatan pada bulan April ada membuat kenyataan bahawa sistem DRG Kebangsaan ini dijangka akan dilaksanakan tahun ini dengan sebagai pilot project terhadap penyakit ringan.*

Saya nak minta pencerahanlah daripada pihak Kementerian Kesihatan what is the progress so far. Progress ini nak kena tahu. Kalau tidak kita pun tak tahu apa terjadi dan sebagainya. Dalam meeting ini kita boleh tahu apa the progress dia. What is the progress so far and adakah dia mengikut perancangan ataupun dia terkebelakang ya?

Number three, the last one. Saya nak tanya dia bersangkutan juga dengan kos perubatan, national health insurance ya. Adakah Kementerian Kesihatan bercadang merancang untuk melaksanakan national health insurance? Negara seperti Indonesia dah ada national insurance. So, minta diberi penjelasan, pencerahan tentang tiga perkara tadi. Terima kasih.

…

***Dato' Sri Zahrul Hakim bin Abdullah [KKM]**: DRG pelaksanaan tahap berperingkat, Yang Berhormat. Kalau ikutkan, kita jangka untuk DRG 2027 onwards. DRG.*
Cuma, saya nak respons berkaitan dengan produk asas takaful insurans. Memang kita ada banyak jawatankuasa di peringkat KKM bersama dengan Bank Negara, EPF, MoF dan sebagainya serta pemain-pemain luar, tetapi dari segi target kita memang kalau dapat, kita nak lancarkan pada akhir tahun ini iaitu produk asas MHIT ini, mampu milik ini pada Disember 2025. Kita nak rancang— kalau mengikut perancangan KKM ialah kalau dapat pelaksanaan penuh produk MHIT ini dapat dilaksanakan sepenuhnya pada akhir tahun 2026."

(Muka surat 24-27, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)

vi. Penjelasan *Senior Researcher* (Penyelidik Kanan) Third World Network

Encik Lim Chee Han [*Senior Researcher* (Penyelidik Kanan) Third World Network] dalam Prosiding Bil. 5(c) bertarikh 25 Februari 2025 menjelaskan bahawa sistem *Diagnosis-Related Groups* (DRG) dapat memberikan struktur untuk menetapkan had harga atau pakej rawatan berdasarkan diagnosis tertentu. Ini dapat membantu kerajaan dan sektor swasta berunding mengenai

harga yang lebih jelas dan terkawal. Walaupun ia tidak menjamin pengurangan inflasi perubatan, ia memberikan sedikit kawalan terhadap kos rawatan. Selain itu, dengan adanya sistem ini, diharapkan ia dapat mengelakkan caj yang tidak wajar dikenakan oleh hospital terhadap pesakit.

DRG akan membantu mengatur dan menetapkan harga rawatan berdasarkan diagnosis tertentu, sekaligus memberi ketelusan dan keadilan kepada pesakit dan kerajaan. Beliau menekankan bahawa walaupun DRG tidak menjamin penurunan inflasi perubatan, ia memberikan struktur kawalan untuk memastikan hospital tidak mengenakan caj yang tidak wajar.

Selain itu, pelaksanaan DRG juga akan mengurangkan keperluan hospital memberikan bil terperinci untuk setiap item kecil seperti sarung tangan dan jarum suntik. Sebaliknya, semua kos tersebut akan dimasukkan dalam pakej rawatan, menjadikannya lebih mudah dan jelas bagi pesakit serta mengelakkan harga / caj yang tidak wajar.

> ***"Dato' Adnan bin Abu Hassan [Ahli PAC]:*** *Dr. Lim, I would like to refer to number six, implementation of DRG. In your point of view do you think that this implementation of DRG definitely will give a positive impact to the reduction of the prices charged by the private hospital? Do you think it will be positive impact?*
>
> ***Dr. Lim Chee Han [Third World Network]:*** *Yes, definitely Yang Berhormat. Because currently is totally unregulated. So, with the DRG at least they set some kind of boundaries or some kind of packages for the treatment for certain diagnosis. So, also they have to— government also have to negotiate with the private sector about the kind of payment range. It's not a range, it is kind of pricing they have to confirm. So that for short term then everyone will be very clear about that kind of expenses and diagnosis involved.*
>
> *It's not a guarantee for reducing the medical inflation but it's one way to do it because DRG also practiced in USA and we know that medical inflation in USA is crazy. So, but it gives some kind of framework of control. I think it's good for the consumer, patient and also government to regulate so that the hospitals cannot charge unreasonable billing charges.*
>
> ***Dato' Adnan bin Abu Hassan [Ahli PAC]:*** *You're meaning to say that it will be more transparent, is it? In terms of…*
>
> ***Dr. Lim Chee Han [Third World Network]:*** *I think it is fairer ya.*
>
> ***Dato' Adnan bin Abu Hassan [Ahli PAC]:*** *Transparent?*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *It will be more transparent compared to you know, traditional way of doing things.*

Dr. Lim Chee Han [Third World Network]: *Yup, so hospitals don't have to bother to give itemise billing for glove and like a small syringe or things like that. There is no need to markup for everything. Just everything in the package, just go. I think it will be very healthy that way.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Okay, thank you Dr."*

[Muka surat 21, Laporan Prosiding Bil 5(c)/2025 bertarikh 25 Februari 2025]

vii. <u>Penjelasan NAMLIFA</u>

Encik G Saseedaran Gengadharan [NAMLIFA] dalam Prosiding Bil. 5(e) bertarikh 26 Februari 2025 menjelaskan bahawa NAMLIFA menyokong pengenalan sistem DRG sebagai satu langkah ke hadapan dalam mengawal kos rawatan perubatan. DRG atau adalah pendekatan yang baik kerana ia membolehkan standardisasi kos rawatan berdasarkan jenis diagnosis dan prosedur. Ciri-ciri DRG telah pun disentuh dalam polisi dokumen MHIT (Medical and Health Insurance/Takaful) oleh BNM. Salah satu mekanisme penting dalam sistem ini ialah perkongsian maklumat caj rawatan dan prosedur antara syarikat-syarikat insurans. Dengan data yang dikongsi, syarikat insurans boleh membuat perbandingan antara caj hospital dan mengenakan had terhadap caj yang tidak munasabah. DRG membolehkan kawalan yang lebih telus dan sistematik terhadap caj rawatan perubatan di hospital swasta.

"Dato' Adnan bin Abu Hassan [Ahli PAC]: *Terima kasih, Yang Berhormat Chairman. Soalan saya adalah kepada persatuan. Apakah pendirian dan pandangan persatuan yang berkaitan dengan pengenalan DRG? Terima kasih.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Okey.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Diagnostic-related group.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *It's a very good way forward sebenarnya. In fact, DRG ini sesuatu yang dekat dengan DRG telah pun disebut di dalam polisi dokumen MHIT oleh Bank Negara tahun lepas iaitu shared information. Maklumat itu dikongsi tentang bil ataupun caj-caj dan kos-kos pelbagai jenis rawatan dan procedures dan mereka boleh— syarikat-syarikat insurans itu dia boleh memantau ataupun membuat perbandingan antara caj-caj ini di kalangan*

semua syarikat insurans. Sekiranya ada hospital yang caj lebih tinggi, mereka boleh gunakan maklumat ini untuk membuat— adakan limit lah ataupun mengehadkan caj yang dibuat oleh hospital itu. So, DRG is a way forward bagi kami."

[Muka surat 20 - 21, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

viii. <u>Penjelasan MMA</u>

Dr. Gunalan @ Arumugam Palari [Ahli MMA] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa berdasarkan maklum balas dari negara yang telah melaksanakan DRG seperti Jerman dan Korea, Sistem DRG tidak ditolak sepenuhnya, tetapi pelaksanaannya di Malaysia mempunyai syarat wajib dan risiko kritikal. Syarat utama untuk DRG berfungsi adalah dengan adanya Insurans Kesihatan Sosial Nasional atau model pembayar tunggal (*single payer*), serta pengekodan DRG yang seragam di seluruh negara (hospital awam dan swasta).

DRG mempunyai kelemahan, termasuk risiko penyediaan penjagaan bawah standard (*under provision of care*) kerana pihak insurans akan menentukan had rawatan, memaksa pesakit dilepaskan awal dan berpotensi meningkatkan kadar kemasukan semula.

Selain itu, hospital swasta mungkin terpaksa memilih pesakit (terutamanya kes berisiko tinggi yang mahal) untuk mengelak kerugian, yang akan membebankan sektor awam. DRG juga meningkatkan risiko mengekod secara berlebihan (*upcoding*) di mana doktor meletakkan pesakit dalam kategori risiko yang lebih tinggi untuk menaikkan bayaran insurans. Pelaksanaan DRG juga boleh meningkatkan kos pentadbiran secara mendadak contohnya di Jerman, tujuh daripada sepuluh kakitangan baharu yang diupah di hospital duduk di jabatan pentadbiran.

Secara kesimpulannya jika faktor luaran seperti kos ubat, teknologi, dan inflasi tidak dapat dikawal, kadar DRG perlu disemak berterusan dan jika tidak, hospital tidak dapat menampung kos. Malaysia, yang kini mempunyai sistem pembiayaan hibrid, perlu menangani kekangan ini terlebih dahulu sebelum melaksanakan DRG.

"Dr. Gunalan @ Arumugam Palari [MMA]: *… Quickly about this, diagnosis related group. I know that Professor Emeritus Syed Aljunid he's very passionate and this is his pet topic. So, I'm not actually going to be tell— diving deep into the detailed aspects of it. But, just a couple of things that we noticed. In fact, we had a lot of conversations with our colleagues from overseas, Germany and Korea where they've actually implemented DRG over the last 20 years or so and gathered feedback from them as well. So, they have mentioned that look the most important thing that you must have to in order to have DRG is social healthcare insurance, number one. That is a must. You cannot have a hybrid way of doing it and then try to implement DRG.*

Second thing is the DRG coding has to be uniformed. It is a national DRG coding. That means whether you are in private or public hospital, the same codes, the same charges should be applicable, then only it will work. If you have just focus on DRG, lets do it for private sector and this is the charges and DRG for the public sector and this is the charges, it is going to be very messy and technically going to be challenged.

We know the advantages. Yes. Easy to reimburse. This is pro insurance. All right. But, let's look at disadvantage. Under provision of care, meaning that the insurance company will dictate what you can and cannot do within that said DRG. Again, like what we had mentioned earlier certain patients may not fall into that particular category. They will need extra work to be done. Some patients because the insurance company say you must discharged in three days may need extension of stay but because it is not paid for, you discharged the patient early. What happens then, the patient will end up readmitting with complications.

So, this is another drawback of DRG system. In private hospital we may end up selecting our patients. Right now, private hospital in Malaysia are actually doing tertiary level work almost equivalent to a public hospital.

Every state you have one big hospital that functions almost like a GH. If DRG comes on board we may actually be underserving that particular population because DRG may not take into account the cost factor especially there is a high-risk patient. We may end up rejecting care for them and moving them back to when already over stretched public hospital. That's one part of it we have to…

And we also found out from our colleagues in Germany, for the purpose of DRG coding, some doctors may end up upcoding. Upcoding means that they put the patients on a higher risk factor, so that the cost actually will be upscale as well. So ended up maybe an appendix we would have charged RM30,000 now the same appendix because you have up coded for the purpose of payment may end up— the insurance company may end up paying RM50,000. These are some of the technical challenges that have been shared.

Number one, back to the same thing again. DRG has to be applicable to both public and private hospital and National Healthcare Financing insurance has to be there. Because that is the one single payer that is going to channel the fund to put public and private hospital because it is DRG.

Let's see how Australia works. Australia has a single-pay called Medicare. All the big hospitals are all public hospitals that are funded by Medicare. But if you say your total knee replacement is going to be done in six months and you choose not to wait. You have your private insurance.

You choose a private hospital that has got the surgical services and there's a quote for that. That quote you pass it on to your insurance company, insurance company will pay that quote, Medicare will pay the private hospital a portion of the fund because the same amount of money would have been paid if you have done the surgery in public hospital as well. There is an allocation of funds from different, different payers, if you were to take on your surgery in a private hospital. This cannot be done in Malaysia at the moment because we don't have that number one, the National Healthcare Financing, a single payer.

Again, looking back at all the countries that has implemented DRG, the single most stand out feature is basically social healthcare insurance. That has to be there in the first place. What we have in Malaysia right now is a hybrid form of financing, works well so far but we know that we need to improve on it.

One thing that was highlighted by our colleagues from Germany is this. When they start DRG there might be potential increase in the administrative cost of implementing DRG. You will need to coders. You need to have technical people, IT specialists, all those additional administrative staff so much so that in his country he has noted that— this is the public health physician, out of 10 staffs hired in a hospital, seven are sitting in the admin and three are actually delivering the healthcare service.

You have to look at that and see whether by implementing a monstrosity called DRG, are you actually going to help the patient and reduce the cost or you may potentially flip it and add on more cost of the overall equation. That's something that we need to look at.

Dr Timothy Cheng Tsin Jien [MMA]: *WMA stands for World Medical Association.*

Dr Gunalan@Arumugam Palari [MMA]: *Yes. Sorry. The other thing that he noted for Germany as well, there are a lot of ambulatory centres. Meaning that ambulatory centres basically you are a step-down facility. You're done with your care, you move to a step-down facility so that you don't incur cost for in-patient care.*

This is the challenge that we are facing at the moment. In principle our view is we are not wholesale rejecting DRG. I know DRG has been mentioned many times. But there are certain limitations.

Number one the external factors for DRG for us is hard to control. Price of medications, currency, costly drugs and technology. If we fix to a particular cost for DRG, for particular procedure, the very next year because of inflation we may find that we may not able to pay the hospitals the amount of money because inflation has caught up.

You need to continuously revise your charges and charges so that you can keep up performing the particular operation. Internal factors you can control. Now doctor's charges we can control it, no problem…"

[Muka surat 31 - 33, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

Selain itu, dalam prosiding yang sama, **Dr Gunalan@Arumugam Palari** mencadangkan agar pelaksanaan DRG dimulakan secara perlahan, stabil, dan berfasa (*slow, steady, phased approach*). Beliau turut mencadangkan pelaksanaan *'Soft Cap'* (contohnya, had RM35,000) untuk memberikan fleksibiliti sekiranya pesakit mengalami komplikasi yang tidak dijangka (seperti serangan jantung selepas pembedahan) yang memerlukan rawatan tambahan.

MMA meminta agar penjagaan kanser dikecualikan daripada DRG sepenuhnya. Ini kerana kemajuan pesat dalam terapi sasaran dan imunoterapi baharu boleh menghalang pesakit daripada mendapat akses rawatan terkini sekiranya kos telah ditetapkan lebih awal di bawah sistem DRG.

"Dr Gunalan@Arumugam Palari [MMA]: *So, just in the interest of time, we come back to one final— we address all the problems that we faced, but moving forward, I think when we talk about DRG, one of the things that we all are worried about, are we actually proposing something that may potentially makes thing worst. So, to be honest with you, I think we have come across with what is the typical bills size of a private hospital? And this one is actually across the board— it is not a study but it's just an anecdotal pull out from my finance team that I can actually tell you that, majority of bills almost 65 percent, is actually below RM10,000. This is what— just one, mainly medical bill.*

So, where the significant chunk which is the surgical bills, it's actually generally falls between RM10,000 to RM50,000. This is the simple straight forward uncomplicated kind of procedure-like appendix, lap coli and what not. So, if these particular procedures can be like fixed a certain amount, then I think we are more than happy to actually looking into it.

Because it is very predictable, but the minute you cross over to the more complex work like cardiac neuro surgery, patient with simple surgery but multiple medical problem, diabetes, blood pressure, IHD, ischemic heart or what not. Then it becomes too complicated for the first phase if at all you want to implement the DRG, the feedback from we get from the other country is basically it has to be a slow, steady, phased approach. It cannot be like tomorrow all 600, 700 DRG codes will be implemented and that's it, we go. We need to look at say what is the common procedures that have being done in the private hospital that are predictable and relatively easy to manage, that can be given say three to five days and they're out— knee replacement, hernia all these things are predictable.

So, if we start like how in Korea, Korea there's only seven categories of patient that they put under DRG. Cataract, appendix, haemorrhoids, Caesar, hernia and tonsil. So, you defined that set criteria which probably will cover a fair bit of current diagnosis and whether you get it done in Subang Jaya kah, Sunway kah or Prince Court kah whatever hospital, it should be the same because it's predictable. Now, if that helps our insurance industry colleague, I am sure as doctors, we are happy to assist because again all these surgeries, our fees are fixed. There is no surprises when it comes to end of the bills. The surprise is only the hospital portion.

So, that is the part where the APHM guys can agree that— look, if you gonna be doing in knee replacement it's RM35,000 here and RM38,000 there and we agree to come, say okay lah all together for the purpose of making sure our populations get access, we agree to RM35,000 and that's it. Let's all move on and get it done because that will be one single fee that will cover a major of it. You ask us whether we like this line-by-line lining? No, we don't. Because it creates a lot of confusion to the public because the public sees that why is my diaper charged at RM20? Why is a cup charged— 15 cent cup charged RM10? It doesn't make sense.

But how we gonna tell the patient that electricity bill is this much, nursing wages is this much. So, those are the things— so if we can just have one fee, negotiated fee, this is the cost, all agree to with we move on. But if you want to do it, learn to do it step by step, phase one, phase two, phase three. If phase one we learn, we understand what are the pinpoint, we can make it better. Then we go to phase two, a lot more diagnosis, a lot more things. But if to begin with itself straight away say, Indonesia has got a very good DRG system, let's implement in Indonesia system, we gonna fail. Because we are hearing feedback from that a lot of things, why are they coming to Malaysia? Because there is not much investment in the hospitals. Because the hospital not getting money to invest in the equipment, so they are coming to Malaysia.

Again, the last point is we propose what we call a soft cap. Soft cap means that some flexibility. So, say for example RM35,000 what we agree for knee replacement and that one particular patient they develops a heart attack after the surgery and now requires admission for further management or whatnot. So, these are the potential patients that we may have to give more treatment per se and all. So, soft cap means that there's some flexibility, majority will fall into that fixed predictable outcome, one or two will have issues, alright.

I think we have touched pretty much a lot about cancer care, I think Prof Aishah and Dr. Mastura anything you want add from your side for cancer? Because one of things that we want actually say is, please do not include cancer care under DRG because if you do that it's going to be difficult because to the private hospital, private insurance company, today they would say I'll fix you cancer surgery. Say for example breast cancer RM40,000 take it, fix already what. But the very next year, there will be a new third generations or targeted therapy that is more advanced. Patients will not be able to have access because we have a pre-negotiated list of things that cannot be done..."

[Muka surat 44 - 46, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

ix. <u>Penjelasan Ketua Jabatan, Jabatan Penyelidikan, Pembangunan dan Inovasi Universiti Malaya]</u>

Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya] dalam Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025 menjelaskan bahawa sistem *case-mix* merangkumi dua komponen iaitu DRG (pengelompokan penyakit) dan mekanisme pengiraan kos. Kos sesuatu DRG sememangnya berbeza antara hospital kerana ia dipengaruhi oleh faktor seperti tahap kepakaran, jumlah staf, fasiliti dan teknologi yang digunakan. Penyeragaman hanyalah *grouping* penyakit, bukannya kos atau tarif rawatan. Hospital swasta, awam dan pengajar akan tetap mempunyai tarif berbeza bergantung pada kapasiti masing-masing.

Kekeliruan timbul apabila hospital swasta menyangka DRG akan menyeragamkan kadar bayaran, sedangkan dalam model insurans kesihatan sosial, tarif biasanya dirunding secara berasingan. Melalui beberapa sesi *townhall* menunjukkan hospital swasta semakin memahami manfaat sistem ini. Bagi PPUM sendiri, case-mix membantu menilai kecekapan dan membandingkan kos dengan hospital KKM yang berbeza tahap (daerah, negeri, tertiari).

> ***"Tuan Sim Tze Tzin [Ahli PAC]:*** *Tuan Pengerusi. Dr., Prof., I bukan pakar ya so, I don't know the details of it. Akan tetapi saya difahamkan bahawa DRG ini sebenarnya perlu mengikut kesesuaian negara masing-masing. There's no like one size fit all and it shouldn't be imported from Australia kah, Amerika kah because their situation is different. Their— maybe they eat too much McDonald's, you know.*
>
> ***Prof. Dr. Maznah binti Dahlui [PPUM]:*** *Yes.*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *So, saya rasa perlu di Malaysia. Ya, I think we need to develop our own. However, saya pun ada feedback from certain expert on this. They feel that UM, PPUM or UKM you are teaching university. So, when you do your grouper, you tend to have more, what do you call kakitangan because you are teaching students, you know, you have more nurses, practice. So, your kakitangan itu there will be more than staffing itu, so whether you can slim it because in the private practice— what is efficiency. I just need this procedure, I just need one nurse, two nurse or something like that.*
>
> *So, is this considered in your grouper and when you elevate it to a national— because the private hospitals they want American or whatever because they can*

charge higher because their cost is higher. Okay, then of course they want the most efficient staffing. But for us Malaysia we need to also have efficient staffing but PPUM is totally different because you are teaching university.

Prof. Dr. Maznah binti Dahlui [PPUM]: *Okey. We are talking about Case-mix system. Case-mix system is where the DRG and then the costing. Yang tadi itu saya cerita fasal DRG. So, with regards to costing sebenarnya kos ini, costing mechanism yang digunakan untuk mengira Case-mix cost ini berbeza daripada costing yang mechanism yang digunakan untuk kos sesuatu penyakit, okey. Costing mechanism untuk DRG setiap hospital berbeza. Mechanism itu sama tetapi tarifnya yang— hasilnya akan berbeza kerana dia melihat kepada, like you said just now tahap kepakaran, bilangan staf and then contohnya facilities yang disediakan.*

Private hospital boleh masukkan, perlu masukkan semua kos-kos yang terlibat dan definitely we are expecting their DRG punya tarif akan berbeza daripada hospital public dan juga hospital pengajar. Hospital pengajar mungkin masih mahal tetapi disebabkan teaching dan juga research yang— komponen yang kita masukkan. So, this is where I think this the misunderstanding from the part of the private hospital because they thought that dia akan ada keseragaman dari segi kos.

Sebenarnya kos itu tidak diseragamkan, yang diseragamkan adalah grouping of diseases. So that, the disease that you treat and disease that I treat is the same, lepas itu kos itu memang berbeza kerana kos bergantung kepada you punya hospital, you punya kapasiti dan you punya fasiliti. Mungkin hospital private dia akan menggunakan robot untuk merawat penyakit dalam group itu tetapi hospital lain tidak menggunakan robot.

Obviously, yang menggunakan robot akan lebih mahal. Okey? So, this is where they misunderstood.

Jika diadakan social health insurance, tidak bermakna semua hospital bayar kadar yang sama. Dia akan ada negotiation on the tariff between the hospital provider and the social insurance ataupun national health funds, whatever you want to call it. Contohnya di Indonesia, setiap hospital berbeza tarifnya walaupun DRG-nya sama. Hospital yang tertiary, hospital yang complicated, hospital yang besar, harganya or kosnya akan lebih— bukan kos, tarifnya akan lebih daripada hospital yang kecil walaupun merawat penyakit yang sama. So, this is where I think it is keperluan untuk kita memberikan penerangan yang lebih lanjut kepada private hospitals.

There are several townhalls that we have done. The first townhall was done one month ago, di mana kita menceritakan berkenaan dengan ini. We actually got a positive feedback from them when they understood. Banyak hospital-hospital di bawah KPJ telah menjalani workshop pertaining to this and they totally understand. Ada banyak kebaikan bila kita gunakan case-mix system ini. Contohnya di PPUM sendiri, kita dah tahu sekarang di mana tahap efficiency kita. Before this, we don't know because we don't know to whom we want to compare.

But with the findings that we get from the KKM hospital, KKM hospital ada tiga level; district hospital, state hospital and tertiary hospital ataupun specialised hospital. We can see clearly that the costs for the same DRG will be different. Okay? Dari situ,

KKM pun boleh tahu bahawa ada district hospital yang perlu diberi bajet lebih kerana walaupun dia district hospital, tetapi dia merawat kes DRG yang lebih complicated. DRG ini ada tiga level untuk satu disease; severity level one, level two dan level three. Kebanyakan hospital district is expected to treat level one, state hospital more of level two dan tertiary hospital more of level three.

Pada asalnya, bila kita buat exercise ini di hospital pengajar, kita dapati bahawa kita ada banyak severity level one. So, this is where we discussed with the pengurusan that is we have to do something. So that— because we have the expertise, we should treat more severity level of DRG. So that, so there are various mechanisms that can be put in place in order to do this. For example, the mild cases should be diverted to the peripheral hospital rather than be treated by the tertiary hospital."

[Muka surat 12 - 14, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

Selain itu **Prof. Dr. Maznah dalam prosiding yang sama** menjelaskan bahawa semua penyakit perlu mempunyai DRG, namun tidak semua perlu diberi kos atau dimasukkan dalam sistem *case-mix,* kerajaan atau pembayar boleh memilih DRG tertentu untuk tidak ditarifkan, seperti kes kanser. DRG ialah alat penyelarasan pengelompokan, manakala tarif boleh diputuskan kemudian mengikut keperluan.

Bagi hospital swasta, pelaksanaan DRG meningkatkan ketelusan kerana kos sebenar dapat dikenal pasti, justeru membezakan antara kos dan tarif yang munasabah. Jika dilaksanakan sepenuhnya melalui *case-mix* system, DRG boleh merangkumi semua komponen kos termasuk prosedur, ubat dan siasatan maka ia secara tidak langsung turut mengawal selia amalan hospital swasta.

"Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, during our session with MMA, mereka sebenarnya mencadangkan bahawa bukan semua boleh di-DRG-kan okey. Jadi, mereka cadangkan actually to control the healthcare cost of— spiraling out. It is said that actually a lot of common diseases are actually below RM10,000. 65 percent of hospital treatment kosnya sebenarnya adalah below than RM10,000. So, they suggest to the government to do grouping lah for those.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Ya.*

Tuan Sim Tze Tzin [Ahli PAC]: *So that everyone cut across, everyone has a consensus-lah. So, then they will reduce the cost. Then the most sophisticated one you go to DRG. What do you think about that Professor?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Saya rasa— bukan saya rasa, this is the practice okey. Semua diseases perlu di-DRG-kan. Tetapi tidak semua diseases*

perlu diberikan costing. For example, just now, kita perlu ada DRG untuk kanser tetapi mungkin this is where DRG kanser ini kita tak attach-kan the cost, kita tak jadikan dia ataupun masukkan di dalam case-mix system. In fact, jika di attach-kan kos kita, ada tiga level yang saya mention just now.

So, there is where we can also decide the payor (pembayar) perkhidmatan kesihatan ini sama ada social health insurance ataupun kerajaan ataupun private health insurance, they can decide later on that DRG yang ini mereka tidak mahu berikan tarif, they want to follow the usual one. Boleh, tetapi itu semuanya perlu di-DRG-kan. Contohnya, 10 orang diberi nama. Tetapi mungkin orang yang nama daripada Z itu kita exclude-kan bila kita hendak buat tarif, itu maksud saya.
…

Prof. Dr. Maznah binti Dahlui [PPUM]: *Ya I think kalau semua private hospitals juga melaksanakan DRG ini so— and then mereka beri kos mereka, we understand. If your cost is that much, that is the cost, kita tak boleh buat dia rugi. Okay but at least we know dia bukan saja-saja hendak menaikkan tarif dia, dia bukan saja-saja hendak caj RM10,000 for example. Kalau kos itu memang RM10,000 we have to accept. So, this is where it's very transparent kalau you buat case-mix system ini.*

Ini kerana we are comparing the same grouper and we know the same group of diseases and we know what is your cost. Your cost will not be the same as our cost and therefore your tariff will not be the same as ours. We understand if your tariff is more expensive than ours. So, this is what yang mereka faham.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Sebab kalau you regulate through this DRG that means you are regulating the private hospital as well. It's not— but it's not full.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *In a way we are regulating, DRG is just the tool to make…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This doesn't cover medicine cost, trucks semua tak cover lagi?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Kalau you hendak buat yang full case-mix system, masukkan juga kos dalam DRG itu, dia cover semua. Dia cover prosedur, dia cover investigation, dia cover medicine.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you Prof."*

[Muka surat 25 - 27, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

Pelaksanaan DRG di PPUM tidak memerlukan pertambahan staf secara besar-besaran; memadai jika hospital mempunyai *electronic medical record* serta memastikan doktor membuat kod ICD-10 dalam *discharge summary* seperti disarankan WHO dan KKM. Hospital hanya perlu menggunakan grouper (sama

ada versi KKM atau yang dibeli melalui geran KPT) dan menempatkan satu atau dua coders untuk memasukkan atau mengekstrak kod diagnosis ICD-10 serta kod prosedur ICD-9-CM ke dalam sistem. Oleh itu, pelaksanaan DRG dianggap tidak sukar dan boleh dijalankan dengan staf sedia ada.

> ***"Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]:*** *Okey. Sebelum explain now the case-mix itu, saya nak tanya since PPUM dah pun buat kan DRG ini, perlu tak staf, dedicated staff untuk laksanakan ini dan juga ataupun perlu hanya staf sedia ada saja melaksanakan DRG ini?*
>
> ***Prof. Dr. Maznah binti Dahlui [PPUM]:*** *Terima kasih, Puan Pengerusi. Apabila kita present kepada— PPUM present kepada KPT dan KPT mahu perkara ini dilaksanakan di semua HPU. Sekarang ini Prof. Nazirah telah diberi geran untuk kami melaksanakan ini. Sebenarnya tidak susah kerana asalkan setiap hospital itu ada electronic medical record dan setiap hospital itu memastikan bahawa apa yang disarankan oleh World Health Organization dan juga KKM iaitu membuat coding diagnosis ICD-10 dan dilaksanakan. Biasanya ICD-10 coding ini dilaksanakan oleh doktor yang membuat discharge summary.*
>
> *So, this should be in place dan kita perlukan grouper. Grouper ini yang macam saya kata tadi, ada grouper KKM dan ada grouper local daripada local vendor, that is case-mix solution. KPT mengguna pakai ataupun kita membeli lesen ini untuk kita gunakan sebagai kita punya grouper. So, all we need is just a coders untuk masukkan ataupun kita extract data ICD-10 ini daripada electronic medical record dan juga data procedure coding iaitu ICD-9-CM dan akan dilaksanakan oleh one or two coders untuk masukkan dalam sistem grouper. So, it is not that difficult."*
>
> [Muka surat 15 - 16, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

x. <u>Penjelasan Setiausaha APHM</u>

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(l)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa APHM menyokong penerokaan sistem *Diagnosis Related Group* (DRG), pelaksanaannya perlu mengambil iktibar daripada pengalaman Thailand yang telah menggunakan model tersebut selama 30 tahun. Model di Thailand dan Singapura menunjukkan bahawa penglibatan hospital swasta dalam skim nasional adalah bersifat sukarela, bagi memastikan pesakit tidak terbeban dengan had pembiayaan tertentu.

Pelaksanaan penuh DRG di Malaysia bukanlah suatu proses yang singkat, sebaliknya dijangka akan memakan masa antara lima (5) hingga sepuluh (10)

tahun yang merangkumi fasa pengumpulan data, analisis, dan projek rintisan sebelum ia dapat dilaksanakan sepenuhnya.

*"**Encik Anwar Anis bin Anis Ahmad [APHM]:..**This is just more information, maybe to just dive in bit deeper on DRG, because I think this is something that obviously is top of mind for policymakers and others. This is the slide we are taking from a speaker Prof. Supanit who presented at the APHM Conference. What we really want to emphasise on this slide because we have mentioned before we are supportive of how DRG you know, to explore DRG or any similar mechanism.*

But Thailand introduced DRG in 1993 and they started with phase one, phase two, or rather version one, version two dan sebagainya. And in 2002, Universal Health Coverage scheme was launched in Thailand. Tapi yang penting, members of PAC, dah hampir 30 tahun DRG ini di Thailand, 30 years and apologies that the slide is a bit small, but if you look at voluntary private insurance, maknanya private insurance, health insurance di Thailand, setelah 30 tahun ini pun, voluntary private insurance is still reimbursed via fee for service. So, we have to ask the question, Thailand that has started 30 years ago, has Universal Health Coverage, why is private insurance not paid through DRG? Because, DRG limits options for private healthcare peers and for patients especially. So, if a patient has taken a very significant policy, they don't want to be limited in terms of their access to healthcare.

So, we really have to ask that question. Why Thailand which is advanced in terms of DRG which has gone through multiple phases and has over 30 years of experience, has this particular model? It is the same in Singapore, it is the same in Thailand—Indonesia as well. So, we have taken the Thai example because we are ahead but that's a question that we all need to ask.

So, this is a zoomed-in view of that particular thing that I mentioned to a private health insurance. Like I said, this is not our slide, this is Prof. Supanit's slide, who came from Thailand and this is how it shows, right. So, you have got three different medical benefits arms which are Ministry of Finance, the National Health Security Office and the Social Security Office. Those are both to public and private that uses DRG.

For private healthcare providers in Thailand, it is voluntary. Maknanya hospital itu dia boleh ambil keputusan sama ada saya nak terlibat dengan National Healthcare Scheme atau tidak. But what is important for the patient, like I said at the bottom is voluntary private insurance is fee for service. I will not read the next slide but this is really just to summarise again from our conference, that was like I said last week, comments that were made about DRG. So, Prof. Maznah is heading the technical committee and she acknowledges like I mean, her experience is in ruling out DRG's in the public universities and her own experience and her own opinion that it will take a few years because like I said, data collection, data analysis, piloting it and moving ahead.

Dr. Khor, who is also in the Prime Minister Advisory Committee (PMAC) also the CEO of Angsana. I mean, his own opinion is that DRG will take full implementation

will take five to 10 years. So, we will leave the members of PAC to be able to reflect on their comments separately, we're moving ahead."

[Muka surat 9 - 10, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

Encik Anwar Anis bin Anis Ahmad turut menjelaskan bahawa pelaksanaan sistem *Diagnosis Related Group* (DRG) tidak menjamin penurunan kos perubatan secara langsung, memandangkan negara-negara yang telah mengamalkannya seperti Thailand, Indonesia, dan Korea Selatan masih mempunyai kos yang mahal berbanding Malaysia. Walau bagaimanapun, DRG yang direka dengan baik berpotensi mengekang inflasi melalui pengurangan pembaziran dan penyalahgunaan sumber dalam struktur kesihatan nasional.

Melalui sistem ini, rawatan akan lebih tertumpu kepada garis panduan klinikal (CPG) yang ditetapkan, sekali gus mengelakkan prosedur berulang yang tidak perlu. Selain memberikan perlindungan perundangan kepada doktor yang mematuhi protokol, DRG diharapkan dapat meningkatkan kecekapan perkhidmatan agar lebih ramai pesakit dapat dirawat, walaupun impaknya terhadap penurunan kos keseluruhan masih sukar untuk dipastikan.

*"**Tuan Sim Tze Tzin [Ahli PAC]:** Okay. So, is DRG going to be able to help to contain medical inflation?*

***Encik Anwar Anis bin Anis Ahmad [APHM]:** So, simple question ya and simple answer. If that were the case, Thailand should be cheaper than us. [Ketawa] Thailand is not cheaper than us. Indonesia should be cheaper than us. Indonesia is not cheaper than us. Korea should be cheaper than us, okay. So, I don't know which country is cheaper than us [Ketawa]. We are quite cheap. So, DRG I think can curb— okay, what we— if you look at the presentation that we had in our conference, what we want to reduce is wastage and abuse.*

Hopefully, hopefully, if properly designed, DRG can help us do that and that has to come again with the national healthcare structure, where if somebody had an MRI somewhere else, they don't have to repeat it somewhere else. If somebody had investigation, we know what needs to be done, we follow a CPG or are guideline based on DRG and we do that and the doctor is protected when they follow the CPG. Because DRG means the patient doesn't get to say, "Oh, I want a pretest MRI or I want a ceramic implant, although 75 years old".

So, hopefully with DRG, what we can have is appropriate treatment reduction of wastage. Now, whether cost can come down, I think that is difficult to say, all right. But what we can have, is more efficiency and more people being treated but not necessarily for the cost to be down."

[Muka surat 46 - 48, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

xi. <u>Penjelasan Presiden & *Managing Director*, KPJ Healthcare Berhad</u>

Encik Chin Keat Chyuan [Presiden & *Managing Director* (KPJ Healthcare Berhad)] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa pelaksanaan sistem DRG adalah relevan untuk memahami struktur kos, namun proses ini harus dimulakan oleh pihak kerajaan terlebih dahulu bagi membina sistem data dan pengekodan yang mantap. Pemaksaan sistem DRG ke atas sektor swasta tanpa persediaan rapi boleh menyebabkan sistem tersebut runtuh, sekali gus menghalang hospital daripada melabur semula dalam teknologi tinggi. Kesannya, Malaysia berisiko ketinggalan berbanding negara jiran seperti Singapura dan Thailand dalam sektor pelancongan kesihatan.

Sekiranya kadar bayaran DRG yang ditetapkan adalah terlalu rendah dan tidak mampu menampung kos rawatan (terutamanya bagi kes berisiko tinggi), hospital swasta mungkin terpaksa berhenti menerima pesakit tersebut, yang akhirnya akan menambah beban kepada hospital kerajaan.

*"**Mr. Chin Keat Chyuan [APHM]:** Can I try this YB? YB, I like the way how just now you mentioned. Do you want the government to come in to regulate everything right in the private? In the private, you should solve it out by yourself, you should be a market force, right? And YB, I really like this because that has been how private healthcare in Malaysia has been actually successfully attracted so many health tourists to come in and that health tourism has significantly contributed to the GDP growth in the country, not only for private healthcare, right? But in general. I think that is actually how to whole thing trends.*

Now, if you ask me, Chin or APHM, do you see this DRG will actually significantly bring down the cost? I think it will but it has to start somewhere, start where? The government has to start the DRG process first because today in government healthcare for example, Malaysia is a heaven, right? We are heaven in terms of public health. Why, we are actually allocating budget based on your previously how much you spent and then this year how much you should get, right.

But DRG would then help you to really go deep down understand the costing, the cost structure and I think that is going to be a normal learning, you know. So, if you ask me, "Chin, is DRG still relevant?" I think it is relevant, relevant but then we need to have a system to capture the data, the coding and all this we need to start from where? From the government first.

The moment when we have successfully adopted the whole thing to get it what Encik Anwar said right, we need the entire healthcare financing model to be reimagine. Because today, government healthcare versus private is two different things, we don't cause subsidise you know, but we are complementing each other. But if you are using DRG to blind it us impose on the private, one thing is for sure, the private healthcare system is going to collapse overnight without a thoughtful process, without a system in place, it will collapse.

Second, while we are doing this, we are going backwards as we all discussed before, right? We would not be able to reinvest as what Erica has mentioned, right? We would have no more resources to reinvest back and that means what? That means healthcare for Malaysia is going backwards or the health tourism they would not come to Malaysia because we would not be investing in high technologies and all this.

Patient would choose to go to Singapore, Thailand, Vietnam and other countries instead of Malaysia, that is for sure. So, then we have to go and ask ourselves, right, has this DRG imposed on private achieve anything and doesn't mean it will make it cost effective. The patient might end up kind for to pay and they will still go to the government because why? We will stop taking private patients for those reimburse values which are actually less than what we can actually cope.

So, we would then choose, you know. So, if you are saying that Chin CABG ya, we are asking your KPJ hospital kah to charge only RM50,000 as per now they counting, we will stop. Because they have a lot of high-risk patients, I would never be able to manage it for RM50,000."

[Muka surat 48 - 49, Laporan Prosiding Bil 5(l)/2025 bertarikh 17 Jun 2025]

xii. <u>Penjelasan KPE CompuMed Services Sdn. Bhd.</u>

Puan Fiona Rebecca Limus [KPE CompuMed Services Sdn. Bhd.] dalam Prosiding Bil. 5(m) bertarikh 17 Jun 2025 menjelaskan bahawa pelaksanaan Sistem Pembayaran DRG (*Diagnostic-Related Group*) sebagai mekanisme untuk mengawal pertumbuhan kos perubatan. Melalui sistem ini, kos purata bagi sesuatu rawatan (seperti demam denggi) ditetapkan berdasarkan data sejarah, sekali gus membolehkan TPA mengenal pasti caj berlebihan dan merundingkan kadar tetap dengan pihak hospital. Beliau turut menekankan kepentingan ketelusan harga dan penyeragaman jadual fi bagi membendung

kenaikan tuntutan perubatan yang dilaporkan meningkat sebanyak 26.2% baru-baru ini.

Selain itu, Puan Fiona berkongsi tentang transformasi digital di CompuMed yang kini mengguna pakai teknologi AI dalam proses adjudikasi tuntutan. Penggunaan AI ini bukan sahaja meningkatkan kecekapan dan ketepatan penilaian tuntutan yang kompleks, malah membantu mengurangkan kos operasi syarikat agar kekal kompetitif dalam pasaran.

> ***"Puan Fiona Rebecca Limus [CompuMed Services]:*** *Okay, another one is DRG Payment System. So DRG stands for Diagnostic-Related Group. So, this is like in a simpler manner it is like a running average of costing, right.*
>
> *So, for example, let say dengue fever. So that is pretty common in Malaysia. So, dengue fever we break it down and say what is the number of days, what are the drugs used, what are the investigation used. So, we have broken down components of dengue fever. From there, we have an average or what we called running average from our database.*
>
> *So, if we have hundred cases of dengue for example, we know that averagely it is about RM8,000, contoh ya. So RM8,000 is what we know is needed to manage dengue, right. So now, with our other hospital admission, the minute when it is touches RM12,000 for example, then it is an alarm to us and say why RM12,000? Why not RM8,000? So, it triggered us to look at it and say why it is so high and perhaps at the latest stage, we are able to negotiate with hospitals and say for dengue, we will only pay you RM8,000 under certain conditions, for example.*
>
> *Countries that have adopted DRG like Europe, Germany have seen their cost growth ya. The cost growth, reduce by two to three percent annually. Because why? You know exactly what it is. So, in a way your exposure it is sort of like ring fence I would say, all right.*
>
> *The other one is transparent pricing. Implementation would be standardizing fees schedule and ensuring transparent billings for medical procedures. The impact is according to LIAM, medical claim rose by 26.2 percent from 2022 to 2023. Now, transparent pricing can help control this escalating cost by overcharging. So, overcharging is when hospital just charge whatever because why, there is no limit to it, right. So, currently for inpatient of course the only one charge that we are able to be very stern and straight about is doctor's charges, right and the anesthetist charges because why, we have got Schedule 13 to protect everybody from – on the fee schedule. So, this one is if they are transparent then we will be able to do standardize billing.*
>
> *Okey, so a little bit on new phase in healthcare management or at least what we are doing and this is something that everybody talks about these days, AI. You know, with artificial intelligence. How does the TPA uses AI and what is our adoption?*

So, the whole idea of using AI is having that competitive aged data driven decision scalability and innovation.

So, it's able to prioritize data privacy and all that. So, in CompuMed we have started adopting AI practices. Right, next and we are able to see that today we are processing some claims using AI because if we continue to use human or straight through processing, there is always limitation. So, just to show that AI is really helping, it has helped us to look at reducing our operation cost.

So, why do we need to be effective, right, because insurance company and our client are forever squeezing us on our TPA fee. So, we too need to be lean and mean, I would say. Ya, next.

Right, some of the things that we are doing is claim adjudication. So, claim adjudication is processing the claims. Meaning that a person who get admitted to the hospital has got – let say was admitted for 20 days, right. So, 20 days usually what happen now is of course we have parameters in the system and then we pump the data in there and then the result comes out but, more and more now we are using AI to analyze claim. So, it's able to do comparison and so on and so forth which actually gives us better outcomes and assessment as well..."

[Muka surat 13 - 14, Laporan Prosiding Bil 5(m)/2025 bertarikh 17 Jun 2025]

xiii. <u>Penjelasan KP Kesihatan / Malaysian Medical Council (MMC)</u>

Datuk Dr. Mahathar bin Abd Wahab [KP Kesihatan / MMC] dalam Prosiding Bil. 5(n)/2025 bertarikh 21 Julai 2025 memaklumkan bahawa KKM sedang melaksanakan inisiatif penggunaan DRG (*Diagnostic-Related Groups*) sebagai hala tuju utama. DRG akan meletakkan nilai atau pakej perawatan yang lebih telus dan bertepatan dari segi nilai. KKM menyasarkan DRG Kebangsaan (*National DRGs*) dapat digunakan seawal tahun 2027 sebagai sandaran kepada penetapan bayaran intervensi di hospital swasta dan sebagainya. Beliau turut memaklumkan kawalan harga bagi perkara-perkara lain seperti hospital *supplies and services* (HSS) bukan di bawah kawalan KKM.

"Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *...Ya dan perlu ada penambahbaikan yang maksudnya di-review oleh pihak maknanya kementerian sendirilah untuk mungkin di apa itu, ditambah lagi item-item penting untuk nak mengelakkan apa yang sedang berlaku itu. Maksudnya, sebagai kawalan kepada kos-kos itu maknanya dapat disenarai dengan penuh ya dan tidak ada celahan oleh pihak ada kepentingan ini untuk dia nak elak daripada dia kena tindakan dan sebagainya. Adakah Datuk bersetuju dengan mungkin pindaan maksud saya, kepada akta ini sendiri?*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Ya, ya, ya, ya. Yang — betul Yang Berhormat. Ini dari segi skop Akta 586 itu, pihak kami perlu berbincang semula untuk memastikan komponen-komponen mana yang perlu ditambah baik terutamanya daripada melihat dari segi aspek peningkatan kos terhadap apa ini, untuk mendapatkan rawatan dan sebagainya. YB cakap itu perkara yang memang kita sedang usahakan. Terima kasih.*

Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, berdasarkan apa yang dicadangkan, yang dibangkitkan oleh YB Sik, adakah kerajaan akan look into DRG untuk mengawal kos atau akan mengkaji HSS (hospital supplies and services) yang tadi item-item yang tidak terkawal itu? Apakah hala tuju kerajaan? Nak kawal hospital supplies and services atau go to DRG? Sebab DRG ini dia mengambil masa dan HSS itu mungkin akan ditingkatkan lagi. Jadi, apa — ini adalah satu dilemalah. Minta pandangan Datuk.*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Buat masa ini YB, kita melihat kepada aspek DRG. Saya rasa semua — DRG is Diagnostic-Related Groups-lah, itu maksud dia. Dengan adanya konsep DRG ini, beberapa negara telah guna pakai, jadi ia meletakkan nilai ataupun pakej perawatan yang sesuatu intervensi dilakukan. Secara terbaiknya untuk makluman YB semua, pihak Kementerian Kesihatan Malaysia sekarang sedang mengusahakan kita panggil penggunaan DRG.*

Ada dua kaedah. Pertama, DRG — kajian-kajian DRG yang dijalankan di hospital-hospital awam, di hospital kerajaan dan sebagainya. Pada masa yang sama, kita menggalakkan penggunaan DRG di hospital-hospital swasta.

Untuk makluman YB juga, ada beberapa hospital swasta yang besar telah pun mengguna pakai aplikasi DRG supaya ia lebih telus dan dari segi kawalan harga adalah lebih kita panggil bertepatan dari segi nilai yang diberikan terhadap sesuatu prosedur atau intervensi ataupun perawatan yang diberikan.

Tetapi pada masa yang sama, YB juga — memang tepat sekali. Untuk membangun sesuatu DRG bukan perlu dalam masa sekelip mata, ia mengambil masa. Thats why mengikut daripada perancangan yang kita telah letakkan dengan menggunakan kaedah DRG ini, kita melihat daripada tahun 2027 baru kita dapat menggunakan kita panggil DRG tersebut kita panggil DRG Kebangsaan (National DRGs). Bila adanya National DRGs ini, syarikat-syarikat ataupun hospital-hospital swasta dan sebagainya jika mereka ingin menetapkan sesuatu bayaran dan sebagainya untuk sesuatu intervensi, dia ada satu sandaran. Sandaran tersebut meletakkan nilai kepada prosedur tersebut. Itu adalah lebih baik.

Untuk yang perkara kedua yang kawalan terhadap harga dan sebagainya untuk perkara-perkara lain, saya mohon maaf, saya tidak boleh respons kepada perkara tersebutlah. Sebab kawalan harga dan sebagainya dari segi bukan di bawah — untuk perkara-perkara tersebut bukan di bawah kawalan Kementerian Kesihatan Malaysia. Terima kasih."

(Muka surat 12-14, Laporan Prosiding Bil. 5(n)/ 2025 bertarikh 21 Julai 2025)

7.10 Kartel Dan Monopoli Dalam Sektor Farmaseutikal

Isu monopoli dalam sektor farmaseutikal di Malaysia mencerminkan kelemahan struktur dalam model operasi serta sistem pengawasan industri yang perlu ditambah baik. Kos ubat-ubatan yang tinggi bukan sahaja dipengaruhi oleh faktor pasaran, malah berpunca daripada jurang maklumat serta ketiadaan pilihan alternatif bagi ubat-ubatan kritikal.

Keberkesanan usaha Kementerian Kesihatan Malaysia (KKM) dalam meningkatkan persaingan pasaran dan menangani amalan tidak kompetitif bergantung kepada tiga faktor utama:

- **Keiltizaman Dasar:** Kesediaan kerajaan untuk meneroka sumber bekalan dari luar negara secara terus bagi mengurangkan kebergantungan kepada dominasi pembekal tertentu.
- **Ketelusan Proses Perolehan:** Memastikan proses tender dilaksanakan secara terbuka bagi memberi peluang kepada pengeluar baharu atau syarikat tempatan melalui mekanisme insentif seperti perjanjian pembelian awal (*offtake agreement*).
- **Pemerkasaan Pengguna:** Penguatkuasaan mandatori pemaparan harga di sektor swasta bagi menjamin ketelusan pengebilan dan mengelakkan pengenaan caj yang tidak munasabah.

Kegagalan dalam mempelbagaikan sumber bekalan dan meningkatkan ketelusan harga akan menjejaskan usaha kerajaan untuk menyediakan akses ubat-ubatan yang mampan serta mampu milik kepada rakyat.

i. <u>Penjelasan KSU KKM</u>

Dato' Sri Suriani binti Dato' Ahmad (KSU KKM) dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM berusaha untuk menangani isu kartel dan monopoli dalam sektor farmaseutikal dengan langkah penyumberluaran (*outsourcing*) bekalan ubat-ubatan. Kementerian tidak lagi terlalu bergantung kepada syarikat-syarikat tempatan tertentu, sebaliknya kini mencari sumber ubat dari negara seperti India, China, Turkiye,

Mesir, Thailand, dan Indonesia demi mendapatkan harga yang lebih kompetitif. Setakat ini, langkah ini terhad kepada hospital awam, namun KKM sedang meneliti mekanisme untuk melibatkan sektor swasta. Bagi meningkatkan ketelusan dan kuasa pengguna, KKM akan mewajibkan pemaparan harga ubat di hospital swasta.

Selain itu, tender bagi perolehan ubat dan peranti perubatan dibuka secara kompetitif, di mana penilaian berdasarkan spesifikasi teknikal dan harga terbaik. Beliau juga mengakui terdapat persepsi bahawa syarikat sukar mendapat akses kepada KKM, namun menegaskan bahawa semua tender terbuka dan berdasarkan merit.

"Dato' Sri Suriani binti Dato' Ahmad [Ketua Setiausaha, Kementerian Kesihatan Malaysia (KKM)]: *Thank you, Datuk Seri. YB, ada lima soalan ini. I'll try to answer some or if not, kita boleh PM tepi sekejap lagi. [Ketawa]*

YB, I think yang tadi itu, on overcharging, unfairly and exorbitant charges, you are saying that the KKM is being resistant about that. I think, tadi dah kita jawab. MMC could be the platform where you can actually place your complaint about the price that is being very exorbitant. But, at the same time, tak apa. Kita boleh try and address it together. We'll see macam mana kita boleh need somewhere, whereby we can actually address this issue.

Panjang nak cerita dengan YB. But I would like to also address yang kartel tadi, the monopoly of the ubat-ubatan itu, ya. For your information, memang PM sebut banyak kali and every time jumpa PM, I cannot hide away from him. The first thing he will ask is when you are going to break the cartel? When are you going to break the monopoly?

For your information, kita akan buat what we called penyumberan [Dicelah] Penyumberluaran. Maknanya, we are going— we are outsourcing. Maknanya, kita tak akan terlalu dependent on apa yang syarikat-syarikat farmaseutikal beritahu dekat kita orang. Okey, ini sahaja yang you boleh beli. You can only buy from us.

Kita akan melangkah lebih jauh lagi. We are going to do this on our own. Kita akan keluar untuk cari sumber ubat-ubatan ini, yang mana akan memberi harga yang lebih kompetitif, berbanding dengan harga-harga yang ditawarkan oleh syarikat-syarikat yang so-called kartel dan monopoli ini.

Maknanya, kita akan ada lebih banyak choices of sumber ubat-ubatan ini dari luar negara. We are looking at India, China, Turkiye, Egypt. China, did I mention it? China dan negara-negara yang mana ubat-ubatan mereka adalah lebih banyak choices. Oh, Thailand dan juga Indonesia.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry, Dato'. When you said 'we' itu, 'kita' itu, that's for the public consumption and the private consumption. Betul?*

…

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *It's for public. For public...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Public sahaja. What about the private because I think, we can reduce the cost, yang kita sibuk-sibuk ini cakapkan? I think, we can reduce because it's now monopolised by a branded company. So, the private ini yang kita sebut semua sebut ini kan? Pembendungan harga perubatan swasta ini, I think we can go for the swasta too, open to the swasta too, I think you can help there.*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *Okey. Kita akan tengok mekanisme dia, bagaimana kita boleh...*

…

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *That is why kita come out with the perintah— pemaparan harga supaya rakyat boleh tengok, boleh buat comparison harga-harga itu di hospital-hospital swasta itu. Ini is imposed untuk hospital swasta. So, they have a choice di mana nak pergi. Hospital mana yang memberikan harga ubatan yang kompetitif kepada mereka? So, they have a choice.*

This is the reason why we giving this to them, kepada rakyat supaya kita mengutamakan rakyat ini dahulu. Kita utamakan rakyat yang akan menerima ubat-ubatan tersebut. So, itu kita akan— we will do that soon. Once we wartakan ubat-ubatan tersebut.

Tadi, YB juga sebut mengenai no access to KKM on devices, medical devices. Actually, we are open YB. Kita open kepada mana-mana syarikat sahaja yang berkeupayaan, yang memenuhi spec, yang mempunyai keupayaan kewangan yang bagus, kita buat open tender, YB.

Datang kalau dapat markah yang tinggi, dia akan dapat. Best man wins from there. Tetapi, we are very open. Kalau datang jumpa kami dan we know that your company is very good, very competitive, you will get the highest mark, you will get the tender. Itu kita sekarang dalam proses membuka tender. All our medical devices memang buka tender, YB.

So, masuk tender, kita akan menilaikan dengan sebaik-baik yang mungkin. So, kalau memenuhi spec, penilaian teknikalnya cemerlang, they will get the contract.

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry. On this point, I think it is much more complicated than a policy-lah. Polisi atas memang— tetapi, when it goes down, they don't translate into the— takkan the whole industry is facing these problems? My question sebab dia bukan syarikat individu. I asked several. Did you, after our sesi dengan KKM, adakah you dapat akses to the KKM? Tak ada, tak ada.*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *Sorry, YB. What do you mean by tak ada akses?*

Tuan Sim Tze Tzin [Ahli PAC]: *No. Maksudnya, dia tak ada— still cannot sell to KKM. That's the thing. I mean, I asked general-lah. Did you manage to, you know, supply or sell or get a contract from KKM? They said, no.*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *Itulah, YB. Kontrak itu comes through the tender process that we open itu. So, bila once they win the contract, then we will buy from the company-lah yang gets the best offer, yang gives us the best offer. So, dari situ, dia akan dapat akses tersebut."*

[Muka surat 42 - 44, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

ii. <u>Penjelasan Menteri Kesihatan</u>

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [Menteri Kesihatan] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM untuk menyokong pengeluar tempatan dalam industri farmaseutikal dan peranti perubatan. Beliau mengakui terdapat syarikat tempatan berkualiti tinggi yang masih belum mendapat sokongan mencukupi, dan beliau secara peribadi mengambil perhatian terhadap isu ini. KKM telah melaksanakan pembelian strategik secara pukal bersama Kementerian Pengajian Tinggi (MOHE) dan Angkatan Tentera Malaysia (ATM) untuk mendapatkan harga ubat dan peralatan yang lebih rendah, namun belum melibatkan sektor swasta sepenuhnya.

Selain itu, sektor peranti perubatan kini menjadi sektor pertumbuhan utama negara dengan nilai sekitar RM18 bilion. Menerusi Medical Device Authority (MDA), Malaysia kini berusaha menjadi hab peranti perubatan serantau, termasuk melalui penganjuran acara antarabangsa seperti *International Medical Device Conference* (IMDEC). Tambahan lagi, KKM menyokong penyelidikan klinikal, pembangunan vaksin, dan biosimilar menerusi perjanjian pembelian awal (*offtake agreement*) sebagai galakan pelaburan domestik.

"Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: *Kalau boleh saya celah, if you want to— if you are talking about strategic purchasing and procurement, kita mengadakan strategic purchasing di kalangan KKM, MOHE dan juga ATM. Itu kita lakukan. We will have the economy of scale, we get the price down tetapi belum lagi dapat kita lakukan bersama dengan sektor swasta.*

But I think that is the way to go. You know, kalau betul-betul sektor swasta boleh bersama dan this will be the way forward-lah. Of course, it is easier said because these are sometimes, they see it as more like a competitor than kita have a synergy with them ya. Tetapi, dalam perolehan dalaman kita, government, ya. Kita lakukan. KKM, MOHE dan juga ATM.

Cadangan untuk kita dengan swasta ini memang lama dah. Saya cuba uar-uarkan tetapi there is a bit of resistance. Tetapi, we will still continue to push for this strategic purchasing in the future, insya-Allah. Dato' Sri, please continue.

…

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: *Ada dua faktor di sini. Satu adalah farmaseutikal. Yang kedua adalah medical device, peranti perubatan dan peranti perubatan menjadi satu fokus sekarang ini dalam NIMP, the New Industrial Master Plan sebab new area of growth sector peranti perubatan menyumbang kurang lebih dalam RM18 bilion to our economy.*

Kita mutakhir ini, especially our the last, our signature event called International Medical Device Conference (IMDEC). Yang hadir into the hundreds and of exhibitors dan medical device players, international and local. Ya, kita memberikan fokus dan saya punya antara perkara yang mungkin tak dapat much of your attention, ketika our people looking healthcare services.

But, medical device is our new area of growth dan we have in our Medical Device Authority (MDA), our CEO, Dr. Murali, they are doing well. This is where we want to ensure that Malaysia becomes the hub and already we are gaining the attraction. Our IMDEC, international conference to testify for itself.

In fact, we are really looking with the particularly, khasnya dengan players tempatan, ya. Kita memang memberikan segala insentif dan lower pharmaseutical, contohnya pharmaseutical industry, we also provide an offtake sebagai satu galakan untuk pelaburan mereka buat, not in just generic but as well untuk kita buat R&D, biosimilars and by way of our clinical driven research, Malaysia had just taken over— mengambil tempat nombor satu in this region, in ASEAN, winning over Singapore.

Because we are giving the emphasis on clinical driven ataupun dia panggil clinical sponsored researches dan we are— In this regard, kita juga telah memulakan first in human research into rheumatology, oncology dan sebagainya. So, memang kita berikan tumpuan dan memang kita berikan segala galakan among others to give off take agreement. Maknanya kita akan— kita jamin kita akan membeli from them because kita nak galakkan mereka buat investment dalam negara dan bukan di luar.

Apa yang menjadi masalah antara lainnya kalau saya boleh minta PRA, Puan Fatkhiah untuk komen later. But we have this problem of as you said Yang Berhormat Bayan Baru, YB Sim, that is this almost like RM1,000 single product

registration. That's where you do not have the competition. That's where the problem is. Sebab itu Dato' Sri KSU sebutkan tadi we are going out, we are going out to meet— because dulunya kita rely only on one or two. Now we are going out to get— others also to come in to invest here, together with our local players. So, that we grow the pharmaceutical industry. Mungkin saya minta untuk Puan Fatkhiah untuk sikit komen lagi, satu.

…

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Saya tahu, this is where— secara peribadi, saya mengambil perhatian perkara ini. We have local yang akan— mungkin saya tak boleh sebut nama-nama itu for matters of— takut prejudis pula ya. But we have our local champions— and we have our local champions who are producing for example— saya mungkin boleh sebutlah ya, on the peritoneal dialysis machine which is state of art and they have their footprint all over the world. They maybe complaining that they are not getting good buy in daripada kerajaan kita. Ini saya personally want to look into because dia compete with MNCs here. Itu saya berani sebut dan ya, kita harus— PMX selalu menyebutkan kepada kami Menteri-menteri supaya memberikan all that we could. Supaya kita memberikan keutamaan dan sokongan dan dokongan kepada our local manufactures, our local champions ataupun even our startup, kita mesti berikan galakan.*

So yes, Yang Berhormat YB Sim, I'm very conscious of that. We need to do more. Saya tidak berpuas hati dengan prestasi kita. There's a lot that we can do, with the lot that we can break the cartel. Saya comeback this way, I want to make sure that especially the pharmaceutical industry ini. There are four or five companies that take about almost 80 percent of ini. They will get into RM2 billion, RM3 billion while others do not get it ataupun suffer, again and again, failures in their tender. How others would also be able to achieve success, it's for us to also educate and make them more sustainable by way of technical expertise, finance dan sebagainya.

Saya mengakui, we need to do a lot more medical device sectors dan juga farmaseutikal dan juga termasuklah by way of other research termasuk our vaccine development dan sebagainya. I take your point Yang Berhormat. Terima kasih.

…

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Thank you Dr. Davis ya. So, kita pun— KKM pun menggunakan a generic first policy because you know very well doctors and others, I'm a former oncologist. So, we know to get the generic status, you have got to do both pharmacokinetics and pharmacodynamics by equivalent. So that dari segi efficacy, dia adalah sama. Cumanya in the generic drugs, they do not do the clinical trial. Maknanya they escape all the billions of dollars in terms of investment during the clinical drug development. So that is the reason why they are cheaper. But by away safety and efficacy, they are equal. Itu sebab dia called by equivalent studies. Begitu juga halnya tentang not just generic but also biosimilar drug we called it."*

[Muka surat 43 - 47, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

iii. Penjelasan Timbalan Pengarah Program Perkhidmatan Farmasi

Puan Fatkhiah binti Haji Khalil [Timbalan Pengarah Program Perkhidmatan Farmasi] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa terdapat lebih 1,500 jenis ubat yang hanya mempunyai satu pengeluar berdaftar di Malaysia, sekali gus menyebabkan berlakunya monopoli dan tiada pilihan alternatif. Keadaan ini menyebabkan harga ubat menjadi mahal dan sukar untuk dikawal. Beliau juga menekankan bahawa syarikat tempatan sering gagal dalam tender kerajaan kerana menawarkan harga yang lebih tinggi berbanding produk import. Hal ini menyebabkan penilaian kewangan mereka lebih rendah dan tidak layak mendapat kontrak. KKM kini sedang aktif mencari alternatif luar negara untuk ubat-ubatan yang tidak mempunyai pesaing dalam pasaran domestik.

> ***"Puan Fatkhiah binti Haji Khalil [KKM]:*** *Tambahan untuk yang Dato' Sri KSU dan Datuk Seri YBMK telah maklumkan tadi, yang mana terdapat 1,500 ubat-ubatan yang tiada alternatif, yang mana ada single product sahaja didaftarkan negara yang menyebabkan inilah monopoli yang memberikan harga ubat itu lebih mahal dan perancangan apa yang telah dimaklumkan oleh Dato' Sri KSU bahawa kita akan— Dato' Sri akan keluar untuk mencari alternatif kepada ubat-ubat yang tak ada alternatif di dalam negara. Itu salah satu.*
>
> *Bagi akses syarikat tempatan kepada kontrak kerajaan, apa yang berlaku dalam perolehan tender ubat-ubatan, produk lokal biasanya menawarkan harga yang lebih tinggi daripada produk import. Jadi bila dalam penilaian kewangan dan perbandingan harga, ini menyebabkan markah dia rendah. Ini yang dimaksudkan oleh Dato' Sri KSU tadi bila penilaian markah dia tinggi, dia boleh masuk dalam tender kerajaan. Itu yang...*
>
> ***Tuan Sim Tze Tzin [Ahli PAC]:*** *Untuk medical devices, sebenarnya mereka lebih rendah device?*
>
> ***Puan Fatkhiah binti Haji Khalil [KKM]:*** *Medical device saya tak pasti tapi untuk ubat-ubatan..."*
>
> [Muka surat 45 - 46, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

7.11 Pentadbir Pihak Ketiga (TPA)

Pentadbir Pihak Ketiga (TPA) merupakan instrumen pentadbiran yang berfungsi untuk meningkatkan kecekapan operasional dalam pengurusan manfaat kesihatan

korporat. Peranan TPA adalah bersifat administratif dan tidak memberikan impak signifikan terhadap inflasi kos rawatan klinikal secara langsung.

Keberkesanan model TPA dalam ekosistem kesihatan Malaysia bergantung kepada dua aspek penting:

- **Ketelusan Peranan:** Memastikan pengguna iaitu pekerja memahami bahawa TPA hanyalah pelaksana syarat perlindungan dan bukannya penentu kualiti atau ketersediaan rawatan klinikal.
- **Kecukupan Perlindungan Korporat:** Keberkesanan sistem ini dalam mengurangkan beban sistem kesihatan awam bergantung kepada sejauh mana syarikat korporat bersedia menyediakan had perlindungan yang mencukupi bagi mengelakkan pesakit beralih ke hospital kerajaan apabila had rawatan tamat.

Kesimpulannya, TPA adalah komponen sokongan dalam pengurusan kos kesihatan, namun kawal selia terhadap had perlindungan dan ketelusan syarat yang ditetapkan oleh pihak pembayar (majikan/insurans) adalah lebih kritikal dalam menentukan akses rawatan yang mampan bagi golongan pekerja.

i. <u>Penjelasan Ahli Lembaga Pengarah APHM</u>

Dr Tan Hui Ling [Ahli Lembaga Pengarah APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa dianggarkan 25% hingga 30% perniagaan hospital swasta datang daripada TPA, yang menguruskan insurans majikan untuk pekerja mereka. Penggunaan TPA tidak menyumbang kepada peningkatan inflasi perubatan secara berbeza berbanding pesakit yang membayar tunai atau menggunakan insurans individu, kerana hospital memberikan rawatan yang sama tanpa perbezaan kos berdasarkan kaedah pembayaran. Walau bagaimanapun, beliau menyatakan bahawa pekerja di bawah seliaan TPA sering berhadapan dengan had perlindungan yang terhad daripada majikan mereka. Apabila had rawatan tersebut melebihi amaun yang ditanggung, pesakit terpaksa beralih semula ke hospital kerajaan, menambah sendiri kos rawatan melalui

tunai, atau menggunakan insurans peribadi untuk menampung baki kos perubatan tersebut.

"Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, kalau boleh saya tanya topik yang lain adalah tentang third-party administrator (TPA). Adakah TPA ini, apakah peranan TPA dalam private hospital setting? Are they actually helping— how many percent of your customers or your clients, patients come from TPA? And then, are they incurring cost, extra cost or driving up inflation in this medical inflation?*

Dr. Tan Hui Ling [APHM]: *Maybe the first question YB, to answer it's about 25 to 30 percent the TPA business in private hospitals because this is largely managed the corporate employers' insurance for their own employees. But in terms of their how much are they driving up the inflation, I don't think it's any difference from cash-paying patients or insurance companies. Because in the end they are just employee, they are coming to us to seek treatment, we would use the same treatment how we treat the cash-paying patients or even insurance companies. Not much of a difference actually.*

In fact, employees sometimes they have a very limited cover as employees. Then by that, they could only subject to a certain level of treatment. After that they have got to go back to government because the company do not tanggung or they have to top up with their personal insurance or by cash. So, short answer is no differentiation in terms of inflation."

[Muka surat 44 - 45, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

ii. <u>Penjelasan Setiausaha Kehormat APHM</u>

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa Pentadbir Pihak Ketiga (TPA) tidak menyumbang kepada inflasi perubatan secara langsung kerana mereka beroperasi menggunakan model pengurusan per kapita, di mana syarikat membayar yuran tetap bagi setiap kakitangan untuk menguruskan manfaat kesihatan. Secara amnya terdapat dua (2) fungsi utama TPA seperti berikut:

i. Membantu syarikat *self-insured* yang mempunyai bajet kesihatan sendiri untuk menguruskan panel hospital dan semakan tuntutan.
ii. Membantu syarikat insurans kecil yang tidak mempunyai jabatan pemprosesan tuntutan sendiri atau kepakaran dalam menguruskan manfaat pesakit luar (*outpatient*).

Secara keseluruhannya, TPA bertindak sebagai pelaksana syarat perlindungan yang telah ditetapkan oleh pihak korporat atau syarikat insurans, dan perkhidmatan mereka dianggap lebih cekap berbanding jika syarikat menubuhkan jabatan pengurusan kesihatan sendiri secara dalaman.

"Encik Anwar Anis bin Anis Ahmad [APHM]: *If I can add, YB. So, TPA or third-party administrator, as Miss Erica said we don't think that is contributing to inflation per se because it is on a capitation model money. Kalau ada syarikat yang ada 1,000 staf ataupun manpower, dia akan bayar kata RM3 per staff per month for them to manage their healthcare benefit. Of course, the research also shows if you try to do that on a large scale yourself, it will cost you more. Then you have to set up your own department dan sebagainya.*

So, dan TPA ini ada dua fungsi dia. One is also for a self-insured company. So, there are certain companies yang tak beli insurans. Dia tak beli insurans. Maknanya, dia ada bajet untuk healthcare cost untuk staf dia. Tapi untuk menguruskan perbelanjaan ini, panel hospital mana for the claim, to review the bill dan sebagainya, dia engage TPA. And like I said, buy at large, it is on a per-head cost. So, doesn't matter what the bill it's a per-head cost. So, that's number one for a self-insured organisation.

Number two, insurans juga menggunakan TPA. Smaller insurance yang tidak ada claim processing department mereka sendiri akan meminta TPA untuk melakukan fungsi ini untuk mereka. Itu satu. Dan kedua, insurans yang jual insurans untuk korporat, di mana the employee benefit. Kalau employee benefit ini, bukan sahaja untuk hospitalisation tapi untuk outpatient juga. Dan, kebanyakan insurans— most of the insurance tidak ada department untuk outpatient management of employee benefit. Yang itu menjadi fungsi TPA.

Secara amnya, kalau ada syarat-syarat dalam apa yang boleh cover, tidak boleh cover actually it's either from the corporate or from the insurance. TPA itu melaksanakan apa menjadi syarat daripada insurans ataupun korporat yang menggunakan perkhidmatan mereka. Secara amnya, itulah fungsi TPA."

[Muka surat 45, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

iii. Penjelasan Presiden & *Managing Director* KPJ Healthcare Berhad

Mr Chin Keat Chyuan [Presiden & Managing Director (KPJ Healthcare Berhad] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa TPA pada dasarnya berfungsi sebagai penyedia

perkhidmatan *outsourcing* bagi tugasan pentadbiran yang bergantung kepada volum perniagaan yang besar. TPA biasanya diperlukan untuk menguruskan manfaat pekerja bagi syarikat korporat yang tidak menggunakan insurans atau syarikat insurans yang memilih untuk tidak menguruskan sendiri tuntutan pesakit luar (*outpatient*).

Peranan TPA adalah sangat marginal dalam ekosistem kos kesihatan kerana mereka hanya menguruskan aspek pentadbiran dan tidak menambah kos rawatan secara signifikan kepada pembayar, sama ada daripada pihak korporat itu sendiri atau syarikat insurans.

> ***"Mr Chin Keat Chyuan [APHM]:*** *Actually, we are not sure about the PTA. TPA in general like what Encik Anwar said. In general, only look at the volume game. You can't be having a TPA manager and corporate if only 20 staff and all these. They literally need a volume for you to manage the administrative work.*
>
> *The payer automatically is still either noninsured, that means they corporate themselves. For example, the TNB, Maybank for example or because the insurance company they in general don't work on outpatients but because some corporates prefer to have that for their outpatients punya employee benefit. So, that's why they are outsourcing it. It is an outsourcing kind of work, general not adding too much. It is very, very marginal for TPA."*
>
> [Muka surat 45 - 46, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

7.12 Hospital Tidak Berasaskan Keuntungan

Model Hospital Bukan Berasaskan Keuntungan merupakan komponen sistemik yang penting dalam ekosistem kesihatan Malaysia bagi mengurangkan jurang perbezaan antara perkhidmatan awam dan swasta komersial. Hospital dalam kategori ini mampu menawarkan rawatan berkualiti pada kos yang lebih kompetitif melalui kecekapan tadbir urus serta ketiadaan orientasi keuntungan komersial yang tinggi. Keberkesanan dan kelestarian model ini bergantung kepada tiga faktor utama:

1. **Konsistensi Sokongan Dasar**: Keperluan kerajaan melalui MOF dan Lembaga Hasil Dalam Negeri (LHDN) untuk mengekalkan serta mempermudah status pengecualian cukai bagi menggalakkan aliran sumbangan daripada sektor korporat dan penderma individu.

2. **Akses kepada Teknologi Kos Rendah**: Strategi mempelbagaikan sumber perolehan peralatan perubatan yang lebih kos efektif bagi mengurangkan beban pelaburan modal tanpa menjejaskan piawaian kualiti rawatan.
3. **Penyelarasan Dana Sosial**: Mengintegrasikan instrumen kewangan sosial seperti Zakat, Wakaf, dan CSR sebagai sumber pembiayaan modal untuk mewujudkan lebih banyak fasiliti penjagaan kesihatan peringkat pertengahan yang mampu milik bagi golongan M40 dan B40.

Tanpa langkah-langkah strategik untuk memperkukuh model hospital ini, ekosistem kesihatan negara berkemungkinan berhadapan dengan ketidakseimbangan akses, di mana sektor awam akan terus menanggung beban pesakit yang tinggi sementara sektor swasta komersial kekal tertumpu pada segmen pasaran tertentu sahaja.

i. <u>Penjelasan Pengarah Hospital Tung Shin</u>

Datuk Ang Chin Tat [Pengarah Hospital Tung Shin] dalam Prosiding Bil. 5(k)/2025 bertarikh 5 Mac 2025 menjelaskan bahawa Hospital Tung Shin merupakan organisasi bukan untung yang telah beroperasi selama 144 tahun dengan matlamat utama menyediakan perkhidmatan kesihatan yang mampu milik kepada rakyat. Hospital yang berdaftar di bawah ROS ini tidak mempunyai pemegang saham, tidak membayar dividen, malah 24 ahli jawatankuasa pengurusannya berkhidmat secara sukarela tanpa sebarang gaji mahupun keistimewaan perubatan. Kelangsungan hospital ini banyak dibantu oleh sumbangan orang awam, termasuk pendermaan peralatan perubatan yang secara langsung mengurangkan beban kos modal organisasi.

Mengenai cabaran kos perubatan semasa, beliau mendedahkan bahawa kenaikan caj hospital swasta sebahagian besarnya berpunca daripada gangguan rantaian bekalan dan kenaikan harga ubat-ubatan yang berlaku dengan kerap. Sebagai jalan penyelesaian, beliau mencadangkan agar penggunaan ubat generik diperluaskan dan mempertimbangkan perolehan mesin perubatan dari China yang lebih murah, namun tetap memerlukan pemantauan kualiti yang ketat. Profil pesakit di Hospital Tung Shin menunjukkan bahawa 70% daripada mereka membayar secara tunai,

manakala hanya 30% yang bergantung kepada perlindungan insurans, sekali gus mencerminkan peranan hospital tersebut dalam menyediakan rawatan yang masih boleh diakses tanpa skim insurans yang mahal.

"Datuk Ang Chin Tat [Pengarah, Hospital Tung Shin]: *Okey, selamat petang Pengerusi PAC, YB-YB. So, good afternoon to everybody. Let me introduce my medical director on my right, Dr. Ashim. Then my COO on my left, Ms. Teng and my admin manager Mr. Chung.*

So, very interesting to be here because after 144 years that we are invited to the Parliament to brief the Members of Parliament on how Tung Shin operates as a non-profit organization.

Yeah, Tung Shin Hospital was established in 1881. Back then, our forefathers already knew that the cost of healthcare is going to be a burden to the rakyat. So, but then back in 1881 that Tung Shin started as traditional Chinese medicine. So, only in 1950 that we started the Western medicine. So, in 1992, we set up an academy of nursing. Then the model of Tung Shin hospital, we run as a nonprofit organisation with a principle of creating affordable healthcare to the public. So, in Tung Shin Hospital, we do not have any shareholders, we are registered with ROS. We do not give any dividends; we do not have any salary to the board of council, there are a total of 24 elected council members and then we are allowed to appoint five more council members after the election.

So, the board of council members have no salary and we do not have any benefit. We do not enjoy any discount on healthcare; we do not get any special privilege, or you know, special discount on anything, even medicine and things. So, council members are there basically as a philanthropy. They are there to make sure that Tung Shin continues to run the objective and principle of the association and also to make sure that the public is enjoying good healthcare.

We do have donations from a lot of public. So, some of our medical equipment are actually donated by the public. So, we do not actually have to— I mean not all the time. Sometimes, we do not have to fork out the money to buy any machinery. So, our machinery is actually sometimes paid by the donor.

So, just now I saw the slide that our PPUM professor had presented to us. One of the concerns of the— I would not say our organisation. Some of the private hospital charges and fees are also because of the supply chain, which actually causes the increase of healthcare. For example, the drugs that are supplied to the hospital, they have been increasing. I would say like— I would not say every year. It is like, it can be every month, you know. That I think have to be looked into it.

The things like a lot of generic drugs also available in the market but are not being used by a lot of hospitals. Currently, with the machinery cost has been increasing as well. But with the late you know the China— China has come out with a lot of machinery and they very, very cheap. They can be very, very cheap

but it has to be properly monitored because these are all the costs that contribute to the healthcare cost as well.

So, in Tung Shin Hospital, surprisingly, we only have 30 percent insurance patients and 70 percent of our patients are cash-paying patients ya. So, before I go further, we would like to show you a corporate video of Tung Shin Hospital. Thank you."

[Muka surat 43 - 44, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

Hospital Tung Shin berjaya bertahan selama 144 tahun kerana mempunyai model perniagaan yang sangat kukuh sebagai hospital kebajikan. Hospital ini amat bergantung kepada lesen pengecualian cukai yang membolehkan syarikat korporat dan individu menyumbang dana. Namun, lesen tersebut pernah ditarik balik pada tahun 2018.

Setelah melalui proses rundingan yang sukar dengan Lembaga Hasil Dalam Negeri (LHDN), termasuk ancaman tindakan undang-undang, Hospital Tung Shin akhirnya berjaya mendapatkan semula status pengecualian cukai tersebut pada penghujung tahun lalu. LHDN memberikan semula lesen tersebut setelah mengiktiraf sumbangan dan peranan besar hospital dalam memberikan perkhidmatan kepada masyarakat.

Pada masa hadapan, hospital ini merancang untuk terus berkembang menggunakan model sedia ada melalui subsidi daripada penderma, sambil menyatakan harapan agar kerajaan Malaysia juga dapat memberikan sokongan atau subsidi yang serupa bagi membantu pelestarian model hospital bukan untung ini.

"Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okey, I'm more interested in your model. It's a kind of a charitable kind of hospital and also for community service. Can survive so long? Or do you still need to like we raise fund for schools, still need to, every year go to get— knock at doors, ask people to give donation to the hospital.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *YB, for the fact that we are still surviving after 144 years means we have a very good model-lah. [Ketawa]*

Ya, first of all, just to brief you a little bit more. I think back in 2018, Tung Shin all the while has been given a tax-exemption license. So, a lot of corporations, individuals actually donate money to Tung Shin. Actually— we do not actually have to run any charity event except one that we did was to have the cardiologist

center, which we do the— you know just now the doctor talked about the stent, right. So, we have that once in 2016, if I'm not mistaken. That was to raise RM10 million. Back then, our Prime Minister of that time also donated RM3 million to Tung Shin Hospital. So, we managed to raise RM7 million and total money spent is actually for that particular ward. After 2018, sadly our tax exemption license was revoked. I think…

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara] Tax exemption license revoked?*

Datuk Ang Chin Tat [Hospital Tung Shin]: *Ya, ya. While you— ya YB, we didn't come to you.*

...

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *How about now? How about now?*

Datuk Ang Chin Tat [Hospital Tung Shin]: *We managed to get it back end of last year.*

Puan Kok Suh Sim [Naib Pengerusi PAC]: *Got it back-lah? Listen.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *Only last year, only last year we got it back ya. Back then we knew we had no tax exemptions and we were— but it was so difficult YB to tell you because once a policy is set, it's very difficult for us to get back. But Tung Shin Hospital we have a very good reason to take it back. To be honest with you, we actually threatened to sue LHDN for that…*

Ya, ya, seriously but then after they looked into our case seriously and they think that we are doing a very good job and they gave back to us at the end of last year. And we actually make the announcement after that. I think in January during our AGM, we made an announcement and to let the public know that you know LHDN actually gave us back the tax exemption license ya.

So, moving forward we are also planning to expand the hospital with the model that we have and we have donors actually willing to— I would not say sponsor us. Subsidising us. And I hope that maybe the Government of Malaysia can also do so. Ya, YB."

[Muka surat 45 - 46, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

Datuk Ang Chin Tat turut menjelaskan bahawa Hospital Tung Shin mengekalkan model perniagaan yang unik dengan memastikan kos barangan dan operasi melebihi 50 peratus daripada pendapatan setiap tahun. Strategi ini bertujuan untuk memastikan hospital tidak mengejar keuntungan, sebaliknya hanya mencapai tahap pulang modal atau

kadangkala menanggung kerugian minimum demi mengekalkan kos rawatan yang rendah. Meskipun berdepan dengan tekanan kewangan, hospital ini tetap komited meneruskan pelbagai inisiatif amal, termasuk pemberian konsultasi dan ubat-ubatan tradisional Cina secara percuma kepada warga emas berumur 60 tahun ke atas pada setiap hari Khamis.

Selain perkhidmatan di hospital, mereka turut mengendalikan unit amal bergerak yang mengunjungi enam lokasi berbeza setiap hari untuk menyediakan konsultasi, ubat-ubatan, rawatan akupunktur, dan urutan secara percuma. Program ini menyasarkan golongan miskin, warga emas, dan penduduk di kawasan luar bandar.

Walaupun terdapat cabaran di mana golongan berkemampuan turut mengambil kesempatan atas perkhidmatan percuma ini, Hospital Tung Shin tetap meneruskan misi kebajikan mereka dan bersyukur kerana masih mampu mencapai imbangan kewangan yang stabil hampir setiap tahun.

> ***"Datuk Ang Chin Tat [Hospital Tung Shin]:*** *YB, you are invited to Tung Shin Hospital. We would love to show you around, seriously. Having said this, just to answer you a quick figure, right? How do we do it that? We make sure that cost of goods for every year is above 50 percent.*
>
> *Which means that if anything more than 50 percent, we are not making profit. We are like breaking even. Technically Tung Shin Hospital is running a minimum loss sometimes. Why? Because every year we do, we continue our charity events such as we provide free Chinese medicines for 60 and above. Every Thursday, YB anyone from your constituency that wants to get free consultation, tell them to come Tung Shin Hospital, we give for free.*
>
> *We also go to— we also have mobile charity that go to six places every day. Every day we go to six places, we do free charity, providing free services, free consultation, free medication. These are all Chinese medicines, acupuncture, massage for the patients.*
>
> *We target rural area and people who are poor and old. But sometimes, we can't prevent people that drive extras and come to do get the free things. We do all— this charity continue to run even though we are making loses but thank God we manage to break even almost for every year."*
>
> [Muka surat 49, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

Sebagai organisasi bukan untung, Hospital Tung Shin mengawal kos perubatan dengan cara tidak mengambil sebarang margin keuntungan ke atas barangan yang dibekalkan kepada pesakit. Beliau memberi perbandingan bahawa hospital swasta lain biasanya akan menambah peratusan keuntungan (seperti 30 peratus) ke atas harga kos barangan, namun Hospital Tung Shin mengekalkan harga jualan pada tahap kos asal bagi memastikan bil hospital kekal rendah.

Walaupun pihak hospital tidak mempunyai kuasa untuk mengawal harga yang ditetapkan oleh pembekal dalam rantaian bekalan, mereka komited untuk tidak membebankan pesakit dengan kenaikan harga tambahan bagi tujuan keuntungan. Beliau turut menegaskan bahawa hanya perubahan polisi kerajaan sahaja yang mampu mengawal rantaian bekalan dan harga barangan pengguna tersebut secara menyeluruh.

> **"*Datuk Ang Chin Tat [Hospital Tung Shin]:*** *Yang Berhormat to answer your question in short ya. We can't control the consumer product, how we control is because we are non-profit organization, so we do not add extra profit into it. So, whatever comes in, let's say if today with my RM1, tomorrow they decide RM1.10, we don't make profit anyway. So, our price in the hospital bill would not add into the profit. You are right, other hospital what Ms. Teng is trying to explain to you that other hospitals they definitely have profit, they were adding let's say if they want to sell 30 percent more expensive, that is where the profit is.*
>
> *So, for us is because we are non-profit organization, so we don't make profit. So, we always keep our cost low because if Tung Shin Hospital buying the diaper, our price is always like nonprofit, other hospitals would always increase. So, other hospitals buying at RM1.10 they increase a 30 percent, ours still don't increase 30 percent. [Dicelah] We can't control the consumer, only the policy can control the supply chain. We can't control them."*
>
> [Muka surat 55 - 56, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

ii. <u>Penjelasan KSP, MOF</u>

Datuk Johan Mahmood Merican [KSP, MOF] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa hospital tidak berasaskan keuntungan memerlukan lebihan hasil (keuntungan) yang mencukupi, bukan sahaja untuk operasi harian tetapi juga untuk pelaburan semula bagi

meningkatkan infrastruktur, peralatan, dan prasarana. Galakan utama kerajaan bagi hospital tidak berasaskan keuntungan adalah pemberian pengecualian cukai tertentu ke atas keuntungan mereka, dengan syarat hospital tersebut tidak mempunyai pemegang saham individu atau syarikat (seperti yang dipegang di bawah struktur amanah) agar keuntungan itu dapat dilaburkan semula sepenuhnya ke dalam perkhidmatan.

Keuntungan adalah diperlukan dalam banyak industri, termasuk kesihatan, untuk menjana pulangan yang membolehkan pelaburan berterusan, dan hospital swasta yang ada kini melayani pasaran yang mampu dan mahukan tahap perkhidmatan tersebut. Kejayaan Malaysia dalam menarik pelancong kesihatan juga membuktikan kualiti perkhidmatan swasta yang kompetitif. Isu dasar utama adalah untuk mencari imbangan yang betul antara membiarkan pasaran berfungsi dan memastikan rakyat amnya yang tidak mampu mempunyai akses kepada perkhidmatan yang sebaiknya.

Beliau turut menjelaskan bahawa kerajaan sudah mengawal selia caj ke atas yuran pakar perubatan, namun isu yang masih cuba ditangani adalah mengawal caj perkhidmatan hospital lain daripada menjadi berlebihan. Walaupun cadangan Cukai Durian Runtuh dibangkitkan, Kerajaan belum mempertimbangkan bentuk cukai tersebut buat masa ini, sebaliknya tumpuan adalah kepada pendekatan inisiatif sedia ada yang telah mencapai penjajaran di antara pihak berkepentingan (Kementerian Kesihatan, Kementerian Kewangan, syarikat insurans, dan hospital) untuk memastikan kenaan caj perkhidmatan kesihatan yang munasabah.

> ***"Datuk Johan Mahmood Merican [MoF]:*** *Izinkan saya tambah. Berhubung dengan hospital yang tidak berasaskan keuntungan. Sebenarnya macam yang contoh yang diberikan, sebenarnya bukan sahaja ia punya tahap hasil revenue hanya mencukupi, memadai hanya untuk operasi tetapi ia perlu lebihan sikit supaya boleh digunakan untuk pelaburan untuk meningkatkan infrastructure, peralatan dan sebagainya.*
>
> *Tapi berdasarkan hospital tidak berasaskan keuntungan. Biasanya antaranya ialah dia distrukturkan supaya dia tiada pemegang saham. So, tiada isu dividen yang disalurkan dalam pemegang saham.*
>
> *So, dengan itu antara galakan yang diberikan kerajaan memberi pengecualian cukai tertentu atas keuntungan yang dibuat oleh hospital tersebut supaya keuntungan itu*

dapat dilaburkan semula untuk meningkatkan prasarana dan kemudahan ialah sebab seperti mana yang dikongsikan kos peralatan perubatan semakin meningkat dan seperti mana yang Dato' Seri Gabenor sebut dalam hospital swasta perlu juga memastikan bahawa keuntungan ini mencukupi juga supaya prasarana dan perkhidmatannya masih dapat di tahap yang sepatutnya.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry Datuk, saya nak tanya macam yang tiga hospital ini you kategorikan sebagai non-profit punya hospital? Is it dia orang yang beritahu kah? Kah macam mana itu? How is it? They apply kah apa?*

Datuk Johan Mahmood Merican [MoF]: *Sebab ada layanan cukai yang tertentu untuk hospital yang tidak bermotifkan keuntungan. So, mereka perlu memohon kepada Kementerian Kewangan dan LHDN untuk mendapatkan status tersebut.*

Tapi antara syaratnya ialah hospital tersebut itu tidak ada pemegang saham individu ataupun syarikat. Biasanya they normally held under trust structure. Macam Tung Shin ia ada Lembaga Pemegang Amanah yang dari segi tata kelola bagaimana ia beroperasi.

Tuan Sim Tze Tzin [Ahli PAC]: *On this point, kalau boleh Pengerusi, saya nak tanya sebab kami difahamkan apabila we did research, some of the country dia tidak membenarkan hospital mereka list on their Bursa. Contohnya di Korea. Mereka tidak membenarkan syarikat hospital untuk list kerana mereka rasa itu adalah satu perkhidmatan. Our health is not for profit. The principle is health is not for profit.*

So, untuk kita di Malaysia ini, kita ada IHH, kita ada KPJ, dan sebenarnya Khazanah dan juga EPF, they invested in this companies, okay. So, at the end, it's a vicious cycle because this is for profit organisation. Their objective is to maximise the profit. I'm not saying that they're profiteering but they maximise to the max. So, if I can— if you read the newspaper, their profit is 10 billion, one billion. The smaller one is one billion. Bigger one 10 billion profit. Okay.

So, saya rasa ini adalah sesuatu yang kita sebagai satu negara, we have to think of whether health is for profit or not? Bolehkah kita you know, I think we should think about this and not to make money out of other people's misery, especially our health.

Dr. Hajah Halimah Ali [Ahli PAC]: *Doctor gets blame, you know?*

Tuan Sim Tze Tzin [Ahli PAC]: *Doctors another issue. Tapi saya rasa is matter of principle we shouldn't let our hospitals to be listed. Itu soalan nombor satu kepada KSP.*

Kedua ialah tentang I nak bagi satu contoh even— okay, we talked about Lam Wah Ee. We talked about Tung Shin. But another model that I think I want to present to this committee and also Bank Negara dan KSP adalah satu model lagi for profit but a charitable hospital. Which I think it exists in Negeri Sembilan.

The hospital is called CMH. It is run for profit but their profit is very minimal and then they return most of the profit back to the patients. I think that model is quite good because it used to be loss-making hospital and then this group— siapa nama dia, dia masuk, they turned around the hospital, now its profitable. They made RM12 million a year but they returned 80 percent which is about RM9 million to RM10 million back to what do we call to help the poor, a charitable fund to help the poor and they don't maximise the profit.

Which I think the model we should look into details, whether how to make it. Okay. Kalau bolehlah. Kita apply juga kepada IHH dan juga KPJ and Sunway lah. I mean this. For example, one of the public hearings mereka bangkitkan bahawa ada satu hospital mereka ada grand piano, ada satu akuarium, tiga tingkat akuarium itu.

This is excessive. Hospitals, go back to the basic lah. Basic is to provide healthcare, provide healthcare. We are not like asking for a six-star hospital. We want a three-star effect, three-star facility but five-star punya healthcare punya delivery. I think this is what people want. Terima kasih.

Datuk Johan Mahmood Merican [MoF]: *I think YB…*

Dr. Hajah Halimah Ali [Ahli PAC]: *Tambah sikit about ini. Do you— who says that this hospital can be a tourism product? Makna yang tadi yang ada akuarium yang ada swimming pool adakah? Apa itu, kan? Who decides? Is it KKM or you all the finance part kah macam mana? Then become jadi hotel. Macam hotel. Ada six-star hospitals, ada yang sebut macam six-stars hotel, six-stars hospital.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Ya lah tapi kalau ada market, ada orang yang mahu itu, macam ada sesetengah hospital kita yang mana presiden di luar negara datang sini untuk dapat rawatan. So, there is a niche for certain market for certain as medical tourism.*

Dr. Hajah Halimah Ali [Ahli PAC]: *That's the question that I'm asking them. Do you have that kind of category or anybody can become six-stars?*

Datuk Johan Mahmood Merican [MoF]: *Yang Berhormat, I'm not— I know YB quoted there's a country where they don't allow for listed companies but seperti mana Yang Berhormat sedia maklum setiap negara ada dia punya model tersendiri dan kebanyakan negara ada dari segi perkhidmatan awam-swasta, perkhidmatan awam and models in between. So, whether it's a private-public and there are also models in between whether they are not for profit or charity-based.*

I think the current model that we have akhirnya in many industries you do need profits in order to generate a return so that there will be sufficient investment in that. I think some of these hospitals they cater for a market that there is there, there are some who are— desire that level of services and able to afford it. Hanya isu ialah dari segi dasar kerajaan ialah supaya memastikan bahawa rakyat secara amnya yang tidak mampu mempunyai perkhidmatan yang sebaiknya lah.

Mungkin dari segi kejayaan negara Malaysia untuk menarik pelancong kesihatan masih menunjukkan bahawa terdapat perkhidmatan kesihatan swasta yang masih

kompetitif dan berkualiti yang menjadi satu tarikan. So, isu yang dibangkitkan yang kita nak tercapai what is the right balance. So, I think that's why there are some things that we should regulate and there are some things which we should leave to market. It's a continuing challenge I think for government to always find the right balance to achieve the best outcomes.

Tuan Sim Tze Tzin [Ahli PAC]: *Untuk poin itu Datuk KSP, saya tidak pertikaikan free market sometimes is better so that the industry grow. Tapi sekarang kita nampak bahawa dia bukan— dia excessive profit. Dia mungkin dah sampai ke excessive profiteering di mana keuntungannya berbilion-bilion ringgit tetapi dia masih caj you know— what do you call this inflation continue to hike the price. It makes, it's drives out the M40. Hanya T20 mampu, yang lain dia push them to the government hospitals. I think this is crumbling the general hospital (GH), government hospital. So, I think government has to come in where there is excessive profiteering.*

Okey, contohnya kalau berlaku macam ini, kalau if we want to let them to continue the lease, maybe can we impose a windfall tax on them and then take the money to subsidise certain health initiative or something or go back to our government hospital? I think the government must actually address isu yang excessive what you call— a bit maximizing the profit dari segi itu.

Datuk Johan Mahmood Merican [MoF]: *Again Yang Berhormat dia mesti cari apa yang— imbangan yang betul lah. So, pada masa ini seperti mana yang telah dibincang, kerajaan pun ada kuasa kawal selia atas caj atas doktor, so specialist fees and all that has already regulated. The issue that we are trying to content with is what is the— how to control the general charging of the other hospitals services whether they are excessive procedures or whether it is— so, I think we are not yet in a position where at the moment we are not looking yet at any form of windfall tax. I think what is put here is the initiatives that we are doing to ensure that there is a reasonable charging for healthcare services.*

But let us work on this approach which is something that has at least achieved some alignment all the relevant stakeholders— whether it's Ministry of Health, Ministry of Finance also the insurance companies and hospitals. This is at least the approach that we approve."

[Muka surat 32 - 35, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

iii. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa perlunya mencapai keseimbangan yang betul antara keuntungan hospital dan penyediaan perkhidmatan perubatan, kerana keuntungan membolehkan hospital melabur dalam peralatan, teknologi, dan kaedah rawatan baharu.

Beliau juga menyokong cadangan mengenai model hospital yang menggabungkan motivasi awam dan amal, dan menggalakkan penubuhan entiti seumpama ini pada masa hadapan.

"Dato' Seri Abdul Rasheed Ghaffour (BNM): *Thank you, Yang Berhormat. Contoh hospital tidak berkeuntungan ini adalah contohnya seperti Hospital Lam Wah Ee di Pulau Pinang, Hospital Tung Shin di Kuala Lumpur dan juga Hospital Assunta di PJ. Di mana mereka beroperasi berlandaskan setakat memenuhi kos operasi mereka sahaja bukan bermotifkan keuntungan langsung. Kita akan menggalakkan lebih banyak hospital-hospital sebeginilah di mana mereka bertujuan untuk memberi perkhidmatan dan sebagainya.*

Ada tiga contoh yang baik dan inilah merupakan idea daripada Kementerian Ekonomi untuk memperbanyakkannya lagi hospital-hospital sedemikian. Itu dari segi hospital tanpa keuntungan ini.

Dari segi keuntungan pihak hospital. Memang pada pandangan kami berasaskan kepada charges ini, kita rasa mungkin tinggi tetapi of course I think we may not be in the position to comment on this sebab apabila kita berbincang dengan pihak swasta mereka mengatakan ROE mereka dalam 10 peratus which is actually lebih kurang sama dengan apa yang dilihat di negara-negara lainlah.

Namun, this is of course, I think something that we need to validate and we need to discuss and see what is the best level of profitibility or reasonable level of profitibility of the private hospitals. Terima kasih."

[Muka surat 31, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

"Dato' Seri Abdul Rasheed Ghaffour [BNM]: *I think maybe if I can a little bit into what KSP has said. I think it's really sebab striking the right balance between I think profitability and also providing services because we also want them to make some profit. Because profit is very important for them to also invest in term of new equipment, new technology, new ways of doing surgery and everything. I think Yang Berhormat you are right, striking the right balance there.*

Kedua, I think I like the point you raised just now in terms of hospitals that has public motivation plus charitable as well. I think it's something a model that we can also look and how do we encourage this kind of establishments in the future. Third, I think as KSP mentioned these are the nine key initiative that we believe may not be the best but this is something that we believe can achieve the matlamat kita untuk menangani dari segi peningkatan kos perubatan yang tinggi ini, insya-Allah. Saya rasa dengan sokongan dan juga kerjasama dari pelbagai pihak dan juga Yang Berhormat sekalian memberi sokongan kepada kami, kami akan cuba sedaya upaya untuk mencapai melaksanakan sembilan inisiatif ini untuk mencapai objektif yang kita inginkan. Terima kasih."

[Muka surat 35 - 36, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

iv. Penjelasan KPE, HTO KKM

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa hospital tidak berasaskan keuntungan bukanlah hospital yang tidak menjana pendapatan, tetapi ditubuhkan atas prinsip kebajikan oleh badan amal atau komuniti. Contoh hospital seperti Tung Shin (KL) dan Lam Wah Ee (Pulau Pinang) menawarkan perkhidmatan berkualiti dengan caj rendah, terutamanya melalui sistem subsidi silang antara wad eksekutif dan wad kelas tiga. Hospital sebegini mendapat sambutan tinggi namun berdepan kekangan dari segi pelaburan modal.

Kerjasama di antara pihak Kerajaan dan pihak lain seperti institusi zakat, wakaf, baitulmal dan sektor korporat memainkan peranan dalam menyokong hospital-hospital berkonsepkan pertengahan ini. Selain itu, tenaga kerja di hospital ini, seperti jururawat, dibayar secara kompetitif, manakala sesetengah doktor pakar memilih berkhidmat kerana komitmen peribadi dan keinginan untuk menyumbang kepada masyarakat.

> ***"Dr. Yap Wei Aun [KKM]:*** *Dia bukan hospital yang tak nak untung, tetapi dia adalah hospital yang ada prinsip, bila mereka ditubuhkan di mana the usual story adalah ada philanthropies yang mahu menyediakan tanah dan bangunan and then mereka minta daripada komuniti untuk share and then they actually build a hospital. Ada yang tiga yang ketahui. Tung Shin Hospital dekat KL, ada juga Lam Wah Ee dekat Penang yang menurut nota saya, kita lawat pada 30 April, tahun lepas.*
>
> *We were very impressed when we visited this hospital. It's a high-volume hospital, memang very popular, charges are below. They have third-class wards which cross-subsidised by executive-class-ward patients and their third-class wards are aircond and quite cheap.*
>
> *So, I will just encourage you all to just have a look and visit all these hospitals like we did. Also when bila saya pergi ke sana, saya pun rasa, if only we have more of hospitals like this. Because, it is lower fees, it's in demand, and it's a survival model.*
>
> *But what they were struggling with perhaps is the capital investments to buy the latest PET scanner dan sebagainya. But the service to the public is there. The value I think, what I hear from you also is the importance— sure, we don't want to melupuskan six-star hotel because— hospital, sorry. Because, that's consumers' choice. But, mungkin as a government, kita boleh menggalakkan the mid-tier and indeed that's what we are planning to do.*

But maybe not just as the government, not just a Federal Government. Maybe when a state government. Maybe as the holder of zakat, dengan wakaf, dengan baitulmal. Maybe as CSR from companies, we can do something along those lines. I think Kementerian Ekonomi, I can't quote them, so, I think also have— they kind of share the same desire as well.

So, ya, I mean it will be great. It doesn't need to be only the government does everything.

Dr. Hajah Halimah Ali [Ahli PAC]: *Just to apa Dr. Yap, what about their pekerja? Are they paid as well?*

Dr. Yap Wei Aun [KKM]: *They are regulated as a private hospital under 586. So...*

Dr. Hajah Halimah Ali [Ahli PAC]: *But is it comparable or is it lower or what?*

Dr. Yap Wei Aun [KKM]: *When we asked them, one harsh— I mean one reality is like this. For nurses and what they told us is that they have to pay their nurses competitively, it's not lower. For the specialist and doctors, some of them ultimately come because they are passionate and they want to make a difference. Maybe they see a wider spectrum of cases, they feel they can practise as how they would want to practise without any distortion or perverse incentive and just trying to make people's live better."*

[Muka surat 37 - 38, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

7.13 Ombudsman Insurans/Kesihatan

Ekosistem Ombudsman dan mekanisme penyelesaian aduan di Malaysia kini berada pada fasa peralihan ke arah sistem yang lebih bersepadu. Keberkesanan inisiatif ini tidak hanya bergantung kepada pengukuhan kerangka perundangan sedia ada, seperti Akta 586, tetapi juga kepada tahap kepercayaan pengguna terhadap kebebasan serta aksesibiliti saluran aduan tersebut. Kejayaan reformasi mekanisme aduan bergantung kepada dua faktor utama:

1. **Pengukuhan Kredibiliti dan Kebebasan:** Pihak Ombudsman Perkhidmatan Kewangan (FMOS) perlu mempamerkan tahap objektiviti yang tinggi dalam proses membuat keputusan bagi menepis sebarang tanggapan mengenai konflik kepentingan yang berpunca daripada model pembiayaan industri.
2. **Optimalisasi Peranan Pusat Sehenti:** Pusat ini harus berperanan sebagai agensi pemudah cara yang aktif dengan mandat pemantauan yang jelas, bagi memastikan setiap aduan diselesaikan secara komprehensif oleh agensi

berkaitan dan bukannya sekadar berfungsi sebagai pusat pengumpulan data pasif.

Tanpa langkah strategik untuk menyelaraskan saluran aduan dan menjamin ketelusan tribunal, pengguna akan terus berhadapan dengan cabaran dalam menangani isu kenaikan kos perubatan serta premium insurans tanpa saluran penyelesaian yang efektif.

7.13.1 Insurans

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa BNM mengawal selia industri insurans/takaful (ITO) dan memberikan panduan bagi penyelarasan premium untuk memastikan produk yang ditawarkan mampu dimiliki. Pemegang polisi yang merasa tertindas boleh membuat aduan kepada ITO, BNM melalui pautan aduan atau kepada tribunal bebas iaitu Ombudsman Perkhidmatan Kewangan (FMOS), yang berperanan untuk menyemak dan menyelesaikan isu yang tidak dapat diselesaikan.

> ***"Dato' Seri Abdul Rasheed Ghaffour [BNM]:*** *…Memang pada masa ini kita regulate. Apabila kita memberi panduan dari segi penyelarasan premium, memang ada beberapa elemen untuk memastikan mereka mengambil kira dari segi kemampuan dan juga affordability of the pemegang polisi dan juga sekiranya harga naik dengan mendadak, mereka perlu memastikan ada produk pilihan kepada pemegang polisi ini.*
>
> *Sekiranya ada berlaku di mana mereka rasa tertindas dan sebagainya, memang mereka boleh pertamanya berhubung dengan ITO tersebut. Kedua, mereka boleh datang ke Bank Negara juga melalui LINK. Mereka boleh complain kepada Bank Negara dan kami akan lihat. Sekiranya penyelesaian pun tidak memihak kepada mereka, mereka boleh pergi kepada— is it OFS, Jess?*
>
> ***Datuk Jessica Chew Cheng Lian [BNM]:*** *FMOS. [Bercakap tanpa menggunakan pembesar suara]*
>
> ***Dato' Seri Abdul Rasheed Ghaffour [BNM]:*** *FMOS, now kita called it— kita dah combined dengan SIDC, it's financial mediation oversight…*
>
> ***Datuk Jessica Chew Cheng Lian [BNM]:*** *ombudsman [Bercakap tanpa menggunakan pembesar suara].*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *...ombudsman. So ada, memang ada this kind of tribunal where they can go there to also complain and we will look into this matter. Memang dah ada.*

Tuan Sim Tze Tzin [Ahli PAC]: *On this point-lah kalau boleh Pengerusi, I received complaint daripada— you know I have a platform, people complain. They told one of the complain that they told us is first, kepada ITO. ITO memang memihak mereka sendirilah, ITO.*

Pergi ke Bank Negara, mereka rasa Bank Negara tidak memihak kepada mereka walaupun ada all these very strong evidence. And then pergi ke ombudsman, ombudsman pun— the ombudsman is funded by ITOs.

So, they feel that ombudsman pun side kepada ITO because it is not independent. The funding for ombudsman by the ITOs. So, mereka rasa itu adalah tidak adil dan on Friday, seorang complain begitu panjang and they drag me on the side and then— you know that guy, I tried to stop him from speaking but he continued to speak to me for half an hour, okay.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Kalau ada those kind of complaints, I think we will be very happy to see it. We will be very happy to know I think the complaint and see what we can do Yang Berhormat. I think that— I'm giving my commitment and that we will look into that matter."*

[Muka surat 38 - 39, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

ii. <u>Penjelasan Timbalan Gabenor BNM</u>

Datuk Jessica Chew Cheng Lian [Timbalan Gabenor BNM] dalam Prosiding Bil. 5(a)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa BNM telah menerima 12 kes berkaitan insurans/takaful sejak Disember, di mana 10 kes daripadanya telah diselesaikan melalui fasilitasi BNM antara syarikat dan pengadu.

Kebimbangan mengenai kebebasan Ombudsman Perkhidmatan Kewangan (FMOS) yang dibiayai oleh industri (ITO), beliau menegaskan bahawa BNM dan Suruhanjaya Syarikat Malaysia (SSM) mengawal selia penubuhan FMOS, memastikan ia mempunyai Lembaga Pengarah majoriti bebas. Struktur fi yang dikenakan kepada ITO ditetapkan sedemikian rupa untuk menggalakkan syarikat menyelesaikan aduan mereka sendiri secara dalaman, kerana mereka perlu membayar fi yang lebih tinggi sekiranya lebih banyak kes dibawa ke FMOS. Selain itu, fi tahunan yang dibayar adalah

mencukupi untuk mengekalkan operasi FMOS tanpa dipengaruhi oleh pihak industri.

"Datuk Jessica Chew Cheng Lian [BNM]: *Thank you, Governor. So YB, since December actually, we have received 12 cases. 12 kes yang dirujuk kepada Bank Negara and we have helped to facilitate dengan pihak ITO dan kesemua 10 daripada 12 kes itu sudah diselesaikan and you know both parties came together and managed to find a solution. Yang dua kes lagi we are still helping to facilitate. So, memang we will help seperti mana yang Gabenor dah cakap.*

On the financial mediation ombudsman service, although the funding is industry-funded, but we have— we regulate the setup of the FMOS together with ACN, it has independent— it is subject to independent board of directors. Majority independent board.

The fees also are set in a way that does not influence the outcome. The ombudsman semua are independent within the organisation. And every year FMOS will be given enough to sustain its operation. So they are not subject to any influence from the industry. That is all regulated. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *I mean principally the ombudsman must be seen to be— must be fair and seemed to be fair. Is should be independent and seen to be independent. I think the money should not come from the ITOs. The way I see it-lah because …*

Datuk Jessica Chew Cheng Lian [BNM]: *In fact, the— just very quickly, the fee structure in such that it setup in the way in encourages the ITOs to settle it themselves because they pay of flat fee, they all pay a flat fee regardless of outcome or whatever cases. But if they have more cases, they pay higher fee. So, that is to encourage them to settle the case at their end instead of ding-donging and then going to the FMOS. So, we set it up in a way to encourage with resolutions of complaints. Thank you. The Chairman is independent chairman as well as board members."*

[Muka surat 39 - 40, Laporan Prosiding Bil 5(a)/2025 bertarikh 24 Februari 2025]

7.13.2 Kesihatan

i. <u>Penjelasan KSU KKM</u>

Dato' Sri Suriani binti Dato' Ahmad (KSU, KKM) dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa penubuhan pusat sehenti (*one-stop centre*) sebagai langkah awal untuk menangani pelbagai aduan berkaitan isu kesihatan. Mewujudkan sebuah suruhanjaya adalah proses yang besar dan mengambil masa, manakala pusat sehenti

lebih praktikal dan cepat dilaksanakan. Pusat ini akan berfungsi sebagai koordinator untuk mengumpulkan masalah yang dibangkitkan dan menyalurkannya kepada agensi atau pihak berkaitan.

> ***"Dato' Sri Suriani binti Dato' Ahmad [KKM]:*** *Okey, commission ini is a very a big thing to do lah, YB. Maybe for the beginning sebab kita faham sekarang YB baru tahu cerita siapa yang ini, siapa yang handle, yang ini siapa yang handle. So, perhaps untuk memulakan dulu inisiatif ini mungkin KKM akan buat, akan establish dulu with your consent, Datuk Seri for a one-stop centre. Whereby semua orang yang ada permasalahan itu, will come to us and then daripada situ kita akan kumpulkan soalan-soalan, permasalahan then we know, we find out dekat mana kita boleh channel-kan this permasalahan ini.*
>
> *Tapi kita akan jadi koordinatorlah, the one-stop centre. Instead of having a commission, commission ini besar, YB. It's going to take time for us to establish it. But why don't we have a one-stop centre, lagi mudah, YB."*
>
> [Muka surat 55, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

ii. <u>Penjelasan Ketua Penolong Pengarah Kanan (KPPK) Bahagian Amalan Perubatan</u>

Dr. Harshinderjeet Singh [KPPK, Bahagian Amalan Perubatan KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa terdapat mekanisme semasa untuk menangani isu caj berlebihan. Sekiranya seorang doktor didapati melanggar etika, perkara itu akan dirujuk kepada Majlis Perubatan Malaysia (MMC) untuk tindakan lanjut. Bagi aduan melibatkan fasiliti atau caj keseluruhan hospital, ia akan dikendalikan oleh Cawangan Kawalan Amalan Perubatan Swasta (CKAPS). Sekiranya terdapat pelanggaran, KKM boleh mengeluarkan teguran berdasarkan peruntukan dalam Akta 586.

> ***"Dr. Harshinderjeet Singh [KKM]:*** *Maybe I can just enlighten a little bit on that. If there is an issue on overcharging, if we find that the doctor is not ethically practicing, he is whatever he is doing, he is not following his ethics then he goes to the Malaysian Medical Council. Malaysian Medical Council, they will look into the ethics part of the doctor.*
>
> *If comes to the hospital and all the charging, overcharging or looking that, we will see as a whole the procedures, what the doctors charge, the hospital charges which we don't regulate. Has a whole bill. It can come to the Cawangan Kawalan Amalan Perubatan Swasta (CKAPS). We can refer to that and we will look at the*

part of the consultation fees or the procedure performed appropriately. So, doctors go to MMC, the facility goes to CKAPS.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Still national health insurance…*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *It is that it is implemented. It is just not that it exists but that there's effective implementation and that benda itu is functional.*

Dr. Harshinderjeet Singh [KKM]: *Yes. As you revealed, appropriately we will base if there is any issue with the doctor overcharging and we will actually issue teguran kepada hospital based on the Akta 586, whatever provision annexes."*

[Muka surat 28 - 29, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

7.14 Insurans Kesihatan Nasional

Inisiatif Insurans Kesihatan Nasional (NHI) merupakan instrumen strategik bagi menjamin kelestarian pembiayaan sektor kesihatan di Malaysia. Namun pelaksanaan NHI bukanlah satu kaedah penyelesaian tunggal yang ringkas, sebaliknya menuntut transformasi menyeluruh terhadap mekanisme mobilisasi serta agihan dana kesihatan. Keberhasilan reformasi pembiayaan ini bergantung kepada tiga (3) faktor utama:

1. **Ketelusan Kos Sebenar:** Penggunaan sistem *Diagnosis-Related Group* (DRG) Kebangsaan sebagai prasyarat utama bagi menetapkan kadar bayaran yang saksama sebelum struktur pembiayaan nasional ditubuhkan secara rasmi.
2. **Kepelbagaian Sumber Dana:** Peralihan daripada kebergantungan terhadap hasil cukai am kepada integrasi dana sosial—seperti Zakat, Wakaf, dan Tanggungjawab Sosial Korporat (CSR)—bagi mengukuhkan Dana Kesihatan Nasional.
3. **Kematangan Ekosistem Digital:** Pemanfaatan sistem Rekod Perubatan Elektronik (EMR) Nasional bagi memantau keberkesanan rawatan, sekali gus memastikan setiap agihan dana memberikan impak kesihatan yang optimum.

Tanpa perancangan strategik dalam membina kapasiti institusi serta pangkalan data yang berintegriti, sebarang cadangan caruman wajib atau insurans nasional

dikhuatiri akan berdepan dengan risiko ketidakstabilan fiskal serta cabaran penerimaan sosial.

i. <u>Penjelasan MMA</u>

Dr. Gunalan @ Arumugam Palari [Ahli Malaysian Medical Association (MMA)] dalam Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025 menjelaskan bahawa inisiatif Insurans Kesihatan Nasional adalah kunci untuk menyelesaikan pelbagai masalah dalam sistem penjagaan kesihatan swasta semasa, dan perbincangan mengenai skim pembiayaan nasional ini telah berlarutan sejak tahun 1985.

Dengan merujuk kepada sistem Medicare di Australia sebagai model berkesan, di mana ia mewajibkan doktor membentangkan borang persetujuan kewangan (*financial consent form*) kepada pesakit. Borang ini memperincikan jumlah bayaran balik dari Medicare (kerajaan) dan insurans swasta, serta jumlah tambahan yang akan dicaj oleh doktor (dikenali sebagai 'gap'). Dalam sistem ini, pesakit mempunyai hak untuk bersetuju dengan caj 'gap' tersebut atau mencari doktor lain, dan sistem ini didapati berfungsi dengan baik serta memberikan ketelusan kepada semua pihak. Justeru, isu pembiayaan kesihatan nasional ini amat mendesak dan perlu diteliti oleh semua.

> ***"Dr Mohamed Namazie Ibrahim [MMA]:*** *Puan Pengerusi, I know there are several YBs here in this committee. I would like to highlight the necessity for a national health insurance. We have been talking about the national health insurance since 1985. I have been involved in these discussions because MMA was asked to come up with the fee schedule for the national health insurance.*
>
> *First edition was produced in 1997 and then after that every five years we have been revising it. Now if we have a national health insurance it can alleviate some of the problems that we are facing today. For example, Dr. Gunalan mentioned about the Australian system by the Medicare.*
>
> *Yes, Medicare has its own schedule. The Australian Medical Association has its own schedule. And then there are the reimbursements from the private insurance. In Australia, it is incumbent, it is mandatory for the doctor to present a financial consent form. So he has to or his staff has to work out whether the patients has got an insurance and then look at the website and see how much it is going to be reimbursed and then the Medicare, how much it will be reimbursed and what the doctor is going to charge in addition to that. So, that is known as a gap.*
>
> *So, this is presented to the patient and the patient has to consent. If he does not agree, he can go to another doctor. But most often, the doctors also will adjust the gap. That is what they are going to charge in addition to what the Medicare and the private insurance are going to reimburse. This has been working very well so far.*

But for GPs, there is a different system where the Medicare will reimburse the fee at a certain amount of fee and many GPs will take what is known as bulk billing. That means they will accept whatever the Medicare gives but some will have non-bulk billing which is where GPs can add on.

There are many benefits to this national health insurance. I think it needs some support from all the YBs and the PAC can also look into this aspect for the national health financing system. Thank you."

[Muka surat 35, Laporan Prosiding Bil 5(j)/2025 bertarikh 3 Mac 2025]

ii. <u>Penjelasan KP Kesihatan / Malaysian Medical Council (MMC)</u>

Datuk Dr. Mahathar bin Abd Wahab [KP Kesihatan / MMC] dalam Prosiding Bil. 5(n)/2025 bertarikh 21 Julai 2025 memaklumkan bahawa sistem *prepaid* perlu diaplikasikan untuk pembiayaan sistem kesihatan jangka panjang bagi mengelakkan bebanan kepada rakyat. Walau bagaimanapun, pelaksanaannya adalah kompleks dan tidak hanya *copy and paste* kerana faktor sosiodemografi.

Selain itu, Insurans Kesihatan Sosial (*Social Health Insurance*) atau Insurans Kesihatan Nasional (*National Health Insurance*) adalah opsyen sedia ada, namun memerlukan kajian mendalam dan input pelbagai pihak sebelum diputuskan. Asas utama adalah untuk memahami kos sebenar perkhidmatan kesihatan (melalui DRG Kebangsaan) dan memastikan dana pembiayaan bersifat *robust*.

"Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Terima kasih Timbalan Pengerusi. Saya nak tanya sikit lagi Datuk ya, ini nak tanya pandangan Datuk sebagai Chairman MMC. Mengenai national health insurance, saya difahamkan, correct me if I am wrong, only Malaysia dengan North Korea yang tak mengamalkan national health insurance. All other countries are having the national health insurance. Apa pandangan Datuk? Terima kasih.*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *… Sebenarnya bila kita melihat kepada pembiayaan untuk sistem kesihatan, I think asasnya adalah pembiayaan kepada sistem kesihatan.*

Kita sebenarnya satu negara yang amat bersyukur sebenarnya, untuk sekian lama pembiayaan sistem kesihatan kita actually sebahagian besarnya adalah daripada kerajaan menggunakan konsep prepaid, prepaid. Kita pun maklum dalam sekarang ini, kita punya out of pocket which is yang kena bayar sendiri pun agak tinggi juga, dah hampir sama 30 peratus if I am not mistaken.

Jadi, untuk jangka masa panjang memang tidak akan membebankan kepada rakyat. Jadi, itulah salah satunya jika kita melihat daripada untuk jangkauan masa hadapan dari segi hala tuju sistem kesihatan negara satu sistem prepaid perlu diaplikasikan sama ada dia kita panggil national health insurance ataupun social health insurance dan berbagai-bagai lagi ada di luar sana kita tidak boleh saja — minta maaf ya, copy dalam izin, copy and paste sebab negara kita mempunyai sistem perubatan tersendiri dan dari segi sosiodemografi pun berbeza-beza, keupayaan rakyat pun berbeza-beza.

Tetapi, apa-apa pun yang lebih penting pada kita sekarang ini adalah memastikan sebagai satu — untuk membuat peruntukan dana pembiayaan tersebut, kita mempunyai satu dana pembiayaan yang bersifat robust dari segi bagaimana dana tersebut dapat dihasilkan. Itulah sebabnya salah satu perkara yang kita cuba usahakan adalah untuk satu bentuk revenue yang boleh diletakkan kepada dana tersebut untuk kita guna pakai bagi sistem kesihatan kita. Sebab kalau kita menggunakan — national insurance ada pelbagai. Sebagai contoh, kalau di-pooling punya itu, kalau kita panggil dia ada earmarked tax, sya ingat ada tax, tax tertentu khas untuk kesihatan. Tetapi di negara kita actually general taxation certain amount been given dan sebagainya.

Jadi, agak sukar untuk — sebab jika kita melihat daripada aspek dana pembiayaan ini adalah agak kompleks sekali sebenarnya. Bukan — it's not as simple that sebagai contoh di luar sana, okey, tak apa dia kata, kenapa susah sangat? Naikkan saja caj RM10. Sekarang bayar RM1 naikkan ke RM20 ke RM50. Sebenarnya dengan berbuat sedemikian pun implikasi lebih besar. Sebenarnya, jika kita menggunakan kaedah sedemikian, actually, out of pocket daripada orang yang membayar itu adalah lebih. Kita tidak mahu yang itu. Apa yang kita mahukan pembiayaan, dana tersebut datang daripada mana.

Buat masa ini Yang Berhormat, saya boleh sambung sama ada social health insurance ataupun national health insurance, semua itu adalah opsyen-opsyen yang sedia adalah. Kita pun masih belum membuat keputusan bagaimana kita akan menggunakan kaedah ini sebab salah satu asas untuk mendapat dana tersebut kita perlu faham apakah kos sebenar kita untuk menjalankan perkhidmatan kesihatan di negara ini. Itu pun satu perkara yang kajian, yang sebagaimana soalan Yang Berhormat tadi berkaitan dengan hala tuju DRG kebangsaan. Itulah sebagai asas untuk perkara tersebut.

***Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:** Soalan tambahan Datuk, sikit saja. Saya ambil contoh Indonesia, dia orang ada laksanakan national health insurance. Dia — penduduk ataupun rakyat kena bayar RM120 sebulan, duit kitalah. Dan kalau rakyat yang tidak mampu, kerajaan akan make the payment. And then, orang yang lebih kaya juga diberikan opsyen, dia tambah bayaran then dapat different service compared to ordinary rakyatlah tetapi dia punya premium itu lebih tinggi ya. Apa pandangan Datuk?*

***Dr. Hirman bin Ismail [KKM]:** I think perkara tersebut merupakan antara opsyenlah yang telah — yang pernah kita bincangkan dalam kita membuat perancangan tentang apakah bentuk pembiayaan kesihatan yang paling sesuai*

untuk diamalkan di Malaysia pada masa akan datang. Sebagaimana yang Datuk KP cakap, a national health insurance or social health insurance are the two main models that we have discussed before dan antara perkara yang telah kita pertimbangkan adalah berkenaan dengan pembiayaan ataupun premium insurans tersebut berdasarkan kepada status sosioekonomi rakyat. Maknanya rakyat yang mempunyai kapasiti ataupun kemampuan yang lebih mungkin akan membayar yang lebihlah berbanding dengan rakyat yang mungkin kurang berkemampuan.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Saya nak tambah dekat sini Yang Berhormat, kalau dibenarkan ada satu kita panggil topik yang disebut sebagai health financing for legislators. Yang ini adalah satu artikel yang ditulis oleh World Bank Group. Dan dalam artikel ini telah menyenaraikan negara-negara yang menggunakan kaedah-kaedah sedemikian tetapi asasnya adalah kita meletakkan kita panggil universal health coverage. Saya tiada halangan untuk share this article kepada semua Yang Berhormat untuk tengok betapa kompleksnya bila kita bercakap berkaitan dengan dana pembiayaan dan sebagainya.*

*Dan dalam artikel ini juga meletakkan negara-negara yang menggunakan social health insurance, national health insurance untuk sekian lama dan apakah implikasi kepada negara-negara tersebut. Saya tiada halangan**,** saya boleh share artikel ini kepada Yang Berhormat semua untuk dihadamkan."*

(Muka surat 14-16, Laporan Prosiding Bil. 5(n)/ 2025 bertarikh 21 Julai 2025)

iii. <u>Penjelasan KPE, HTO KKM</u>

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025) menjelaskan bahawa buat masa ini, belum ada keputusan muktamad untuk melaksanakan sistem Insurans Kesihatan Nasional (NHI) atau Sosial (SHI) kerana wujudnya perbezaan pandangan dalam kalangan pakar dan isu sensitif berkaitan keperluan caruman wajib tambahan ke atas gaji pekerja formal. KKM sedang meneliti pendekatan yang wajar bagi memastikan kestabilan kewangan dan keadilan kepada semua pihak.

*"**Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:** ... Number three, the last one. Saya nak tanya dia bersangkutan juga dengan kos perubatan, national health insurance ya. Adakah Kementerian Kesihatan bercadang merancang untuk melaksanakan national health insurance? Negara seperti Indonesia dah ada national insurance. So, minta diberi penjelasan, pencerahan tentang tiga perkara tadi. Terima kasih.*

…

Dr. Yap Wei Aun [KKM]: *National Health Insurance. If you look at the Health White Paper, Health White Paper involved a lot of stakeholder engagement with experts and engagement on the ground. And, health financing is one of the critical things that they were exploring because it's key.*

Despite all these engagements, what they managed to come out with is not a definite saying that we are going for— to carry on with general taxation system or even a commitment saying we are going to NHI or SHI. The reason for this reflects the fact that there is lack of consensus on the ground as to where we want to head.

The simple reason is because a national health insurance or social health insurance system is a mandatory contribution system from formal labor. In other words, as you all's MPs, will you feel comfortable signing into a law requiring everybody who is working formal labor force to have in their paychecks "sumbangan SOCSO", "sumbangan EIS", EPF, LHDN and then a mandatory health contribution?

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]*: But why Indonesia, I think Singapore also can implement this.*

Dr. Yap Wei Aun [KKM]*: I'll get there. Okay. So, that's what NHI or SHI system is. When we consulted the experts, just two or three of them, closed door. The views are extreme. On one hand, we have the expert A which says, "You do NHI, SHI, just like Indonesia, all your problems are solved". On the other hand, another person says, "Do NHI, SHI, your government will collapse". It's as extreme as that.*

So, we can't just depend on perceptions. We need data. And therefore, you're asking me on Indonesia. So, for Indonesia, when they introduced the JKN in 2014, what we see is, "Is there an increase in expenditure from NHI to SHI as a total part of their health expenditure?" Surprisingly as a proportion, that did not increase. The part which actually increased, if you check WHO National Health Accounts for Indonesia is the government tax funded incentives to cover the poor and the informal labor force. That really expanded dramatically.

So ironically for Indonesia, even the headlines say, "We are introducing NHI, SHI", the key push for the funding is the government subsidies to support those who are poor and those who are the informal sector. So, one good thing is that for Indonesia they expanded the coverage which is a great thing. But don't forget that Malaysia throughout existing general taxation system already achieved that decades ago.

Then the next question is, "Is Indonesia system more sustainable?" If you just check the news, you'll find that for the last several years since JKN was initiated…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]*: But Indonesia is not the only country implementing this. There are some other countries as well.*

Dr. Yap Wei Aun [KKM]*: Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Some are developed countries.*

Dr. Yap Wei Aun [KKM]*: Maybe you just allow me to finish. So, if you look at the news, every year there has been a deficit or most years has been a deficit for BPJS requiring the government to bail it out and I think more recently the person in charge of BPJS announced that by 2026, they are not even sure it's going to be sustainable.*

The reason why is because like Indonesia, Malaysia has a high proportion of informal labor force. The typical countries which are associated with NHI and SHI would be— for example is Germany, a very advance country which has a very solid formal labor force, able to contribute to assist NHI, SHI.

But even globally speaking, when you look at NHI and SHI countries, the question of how do you cover it in a context where people is increasingly aging— just like us where they are poor people, who is going to cover them? And so even for those countries, they are going towards a more of a planned system.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]*: The poor people will cover by the government.*

Dr. Yap Wei Aun [KKM]*: Exactly, exactly. So, if we are thinking of a system where NHI, SHI is going to absolve the government of the need to pay for healthcare for the people, that's a wrong approach. So, what we are trying to propose actually which is mentioned in my SPC, as well also mentioned in RMK13 is a middle of the ground approach rather than just going to extremely saying "Okay, we are suddenly going to push the burden completely on the formal labor to fund it".*

Can we actually form a national health fund which collects together various public sources of funding from the government, perhaps from state, perhaps from zakat, perhaps from Baitulmal, perhaps from various different sources, put it together in national health fund? If there is political will, even to mandate an additional contribution from the formal labor force, let's put it in as well and more importantly, shift away from a form of payment which is not going to incentivize efficiency but to actually go towards a means of payment which emphasize accountability for health coverage and health outcomes delivered.

So, that's basically what we're hoping to deliver through the Dana Kesihatan Nasional. I think as Members of Parliaments, probably in the coming years, God willing, these will be things you have to debate and raise a wave. But we wanted two sidestep the need to have this first step of saying—

First thing is we just ask for money and mandate it. We need to fix a lot of things. And then, you also ask about the status pelaksanaan because you know things take a while for institution and capacity to be build.

So, in the first phase of our national health financing transformation, we want to create ways small stepping stones where we can create the push and the importance for creating different institution and capacity need to support a modernize health financing system regardless of whether we are going to continue to depend wholly on general taxation or whether we are going to bring in some this mandatory contributions.

So, that's in a nutshell, where we are trying to had in terms of the health financing system.

***Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]**: Thank you Dr. It's a matter of determining what is the right modal-lah. Thank you.*

***Dr. Yap Wei Aun [KKM]**: It is quite critical in — I think this agenda will raise up the political agenda as countries naturally become more advance and more edge. And we are seeing that here. So, I think that's just to highlight to you all. All the healthcare issue is going to come more and more. So, just so you all know. It's also to say, I can't think of any country which is not struggling with thinking how their fund their age care and their healthcare.*

So, let's not also have unreasonable expectation that with just one paper suddenly we jump to have five percent of GDP allocated health just because we passed one paper. It's really not as simple as that ya."

(Muka surat 24-30, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)

7.14.1 Medical Health Insurance and Takaful (MHIT)

i. <u>Penjelasan Gabenor BNM</u>

Dato' Seri Abdul Rasheed Ghaffour [Gabenor Bank Negara Malaysia] dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025 memaklumkan mengenai produk MHIT seperti berikut:



Sumber : Slide pembentangan BNM dalam prosiding Bil 5(q)/2025 bertarikh 19 Jun 2025

ii. Penjelasan Setiausaha APHM

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(I)/2025 bertarikh 17 Jun 2025 menjelaskan bahawa pembangunan produk insurans Medical Health Insurance and Takaful (MHIT) asas bertujuan untuk menampung kumpulan pesakit yang lebih luas melalui kerjasama dengan Pejabat Transformasi Kesihatan (HTO). Faktor utama bagi menarik pelabur dalam sektor kesihatan, terutamanya bagi pelaksanaan sistem DRG, adalah kepastian jangka panjang (*certainty*) terhadap reka bentuk produk dan skop perlindungannya.

Mengambil contoh model di Thailand, di mana hampir separuh daripada hospital swasta menyertai skim perlindungan kesihatan nasional, beliau menjangkakan trend yang sama boleh berlaku di Malaysia. Model ini akan didorong oleh kuasa pasaran di mana hospital boleh memilih untuk terlibat bagi mendapatkan skala volum rawatan yang lebih besar, manakala doktor, terutamanya mereka yang baru memulakan amalan swasta, boleh memanfaatkan peningkatan volum tersebut untuk menimba pengalaman sebelum beralih sepenuhnya kepada amalan swasta penuh di kemudian hari.

> ***"Encik Anwar Anis bin Anis Ahmad [APHM]:*** *Yes. Maybe just to very quickly add. I think YB Sim what you mentioned is in fact some of the early conversation that we had with the Health Transformation Office (HTO) under KKM is really for base MHIT to function in that way to cater to an expanded pool of patients. Maybe coming back to YB Teresa and YB Tuan Zahir questions, right? For investors like Stanley mentioned, as an investor what you want is certainty because when you put your money it's not for one year. It's for five, 10, 15 years.*
>
> *So that certainty I think as we develop DRG, who does it cover, how does it cover, if the investors can see that there is certainty in the product, they will be willing to come in, right? Even if it is a lower margin. Because YB Teresa you mentioned correctly, right? So, the certainty, the design of the product and who it covers will then encourage people to look at that opportunity.*
>
> *If I just go back to the Thai example again, so in Thailand I think the statistic that we heard was 40 to 50 percent of the private hospitals do accommodate their national healthcare or the universal healthcare cover. So, you can already see that maybe 40, 50 percent of hospitals in Malaysia will decide, "Okay, I will participate in providing service to the MHIT product." Within the group they can also decide to do that because it gives you scale or volume and there will always*

be doctors who want to do more volume or doctors who are just come in to the private practice will decide I need more volume. I will participate in a hospital that does MHIT because I want to gain experience and do volume.

But then maybe when they reach 65, "Okay, it's time for me to slow down a bit and go to full private practice." So, all these market forces will dictate to a certain extent. So, you were right. I think if we are moving in that direction, there is an opportunity for all of us to contribute."

[Muka surat 50 - 51, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

7.15 Rakan KKM

Dato' Sri Zahrul Hakim bin Abdullah [TKSU KKM] dan **Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)** menjelaskan Rakan KKM adalah penambahbaikan kepada inisiatif lama (FPP) kerana keuntungannya digunakan untuk manfaat semua pesakit awam, bukannya semata-mata untuk keuntungan pihak tertentu. Rakan KKM adalah pilihan perkhidmatan tambahan yang dijalankan di premis hospital kerajaan untuk golongan M40 bagi kes-kes rawatan elektif yang tidak mendesak. Ia bertujuan utama untuk mengekalkan doktor pakar daripada berpindah ke sektor swasta dan menjana dana tambahan melalui subsidi silang untuk meningkatkan mutu rawatan pesakit B40 dan membeli peralatan baharu. Walau bagaimanapun, kes kecemasan dan kritikal akan tetap diutamakan mengikut keperluan klinikal.

*"**Dr. Hajah Halimah Ali [Ahli PAC]:** Pengerusi, last kut ya. Nak tanya about your Rakan KKM itulah kut. I just want to have a clearer picture of what it is and what does it means. What's the implication and implication to the orang biasalah kan. Ini for the able to pay, kan yang Rakan KKM is yang buat apa? Boleh bayar.*

Kalau saya nak share sikitlah, to give you some context ya, what I'm concern. Saya ada seorang — ada abang angkat. Umur dia sekarang umur 75 tahun. Dia ada heart attack and dia ada buat apalah angioplasti and all that because dia ada insurans, so dia pergi private lah. It's done and he's quite okay.

Last year, menantu dia, penjawat awam, 48 tahun nak buat angiogram, belum apa-apa lagi. Dia penjawat awam, dia kena toe the line. The day that dia nak buat investigation itu, dia meninggal sebab dia tak sempat. So, orang lain kena lebih — lebih awal. What I'm worried about is saya difahamkan — that's why I need clarification from you. Kita ini — why you were suggesting this, I think if I'm — inilah kalau betul dia punya apalah ya, maknanya kita tak cukup doktor pakar,

kan? So, ramai yang queue daripada merata-rata tempatlah kan. So, dia ikut dia punya inilah a turn.

Tetapi, yang difahamkan — this is what the people are telling me. Orang yang boleh bayar, you can go faster. You can potong line. [Dicelah] Potong queue ya. Potong queue itu kan. So, he gets first. Walaupun you punya tahap itu tadi, your seriousness not as bad. So, the worry is kalau tadi penjawat awam ini, 48 tahun dia boleh meninggal due — because sekarang ini 30 tahun mana ada sakit jantung kan. So, dia boleh apa and abang dia — eh bukan, bapa mertua dia 75 tahun because dia pergi swasta and dia cepat kan, diagnose cepat, treat cepat, dia boleh survive. So, macam mana you apa ini? What's the story actually?

Dr. Yap Wei Aun [KKM]: *Terima kasih Yang Berhormat and very to hear about that story. Kami memang ada prepare beberapa slaid pembentangan tentang Rakan KKM kerana ini adalah soalan ramalan yang dijangkakanlah. I think the first thing is a… [Dicelah] I think the first thing untuk memaklumkan adalah bahawa terdapat banyak misinformation di kalangan social media dan sebagainya. Sumber maklumat yang paling benar saya rasa adalah daripada microsite daripada KKM, rakankkm.moh.gov.my. Jadi, I think it's best to refer to the reliable resources. You just imagine after pandemic, all the information about healthcare is totally — when you just rely on social media where there is our vaccine, Rakan KKM, all so much misinformation lah.*

Jadi, I think the importance in this DNH, especially in the health sector to be very careful in weighing the sources of information. It's really, really critical. So, anyway, let me share some slides from Rakan KKM and I see some people sudah mula makan. Silakan because that's a few slides on this. So, antara — ya, I'll be as brief as possible.

So, I think you already highlight antara cabaran yang utama yang semasa di ke arah retensi tenaga kerja kesihatan bukan sahaja pakar tetapi juga jururawat. And then the number is roughly 400 specialists resigned from KKM last year in 2024. It's very serious, is more than one day. Jika kita tidak mengatasi masalah ini, how do we cover all these people who are coming in as your 'menantu', for example, and many other people? What's the point of saying that we have just one system and we — a lot of people, are even able to see a doctor because they have left to go to the private sector. So, retention of tenaga kerja kesihatan is a very, very, very critical issue. It's really quite bad right now.

Inflasi perubatan sektor swasta, I think just your — I don't have to convince you all this is the key issue why you all even convening that I think it's also obvious that there's kurang dana kesihatan. So, keep on is that Rakan KKM is actually a solution. It's in response to one of these many challenges that we have. So, I think — when you think of Rakan KKM, just think of the headlines. It is actually created for the public benefit. Unlike what you are hearing in social media and everything.

So, it's a partnership and that is what is called Rakan and it's a whole-of-government partnership which is designed to actually to preserve and to advance the public interest (kepentingan awam). How so? With five things. One is untuk

meningkatkan siling terutamanya bagi golongan M40 dengan perkhidmatan pilihan ekonomi premium yang mampu milik especially important dalam konteks inflasi perubatan yang tinggi, yang ini. Especially important when you are ageing and you all may also have parents who you may have to cover their healthcare costs and you may feel a little bit sad if you have to send them to a public hospital only. You may feel an obligation to send them to a private facility but it could be unaffordable but here, this is an intermediate option for you.

Number two is to menambahkan pendapatan petugas penjagaan kesihatan bagi mengekalkan mereka dalam sistem penjagaan kesihatan awam untuk memberi manfaat kepada semua pesakit. So, if we lose our doctors and nurses, who's going to benefit it?

Number three, untuk meningkatkan lantai terutamanya bagi B40 melalui subsidi silang dan peningkatan pelaburan dalam sistem penjagaan kesihatan awam. This is where Rakan KKM is different from the preexisting initiatives such as full-paying patients. That actually, we are going to collect more than just the cost, so we generate some additional revenue which can then be used to improve things for the public patient, including optimising capacity.

Number four is basically in conflict of inflation to have a benchmark competitor.

Number five is really to say that because this is a sustainable initiative, a financially sustainable initiative. We do not need to pump, pump money from the government budgets to expand it. We can just go to a GLIC who and just so they can fund the expenditure of it. And that means our government budget can be focused on things for the existing B40, for example. But, of course, the GLIC will just aspect a profit return. I mean, this is for example, if you have members. Of course, you'll expect them to have appropriate returns.

It's also structured for the public benefit. Rakan KKM distrukturkan untuk manfaat awam. On the left, you see that we want to preserve the existing system dengan kadar fi yang rendah, yang dapat dikekalkan. So, the existing public coverage that people get is going to be there. You are also very concerned about people who may have a more severe condition and need to be seen more urgently. Bagi kes kecemasan, dia akan diutamakan mengikut keperluan klinikal, bukan kebolehan untuk berbayar.

On the right-hand side, Rakan KKM is a pilihan tambahan. I think that's important to say again and again. We are not forcing everyone to suddenly become fee-paying. We are telling people if you want this added option, not as a replacement of the existing public system but as an added option. You can get this perkhidmatan ekonomi premium dengan pilihan doktor, keselesaan tambahan, privasi yang lebih, and this applies only to elective cases and we plan to just charge more affordable payment for this.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry Dr. Tan, to interrupt you. But, where is it done? The ward, the clinic, is it the public hospital or is it a totally hospital swasta?*

Dr. Yap Wei Aun [KKM]: *No, it is as you see that diagram, it is basically side by side with the government facility. So, for example, we are making use of wards and other facilities where there's not enough staff. I mentioned beforehand, we have a huge problem with retensi tenaga kerja kesihatan. If you read the news when we open the new Hospital Pasir Gudang, what's a limiting factor? Is it infrastructure? The limiting factor right now in the kementerian is actually staff, all right. So, we want to make use of untapped capacity in the public sector. So, that means…*

Dr. Hajah Halimah Ali [Ahli PAC]: *It is a public — the answer is a public hospital, premise? Right?*

Dr. Yap Wei Aun [KKM]: *Betul.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Ya, okay.*

Dr. Yap Wei Aun [KKM]: *Yes, yes.*

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: *Ya, private hospital.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Okey.*

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: *Betul, Yang Berhormat. Berfasa. So, kita mula dengan empat hospital dahulu untuk tahun ini. Kita jangka fourth quarter, melibatkan Cyberjaya Hospital, Putrajaya Hospital, Serdang Hospital dan juga Institut Kanser Negara (IKN) dan akan diperluaskan untuk hospital-hospital utama yang lain pada tahun 2026.*

Dr. Yap Wei Aun [KKM]: *Yeah, I think it is important to know it's a public initiative because the hasil pendapatan, besides going towards the cost of operations, will be used for the public benefit dari segi subsidi silang kepada the B40 and also to pay back the GLIC. So that, basically the peluasan Rakan KKM tidak memerlukan bajet kerajaan which can again be used for other things.*

I think it is also very, very critical to know that this is an improvement of pre-existing initiatives such as full-paying patient which was started in 2007. So, full-paying patients which has been going from 2007 is probably the one which you most associate with queue jump paying. The purpose of it is untuk mengekalkan pakar, hanya. Okey.

But for Rakan KKM, besides mengekalkan pakar, we want it also to menambahkan dana untuk semua pesakit melalui subsidi silang. The critical point of change is to think that full-paying patient is a zero-sum game because you are running this service with the existing budget. Rakan KKM is not a zero-sum game because you can charge the cost plus and retain it to improve things for all patients. So, therefore you can see why it's an improvement of the existing unequal initiatives.

So, we can menawarkan pilihan perkhidmatan penjagaan kesihatan tambahan mampu milik as a benchmark competitor. I think that benchmark competition, I

think that's something which is quite clear for this— in this inflation context. You also may not be aware that under full-paying patient, hanya pakar yang akan dibayar. But under Rakan KKM, when a patient is seen and needs to go for operation, the scrub nurses are also paid. All the other relevant people who are providing the care are also paid. Isn't that a fairer improvement of the existing status quo?

And then, from the rakyat's perspectives, it's quite important to know that FPP is a zero-sum game. When it's run, when the foreigners use it, people who can pay use it, it is at the expense of the same resources use to serve them. Whereas Rakan KKM, they are paying fully for that and more, and that more is used to improve things for other people.

There's also another initiative called flexi hours which allows our doctors, our specialists to work in a private hospital during office hours, one day a week. You may not see this happening because it's not so visible. But doesn't that— YB Kapar, doesn't that worry you about your 48, your own menantu? When— now the existing initiatives allow a hospital— pakar to be going to private sector one day a week. That's the existing initiatives.

Whereas with this one, the profit doesn't just go to the pemegang saham. YB Bayan Baru, you are very concerned about why is it only the shareholders which are benefitting. But with Rakan KKM, the benefit is that the specialist who want to serve in this don't have to commute across to another part of town. They can serve right there in the same public hospital, providing continuous clinical leadership to the team. If there's a problem in the ward, they can find their pakar. And the profit from this go to the public purpose. So, I think that's a very critical difference. That's why it's very important to discern what actually is correct or not correct from social media.

Also, we find that many, many countries do something which is similar to Rakan KKM. This includes fairly advanced, fairly rich countries such as France. You may know France has its logo about being very egalitarian. Many egalitarian countries, you see that UK there which with NHS, have a system which is similar to this.

The equity issue is not seen as a problem in many of this because of the mitigation and because of its ultimate benefit to the public purpose. Even our neighbors, both down South, both North, do something similar. Even within Malaysia is also unique that there's something along this line to retain people.

So, finally I think it's also important to know that this is a quite a popular initiative among our doctors. But we have to also realise that our doctors don't like to self-promoted. They don't want to just say, "We want this because it makes us richer". But the silent majority want them. Three-quarters; amat sangat berminat, sangat berminat, or berminat to serve in this because they know it's not just to benefit them. Even the nurses and the whole team get the benefit. The profit maybe can be used to upgrade things like getting more equipment for the department. So, they can practice their craft for the public benefit in the best

possible way with the most interesting cases which you only find in the public sector.

So, it's quite a— I think the people who actually understands this initiative are quite keen on this. So, I think from the political perspectives, we just want to emphasise a few key messages. The first one is the reassurance that akses kepada perkhidmatan kesihatan awam yang sedia ada dilindungi dengan kadar fi rendah untuk semua akan dikekalkan. Iltizam Rakan KKM hanya memberi pilihan tambahan. It's an added option, bukan pengganti. For those who want it and for elective cases only to address the inflation issue so that you have the alternative.

Kes kecemasan diutamakan mengikut kepentingan klinikal. Rakan KKM memberi peluang sukarela. So, they will say, "Oh, doctors are already too busy. Why do we force them to work Rakan KKM?" Nobody said we are forcing any of our doctors or nurses to do so. It is an option for them. Many of them serve doing locums outside and the benefits accrued to private hospital.

But now there's a chance for them to do so within our facilities, to retain them and to also retain the revenues for our purposes. But you may say to me the nurses are very busy. Even private hospitals don't have enough nurses. Where will we get them? It's very simple. Some of the JPA rules make our nurses and doctors retired at the stage when they actually at their peak, when they have been trained and very skilled for 20, 30 years working operating theater.

And then, just because of a rule, they have to force and be retired. Many of them want to continue to work in the public sector if they had the opportunity. This gives them the chance to do so, to make use of their skills, the amount of hour that they wish to serve.

And I think another third important point on the equity issue is that this is an improvement on those existing initiative like full-paying patient and flexi hours. Because those initiatives are zero-sum games where's this one uses the added revenue for the benefit of non Rakan KKM patients as well. This initiative is not so unique that it is least conceived of and we are the only country in the whole wide world which would think of something as unusual as this. It is very, very common.

So, key message, it is diwujudkan demi kepentingan awam and bukannya satu inisiatif penswastaan atau mengarah ke penswastaan. I hope that's clear here. So that you all are also able to explain to your constituencies that, "Yes, this is a bit like the pandemic", you know. People are saying like, "Oh, we don't want COVID-19 vaccine. It going to cost all this problems, et cetera" and all the crazy misinformation. So, I think— I hope this gives you all the tools to explain to them what the facts are. Thank you."

(Muka surat 36-42, Laporan Prosiding Bil. 5(o)/ 2025 bertarikh 14 Ogos 2025)

7.16 Cadangan dan Halatuju Sistem Insurans Kesihatan di Malaysia

Strategi dan halatuju sistem kesihatan di Malaysia kini beralih ke arah model yang lebih bersepadu, telus, dan berasaskan nilai. Analisis ini menunjukkan bahawa usaha menangani tekanan inflasi perubatan memerlukan pendekatan komprehensif yang merangkumi aspek pembiayaan, kawal selia, dan perubahan tingkah laku pengguna. Keberhasilan transformasi ini bergantung kepada tiga (3) faktor utama:

1. **Pemantapan Kerangka Kawal Selia dan Institusi:** Keperluan terhadap pewujudan badan penyelaras atau suruhanjaya bebas dengan mandat khusus untuk memantau rantaian kos secara menyeluruh, bermula daripada harga perolehan farmaseutikal dan peralatan perubatan sehingga kepada penetapan premium insurans yang saksama.
2. **Pemanfaatan Teknologi Digital dan Integrasi Data:** Pembangunan pangkalan data tuntutan nasional serta Rekod Perubatan Elektronik (EMR) sebagai prasyarat utama bagi mengoptimumkan pengoperasian sistem DRG dan memperkukuh mekanisme pengesanan ketidakpatuhan atau pembaziran (*fraud and abuse detection*).
3. **Kelestarian Model Pembiayaan:** Peralihan ke arah produk insurans asas yang mampan serta penerokaan sumber dana alternatif, seperti Dana Kesihatan Nasional atau instrumen percukaian khusus, bagi mengurangkan kebergantungan fiskal terhadap peruntukan hasil cukai am sedia ada.

Tanpa keselarasan strategik yang mengintegrasikan kepentingan pihak pembayar, penyedia perkhidmatan, dan pengguna, ekosistem kesihatan negara berkemungkinan berdepan dengan risiko ketidakstabilan jangka panjang yang boleh mengehadkan akses rakyat kepada kualiti rawatan yang mampan dan mampu milik.

7.16.1 KKM

Dr. Yap Wei Aun [KPE, HTO KKM] dalam Prosiding Bil. 5(b)/2025 bertarikh 24 Februari 2025 menjelaskan bahawa KKM sedang bekerjasama dengan BNM dan agensi berkaitan untuk merangka satu produk insurans kesihatan atau takaful swasta asas yang mampu milik dan mampan. Produk ini disasarkan kepada golongan yang bekerja di sektor swasta, PKS, GLC serta individu berpendapatan tinggi dan keluarga mereka. Perlindungan ini

akan meliputi sepanjang hayat dan boleh dibawa merentas majikan serta selepas persaraan. KKM juga merancang menggunakan insentif sedia ada seperti potongan cukai dan Akaun Sejahtera KWSP bagi membolehkan rakyat membiayai produk ini tanpa memerlukan dana tambahan daripada kerajaan. Selain hospital swasta mewah, produk ini juga akan melibatkan hospital yang bukan berasaskan keuntungan, klinik serta Rakan KKM.

Perbezaan antara cadangan tersebut dengan sistem insurans kesihatan negara adalah di mana insurans Kesihatan negara bersifat wajib (*mandatory*), yang mungkin memerlukan pemotongan pendapatan rakyat. Pendekatan wajib sukar dilaksanakan kerana KKM memilih untuk mengemukakan pilihan sukarela dan tidak membebankan rakyat atau kewangan negara, selaras dengan prinsip Malaysia Madani. Inisiatif ini bergantung kepada insentif cukai sedia ada, potensi penggunaan Akaun Sejahtera KWSP, dan kerjasama sektor insurans swasta.

"Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Any response on national health insurance system? Kubang Pasu tanya.*

Dr. Yap Wei Aun [KKM]: *Thank you. As you can see, actually, we sudah ramalkan three. There's only one question yang kita ramalkan yang belum dijawab, ditanya... [Ketawa] Okay, so anyway, jokes aside.*

Basically, we have been working very hard with Bank Negara and relevant agencies on thinking on how we can transform the whole insurance sector, private health insurance sector in Malaysia. So, one of the proposals that we have been working on together is really to come out with a based private health/takaful insurance option.

When we said based, this one will be proposed by— it will be the one which we will encourage Malaysian who really want private healthcare to select as their default option moving forward. So, if you are somebody who thinks I kind of one private healthcare, let me at least take tick box for getting this base product.

We want this product to be mampu milik and sustainable. So, we want to add up all the best practices for health insurance products to be developed. We want it to be also, therefore to contribute to reducing the inflation rates. Just be aware, the price level is different from the insurance rate ya. Insurance rates just put things how its changes year by year. We want to do this by introducing value-based healthcare. We want to make sure that this product is also something which is very useful for people. So, it has life course coverage.

We encourage people when they are young working people in their 30s and 40s before they develop, all the co-existing illnesses, to start signing up for this product. Then, to have a very fair rule so that as the progress in their career despite even breaks in their career and the progress even before— after retirement, that this coverage can stay with them across employers and across different life seasons.

Hong Kong for example, has a system VHIS where they don't allow insurance to deny renewals for the insurance up to the age of 100. So, that is quite good. If you start young. And also, we want— from the KKM perspective, we want it also to slightly shift the usage away from public hospitals to allow people the option of just choosing to shift toward private hospitals.

So, when you see the diagram here, the populations coverage that we are thinking of is really people who are working in private companies, in a SMEs and also in GLCs and perhaps even an option for their families as well as people who have high net disposable income or very high net worth, et cetera or fairly very high net worth.

And we want to use existing, we want to fine-tune existing incentives such as tax incentives for personal and corporate income tax as well as the potential to use Akaun Sejahtera from EPF which is already at discussion with them to unlock that amount of money to be used for these base products. Then, to allow the existing private takaful and insurance in the country who which already have got a capacity to do so to offer this as a very standard structure product.

So, it's highly regulated. You tell them what the rules are in terms of the benefit package, in terms of the providers, the network and how you going to pay for it, et cetera. We make use of a shared strategic purchaser in the form of PH Corp. Through contracting mechanisms, we can use DRG, et cetera to introduce into this market and make use not only of the six-star hospital/ hotel. I intentionally said hotel when you described the three stories of aquarium and also the grand piano which place itself in the lobby.

We also want to make use of non-profit hospitals as well as Rakan KKM as well as shift care away from hospitals even potentially to clinics. So, this is an ongoing process that we are working on together as a whole of government initiatives. Just to let you all know, some of the details, many of the deals have not been finalised. So, some of these can change. But just to give— so, don't just look at this slide and think this is going to be it. It's not fixed in note. It's not a finalised policy but it's an aspiration which is being discussed with at working level.

What about— how is this different from national health insurance? National health insurance, just let's be very clear. It is going to be mandatory insurance. That means we are going to the rakyat and say, "Everybody who's in a formal work force, you've got your EPF, your LHDN, your SOCSO. Now you are going to have pay an additional amount, mandatory for healthcare coverage".

People in the informal sector which is very substantial in Malaysia, will need substantial government incentives to do so. As you all are politicians, you will just

tell me whether you feel that you can go to your constituents and tell them that tomorrow we are going to make you pay, paksa. It's compulsory. A certain proportion of your pendapatan is going to go to a required national health insurance.

The next question they will ask you is, "What will I get?". In Malaysia, I know that there's a perception that government services are under attack and not sustainable, et cetera. But the reality and we can show you data is we are continuing to increase our service probation despite being underfunded. So, I think your constituents will ask, "If you are going to force us to get this coverage, what will we get in return?".

The only thing better than Ministry of Health hospitals is private hospitals. The question is whether it's going to be very sustainable for most of our former labour force and most of our country to be able to move it into that coverage. That's a political decision. But what we want to do is at least in the short term, make sure that they are Madani-like options where we are not going to Ministry of Finance and ask them for yet more money and we are not going to go to politicians and say, "We want you to ask your constituents. We want you to go to Parliament and put some akta saying their take home pay is going to be reduced because they must get national compulsory health insurance".

Isn't it better to think of a more Madani way to encourage people voluntarily to take up a product which is a life cost coverage is linked to DRGs and cost continuing measures, allows life called coverage, a mechanism to bring in preexisting conditions in an actually sound manner?

I know we want to adhere to its committee rating at some point but this is not her. This is a— we are talking about a lifetime. I mean— it's a multiyear initiative right to get this really done. So, this is one of the options that we want to allow the government to be able to offer which does not affect the take home pay of our rakyat, it does not shake down our measures of finance for additional budget but actually unlocks let's see existing tax incentives and account Sejahtera 2 and gives them an option which many would choose to have if they know what is going to be."

[Muka surat 29 - 31, Laporan Prosiding Bil 5(b)/2025 bertarikh 24 Februari 2025]

7.16.2 Third World Network

Encik Lim Chee Han [*Senior Researcher* (Penyelidik Kanan) Third World Network] dalam Prosiding Bil. 5(c) bertarikh 25 Februari 2025 menjelaskan bahawa untuk memperbaiki peraturan harga ubat dan ketelusan dalam sektor kesihatan di Malaysia, Third World Network telah mencadangkan perkara-perkara berikut:

a. Polisi Paparan Harga Ubat / *Medicine Price Display policy* perlu dilaksanakan bagi tujuan pengawalan harga. Mempertimbangkan pelaksanaan Mekanisme Harga Ubat / *Medicines Price Mechanism* (MPM) dalam masa terdekat untuk mengawal tokokan harga (*mark-up*) yang tidak munasabah.

b. Tingkatkan ketegasan Kebolehpaten dan hentikan *Patent Evergreening* iaitu amalan mengeluarkan patent sekunder untuk ubahsuai kecil terhadap ubat asal bagi memanjangkan monopoli pasaran mereka selama 20 tahun lagi.

c. Sektor swasta iaitu syarikat farmaseutikal dan hospital swasta perlu bekerjasama dalam menyediakan maklumat penting berkaitan harga dan keadaan pasaran. Ini untuk memastikan ketelusan dan pengawalan harga yang lebih baik.

d. Syarikat insurans perlu memberikan penjelasan mengenai penetapan harga semula (*repricing*) kepada pemegang polisi mereka dengan menyediakan maklumat lengkap dan tepat mengenai risiko polisi dan dana mereka.

e. Insurans kesihatan perlu bergerak ke arah penilaian berdasarkan komuniti (*community rating*) berbanding penilaian berdasarkan risiko peribadi. Ini bertujuan untuk mengumpulkan lebih banyak risiko dalam satu kumpulan yang besar, supaya individu yang lebih tua atau yang berisiko tinggi tidak perlu membayar lebih banyak daripada yang lain.

f. Membangunkan *Diagnosis-Related Group* (DRG) untuk caj bil hospital dan memperkenalkan langkah pengekalan kos dalam insurans Kesihatan.

g. Melaksanakan kajian pasaran bagi penyedia penjagaan kesihatan swasta, seperti yang disyorkan dalam MyCCMarket Review on

Pharmaceutical Sector (2017). MyCC perlu memastikan persaingan pasaran yang sihat dan saksama bagi sektor penjagaan kesihatan.

"Dr. Lim Chee Han [TWN]: *… So, now comes to our recommendation from Third World Network. We say we need to implement the medicine price display policy as soon as possible. There is no excuse. It's very lame for them for not able to do that and for the government to consider implement the full medicine price mechanism in the near future to control the unreasonable markup.*

I showed you the markup can be two times, up to six times more and for the extreme cases, they will nine times also. Extreme cases. So, we need to get everything in the most transparent manner to see the price get controlled and have to increase the stringency of patentability to stop patent evergreening, to stop granting undeserving secondary patents for those trivial changes to a drug. Because once they got the patent, they can get a monopoly for 20 years, okay.

Private sectors must be mandated to cooperate in providing key information for the purpose of market transparency and regulation in particular pricing information. It's very important. This is the area that we need to go at.

Insurance companies must justify their repricing to their policyholders by providing more information on the risk of their policies and their fund pool. So, that they are well informed— so, you can justify, yes because of our funding shrinking, we cannot have capital. So, they are on the risks of liquid. So, the risks of the policy cannot carry forward. Okay.

Health insurance should also move towards community rating rather than personal risk rating. We need more risk pooling needed because we heard from so many people saying that when they get ageing, they must pay even more because they have higher risks. So, this very unfair to those people. I think we need to have more risks pooling, so that it will be fair for those who needed the most at the time they need to have the coverage get the insurance.

To develop the DRG for the hospitals billing so everyone knows what will be the charges like. There's no surprises okay. If there is anything hospitals have to do more, they have to find their ways to help it to make sure the patient gets treated until recovered okay. To introduce the cost containment measure also in the health insurance.

Lastly, importantly I think its time for us to do a market review on the private healthcare providers, what do you think. I think we have done on the pharmaceutical sector just at the last level of retail pricing and all these we actually don't know how they do the markups, why they do it this way and that way. So, MyCC— the Malaysian Competition Commission have to ensure that the healthy and fair market competition for the healthcare sector. With that I thank you for your attention.

[Muka surat 19 - 20, Laporan Prosiding Bil 5(c)/2025 bertarikh 25 Februari 2025]

7.16.3 Persatuan Penasihat Kewangan Malaysia

Prof. John Chan Ninyii (Persatuan Penasihat Kewangan Malaysia) dalam Prosiding Bil. 5(c) bertarikh 25 Februari 2025 menjelaskan bahawa bagi menangani isu kenaikan harga insurans perubatan yang drastik, terutamanya bagi pemegang polisi lama yang berisiko tinggi, empat cadangan penambahbaikan utama telah dikemukakan seperti berikut:

Bil.	Tonggak Penambahbaikan	Cadangan Ringkas	Justifikasi/Kesan Utama
1.	Pengagregatan Risiko	Gabungkan semua risiko (polisi baharu, lama, sihat, sakit, dan produk *bundle* lain) ke dalam satu Kumpulan Aktuari Tunggal setiap syarikat.	Memastikan yang sihat melengkapi yang sakit (tujuan insurans) dan keuntungan dari produk lain menstabilkan premium perubatan.
2.	Deduktibel Menyeluruh	Wajibkan deduktibel minimum RM500 untuk semua polisi (lama & baharu) melalui pindaan Akta FSA 2013. Wajibkan pilihan deduktibel yang lebih tinggi (sehingga RM10,000).	Mengurangkan salah guna/penggunaan hospital yang berlebihan, memastikan konsistensi, dan menawarkan pilihan premium yang jauh lebih rendah kepada pemegang polisi.
3.	Kawal Selia Bil Berperincian	Tubuhkan badan kawal selia bersama yang melibatkan Kementerian Kesihatan (MOH) dan Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup (KPDN).	Mengawal harga caj hospital, terutamanya bagi caj perkhidmatan bukan perubatan/perkhidmatan.
4.	Pilihan Bayar dan Tuntut	Wajibkan syarikat insurans menawarkan pilihan Bayar dan Tuntut (selain Tanpa Tunai) untuk semua polisi.	Menawarkan premium yang lebih mampu milik, menggalakkan perbelanjaan perubatan yang bertanggungjawab, dan memberi pilihan kepada pemegang polisi yang mempunyai simpanan.

"Prof. John Chan Ninyii [Persatuan Penasihat Kewangan Malaysia]: ... *So, there are four things that we can do. First, four additional pillars of improvement other than what the doctor says and FOMCA says just now. Four additional things. First, segregating risk into are single risk pool. [Merujuk pada pembentangan slaid] So 1.1, aggregating all aggregating risk into a single risk pool. What I mean here,*

there are two ways of doing it. 1.1 aggregating all medical plans both new and old into a single actuarial pool. Which means the sick and old, the leftover and the new policies when you design new policies, new riders, those risks should be aggregated together with the entire insurance company's old pool. So, one insurance company, one risk pool. But now, one insurance company they segregate by product pool.

So that is actuarial problem, you could refer to Bank Negara on these things. So when the whole company, old and new segregate into a new single, one pool it means the healthy, the young, the new comer, the new policyholders, those healthy ones will complement the sick ones. That is the purpose of insurance, right?

Insurance is not about sick insuring the sick but the healthy complimentary the weak one, right. So, task aggregating both the new and 1.2, aggregating all medical risk together with other insurance benefit. Why we say like that? So, ladies and gentleman, when we buy one medical insurance, sometimes we buy it through a package bundle, right. You buy life insurance, critical illness, PA and also medical into one plan especially investment-linked plan. We have all riders into one policy.

So, when the actuaries design the product or looking at the profitability of the insurance, it could be looking at those benefit complementing each other. Now, the life insurance company earn huge money on life and critical illness by the way, right. But they lose money or breakeven at the medical plan. So, but when they sell it in the bundle, it maybe coming from the perspective that we regulate it using a complimentary total risk pool. I don't know whether you understand what I mean you know. [Ketawa]

With all the life CI medical under the risk calculation on actuarial point on aggregating all the insurance benefit including medical insurance, life and critical illness into a same risk pool. So, that insurance company will not say, "Oh, I breakeven on my medical but I earn a lot of money on my critical illness or my life, or my saving plan or whatsoever…". But when you aggregate what everything together it complements each other. That could control the price down from actuarial point of view.

Right, so this 1.2. 1.1 is about aggregating all the new and all medical insurance risk together. 1.2, is bundle, also according to bundle. I hope you understand lah ya, right. 2.0, implementing blanket. Just now talking about aggregating risk pool from actuarial perspective. 2.0 we talking about blanketing deductible for old and new medical plans.

Ladies and gentleman, we know that now Bank Negara come out with the policy that all new policies must have deductible RM500. But that is to new policies but what about the old policies? Ladies and gentleman, the problem here that can threaten our public healthcare is the old policy not the new policies. Again, I say, the leftover the sick, the poor, the sick not insurable cannot upgrade. The old customers are the problem to our public healthcare not to that healthy one, right.

So, if you are implementing a deductible on the new plan what about the old plan? We should blanket it. When we blanket it, the old policy, the new policy the all the

existing policy when they go to the hospital, they have to come out with minimum RM500 for example, let say a deductible. Then the hospital will understood, "Oh from now onwards all the plan whether is old one, new one all they have to pay RM500 yourself…". So, the doctor will not be misused the— because it will not confuse already. Everyone needs to do that RM500 minimum right. So, the doctor will not say, "Eh, you tak apalah pergi masuk hospital, full claim punya, full claim punya…". So, especially the children. Children's policy ya, is one of the highest claims, short, short go hospital one. Sedikit, sedikit go hospital one so because full claim ya.

So, if they have a mandatory RM500 I think the misused or over used of hospitalisation will drop tremendously, you know. So, by blanketing deductible insurance, deductible RM500 you need to amend the act. It is not about Bank Negara guideline. Why, because insurance companies are bound by their insurance contract. All policy document are contract, insurance contract. You cannot say, "Oh, today you get full claims, or your medical card is full claim one you can do full claim…". Suddenly ya. "Oh, no, no, no you have to pay RM500…". They will complaint to FOMCA lah you know.

"I got human right one, you breach the insurance contract you should pay in full, right…". But by amending FSA, for example. FSA insurance Financial Services Act 2013 we add another clause all medical insurance needs to have deductible of RM500. So, when it falls under the act all the old insurance policy, they had to follow it is a regulatory requirement to follow the act. So, everyone has to follow RM500 minimum than this problem will solve. You know so that is one thing that our proposal is to blanket the deductible for old and new policy.

So, 2.1 ensuring consistent. For by blanketing the old and new one it will ensure consistent and reducing confusion among the stakeholders. Because a standardised blanketing deductible structure across all medical plan old and new would create a uniform understanding among stakeholders including insurance policy holder and hospital. Because hospital may not know your plan got deductible or not. They thought that you are full claim then go warded lah. A lot of customers they do not know their policy got deductible or not, that is why they are confused. If we blanket it then everyone knows if I want to go to the hospital, I have to pay RM500 first then I need to think is it necessary I need to hospitalise or not because I have to pay RM500, right. So, hospital and policyholder may not aware whether the policy have.

So, 2.2 managing healthcare risk and ensuring sustainability. Policyholder who pose a higher risk to public healthcare system often belongs to leftover policyholder group therefore implementing a mandatory deductible for all block business is crucial to ensure sustainability.

A blanket deductible for old policy would improve claim ratio directly by discouraging unnecessary medical utilisation and mitigating potential misuse of medical insurance and deductible mandatory deductible. By the way to clarify right, there might be people do not know what is call deductible. [Ketawa] Define deductible first. Deductible means when you go hospital, let say deductible RM500 means you

have to pay yourself RM500 others only can claim by insurance company. So that call deductible by the way ladies and gentleman.

So, we hope that we amend the act to make a RM500 deductible across all old and new right. So, that is a suggestion. The deductible RM500 will help stabilise or even reduce assisting premium and benefit policyholder and insurer alike. So, ladies and gentleman, RM500 deductible at this current inflation inflated medical pricing it could actually drop the insurance premium by 10 to 15 percent already if RM500 deductible.

With deductible of RM2,500 ya deductible ya. If let say RM2,500 the insurance premium will drop 50 percent, discount 50 percent you know by deductible RM2,500 only by our current medical pricing whatever you say just now lah. But if the customer willing to pay in front RM2,500, the insurance premium drop 50 percent. That is significant. That is really significant.

So, now maybe RM2,500 a lot of people didn't have lah right. By RM500 first lah but it is good if we can also amend the act to make every policy have a choice of deductible also. Mandatory RM500 but every policy old or new must come with the option RM1,000 deductible, RM2,000 deductible, RM5,000 deductible or RM10,000 deductible, let the old people choose, let the sick people choose instead of paying RM10,000 premium or RM7,000 for a medical insurance.

If let say deductible RM10,000, that premium only RM2,000 other than if no deductible is RM8,000 premium right. With deductible RM10,000 the premium could fall to RM2,000 he can afford it because he might have a saving RM10,000 inside the bank. He can afford RM2,000 premium but he cannot RM8,000 premium, that's the story. So, we can actually amend the act by make a RM500 deductible mandatory blanketing everything and by the act we need to have a choice. Every policy old or new have a choice of deductible.

You know let say, RM1,000, RM2,000, RM10,000 let the client choose you know. Amend the act FSA 2013. Why, implementing a mandatory deductible for all block need to amend the act because every policy are subjected to contract. So, 3.0 regulating the H&S itemised bill. Like what just now FOMCA said about itemise, I think Dr., also about itemised bill. So, this regulatory body to regulate the itemised billing should be from two parties from the government, MOH and also the Ministry of Domestic and Trade and Cost of Living, Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup that representing the rakyat interest. The MOH representing the hospital and professional interest. So, I think a regulatory body should be formed for this purpose.

For itemised billing right wait ah. For itemised billing for itemize billing lao hua already, cannot see. I have to see so far, right. Especially itemised billing this today the pricing of a medical claim right, the issue here is sometimes falls other than the medicine or whatsoever. It falls under the non-doctors you know and non-medical charges. Why? Like what you said you know, all those, all those, all those you know, like HDU you know, they blanket the nursing care you know, separately, separately like we buy a chicken last time during MCO. Chicken right, potong

chicken also they charged you RM3 because they control the chicken price ma. So, the service charge potong, potong, potong ayam pun RM3, kind of lah.

Maybe after my presentation maybe Mr. Ethan will add something. Let me finish my point number four. Okay, point number four, mandatory option for pay and claim medical plan. This one is okay, some of the general insurance companies, they offer pay and claim and cashless. Two options. Same medical plan, they have cashless, they have pay and claim premium table, different. With the current medical pricing, the premium is having a different— is really different, much cheaper, right. So, with that, I think that whether it's an old plan or a new plan, the insurance company should come out with the table, the pricing table, cashless option which is you go the hospital and you no need to take out your own— you pay the deductible and others are settled by the hospital with the insurance company using the panel hospital, you know. That is called cashless option or the pay and claim option. Meaning, you pay your whole bill and you file your claim to the insurance company. So, these are two options, the prices are much different although the same benefits.

For the reference of tuan-tuan dan puan-puan, from our client's experience told us, for cashless, usually insurance company will pay in full in the claim. But, when our client goes and do a pay and claim, let's say the claim is RM40,000. When come to pay and claim, certain insurance companies will reject. Oh, this one I pay only RM7,000. This one I pay only RM3,000. This one so you know, when you come to pay and claim, the RM40,000 bill becomes RM30,000 you know. But, if you go for cashless, right, the RM40,000, they full claim one. That is the you know, that's something that it makes a difference. So, if kalau boleh right, we make a mandatory to have these two options to our old and new policies.

Ladies and gentlemen, certain of the old people right, they got money in the bank, but they just don't want to pay the premium because they think the premium is too high. So, but they can still actually pay and claim, if the premium is affordable. But they have no choice now because insurance companies have only one option, cashless. No deductible some more. So, they have got to pay, whether you pay or you leave it. So, they are left with choice, now they are no choice. End up, if they leave it, then it's a public healthcare issue, right?

So, maybe Mr. so, the pay and claim option could lower the claim ratio; encourage responsible medical spending; reduce in overall claim amounts; prevent misuse; meditate the overprice of medical bill because the customer needs to pay; the client will oversight the doctors you know, because they have to come out with their own wallet right and it will make the premium more affordable..."

[Muka surat 33 - 38, Laporan Prosiding Bil 5(c)/2025 bertarikh 25 Februari 2025]

7.16.4 Citizens' Health Initiative

Dr. Chan Chee Khoon (Citizens' Health Initiative) dalam Prosiding Bil. 5(c) bertarikh 25 Februari 2025 telah mengemukakan cadangan bagi

penubuhan Tabung Kesihatan Negara (TKN) khusus sebagai penyelesaian yang lebih baik untuk isu pembiayaan dan kesesakan sistem kesihatan Malaysia. TKN dicadangkan untuk dibiayai oleh pelbagai sumber progresif, termasuk cukai kesihatan progresif tambahan (ditambah kepada cukai pendapatan sedia ada, dengan kemungkinan hanya dikenakan kepada T20), cukai korporat, cukai hartanah dan keuntungan modal, Cukai Tobin dan zakat. Pengendalian TKN ini perlu tertakluk kepada tadbir urus yang mantap, kebertanggungjawaban, dan ketelusan.

Dana TKN akan digunakan untuk menyegarkan semula peruntukan kesihatan awam, termasuk memperluaskan kapasiti penghantaran, merekrut lebih ramai kakitangan, dan mengukuhkan penjagaan primer komprehensif. Selain itu, sebahagian dana akan digunakan untuk menubuhkan suruhanjaya perkhidmatan kesihatan bagi menangani isu aliran keluar kakitangan senior. Untuk mengurangkan kesesakan, KKM boleh bertindak sebagai pembeli pukal perkhidmatan tambahan daripada hospital swasta panel bagi pesakit limpahan, menggunakan jadual bayaran berasaskan DRG.

Beliau memaklumkan mengenai potensi Cukai Tobin (cukai transaksi ke atas pasaran kewangan) sebagai sumber pendanaan yang sangat besar. Berdasarkan data separuh pertama 2024, Cukai Tobin 1.0% ke atas semua urus niaga saham di Bursa Malaysia dijangka dapat menjana sekitar RM4.26 bilion setahun, yang boleh meningkatkan peruntukan KKM sebanyak 20%. Lebih penting lagi, Cukai Tobin 0.05% ke atas urus niaga pertukaran asing (Forex) dianggarkan dapat menjana kira-kira RM20.73 bilion setahun, iaitu menyumbang sekitar 50% daripada peruntukan tahunan KKM 2025. Jumlah ini menunjukkan Cukai Tobin merupakan jalan yang realistik untuk menyelesaikan masalah pendanaan kronik KKM.

> ***"Dr. Chan Chee Khoon [Citizens' Health Initiative]: ...****Okay, so, basically we put the question what might be better solutions. We could consider to address those two problems raising more funds and how we going to use our funds through some provided payment system. So, what the season health initiative? Favours is a dedicated ring-fanced Tabung Kesihatan Negara which is funded by a supplementary progressive health tax in other words, add on to income tax. Now, how progressive it is, is a matter they can be debated. There are some*

people will think that well maybe M40 and B40 should be exempted from this supplementary income tax again shall apply to T20. That's one possible scenario.

So, more progressive supplementary health tax, corporate taxes, property and capital gains taxes, Tobin tight taxes I'll say a bit more in the last slide. Sin taxes; tobacco, alcohol et cetera. Other public revenues perhaps as zakat. And so, and this fund like this Tabung Kesihatan Negara would be subjected, should be subjected to robust governance provisions and stakeholders representation, accountability and transparency. This national this tabung would be used to reinvigorate public provision of healthcare, expanded delivery capacity recruit and contract for more staff, strengthen public comprehensive primary care with continue the new care et. cetera, et. cetera.

Establish the health services commission to address some of those primary grouses which is the driving the concern outflow of senior experiences staff from the public sector, rationalised and re-organised use of resources, build and equipped more health facilities when it needed to ease congestion and bottlenecks. Where shortfalls in delivery capacity exist in the public sector, spillover patients from public hospitals can be channelled to panel private hospitals in accordance with DRG-based fee schedule or case-mix-based institutional grants.

So, KKM could be a bulk purchaser of supplementary of top-up services from the private sector at negotiated these counters prices required of licensed private providers, licensed hospitals in other words. Much like how housing developers are being required to fulfill a certain quota of low-cost housing. Alright, the last slide okay gives some figures on how realistic some of these additional alternative sources of funding are which can be— which can be which can contribute towards Tabung Kesihatan Negara.

Tobin taxes it is Tobin taxes are named after well-known economist in the James Tobin. He basically suggested initially his initial idea was a he was concerned about excessive speculation and volatility in a foreign currency market so he thought of this idea of applying 0.5 percent tax on foreign currency trades. So as to dampen down the volatility. He has stabilised foreign currency markets.

But eventually, the idea was extended to also look at Tobin tax as possible ways of raising funds for public finances. So again, at the meeting a few days ago at the Bank Negara this was my second suggestion with them to Bank Negara whether the Bank Negara well actually not quite the Bank Negara as far as Bursa Malaysia because Bursa is under Security Commissions. We separate Bank Negara handles insurance but also foreign currencies trades.

So, but as far as Bursa Malaysia. If you share you find that the average daily trading value recently in a first half of 2024 differences. If you look at that trading volume and you apply a 0.5 percent Tobin tight tax on all share transactions conducted on Bursa Malaysia. You can raise 4.26 billion annually. Tobin eventually increased tax recommendation to one percent.

So, if you raised that to one percent, one percent tax on all share transactions on Bursa Malaysia will raise about 20 percent of the current allocation, 2025 for Kementerian Kesihatan. This 2025 allocation was 45.3 billion. You can increase up by 20 percent if you apply a one percent tax on share transactions on Bursa Malaysia.

Now, more relevant to Bank Negara is a foreign exchange. So, again looking at the first half of 2024 again in the daily average foreign exchange trading volume. If you apply a 0.05 percent tax right, 0.05 percent not 1.5, 0.05 percent Tobin tax can raise in a year.

USD4.69 billion which is equivalent to RM20.73 billion. So, a 0.05 tax on foreign currency trades you know between Malaysia and foreign currency can raise about 50 percent of the allocation for KKM for 2025. Okay, thank you very much."

[Muka surat 49 - 51, Laporan Prosiding Bil 5(c)/2025 bertarikh 25 Februari 2025]

7.16.5 Wakil Akademik

i. <u>Penjelasan Associate Prof. Fakulti Perubatan, Universiti Malaya</u>

Prof. Dr. Tharani Loganathan (Fakulti Perubatan, Universiti Malaya) dalam Prosiding Bil. 5(d) bertarikh 25 Februari 2025 menjelaskan bahawa penyelesaian kepada kos penjagaan kesihatan swasta yang meningkat bukanlah satu penyelesaian tunggal, tetapi memerlukan pakej reformasi menyeluruh.

a. Reformasi diperlukan dalam cara penyedia swasta dibayar. Sistem bayaran mengikut perkhidmatan (*fee-for-service*) dan pengebilan item demi item sedia ada memberi galakan kepada pembaziran dan perbelanjaan berlebihan. Oleh itu, beralih kepada mekanisme pembayaran yang lebih baik seperti DRG (*Diagnosis Related Group*) yang menetapkan bayaran standard bagi setiap prosedur serta menggalakkan Pembayaran Berasaskan Prestasi dan Penjagaan Berasaskan Nilai adalah disarankan bagi memastikan keberkesanan kos ubat-ubatan dan teknologi.

b. Mekanisme pembayaran pengguna insurans seperti *co-payment* dan *deductible* mesti dikawal selia dengan ketat. Walaupun *co-payment* dan *deductible* dilihat lebih adil, mekanisma *co-share* (peratusan bil) boleh

meningkatkan kos luar poket (*OOP*) pesakit secara mendadak. Oleh itu, semua mekanisma ini mesti dihadkan dan dikawal selia untuk melindungi pengguna daripada beban kewangan.

c. Pengawasan kawal selia yang menyeluruh diperlukan untuk kedua-dua sektor swasta dan insurans. Dalam sektor swasta, semua caj selain yuran doktor perlu dikawal selia untuk membendung inflasi kos, manakala syarikat insurans memerlukan badan pengawasan seperti ombudsman.

"Prof. Dr. Tharani Loganathan [Universiti Malaya]: *... Let's look at this in broader way. If you look at private healthcare fees. Healthcare fees actually this the solution for private healthcare fees actually is not easy. It is not one size solution. It is actually a package of solutions. We need to look at how providers are paid for. Right now, providers as in they're paid for fee for services. It's itemised and every single thing is paid for.*

So, that is better ways to pay for providers. That does not give incentives for overspending or overcharging, or overprescriptions.. So, pay for performance and so on. The drugs, the technology that they prescribe and so on that should be some evidence-based for those prescriptions. Strategic purchasing, value-based care. We are talking about like how technology assessment, cost-effectiveness analysis to make sure that the medications, the drugs the technology that we are getting are value for money.

One of the things that Ministry of Health is considering is DRG. So, that might actually it might work in terms of payment mechanism. So, instead of paying for each single thing, there is cap or there is a standard for each procedure that you are paying for a surgery and so on. So, instead of paying for multiple items inside that one thing. You are paying this is the average and this is the payment. So, a lot of that needs to be looked at. For private health insurance. There are a lot of things that they can actually do but my concern is it puts the owners on the consumers.

So, like things like co-payment, co-share deductibles. That concern is the same mechanism is given to everybody or consumers. Irrespective of them being rich and poor and so on. So, we really have to be careful about it especially things like co-share which— or co-insurance that means a percentage of the bill the patient has to pay.

So, that can actually drive up out-of-pocket cost quite a lot. But a co-payment, a co-payment is like a fixed amount that agreed upon like for instance maybe an insurance policy says that for each admission, the consumer has to pay like RM100.

I think that kind of thing is still fair. A deductible is maybe a certain amount that you have to pay in access per year. But there must be a cap to this and this need— This kind of thing mechanism needs to be regulated to ensure that the consumer is protected.

...

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Okay. So regulatory oversight. I would say private healthcare and insurance, both need regulatory oversight. So, in private healthcare right now, the only thing that is regulated is doctor fees. Doctor fees are regulated. So, they cannot— it's a fixed amount that you are paying the doctor— of the bill that's going to the doctor but everything else is not regulated. This we should look at as well. So, to make sure that there's no cost inflation here. Private insurance also needs— like an ombudsman body oversight regulatory body to look at them.*

...

Prof. Dr. Tharani Loganathan [Wakil Akademik*]: Next slide. No, sorry the slide before. I really think that we should look at this issue as a bigger problem in our health system and the bigger problem in our health system is lack of financing in the public healthcare system and universal health coverage. So, a solution that is long-term is actually a health transformation and social health insurance. Social health insurance would cover everybody and would allow— could be designed to allow patients to go to public and private healthcare. So, this is something that MOH have discussed and have worked together with their Health White Paper.*

So, next slide. It's actually my final slide. So, we really that the healthcare system needs to serve everybody, not just the privileged few and we really need to remember this. Okay, thank you."

[Muka surat 5 - 7, Laporan Prosiding Bil 5(d)/2025 bertarikh 25 Februari 2025]

iii. <u>Penjelasan Ketua Pegawai Eksekutif, Galen Centre For Health and Social Policy</u>

Encik Azrul Mohd Khalib [Ketua Pegawai Eksekutif, Galen Centre For Health and Social Policy] dalam Prosiding Bil. 5(d) bertarikh 25 Februari 2025 mencadangkan Suruhanjaya Penjagaan Kesihatan Swasta (*Private Healthcare Commission*) diwujudkan kerana pada masa ini tiada agensi yang mempunyai kuasa untuk mengawal selia caj perkhidmatan kesihatan swasta dan kenaikan premium insurans.

Suruhanjaya baharu ini perlu diberi mandat sebagai agensi perlindungan pengguna untuk menyemak dan mengawal selia caj dan fi penjagaan kesihatan swasta, termasuk premium insurans**.**

> ***"Encik Azrul Mohd Khalib [CodeBlue]:*** *... So, my final slide is the recommendations. We need a private healthcare commission to regulate charges in the private healthcare sector. I don't like to set up new bodies or agencies yet another commission dan sebagainya. Tetapi dalam isu ini, disebabkan ia mempunyai impak yang cukup tinggi kepada masyarakat dan juga kepada mereka yang menggunakan private healthcare ini perlu ada regulator.*
>
> *Sekarang ini fungsi itu tidak ada pada Kementerian Kesihatan atau pun Bank Negara. Dalam perbincangan saya dengan Bank Negara minggu lepas, telah ditekankan bahawa walaupun Bank Negara ada fungsi untuk take care of insurance industry but it's more like we will take care of the standard. Make sure there is nothing illegal dan sebagainya. Tetapi when merujuk pada peningkatan the premium itu tidak ada punca kuasa.*
>
> *So, right now we need a consumer protection agency sebab ia tidak wujud untuk isu ini pada waktu ini dan komisyen ini boleh dimandatkan untuk review dan regulate private healthcare charges and fees termasuklah insurance premium yang kenaikan yang kita katakan tadi. I think it's the only way forward sebenarnya untuk isu ini dan kita raise one recommendation sahaja.*
>
> *There is no quick fix ya. Masalah sekarang ini, walaupun you boleh cerita fasal DRG. You boleh cerita fasal this Bank Negara punya polisi dan sebagainya. Ini semua sementara ia not a silver bullet. You cannot fix it. Because right now we don't have the tools to fix it. Kita perlu wujudkan this commission to get it done. So, dengan itu saya mengakhiri and then kalau ada soalan-soalan. Sekian, terima kasih."*
>
> [Muka surat 26 - 27, Laporan Prosiding Bil 5(d)/2025 bertarikh 25 Februari 2025]

7.16.6 FPMPAM

Dr. Shanmuganathan Ganeson [Presiden FPMPAM] dalam Prosiding Bil. 5(g) bertarikh 4 Mac 2025 mengemukakan beberapa cadangan utama berkaitan dengan isu-isu yang dihadapi oleh Pengamal Am (GP) dan sistem penjagaan kesihatan swasta:

a. <u>Semakan Jadual Fi & Paparan Harga:</u>

Menyemak semula jadual fi dan memberikan fleksibiliti pada paparan harga kerana menghilangkan *markup* ke atas ubat-ubatan akan

menjejaskan sumber pendapatan GP dan bagi menampung kos operasi.

b. Peraturan TPA:
   Mewujudkan peraturan yang jelas untuk Pentadbir Pihak Ketiga (TPA) kerana pada masa ini mereka tidak dikawal selia oleh mana-mana pihak.

c. Penyelesaian Kecuaian Perubatan (ADR):
   Penyelesaian Pertikaian Alternatif (ADR) untuk kes-kes kecuaian perubatan bagi mengelakkan tuntutan mahkamah yang semakin meningkat.

d. Akta Makmal Patologi:
   Keperluan kepada Akta Makmal Patologi bagi menetapkan standard untuk ujian makmal dan mengisi kekosongan undang-undang sedia ada.

e. Penglibatan dalam Skim Kebangsaan:
   Pengamal perubatan swasta dilibatkan dalam Skim Kewangan Penjagaan Kesihatan Kebangsaan.

"Dr. Shanmuganathan Ganeson [FPMPAM]: ... *Next, so these are the recommendations. Revise the fee schedule, have a flexibility on the price display requirement. The price display is not a matter of transparency, who are the GPs is going to kill them. Because patients are not going to want to medicine at the thing and we got two revenue sources. One is the consultation and one is the mark up on the drugs. You take away the mark up, we can't run the place. Where do we pay the salaries, rental and et cetera. I'm sure you've heard a lot of this.*

Next for the TPA, you need to establish clear regulation. Now, there are unregulated. They can do anything the like. They can have all kinds of regulations imposed on the GPs. They can act judge, jury and executioner in many of the issues that raised within the doctors and the MCOs. Also, PHFSA regulation need to be revised.

...

Dr. Shanmuganathan Ganeson [FPMPAM]: *Thank you. All right. Number six, I think for medical negligence cases, we need to look at alternative dispute resolution (ADR) which is needed to stop going to the court. I think including for*

the government itself and the lawsuit and all to coming into millions. It is just unimaginable. Only now at the tip of the iceberg, the cases five, 10 years ago coming up now. We are already alarmed. What more? In five-year times, there are going to be many, many more cases with all these various lawsuits for medical negligence.

Number seven, we need to keep an eye on the Pathology Laboratory Act. We must have the vacuum that there's no act where the standards of laboratory test concern. Lastly, we actually appeal to have private practitioners be involved in the National Healthcare Finance Scheme. Thank you. I think that's all."

[Muka surat 11 - 13, Laporan Prosiding Bil 5(g)/2025 bertarikh 4 Mac 2025]

7.16.7 The Association Of Specialists In Private Medical Practice Malaysia (ASPMP)

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP] dalam Prosiding Bil. 5(g)/ 2025 bertarikh 4 Mac 2025 mencadangkan pendekatan berasaskan nilai untuk mengawal kos perkhidmatan hospital swasta, khususnya berkaitan peralatan perubatan, bagi mengatasi isu caj hospital yang tinggi, di mana item bukan perubatan menyumbang sehingga 40% daripada bil.

Hospital diwajibkan mengisytiharkan kos pembelian mesin serta Pulangan Pelaburan (ROI) yang dijangkakan dalam tempoh masa yang munasabah. Perkara ini berbeza dengan amalan semasa di mana hospital mengenakan caj ROI sepanjang jangka hayat mesin yang panjang sehingga 20 tahun.

Caj perkhidmatan perlu dikurangkan secara signifikan daripada 20% hingga 50% sebaik sahaja ROI dicapai, kerana amalan mengenakan caj ROI secara berterusan selepas kos mesin diperoleh adalah "wang percuma" bagi hospital.

Untuk memastikan mekanisme ini berkesan dan mengelakkan pakatan harga (*price fixing*) antara kumpulan hospital swasta utama, beliau menggesa agar Suruhanjaya Persaingan Malaysia (MyCC) dibawa masuk untuk mengawal selia penetapan harga.

"Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *… So, we are proposing a value-based approach on equipment whereby payers pay for the exact value of services. Of course, this is unlike the DRG which averages cost of limit without taking into account, all these things, drugs, equipment, et cetera, et cetera.*

So, just for the equipment alone, our approach includes the hospitals declaring the cost of the instrument of the machines. So far, if you want to buy a new MRI machine, buy. But declare to MOH. Declare to LHDN, declare to everyone that needs to be declared to, what the price is at sale, at buying. Then, declare the ROI that you are expect to get and the margin, the reasonable margin over how many years.

The ROI must have declaration of life span. So, some instruments can last 15 to 20 years, ladies and gentlemen. Bukannya tiap-tiap tahun kena beli pun. So, if somebody's buying laparoscope or a bronchoscope every year, something's wrong. Something's wrong there. So, currently even though—the current practice they will charge for as long as they have the machine. So, if the machine is with the hospital for 20 years, it's for 20 years they will be charging for the ROI.

What we are suggesting in our formula is that the ROI now will be calculated over more reasonable time frame. Maybe five to eight years. So, then the cost of services charge and bill must be based on the calculator ROI.

Once ROI is achieved, so if the machine cost RM250,000 and you've got you money back, subsequence charges should be reduced between 20, 30 maybe even 50 percent including your mark up. You can still make money. The hospital still makes money. But what doesn't end, you can increase reasonably the next year but not including for the ROI. So, this is very important because at the moment, this is what the hospitals are doing. This is free money.

So, they've got the ROI already after four years. But in the fifth, sixth, seventh, eight, nineth, tenth, they still charge you for it and every year is increases by 10 percent, five percent, eight percent. So…

…

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *… Now, this is another thing ladies and gentlemen, whether ROI, whether drug mark up, whether the non-medical charges mark up, the government needs to put into play or bring MyCC into the picture. Again, within these four walls, we know that the major private hospitals group at least talks to each other and so their charges are about the same, for main things.*

So, if that continues then even if we try this mechanism, it may not work so well because they won't bring down the prices, everybody keeps increasing their prices every day.

…

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *… So ladies and gentlemen, what we are proposing here in terms of— this is just for the equipment but it can like I said be translated into other aspects as well ya. So, this values-based approach. So, you pay for what you get, the value of what you get. If it is a new machine, you will a bit more. If it is an older machine, you don't have to pay that markup for the new machine…"*

[Muka surat 37 - 40, Laporan Prosiding Bil 5(g)/2025 bertarikh 4 Mac 2025]

7.16.8 NAMLIFA

Encik G Saseedaran Gengadharan [NAMLIFA]dalam Prosiding Bil. 5(e)/2025 bertarikh 26 Februari 2025 mencadangkan penubuhan Skim Perlindungan Perubatan (Insurans Sosial) untuk setiap rakyat Malaysia bagi mengukuhkan penjagaan kesihatan awam dan mengurangkan kebergantungan serta permintaan terhadap sektor swasta. Konsep skim ini merujuk kepada sistem penjagaan kesihatan kebangsaan yang sedang dipraktikkan di Taiwan. Cadangan utama NAMLIFA adalah:

a. Skim Perlindungan Perubatan Kebangsaan**:** Mewujudkan insurans sosial dengan had perlindungan tahunan yang mampu menampung kos rawatan standard Kementerian Kesihatan (MOH).
b. Pilihan Insurans Swasta Tambahan: Mereka yang mahukan perlindungan melebihi had standard ini boleh melanggan insurans perubatan persendirian sebagai tambahan.
c. Penggunaan Fleksibel: Perlindungan skim ini sah digunakan di kedua-dua hospital awam dan swasta.
d. Kemasukan Tanpa Pengesahan Kesihatan (*Underwriting*): Kelayakan memasuki skim adalah tanpa pengesahan kesihatan dan melindungi penyakit sedia ada (*pre-existing illness*); ini mewujudkan *risk pool* yang sangat besar untuk mengagihkan risiko secara sama rata dan memastikan kos mampan.
e. Mekanisme Caruman & Had Umur: Mekanisme caruman/sumbangan dan had umur maksimum kelayakan untuk skim ini akan ditentukan oleh pihak kerajaan dan pakar aktuari yang bertanggungjawab. Had umur minimum pula bermula dari bayi (*one-day-old baby*).

"Encik G Saseedaran Gengadharan [NAMLIFA]: *... ini saranan daripada NAMLIFA selepas mengambil kira banyak feedback daripada masyarakat dan*

juga selepas kami berbincang, buat perundingan di sini, berunding di pelbagai tahap. Saranan kami ini lebih ditujukan kepada mengukuhkan healthcare penjagaan kesihatan awam.

Itu kami punya saranan. Lebih kepada— kalau public healthcare ini, dia boleh menampung. Jadi, saya rasa yang swasta ini tidaklah— apa orang kata dia punya perbandingan itu. Tuntutan daripada swasta ini boleh dibendung sedikit. Sebab bila kita pergi ke hospital kerajaan dan pada masa yang serupa, hospital kerajaan ini dia juga menggunakan perlindungan insurans.

Jadi, saranan kami ialah nombor satu, skim perlindungan perubatan untuk setiap rakyat Malaysia. Macam sosial insurans untuk rakyat Malaysia, contohnya. Di mana had perlindungan rawatan kemasukan tahunan harus mampu menampung kos jenis rawatan standard MOH. Ada rawatan standard yang contoh appendicitis, contohnya ataupun pembuangan fibriod, contohnya.

Jadi, dia had perlindungan rawatan itu. Apa yang dibagi, contohnya dalam medical national healthcare, whatever name kita boleh bagi, skim insurans sosial ini. Katalah tahap tahunan dia bagi RM50,000 atau RM100,000. Kalau sesiapa yang mahukan lebih daripada itu, mereka boleh melanggan ataupun memiliki insurans perubatan persendirian. Itu saranan kedua.

Ketiga, perlindungan ini sah digunakan di hospital awam dan juga di swasta. Kalau ada skim national healthcare, contohnya, national health policy, di mana dia boleh pergi ke hospital swasta dan juga ke kerajaan. Itu dua-dua tempat di boleh guna.

Nombor empat, mekanisme caruman premium ataupun sumbangan boleh ditentukan oleh pihak kerajaan sendiri. Itu memang dia ada perkiraan actuarial di mana kita bagi saranan secara am tapi mekanisme dia itu, only the experts can determine.

Lepas itu nombor lima, had umur maksimum kelayakan memasuki skim ini boleh ditentukan oleh pihak pengunderaitan yang dipertanggungjawabkan. Itu pun pihak kerajaan boleh determine by yourself.

Nombor enam, kelayakan memasuki skim ini adalah tanpa pengesahan kesihatan serta melindungi penyakit dan status kesihatan semasa ataupun pre-existing illness. Maksudnya, pool ini it's very big pool iaitu dia punya exposure ini besar. Di mana kalau kita ada satu tabungan yang sangat besar dan ia diurus contohnya menerusi macam satu konsortium contohnya, ia boleh membantu mengurangkan ataupun mengagihkan risiko itu sama rata di mana dia punya kos itu boleh sustain. Itu maksudnya. Kita kata we need a very big pool for this. Kelayakan memasuki skim ini adalah tanpa pengesahan kesihatan serta melindungi penyakit dan status kesihatan semasa."

...

Encik G Saseedaran Gengadharan [NAMLIFA]: *Ya. Sistem yang sedang dipraktikkan di Taiwan di mana kepadatan penduduk Taiwan itu lebih kurang*

macam Malaysia, population dia itu. Tetapi dia ada satu macam national healthcare scheme, ciri-ciri dia macam yang kami ceritakan tadi. Sebenarnya kami ambil contoh dari Taiwan. Tapi dia punya umur had maksimum maklumat itu tidak ada. Sebab ia terpulang kepada dia punya— macam kita punya jangka hayat kita. Our life expectancy dekat Malaysia ini, it all depends. Kita punya risk exposure dan statistik kita itu. That yang dia boleh determine oleh kita punya actuarial di mana what is the maximum age capping yang dia boleh gunakan untuk skim yang kita sarankan ini. All these mechanisms ini boleh di-construct, yang kita cerita sekarang ini konsep.

Satu lagi, semua hospital swasta wajib menyediakan jumlah katil mengikut kapasiti masing-masing untuk peserta skim ini dengan kos rawatan yang telah ditetapkan. Something very near to DRG. So, di mana kalau seseorang itu memiliki kad perubatan— katalah national healthcare kah, national insurance kah, whatever name that it can be coined-lah kan, kalau dia pergi ke hospital swasta, depends on the capacity hospital itu, certain percentage of the katil itu, dia kena untuk mereka yang memegang kad ini dan dia punya charges itu must be very controlled ataupun dia memang sudah ada scheme chargers ini, anggaran dia.

So that, kalaulah perlindungan ini, had tahunan dia contoh, contoh RM50,000 saja tapi dia pergi hospital swasta, satu hari RM50,000 itu boleh sapu. Jadi, kalau dia pergi ke hospital swasta tapi untuk charges dia itu mesti something that exactly macam government punya charges itu.

Kami, we are very sure, kalau kita sudah ada satu konsep yang sebegini and then dia punya costing, cara dia, mechanism dia, dia punya operational dia semua itu, it's a happy problem for everyone to do. So, this is our concept that we would like to share. Konsep yang kami nak kongsi dengan pihak PAC hari ini..."

[Muka surat 11 - 13, Laporan Prosiding Bil 5(e)/2025 bertarikh 26 Februari 2025]

7.16.9 LIAM

Encik Mark Steven O'dell [Ketua Pegawai Eksekutif, LIAM] dalam Prosiding Bil. 5(f)/2025 bertarikh 26 Februari 2025 mencadangkan perkara-perkara berikut:

a. Pelantikan Perunding Bebas yang dibayar oleh pihak insurans dan hospital untuk menganalisis dan mengesyorkan tindakan pihak berkepentingan bagi mengurangkan inflasi tuntutan.

b. Tawarkan bantuan kepada pelanggan yang terjejas oleh harga semula yang tinggi. Kuatkan amalan jualan, pendedahan, dan tingkatkan ketelusan komunikasi mengenai penetapan harga semula.

c. Mewajibkan bayaran bersama (*co-payments*) oleh pemegang polisi (terutamanya *co-insurance*) untuk menjajarkan kepentingan dan mengurangkan penggunaan perkhidmatan secara berlebihan.

d. Galakkan gaya hidup sihat melalui insentif seperti bonus tanpa tuntutan (*no-claim bonus*).

e. Tubuhkan pangkalan data tuntutan seluruh industri (sebaiknya pangkalan data semua kemasukan) untuk analisis yang lebih baik dan mengurangkan penyalahgunaan. Terbitkan kos purata prosedur hospital swasta untuk meningkatkan ketelusan harga.

f. Kecualikan Insurans Kumpulan daripada SST 8% untuk menggalakkan lebih banyak majikan mengambil pelan, termasuk untuk ahli B40.

g. Insurans perlu membangunkan kerangka harga semula yang sesuai dan diperkemas, lebih kepada harga semula tahunan (lebih kerap tetapi kenaikan lebih kecil), untuk mengurangkan kejutan kadar yang besar.

h. Pembekal (hospital/doktor) dan insurans perlu menjajarkan kos. Sokong penggunaan harga Kumpulan Berkaitan Diagnostik (DRG) / Package Pricing untuk mengawal kos. Penggunaan Ubat Generik dan Kawalan Harga.

i. Bekerja dengan MOH untuk mewajibkan penggunaan ubat generik dan mengawal harga semua ubat. (48% keuntungan hospital swasta datang dari farmaseutikal).

j. Minta hospital swasta membekukan kos untuk tempoh yang sama di mana premium insurans/takaful diminta untuk mengehadkan kenaikan.

k. Gunakan program Rakan KKM sebagai penandaarasan harga (*benchmark*) untuk DRG penjagaan swasta.

l. Semua pihak berkepentingan (insurans, hospital, doktor, pengawal selia, pemegang polisi) mesti bekerjasama dalam pendekatan seluruh negara untuk menangani peningkatan kos.

"Encik Mark Steven O'dell [LIAM]: *…Last, I want to conclude with just a couple of pages and we've sent this to Bank Negara and so we are working with them on trying to prioritise and implement these recommendations and responses.*

First of all, we're in favour of appointing independent consultant paid for by insurers and hospitals to analyse and recommend stakeholder actions to reduce claims inflation. I know this is time sensitive but there are experienced consultants out there that could add value to this process.

The interim measures offers assistance to customers at risk of losing financial protection due to inability to cope with repriced solution. We aim to strengthen sales and disclose practices and improve communication and transparency around repricing. This has been— many of us attended the open door, I guess you called it open door session on Friday and this was one of the complaints and we heard it loud and clear.

Number three, policy of the co-payments. We're seeing a take up, an increase take up rate although still many new policyholders are opting for policies without co-payments. But co-payments especially co-insurance where the policyholder pays a percentage of bill up to a certain maximum has proven to lead to reduce the buffet syndrome and lead to more responsible consumption.

ITOs are encouraging and assenting healthier lifestyles through no-claims bonuses, perhaps not all have but many have no-claims bonuses now. Establishment of an industry-wide claims database and actually an all-admissions database would be even better, then we would be able to claim those who are insured against those who are not insured.

But the claims database will allow us to look for waste and abuse across the whole ecosystem. Because right now, it's very difficult to have a discussion with one doctor about one patient. There's always a reason why this patient needs this or needs that. But when you see patterns across the whole ecosystem, then you can open up different kinds of conversations.

Develop a long-term sustainable medical product together with Bank Negara. We have our first meeting scheduled next week and we'll see what progress we can make. If we can be successful in that way, then insurance and takaful operators can offer top-up schemes to the basic plan.

One thing that would help would be to exempt group insurance from eight percent SST. About a third of our insured or four million people have group insurance and that includes a lot of B40 members. And if the group insurance was exempt from eight percent SST, we think it would make it more attractive for more employers to come on board.

Next— eight, insurance to consider to develop suitable and streamlined repricing framework, more like annual repricing. Part of outrage by the consumer has been of this 40 to 70 percent rate increase which is not apparent that it covers multiple years. And we think it might be more tolerable for an insured if there are more frequent but much smaller rate increases.

Nine, providers and insures need to better align regarding costs and consumption of healthcare services. Cost containment measures must be adopted by providers. The insurance and takaful industry support the adoption of diagnostic relating group pricing which is really a fancy word for package pricing that takes into account comorbidities.

This is where hospital will get an agreed lump sum for a certain procedure and they're to make the best use of that. Therefore, driving efficiency rather than billing for fee for service which is pushes them to add more fees, add more services.

This I think in my opinion is the number one problem that we have is the economic conflict between the provider and the payer. The provider wanting to basically sell or have the patient consume as much services as possible and the payer wanting to have necessary and adequate treatment to get the patient well. And they're at odds because in one hand, the shareholders want to make profit and the other hand, although insurance shareholders want to make profit, the profit is much lower at least in recent years. The total cost is really what the issue is.

10— work with MOH require the use of generic drugs and control pricing of all drugs. It's very interesting to note and I have the book here— APHM issued a fact book. In it, it says that 48 percent of the private hospitals profit comes from pharma, 48 percent. That's a very big number.

There's another 10 percent number that comes from diagnostics. But the 48 percent number really stuck out. We want to request private hospitals to freeze costs for the same period that insurance and takaful operators are SST capped, premium increases. The cost of the interim measures if inflation is not brought under control is well over RM40 billion to insurers and we think that the hospitals need to do more.

Second last, the Rakan KKM which is a pilot program by MOH— we are supportive of that. We hope that can lead to benchmarking for private care DRG.

Last and maybe, it needs to go unsaid. But last, all stakeholders including insurance and takaful operators, private hospitals, doctors, regulators,

policyholders, all must come together in whole-nation-approach to address the challenges contributing to rising costs in premiums. Thank you, that's the end of my presentation."

[Muka surat 9 - 11, Laporan Prosiding Bil 5(f)/2025 bertarikh 26 Februari 2025]

7.16.10 APHM

Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(h)/2025 bertarikh 10 Mac 2025 menjelaskan bahawa APHM telah menggariskan senarai langkah interim oleh hospital swasta dalam tempoh tiga tahun dan tindakan berterusan yang akan diambil untuk menangani isu kos dan ketelusan dalam ekosistem penjagaan kesihatan seperti berikut:

a. Pengoptimuman kos dan kecekapan (*Cost Optimization and Efficiency*) melalui pengurangan kos operasi dan penggunaan ubat yang berkesan.
b. Ketelusan harga (*Price Transparency*) dengan melaksanakan ketelusan harga ubat untuk Jabatan Pesakit Luar (OPD) di semua hospital APHM menjelang 1 April 2025, seperti yang diarahkan oleh MOH.
c. Hospital swasta juga komited terhadap pembangunan Sistem Penentuan Harga Jangka Panjang (*Long-term, Sustainable Pricing Systems*) yang mampan dan akan terlibat dalam Advokasi Kawal Selia dan Dasar, termasuk meneroka model pembayaran balik alternatif yang selaras dengan pembangunan sistem penjagaan kesihatan nasional yang boleh diakses.
d. Memperbaiki Produk Insurans melalui kerjasama rapat dengan syarikat insurans, dengan memperkenalkan produk insurans berperingkat dan pembayaran bersama (*co-payments*) mandatori.
e. Meningkatkan Kesedaran Awam melalui pendidikan pemegang polisi mengenai polisi dan tuntutan insurans.
f. Strategi Perhubungan Awam Bersepadu bersama semua pihak yang berkaitan.

Selain itu, APHM juga telah menggariskan beberapa langkah jangka panjang untuk memastikan ekosistem penjagaan kesihatan yang mampan. Langkah-langkah adalah seperti berikut:

a. Pelaksanaan Model Penjagaan Bersepadu melalui kerjasama dengan Pengamal Am (GPs) dan klinik akan diperkukuh untuk meningkatkan pengurusan penyakit kronik dan memberi keutamaan kepada penjagaan yang bermula sebagai pesakit luar (*outpatient-first care*).
b. Menyarankan Penjagaan Kesihatan Berasaskan Nilai dengan mengguna pakai model pembayaran balik baharu yang diselaraskan dengan Skim Pembiayaan Penjagaan Kesihatan Kebangsaan. Model ini bertujuan membenarkan rakyat Malaysia mengakses kemudahan awam dan swasta, sekaligus meningkatkan mutu penjagaan kesihatan secara keseluruhan.
c. Menyokong Penghapusan Diskaun Secara Berperingkat, di mana diskaun yang dianggap tidak mampan akan dihapuskan secara berperingkat sambil memastikan rundingan kontrak yang adil dengan syarikat insurans untuk menjamin kelestarian kualiti perkhidmatan penjagaan kesihatan.

[Sumber slaid APHM dalam Prosiding bertarikh 10 Mac 2025 dalam Prosiding Bil 5(h)/2025 bertarikh 10 Mac 2025}

Selain itu, **Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM] dalam Prosiding Bil. 5(l)/2025 bertarikh 17 Jun 2025** menjelaskan bahawa APHM juga menggariskan lapan (8) langkah untuk menangani inflasi perubatan dan meningkatkan kecekapan industri:

1. Menyemak Struktur Bil & Harga Hospital (*Fair Pricing*)
   - Menubuhkan jawatankuasa khas untuk menyemak struktur bil hospital.
   - Mengurangkan kebergantungan *kepada cross-subsidisation* (contohnya bil sarung tangan atau ubat jadi lebih mahal kerana caj bilik tidak naik).

- Mewujudkan model harga lebih adil melalui kerjasama hospital, syarikat insurans dan kerajaan.

2. Menambah Baik Komunikasi Industri (Hospital–Insurans–Orang Awam)
   - Menubuhkan kumpulan komunikasi industri untuk mengelakkan salah faham antara hospital dan insurans.
   - Mengurangkan kegusaran rakyat agar mereka terus membeli polisi insurans dan tidak beralih sepenuhnya ke hospital kerajaan.
   - Mengadakan pendidikan awam tentang polisi asas dan mengelakkan pembelian rider yang tidak perlu.

3. Membentuk Jawatankuasa Bebas Kos Kesihatan & Bayaran Balik
   - Jawatankuasa bebas ini akan memantau harga rawatan, kadar bayaran balik, dan penyelarasan premium.
   - Penting kerana moratorium 3 tahun Bank Negara hampir tamat, dan garis panduan baharu perlu ditetapkan.

4. Meningkatkan Ketelusan Kos & Premium Insurans
   - Mendedahkan bahagian premium yang digunakan untuk rawatan kesihatan, kos pengurusan, dan kos memperoleh polisi.
   - Mencontohi negara lain yang mewajibkan 75–85% premium dikembalikan kepada penyedia rawatan.
   - Membolehkan industri memahami aliran kos sebenar.

5. Menubuhkan Jawatankuasa Perundangan Perubatan Nasional
   - Menangani peningkatan kes saman perubatan dan kos *defensive medicine.*
   - Memberi perlindungan kepada doktor yang mengikut CPG (*Clinical Practice Guidelines*).
   - Mengurangkan beban kerajaan dan sektor swasta terhadap tuntutan *medical negligence*.

6. Mengurangkan Beban Regulatori (*Licensing & Compliance*)
   - Mengkaji semula regulasi yang membebankan dan meningkatkan kos operasi hospital.

- Cadangan utama: memisahkan proses pelesenan fasiliti dan pelesenan perkhidmatan untuk mengelakkan kerugian besar sebelum hospital beroperasi.
- Menyokong langkah-langkah yang boleh mengurangkan inflasi perubatan melalui kecekapan operasi.

7. Memperkukuh Peranan Penjagaan Primer (GP/klinik swasta)
   - Mengintegrasikan klinik dan GP dalam laluan rawatan pesakit (*patient pathway*).
   - GP boleh merujuk kepada pakar hanya bila perlu, mengurangkan kos dan elakkan rawatan tidak perlu.
   - Hospital bersedia melatih GP dan membangunkan polisi bersama kerajaan.

8. Memperketat Proses Daftar Polisi Insurans (*Health Screening*)
   - Mewajibkan pemeriksaan kesihatan asas sebelum membeli polisi untuk mengelakkan *under-declaration*.
   - Risiko kesihatan yang tidak diisytihar (contoh diabetes, hipertensi) menyebabkan premium rendah tetapi bil rawatan sangat tinggi.
   - Memastikan premium mencerminkan risiko sebenar dan memudahkan pembayaran tuntutan.

"Encik Anwar Anis bin Anis Ahmad [Setiausaha Kehormat APHM]: *..,Next slide, next as team members of the PAC, allow me to outline the eight measures that were put out by APHM where we also has put it out as press release, also share it with Bank Negara and others. One, firstly is to establish working committee to review billing structure and fair pricing and I think during our first presentation to PAC, we try to explain and you can go back to those material and look at the fact that we have to charge certain things perhaps perceived as being a lot higher because they are a lot of thing we cannot charge in our bill and because of that, we can use term cross subsidization.*

So we do think again we need a working committee to review our billing structure. So that, the public regulator, anybody else can appreciate that we charge for the right item in the right place. Simple example really it just room rates where those as remain, I think I mention the last time you know 20 years ago when you buy insurance RM200 still remain RM200 and because of that but the gloves, medication all that has to carry far heavier burden in terms of the billing and cost recovery in the hospital.

And for this really need to collaborate with insurances ITOs to create a fair pricing model especially on drug and supply, balancing that with affordability procurement and other cost as well. But this we really need government support, we need PAC support because somebody has to sit down between the hospital and the insurance and payers to say okey, this need to happen and how it needs to happen, timeline and so on.

Number two is to establish industry communication work group. We believe that what had been happening was last six, seven month will have an impact as a to the nation as a whole. If the public sees that private hospital and insurer are fighting each other, saying thing again each other. We heard from certain insurer that they are number of new policy has drop. So, if new policy sales are dropping, what that mean people be shifting to public health care.

So, if people feel I cannot trust the insurer, I cannot trust the hospital, I'm not want to buy insurance, I'm not going to the private health care, I will end up in public, we can try to avoid these issues because otherwise the burden will shift to the government.

So, to develop this strategy again, we do need a third party to pop come in and guide us and push us along. So that we can work together. So, I think a hospital should really work together and public education to help policy holders make in firm decision on health care, understand that when they buy medical insurance, they don't have to buy a lot of other, riders and so on. So that medical insurance remain affordable because we understand for the agents obviously when they selling insurance, lebih banyak saya jual, lebih banyak komisen saya. Tapi mereka tak faham yang health insurance itu sebenarnya can be quite affordable. Tak perlu nak beli rider yang banyak. So, some of this communication we need to work together between ITOs and hospital, with assistant the government and hopefully the PAC can support us.

Thirdly, to form an independent health care cost and reimbursement committee. This is really to oversee fair pricing reimbursement, regular review of premiums and reimburse structure. So, Bank Negara measures, we understand the three years actually will end somewhere next year. So that quite fast right? Because three years will come up which mean by next year, by middle of next year we need to have all these things in place.

Otherwise, we don't know what will happen after the three-year moratorium.
So, if you have independent committee, which we certainly want to be part of and contribute, we can align with actual health care course, market condition and how much reimbursement so that insurer and we have further recommendation that dwell deeper into this.

Number four, is to improve transparency of health claim volume and cost and again we do have more detail explanation of this later. But is this to enable the industry really to discuss how much of premium are being paid to hospital, how much actually going to for accusation cost, right.

So, to sell insurance, to get before the buying insurance their cost as well and how much the admin cost. So, while hospital are very transparent in terms of what their cost is, we do not know when you buy insurance and how much of it actually going to pay their health care, how much is going for accusation of the policy, that mean to the agency force and so on and how much the admin cost and their example other country where they clearly say for example that when you buy of health insurance as the whole, 75, 80, 85 percent must be paid back to health care providers and that kind of transparency certainly help Malaysia as well. So those are the four, I'll proceed to the other four commitment and initiatives that with outline.

Number five is we strongly encourage this establishment of a national medical legal committee. I think we explained before that we see a huge burden in terms of health care legal cost and suit been there the government and then also encouraging defensive medicine. So, if we talk about and we touch on this, we talk about MHIT product and we going to use Clinical Practice Guideline (CPG) from MOH to be able to provide those product in more stream line standardize manner.

Doctors must be able to defend themself, that say I'm followed the CPG and somebody decide to sue the doctor, all the doctor that were involved, there have been some protection for them. This is impacting, not just private health care but I'm sure the PAC members are aware that the government pay out the medical negligent suit, so also increasing dramatically and again we are prepared to come in and spend time again the government, the PAC can establish, a national medical legal committee, we can look at transformation for our medical legal system.

Number six is to review and adopt recommendations on reducing healthcare regulatory burden. Many of us in the private healthcare through APHM have spent years through NPC, another bodies to really provide recommendations we've been outlined in formal recommendations to the Ministry of Health on reducing healthcare burden, regulatory burden.

And we believe this cost if we can contain this cost, we can certainly then look at reducing operating cost and being far more efficient and making sure that we can contain medical inflation.

So, well, self-regulation is perhaps a few years down the line, we really need assistance to look at the recommendations that have been prepared formally through a government agency, with the assistance of the government through NPC and this includes like I said increasing the period of relicensing which is right now every two years. Splitting licensing and I will very quickly give an example, until today, if you build a 200 bedded hospital, we have to hire all the staff and then call MOH to come in for licensing. Can you imagine? 200 staff, 200 beds, the number of staff that we would have, our salary and wages would be close to RM3 million to RM4 million per month. And if the license is delayed by five, six months, you can take four months— I mean four million times six months and that is the cost that is being paid before we would start operating and again, somebody has to bear that cost, we mentioned that before.

Our recommendation to MOH for the past five, six years has been simple, split licensing into two. I licensed the physical facility, makna kita dah bina hospital 200 katil, kita lihat fasiliti, kita licensed. Katakan fasiliti ini selamat mengikut segala regulation daripada CKAPS. So, the facility is licensed baru kita boleh licensed the service, then we hire the staff and so on. At this moment, the licensing is one step. We build, we have to hire only then we can call MOH and CKAPS for licensing.

So, this recommendation has been there for a while. We really hope that some of this and other recommendations can be taken up.

Number seven, expansion and inclusion primary care as part of the patient pathway. So, mungkin this one contrary to what most people may think. Although we are private hospitals, mostly in secondary care and tertiary we really do believe that to make the Malaysian healthcare system more efficient is for the primary care. As for the clinics and the GPs to play a much bigger role. And suddenly, we are keen and willing to come in to train, to have code, to have co-developed policies because what we want again for the patient to be save.

You've seen the GP and the GP needs help. They have somebody to reach out to, they can reach out to the specialist of the hospital, they don't have to send the patient first. Only if needed, then they send the patient across. This will help the patient save cost, this will help the insurance save cost, this will certainly make the Malaysian healthcare system more equitable and efficient as well.

And again, our commitment is, if such a committee is created to look at transforming and including primary healthcare as part of the entire patient pathway, we at APHM will come in and play our roles.

And lastly, is to improve healthcare holder enrolment process. We mentioned this and again we have not had any discussion or seen any movement on this. Today, you can still buy an insurance policy without having any form of healthcare screening and this is resulting in a lot of under declaration. So, patients who have got preexisting conditions who are diabetic and so on so forth, are not declaring it when they buy insurance and so the insurance policy and premiums are lower.

So, we understand kalau pesakit ini dia dah ada komorbiditi, dia dah ada darah tinggi, kencing manis dan sebagainya, bila dia masuk hospital, merawat dia lebih rumit daripada merawat pesakit yang tidak ada komorbiditi. Tetapi kerana tidak ada deklarasi, they are not declaring it, the insurance premium is lower, and when they come to the hospital, their bills are higher. And so, the insurance also finds it very difficult to pay the right amount of payout because they've collected a much smaller amount.

So, this really needs to be fixed. Because like I said, in Malaysia today I can buy an insurance without any healthcare screening. So that's our eight recommendations and out of these eight, which we have not, we really had not yet received a lot of support to get this conversation going.

Jadi, mungkin di sinilah kami minta PAC dan pihak kerajaan untuk menubuhkan jawatankuasa ataupun forum-forum di mana perkara-perkara ini boleh dibincangkan where it can be discussed and working committee where— like I said. we are more than willing to come in and assist to make sure that some of these things are moving ahead…"

[Muka surat 4 - 8, Laporan Prosiding Bil 5(I)/2025 bertarikh 17 Jun 2025]

7.16.11 PhAMA

Puan Chan Li Jin [Pengarah Eksekutif PhAMA] dalam Prosiding Bil. 5(i)/2025 bertarikh 6 Mac 2025 mencadangkan tiga (3) langkah ke hadapan bagi menangani inflasi kos penjagaan kesihatan iaitu:

a. Fokus kesihatan pencegahan, kerana kos rawatan menjadi melambung apabila pesakit hanya mendapatkan rawatan pada peringkat penyakit yang lewat (seperti kanser Tahap 3/4).
b. Pembiayaan kesihatan inovatif diteroka, termasuk menyemak semula struktur produk insurans sedia ada yang memecahkan fokus perubatan dengan terlalu banyak tumpuan kepada *investment link*.
c. Peruntukan bajet kerajaan untuk sektor kesihatan ditingkatkan, kerana peruntukan sedia ada dianggap masih tidak mencukupi.

Selain itu PhAMA juga telah menyumbang secara besar-besaran kepada negara melalui Skim Akses Pesakit (*Patient Access Schemes*). Skim ini melibatkan pelaburan dengan menawarkan diskaun dalam bentuk rawatan percuma kepada lebih 100,000 pesakit yang memerlukan rawatan kronik, khususnya kanser.

***"Puan Chan Li Jin [PhAMA]:** Sorry. Saya akan present secara ringkas sahaja. So, the way forward yang kita nak unjurkan adalah kita mesti fokus more on preventive health. So, sekarang ini kebanyakan kos terlalu tinggi sebab ramai patient yang datang ke hospital pada peringkat yang sangat lewat. Mereka keadaan yang sangat sakit, sangat teruk baru datang ke hospital. Sebab itulah ubat dengan harga rawatan sangat tinggi.*

Kalau mereka boleh menangkap ataupun boleh mendapati penyakit mereka pada peringkat yang awal seperti kanser especially. Kalau mereka boleh detect pada tahap yang awal, apabila mereka pergi ke hospital, rawatannya akan

sangat lebih murah daripada apabila rawatan sudah stage 3, stage 4. Rawatan akan sangat tinggi.

So, the second one is innovative healthcare financing. Kita syorkan supaya— for example, insurans sekarang ini kan. So, insurans itu dia punya formatting itu, dia tidak berapa friendly sebab dia dipecahkan kepada banyak-banyak lagi sektor-sektor lain. Contohnya dalam satu insurans itu, satu sahaja bahagian adalah untuk perubatan. Yang lainnya untuk investment link, untuk live coverage. So, dia menjadikan the medical punya aspek itu sangat rendah. So, kita kena fikir balik macam mana kita boleh expand innovative healthcare financing supaya healthcare punya cost inflation boleh diturunkan.

Last sekali itu, kita rasa and kita berharap lah Dewan ini boleh membantu untuk meningkatkan lagi investment dalam kesihatan. Setiap tahun pada pembentangan bajet, kita selalu syorkan supaya lebih allocation is given to kesihatan. Sekarang ini every year pun kita tengok bahawa the alokasi untuk kesihatan itu masih lagi tidak mencukupi. Itu sahaja syor daripada kita. Terima kasih.

…

Puan Chan Li Jin [PhAMA]: *We have been investing heavily in patient access schemes. So, dalam patient access schemes itu selama banyak tahun dah. So, it is like for cancer treatment and untuk ramai banyak-banyak rawatan yang sangat kronik, kita memang ada macam beli dua, dapat satu treatment free. Beli satu, dapat satu treatment free.*

So, ini adalah data daripada tahun-tahun yang lepas. So, setiap tahun itu— actually this is a bit outdated. Ini daripada tahun lepas apabila kita present kepada Menteri Kesihatan tapi keseluruhannya, we have given out the value of treatment yang lebih daripada— sekarang ini saya rasa dah menjangkaui 100,000 pesakit yang mendapatkan patient access schemes daripada kami. So, that is our contribution back to the country."

[Muka surat 26 - 27, Laporan Prosiding Bil 5(i)/2025 bertarikh 6 Mac 2025]

7.16.12 PPUM

Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya] dalam Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025 mencadangkan enam (6) strategi utama untuk mereformasi sistem penjagaan kesihatan di Malaysia, khususnya dalam usaha mengawal kenaikan premium insurans kesihatan dan memastikan keterjangkauan.

a. Memperkukuh Insurans Kesihatan Sosial (*Social Health Insurance*) melalui pembentukan sistem insurans kesihatan sosial dengan

liputan luas bagi memastikan semua warganegara dapat mengakses perkhidmatan kesihatan tanpa beban kewangan.

b. Menggalakkan Penjagaan Kesihatan Pencegahan dan Program Kesejahteraan
c. Mengawal Amalan Industri Insurans di mana peraturan diperlukan untuk mencegah atau mengawal **"***moral hazard*" dan "*adverse selection*" iaitu syarikat insurans cenderung memilih pelanggan berisiko rendah.
d. Menggalakkan Perkongsian Awam-Swasta (*Public-Private Partnership*)
   Kerjasama antara sektor awam dan swasta perlu digalakkan, selaras dengan rangka kerja kertas putih kesihatan (*health white paper*).
e. Memanfaatkan Teknologi dan Analitik Data
   Kemajuan teknologi, termasuk Kecerdasan Buatan (AI), boleh menjadi mekanisme untuk mengawal kenaikan premium insurans kesihatan.

"Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya]:.. *First of all, we need to strengthen social health insurance. Unfortunately in Malaysia there is no wide coverage of social health insurance other than the one that we have for SOCSO.*

So, I think it is high time for us to have a social health insurance because social health insurance as I mentioned just now, memastikan bahawa setiap penduduk ataupun setiap netizen mempunyai kaedah untuk access healthcare services tanpa memberikan beban kewangan kepada mereka. And then, it's also for expanding of this pooling and cross-subsidisation.

Sebagai rakyat Malaysia, I think sama ada yang kaya ataupun yang miskin, I think we have to work as a team ataupun kita berkongsi masalah dan juga beban penyakit dan berkongsi sumber kewangan untuk kita mendapatkan kesihatan— perkhidmatan kesihatan. Third is with regards to promoting preventive healthcare…

...

Tuan Sim Tze Tzin [Ahli PAC]: *Saya nak tanya tentang what is difference between social health insurance and national health insurance?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Sebenarnya it's just a nama saja yang berbeza tetapi pada kaedahnya adalah sama. National health insurance bermakna untuk sesebuah negara, social insurance maknanya sosial. So, it's interchangeably. So, ada negara yang panggil sebagai national health insurance tapi pada dasarnya, ia adalah social health insurance, okay.*

So, with regards to promoting preventive healthcare and wellness programme, we know that mencegah adalah lebih baik because we know that the treatment is very expensive and not only that, morbidity dan juga mortality ini. Kalau morbidity itu melibatkan reduce in quality of health of an individual and therefore reduce in productivity and mortality as we know, secara keseluruhannya akan menyebabkan negara kerugian.

So, it's better for us to promote and we have shown and we have made the calculation that the treatment of diseases is very expensive especially with regards to cancer. Although there is no absolute prevention for cancer but at least from the beginning, if we're able to detect early when it's at the earliest stage, there are some mechanisms ataupun intervention that we can take up to prevent it from being a more severe case.

For example, for breast cancer treatment, for the treatment of first stage is only like about RM3,000 to RM4,000 tetapi for the treatment of second stage and onwards, almost RM14,000 and up to RM50,000 or RM60,000 per year, jika melibatkan rawatan yang advanced.

And then, with regards to number four, regulating insurance industry practices, I think what we are doing now is actually the government is also trying to regulate insurance industry practices because jika tidak di-regulate, makin banyak moral hazards yang akan berlaku especially perkara-perkara yang boleh merugikan rakyat.

When we talk about health insurance, we are talking about terms seperti adverse selection di mana the company of health insurance tend to memilih ataupun masukkan pesakit ataupun rakyat ataupun people yang tidak ada risk ataupun mempunyai risk yang rendah untuk sesuatu penyakit.

And then, when we talk about moral hazards, we are talking about the practices of health providers apabila mereka tahu bahawa seseorang pesakit itu ada health insurance, they tend to membuat penyelidikan ataupun investigations ataupun rawatan yang tidak perlu sehingga boleh menyebabkan kos itu menjadi tinggi. And then, nombor lima adalah berkaitan dengan…

…

Prof. Dr. Maznah binti Dahlui [PPUM]: *… Nombor lima adalah berkenaan dengan encouraging public-private partnership. I think this has been promoted ataupun memang telah diuar-uarkan untuk dilaksanakan even di dalam health pillars untuk white paper.*

And then, nombor enam adalah berkenaan dengan leveraging technology and data analytics. We know that the advancement in technology and with the AI and whatnot, this will actually help us as one of the mechanisms to control the increase in health insurance premium. The next slide akan menyatakan dengan lebih terperinci..."

[Muka surat 6 - 8, Laporan Prosiding Bil 5(k)/2025 bertarikh 5 Mac 2025]

7.16.13 Pentadbir Pihak Ketiga (TPA)

Penjelasan KPE CompuMed Services Sdn. Bhd.

Puan Fiona Rebecca Limus [KPE CompuMed Services Sdn. Bhd.] dalam Prosiding Bil. 5(m)/2025 bertarikh 17 Jun 2025 mencadangkan strategi kawalan kos perubatan ini dilaksanakan melalui dua pendekatan utama iaitu mekanisme penjaga pintu dan model perkongsian kos. Melalui mekanisme penjaga pintu, fokus diberikan kepada program kesejahteraan dan penjagaan pencegahan bagi menangani penyakit kronik yang kini menyumbang kepada 70% kos kesihatan di Malaysia, sekaligus mengurangkan kadar kemasukan ke hospital. Manakala melalui model perkongsian kos, sistem *co-payment* diperkenalkan untuk memupuk sikap bertanggungjawab dalam kalangan pemegang polisi. Langkah ini dijangka dapat mengurangkan tuntutan yang tidak perlu sebanyak 15% hingga 20% kerana pesakit akan lebih berhati-hati dalam menggunakan kemudahan kesihatan apabila perlu menanggung sebahagian kos rawatan sendiri.

> ***"Puan Fiona Rebecca Limus [CompuMed Services]: …*** *So, some of the strategies that we would like to share is number one, Gatekeeping Mechanisms, right. Implementation: promoting wellness programmes and preventive care to reduce chronic illnesses. Impact is that chronic diseases account for 70 percent of total healthcare costs in Malaysia. So that would be the target. Preventive care can significantly lower the burden by reducing hospital admission.*
>
> *The next one is Cost-Sharing Model. This is not welcome but it is one way of ensuring that cost is at least managed. For example, when you implement co-payment, so we go on cost-sharing method right, and this will be reduced the unnecessary claims by up to 15 to 20 percent, as policy holders become more mindful of healthcare usage. So, if I have to take money out from my own pocket, I will think twice before going. So, cost-sharing model is quite healthy if you ask me."*
>
> [Muka surat 11 - 12, Laporan Prosiding Bil 5(m)/2025 bertarikh 17 Jun 2025]

7.16.14 Munich Reinsurance Company

Penjelasan Ketua Serantau Kesihatan Asia Tenggara Munich Reinsurance Company

Puan Catherine Love Soper [Ketua Serantau Kesihatan Asia Tenggara, Munich Reinsurance Company] dalam Prosiding Bil. 5(s)/2025 bertarikh 14 Ogos 2025 menjelaskan bahawa trend tuntutan perubatan tinggi yang pada mulanya dianggap sementara selepas COVID-19 kini menjadi kekal disebabkan oleh dua faktor utama: peningkatan penggunaan insurans oleh pemegang polisi dan kenaikan kos perubatan (inflasi). Beliau menekankan bahawa kesedaran kesihatan yang meningkat, gaya hidup tidak sihat, "sindrom bufet" (kecenderungan menuntut untuk mendapatkan nilai premium), serta isu penipuan dan pembaziran adalah pemacu utama tuntutan. Dari aspek kos, kemajuan teknologi perubatan, inflasi harga runcit, dan turun naik mata wang turut memberi kesan. Bagi menangani isu ini, beliau mencadangkan tiga pendekatan utama:

a. **Reka Bentuk Produk Mampan:** Melaksanakan sistem *co-pay* untuk memberi insentif kepada pengguna memantau caj, memperkenalkan diskaun tanpa tuntutan (NCD), serta penyelarasan harga tahunan secara berperingkat.

b. **Pengurusan Penyedia Kesihatan:** Menekankan ketelusan harga prosedur, keperluan pra-kelulusan (*pre-authorisation*) sebelum kemasukan hospital untuk mengelakkan rawatan berlebihan, serta mengubah struktur ganjaran Pentadbir Tuntutan Pihak Ketiga (TPA) kepada berasaskan prestasi bagi mengawal tuntutan yang meragukan.

c. **Inisiatif Kerajaan:** Mencadangkan sistem rekod perubatan digital nasional untuk pengesanan penipuan masa nyata, pembangunan produk perubatan asas yang mampu milik, serta promosi penjagaan kesihatan pencegahan melalui kempen kesedaran dan vaksinasi percuma.

"Puan Catherine Love Soper [Munich Re]: *So, in terms of reporting our clients' experience, I have grouped all the plans together for each client. Again, going back to graph on page 13, you can see that the very high and your increases of inflation aren't respective all the plans which include plans returned many years ago and also very recently and this is the way to the average experience. I would say that we are actually as we takaful, we don't have many plans that are results as your — you're talking about, how plans and products tend to be much younger. Okay.*

So, if we head back to slide 19. Sorry. Next slide. Okay, thank you. So, this section has talking about the drivers of increasing medical insurance claims. So, what is driving these higher medical insurance claims? This is a summary about observations. Immediately post-COVID, it was assumed that the causes of the high medical claims incurred by the insurance sector was due to delayed elective procedures and perhaps worsened immunity as well, especially with the young children and the elderly.

This is getting back to your point earlier. These high medical claims were there for presumed to be temporary. However, the high medical claims that are being faced by the insurance sector have continued to persist for years post-COVID-19, I mean write up to today. Which has now invalidated this earlier presumption and indicates that other causes are driving this trend real long-term causes. So, the drivers can be taught of as being bucketed into two main areas.

Number one, increased usage of medical insurance. So, this is policyholders' increased usage of their insurance benefits, coupled with health facilities practices that encourage policyholders to utilise their medical insurance coverage. And the other bucket is increased medical inflation cost. So, increase in the costs themselves. This is where healthcare costs are going up due to more advanced treatments, rising prices from retail price inflation, currency movement, so will see affect imported medicines and medical equipment.

Next slide, please. So, I'm going to deep dive into both two areas and a bit more detail. So, what is driving these higher medical insurance claims in respect of the policyholder's increased usage of their insurance benefit. Firstly, growing awareness and concern about health issues following COVID-19, especially nowadays, there's more ease of information access online with social media. There are also potential long-term adverse health effects for individuals who have had COVID-19, again a point that you mentioned earlier. It is a real phenomenon that we have observed.

This always see a lifestyle and environmental factors, for example, a more inactive lifestyle and an unhealthy diet, potentially contributing to more non-communicable diseases and the development over them into longer-term chronic conditions. And worsening levels of pollution, for example, causing more respiratory conditions. Respiratory issues have been a key area of causes of claims that we observed.

There is also what is commonly known as buffet syndrome mindset where policyholders tend to claim in order to receive back with perceived value of what

they have paid for with their insurance premiums. This is also made easier with cashless cards, where policyholders are less incentivised to understand or question what charges are actually being billed.

And then there is of course, fraud, waste and abuse incidents where unnecessary medical tests may be carried out and unnecessary medication prescribed, unfortunately.

And next slide. And if we deep dive into what is actually increasing the medical cost themselves, again, advancements in medical treatment which incur higher costs. Underlying retail price inflation that affects the costs of the medical equipment, transportation and the drugs and currency movements, as I mentioned before, where imported medication or imported medical equipment is affected and recently trade tariffs will play the part as well. Okay, next slide please.

So, the next section talks about managing medical insurance claim cost and particular the practices that we have observed elsewhere. Next slide. So, the observed practices — the practices we have observed that may mitigate unsustainable increases in medical claims cost can be thought of us again bucket in three different areas.

The first one would be around building sustainable product design. The second one would be around managing the health provider practices and the third one would be government-driven initiatives. And I will talk three several points under each of those topics. So next slide.

This talk about the observed practices with regard to sustainable product design. The three key areas are this set up in the slide. Firstly, co-pay. So, co-pay design where policyholders share a portion of the medical claims can be very effective. This policy provides an incentive for the policyholder to scrutinise what is being charged. This is a pretty common product design that we see practised across the Southeast Asia region these days.

The second point is a no-claim discount and it encourages policyholders to only claim when truly required. And again, it's a common product design in Southeast Asia this time at these days and also for the other lines of insurance, as well as, for example, mutual insurance is very common.

And thirdly, annual repricing for medical products. So regular incremental rate rises or rate increases will help to mitigate against sudden large rate rises being needed.

So, now discusses the key practices observed with regard to managing health provider practices. So, number one, price transparency is key and for standard medical procedures and fees charged by the providers. This allows consumers to compare prices and reduces incidences of complicated pricing structures and hidden costs.

Number two, pre-authorisation which refers to authorisation prior to hospital admission. These allows the insurers to evaluate and approve coverage for medical expenses strictly based on the policy benefits and the medical information provided. This can really help to curb over consumption, overtreatment and fraud. And this is quite common in Europe and across the US.

And lastly, a move away from a purely fixed fee-based remuneration structure for Third Party Claim Administrators to one perhaps that is performance based and linked, for example to claim experience or loss ratio..."

[Muka surat 13 - 16, Laporan Prosiding Bil 5(s)/2025 bertarikh 14 Ogos 2025]

"Puan Catherine Love Soper [Munich Re]: *Yes, sure. There are lots of pricing structures that can be implemented with your TPAs. The worst kind I've seen is where they are financially incentivised per claim that they approve. [Ketawa] That's at the worst but that is actually quite common because obviously then they are incentivised to approve claims without question.*

So, what we've suggested here is sort of the opposite where it is a performance-based. I do want to emphasis we are here to pay medically necessary claims — that's very important to us and that serves the greater public good.

But, where there is wasteful abuse of fraudulent claims, it is important that someone is keeping a check on them in order to keep the prices as reasonable as possible, again for the wider good. And certainly, for medium to smaller sized insurance companies, really is the TPA that has most ability to control the claims because they're the ones that approve the claims. So, yeah. So, the financial remuneration incentivises them in the right way is something we encourage.

Lastly, this is about the practices that we have observed relating to government-driven initiatives. Firstly, we do recommend establishing a national digital platform that requires health providers to produce structured digital medical records that can be transferred to insurers and TPAs in real time. That really does help with detecting fraud, waste and abuse. We recommended it particularly because we've seen it operated in the UAE, where Munich Re also has a big branch there.

Number two, the development of a long term sustainable base no-frills medical product by all insurers, again it supported by the government. This product would be focused on medical necessity and affordability. So, needs to have rather than nice to have.

Lastly, promoting preventative care, so free vaccines to greater proportion of society, free regular medical checkups through public health campaign to raise public awareness that prevention is really better than cure..."

[Muka surat 16 - 17, Laporan Prosiding Bil 5(s)/2025 bertarikh 14 Ogos 2025]

RUMUSAN & SYOR JAWATANKUASA KIRA-KIRA WANG NEGARA (PAC) PARLIMEN

8. RUMUSAN PAC PARLIMEN

PAC Parlimen merumuskan perkara-perkara berikut:

8.1 BNM beroperasi mengikut mandat yang menggalakkan kestabilan dan kemampanan sektor insurans dan takaful bagi melindungi kepentingan pemegang polisi. Walaupun mempunyai kuasa punitif, ia bersifat reaktif dan BNM tidak mempunyai instrumen undang-undang untuk mengawal punca luaran kenaikan premium, iaitu kos rawatan di hospital swasta.

8.2 Konsep insurans sedia ada di Malaysia terdedah kepada amalan pemilihan risiko (*risk selection*). Strategi segregasi risiko oleh syarikat insurans menyebabkan golongan yang paling memerlukan perlindungan sering dipinggirkan melalui mekanisme harga.

8.3 Terdapat amalan menutup kumpulan risiko lama (*closed pool*) untuk menawarkan harga kompetitif kepada peserta baharu. Amalan ini boleh memberi kesan kepada peserta setia yang lama kerana apabila kumpulan tersebut mengecil dan hanya tinggal peserta yang sakit, kadar tuntutan melonjak dan memaksa kenaikan premium yang mendadak.

8.4 Polisi insurans berkaitan pelaburan (ILP) memindahkan sebahagian risiko pelaburan dan kenaikan kos perubatan kepada pengguna. Ramai pengguna tidak menyedari bahawa *Cost of Insurance* (COI) akan meningkat mengikut usia, yang menjejaskan kelestarian perlindungan jangka panjang.

8.5 Model penetapan harga berkala (*cyclical repricing*) oleh industri yang bertujuan menyelaraskan harga premium sering mencetuskan kejutan kewangan kepada pengguna dengan kenaikan sekaligus mencecah 40% hingga 70%.

8.6 Kenaikan harga premium yang tinggi mengakibatkan terdapat segolongan pemegang polisi yang berusia 60 tahun ke atas terpaksa membatalkan polisi insurans mereka akibat faktor ketidakmampuan kewangan, sekali gus mendedahkan mereka kepada risiko tanpa perlindungan pada waktu ia amat diperlukan.

8.7 Mekanisme pasaran bebas tidak dapat mengekalkan harga premium yang stabil dan konsisten kerana inflasi perubatan secara berterusan melebihi inflasi umum. Kenaikan premium berkait rapat dengan peningkatan kos rawatan kesihatan yang memerlukan pendekatan menyeluruh merangkumi sektor kesihatan dan bukan sektor insurans semata-mata.

8.8 Ketiadaan struktur pengebilan hospital swasta yang standard ketika ini menyebabkan kos sebenar perkhidmatan dan item-item asas tidak dapat dicerminkan secara telus. Isu harga ubat yang tinggi sering digunakan sebagai alat untuk menutup kos operasi lain yang tidak dicaj secara langsung, seperti kos kejururawatan dan utiliti.

8.9 Terdapat amalan memecahkan caj (*unbundling*) bagi item-item asas seperti pelupusan sisa klinikal, sarung bantal, dan alkohol swab, yang sepatutnya termasuk dalam caj bilik atau perkhidmatan asas.

8.10 Wujud amalan diskriminasi harga di mana hospital mengenakan kadar caj yang lebih tinggi kepada pesakit yang menggunakan surat jaminan (GL) berbanding pesakit yang membayar tunai atau *pay-and-claim*.

8.11 Faktor utama inflasi bukanlah yuran profesional doktor yang telah dikawal sejak 2013, tetapi lonjakan caj komponen bukan profesional. Ini termasuk bekalan dan peralatan ubat-ubatan, peningkatan harga ubatan, caj ujian diagnostik dan makmal, penggunaan teknologi dan rawatan yang lebih mahal, kos operasi hospital swasta yang semakin meningkat seperti tenaga kerja, utiliti dan teknologi. Dalam masa yang sama kos litigasi dan rawatan defensif juga semakin memberi tekanan.

8.12 RESET merupakan pelan komprehensif 11 inisiatif yang merangkumi ketelusan harga, transformasi insurans, pemantapan sistem digital dan pelaksanaan pelan asas MHIT. Namun, kejayaannya bergantung kepada penyelarasan dasar dan kerjasama merentas agensi jika kerjasama industri tidak mencukupi.

8.13 *Diagnosis-Related Group* (DRG) ialah satu kaedah untuk menentukan bayaran rawatan kesihatan berdasarkan jenis penyakit atau keadaan pesakit dan

bukannya berdasarkan setiap ujian, ubat atau prosedur yang dilakukan satu per satu.

8.14 Pelaksanaan DRG antara lain dilihat mampu mengalihkan model berasaskan keuntungan prosedur kepada kecekapan klinikal. Walau bagaimanapun, ia perlu memenuhi beberapa prasyarat terlebih dahulu termasuk pangkalan data yang lengkap dan sistem Rekod Perubatan Elektronik (EMR) yang bersepadu.

8.15 Wujud *mark-up* median yang sangat tinggi pada pelbagai peringkat rantaian bekalan ubat, di mana ubat generik di hospital kadangkala dicaj lebih mahal daripada ubat berjenama (*innovator*).

8.16 Terdapat lebih 1,500 jenis ubat yang hanya mempunyai satu pengeluar berdaftar di Malaysia, mewujudkan monopoli yang membolehkan penetapan harga tinggi tanpa persaingan.

8.17 Wujud persepsi terhadap kebebasan Ombudsman Perkhidmatan Kewangan (FMOS) kerana model pembiayaannya datang daripada industri insurans sendiri.

8.18 Kegagalan Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 (Akta 586) berkembang mengikut peredaran zaman membolehkan hospital mengenakan "caj kreatif" yang sah di sisi undang-undang tetapi membebankan rakyat secara moral dan ekonomi.

8.19 Data menunjukkan bahawa kebanyakan rakyat Malaysia kurang kesedaran dan minat untuk melakukan saringan kesihatan yang seterusnya menyumbang kepada peningkatan tuntutan rawatan serta kelewatan rawatan yang lazimnya melibatkan kos yang lebih tinggi berbanding rawatan pengesanan awal.

8.20 Berlakunya kesan domino terhadap Sektor Kesihatan Awam di mana kegagalan rakyat untuk mengamalkan gaya hidup sihat selain kemampuan untuk terus mengekalkan perlindungan insurans swasta telah menyumbang kepada peningkatan pesakit di hospital kerajaan. Ini meningkatkan lagi kesesakan di fasiliti kesihatan awam, memanjangkan tempoh menunggu, dan

memberikan tekanan fiskal serta operasional yang hebat kepada sistem kesihatan negara.

9. SYOR PAC PARLIMEN

Bagi tujuan penambahbaikan PAC Parlimen mengesyorkan kepada Kerajaan perkara-perkara berikut:

9.1 BNM diminta untuk menambahbaik keperluan untuk mengukuhkan pengumpulan risiko merentas kumpulan (*cohort*) yang serupa, termasuk portfolio tertutup, dan mengesyorkan agar keberkesanannya terus dipantau.

9.2 BNM harus mengeluarkan garis panduan operasi yang lebih terperinci dan seragam (*standardized FAQ*) bagi mengelakkan syarikat insurans memanipulasi tafsiran langkah-langkah interim.

9.3 Bagi menjamin keberkesanan intervensi kerajaan, BNM perlu mengenakan tindakan punitif yang tegas ke atas mana-mana pengendali insurans yang dikesan memanipulasi tafsiran atau gagal mematuhi langkah interim sehingga menjejaskan kebajikan dan kepentingan pemegang polisi.

9.4 BNM perlu memastikan industri insurans dan takaful perlu beralih kepada pelarasan premium tahunan yang lebih kecil dan stabil (*incremental annual repricing*) untuk mengelakkan kejutan kenaikan kewangan yang besar terhadap pemegang polisi.

9.5 BNM harus mengkaji semula penetapan premium mengikut kumpulan (*cohort*) dan mempertimbangkan pendekatan yang bersesuaian dan mengkalibrasi dengan teliti bagi memperkukuh keadilan dalam perkongsian risiko sambil mengekalkan kemampuan serta kemampanan jangka panjang.

9.6 Suruhanjaya Persaingan Malaysia (MyCC) perlu memberi panduan kepada pihak yang berkepentingan supaya amalan rundingan diskaun antara pihak hospital dan insurans bagi memastikan proses tersebut adil dan tidak menjejaskan akses pesakit.

9.7 KKM perlu memastikan pelaksanaan sistem DRG di sektor swasta disegerakan untuk menggalakkan kecekapan kos.

9.8 KKM hendaklah memastikan pindaan Akta 586 dilaksanakan bagi memberi kuasa kepada Kementerian Kesihatan (KKM) mengawal selia caj perkhidmatan hospital swasta selain yuran doktor.

9.9 KKM dan BNM hendaklah memperkasakan saluran/mekanisme penyelesaian aduan bagi isu insurans dan kos perubatan supaya dapat diselesaikan dengan efisien dan berkesan.

9.10 KKM dengan kerjasama KPDN perlu menetapkan mekanisme pengawalan harga bagi ubat-ubatan dan peralatan perubatan agar kekal munasabah untuk mengelakkan tiada pihak yang mengambil keuntungan berlebihan.

9.11 KKM perlu meneroka sumber bekalan dari pengeluar secara terus (*outsourcing*) dengan mengutamakan pengeluar tempatan bagi mengurangkan kebergantungan kepada dominasi pembekal atau kartel tertentu.

9.12 MOF, BNM dan KKM perlu mewujudkan tadbir urus yang baru dan bebas untuk penjagaan kesihatan swasta bagi melindungi pengguna termasuklah untuk menyemak dan mengawal selia caj dan manfaat insurans kesihatan.

9.13 KKM perlu memperkasakan dan meneroka inisiatif-inisiatif yang meluaskan akses kepada perubatan mampu milik sekali gus bertindak sebagai penanda aras harga (*benchmark*) bagi industri kesihatan swasta.

9.14 MOF, BNM dan KKM hendaklah menyegerakan pelaksanaan sepenuhnya inisiatif RESET dan semua pihak berkepentingan perlu memberi sokongan berterusan bagi memastikan kos rawatan di sektor swasta dan premium insurans dapat dikawal dalam jangka masa panjang.

9.15 MOF, BNM, KKM dan Kerajaan secara keseluruhannya bersama industri insurans dan takaful serta industri perkhidmatan kesihatan, perlu menggalakkan gaya hidup sihat dan penjagaan kesihatan pencegahan melalui insentif serta penawaran produk insurans dan takaful yang bersifat preventif.

9.16 KKM hendaklah mempergiat kempen kesedaran awam dan pembudayaan gaya hidup sihat secara komprehensif. Dalam hal ini, semua Kementerian, Agensi Kerajaan, GLC dan institusi pendidikan di semua peringkat perlu diwajibkan untuk menggalakkan amalan kesihatan bagi mengurangkan risiko

penyakit tidak berjangkit (NCD), membendung inflasi kos perubatan serta mengatasi isu kesesakan pesakit yang kritikal di hospital-hospital kerajaan.

9.17 MOF, BNM dan KKM perlu menetapkan satu garis masa pelaksanaan yang munasabah dan jelas bagi semua langkah inisiatif RESET dan memastikan semua persiapan dilaksanakan secara tersusun bagi menjamin kesan yang mampan dan berterusan.

JAWATANKUASA KIRA-KIRA WANG NEGARA (PAC) PARLIMEN

LAPORAN PROSIDING (HANSARD)

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Jumaat, 14 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding Pendengaran Awam:
Peningkatan Bayaran Premium Insuran Kesihatan,
Caj Hospital Swasta dan Impak kepada
Kesihatan Awam di bawah MOF, MOH & BNM

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

SESI PENDENGARAN AWAM
JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN MALAYSIA

AC HOTELS BY MARRIOT, PULAU PINANG

JUMAAT, 14 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]

Tidak Hadir *(Dengan Maaf)*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Puan Vivian Wong Shir Yee [Sandakan]

URUS SETIA

Siti Noor Akmar binti Zulkafli [Juruaudit (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

HADIR BERSAMA

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SAKSI

Encik Murugappan
Encik Hazwan Arif bin Hassan [Muqmeen Group]
Puan Kelvindejit Kaur
Encik Poh Hup Lin [LIfe Planner AIA Berhad]
Encik Choo Chon Kai [Parti Sosialis Malaysia Pulau Pinang]
Encik Harbhajan Singh
YBrs. Dr. Tan Huat Tian
YBhg. Dato Dr. Jayabalan a/l A. Thambyappa [Health & Safety Advisory Centre (HSAC)]
YBrs. Dr. Sim Joo Seng
YBrs. Dr. Chee Heng Leng [Citizens' Health Initiative]
Encik Oon Soon Hock
Puan Lim Cheng Ean
YBrs. Dr. Ch'ng Ewe Seng
YBrs. Dr. Teo Aik Howe [Hospital Pulau Pinang]
Encik Chew Kean Khoon [Prudential]
Encik Ambigapathi a/l K.A Samarasan
Encik Ong Eng Ker
Encik Kwan Nam Poh
Encik Oh Ee Teik
YBrs. Dr. Sng Kim Hock [Hospital Pantai Kuala Lumpur]

LAPORAN PROSIDING

SESI PENDENGARAN AWAM
JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

AC HOTELS BY MARRIOT PULAU PINANG

JUMAAT, 14 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 9.10 pagi

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
mempengerusikan Mesyuarat]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Bismillahi Rahmani Rahim, assalamualaikum warahmatullahi wabarakatuh* dan selamat pagi dan salam sejahtera. *[Membaca doa].* Terima kasih saya ucapkan kepada sudara Iman, sekali pengacara majlis pada hari ini.

Yang saya hormati Yang Berhormat Ahli Parlimen PAC Parlimen ke-15. Saya perkenalkan satu persatu; yang pertamanya, Yang Berhormat Tuan Sim Tze Tzin, Ahli Parlimen Bayan Baru. Keduanya, YB Datuk Ali anak Biju daripada Saratok, Sarawak. Ketiga, Yang Berhormat Dato' Wira Dr. Ku Abd Rahman daripada Kubang Pasu, Kedah dan yang hujung sekali Yang Berhormat Tarmizi daripada Sik, Kedah juga. Terima kasih kepada semua Ahli Jawatankuasa PAC yang berkelapangan pada hari ini serta tuan-tuan dan puan-puan yang turut hadir pada hari ini.

Jadi, saya ingin mengucapkan bagi pihak PAC Parlimen Malaysia ingin mengucapkan ribuan terima kasih kerana dapat meluangkan masa untuk bersama-sama dengan kami bagi sesi pendengaran awam pada hari ini. Seperti semua sedia maklum sesi pendengaran awam pada hari ini kita tumpukan kepada isu Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan juga Impak Kepada Kesihatan Awam.

Terima kasih juga kepada TKSU Kementerian Kesihatan yang turut bersama dengan kita pada pagi ini. Untuk makluman semua, hari ini PAC adalah kali pertama, julung-julung kalinya PAC Parlimen Malaysia mengadakan pendengaran awam secara terbuka bersama dengan orang awam.

PAC Jawatankuasa Kira-kira Wang Negara secara kolektifnya dengan persetujuan daripada Yang Berhormat Speaker telah memutuskan untuk kita mengadakan satu sesi pendengaran awam untuk isu ini yang mana ia perlu diadakan. Jadi, ianya berhubung dengan kesihatan awam. Satu isu yang saya rasa

yang sangat penting dan ia terpakai kepada semua seluruh rakyat Malaysia. Jadi, ia juga adalah merupakan salah satu hak asasi manusia.

Jadi, amat penting untuk PAC turun dan dengar sendiri situasi sebenar yang dialami oleh masyarakat di negara kita ini. Untuk makluman semua, sesi diadakan sebelum PAC memulakan prosiding yang berkaitan. Kita nak mulakan prosiding ini dekat Parlimen Malaysia kita nak memanggil pihak-pihak yang terlibat. Kita nak panggil saksi-saksi. Kita nak panggil kementerian, agensi yang terbabit. Jadi, sebelum kita nak panggil mereka jadi kita nak dengar dulu apa kata orang awam. Apa kata daripada mereka yang terkesan. Apa kata daripada mereka yang terlibat dalam industri ini.

Sebab itulah segala apa yang dilakukan dalam waktu kita pendengaran awam ini untuk kita kumpul persoalan. Kita kumpulkan rintihan, kerisauan, keluhan rakyat berhubung dengan isu ini dan perkara-perkara yang dibangkitkan dalam sesi ini akan kita jadikan sebagai panduan dan juga persoalan yang telah pun tuan-tuan dan hadirin ajukan kepada kita dan kita dapat gunakan ini, dapat kita gunakan untuk kita panjangkan sewaktu dalam prosiding PAC nanti.

Jadi, ini adalah merupakan salah satu titik tolak yang penting dan bersejarah buat negara kita kerana ini adalah merupakan salah satu inisiatif ke arah kerajaan yang lebih baik dan juga bertanggungjawab terhadap kebajikan rakyat.

Jadi, tanpa membuang masa saya dengan ini menyerahkan sesi pendengaran awam ini kita kepada Yang Berhormat Tuan Sim Tze Tzin, Ahli Parlimen Bayan Baru dan juga sebagai moderator pada hari ini. Jadi, saya ucapkan ribuan terima kasih kepada semua.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih saya ucapkan kepada YB Mas Ermieyati sebagai Pengerusi *Public Accounts Committee,* Jawatankuasa Kira-kira Wang Negara dan YB Saratok, YB Kubang Pasu dan juga YB Sik. Juga bekas ADUN Batu Uban, YB Dr. Jayabalan. Ini kawasan DUN Batu Uban. Walaupun Parlimen tapi dia bekas tuan rumahlah. Selamat datang.

Saya ucapkan terima kasih juga kepada Dato' Sri Norazman sebagai TKSU MOH, memberi sokongan kepada PAC dalam pendengaran ini. Saya juga amat terima kasih kerana Dr. Sng bekas *what do call Specialist Association President* berada di sini bersama kita dan juga wakil daripada LIAM, daripada Takaful-4-All. Juga *I saw some of the specialists here* dan juga daripada *public* dan semua rakyat Malaysia yang sudi hadir pada pagi yang mulia ini.

Selamat pagi saya ucapkan. Saya mulakan dengan satu pantun dululah.

Pergi berubat di hospital swasta;

Layanan mesra tiada cela;

Kos rawatan dan insurans biar selesa;

Agar rakyat tidak merana. [Tepuk]

Okey, semalam kena fikir pantun. Okey, kita berada di sini pada *public hearing* ini, kita ingin membantu negara, membantu kerajaan untuk mencari penyelesaian kepada kenaikan kos *medical inflation* dan juga kenaikan kos insurans. Kita tahu bahawa di Malaysia ini, ia ada dua sistem. Satu *public hospital, universal healthcare. This is a very good thing about Malaysia, we have universal healthcare.* Semua rakyat tak kira yang kaya, yang miskin semua boleh dapat perubatan daripada hospital kerajaan.

Pada masa yang sama, kita ada sektor hospital swasta. Hospital swasta ini kalau mampu bayar, ada insurans boleh mendapat layanan yang mungkin lebih cepat, mungkin lebih rapi. Itu selama ini dua sistem ini berjaya memberi satu *healthcare coverage* yang paling baik saya kiralah paling baik di rantau Asia dan tidak kurang juga sangat setanding dengan negara maju.

Jadi, ini adalah *a very successful model.* Walau bagaimanapun, kita tahu bahawa selepas COVID memang mendapat cabaran pelbagai dengan inflasi dan juga kos *of medicine* dan sebagainya. Jadi, kita menghadapi masalah kerana kenaikan di hospital swasta. Pada masa yang sama, kita pun tahu bahawa hospital swasta walaupun *specialist* dan juga kos konsultan *doctors* adalah dikawal tetapi *hospital services and supply* tidak terkawal. Maka ia telah mendapat— ia telah melonjak.

Contohnya, *diapers* boleh kena caj RM50 satu keping *diaper.* Satu pasang *gloves* boleh caj RM20 *which is a bit too much* lah. Sebenarnya kos rendah. Contohnya, Panadol mungkin caj RM10. Ini adalah praktis yang saya nampak bahawa ada sesetengah hospital swasta yang agak terlalu tinggilah.

Jadi, itulah sebab kos perubatan di hospital swasta menjadi terlalu mahal sehinggakan rakyat yang biasa tidak lagi mampu masuk ke hospital swasta dan insurans terpaksa naik juga ekoran daripada tersebut. Maka kita tahu bahawa tahun lepas insurans naik 30 hingga 70 peratus.

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Ada yang *complaint* kepada kami sebagai Ahli Parlimen, kenaikan insurans mencecah 186 peratus. Itu paling tinggi yang saya dapati. Jadi ini menyebabkan ramai yang *surrender* insurans mereka. Yang ada *cancer patient,* yang mengadu kepada saya, mereka tidak mampu lagi membayar insurans, mereka *surrender. Now they have to go to general hospital.* Jadi ini menyebabkan lambakan dan impak kepada hospital kerajaan. Dulu mereka mampu pergi ke hospital swasta. Sekarang

terpaksa beratur di hospital kerajaan dan hospital kerajaan menjadi terbeban. Jadi *the whole ecosystem* ini perlu mendapat satu reformasi dan rombakan supaya kita boleh ada satu *sustainable healthcare,* dua sistem yang baik. Kita tidak— hari ini kita adakan *public hearing* ini. Kita tidak akan bercakap banyak dan kita akan dengar daripada rakyat.

Jadi formatnya adalah kita buka kepada semua yang ingin memberi pandangan, memberi aduan pun boleh dan juga yang penting adalah mendapat *feedback* daripada rakyat supaya kami boleh tahu sebagai Ahli-ahli PAC, kami *layman,* kami bukan *expert.* Itu sebab kita perlu dapat mendengar *what is your problem, what is your suggestion.* Jadi kalau boleh formatnya, tampil ke depan, beri nama. Kalau rakyat biasa, *it's okay.* Kalau daripada mana-mana *association, just give your piece of*— beritahu persatuan atau daripada hospital mana dan terus cakap, okey? Semua yang kita cakap di sini demi negara, demi untuk memperbaiki sistem kesihatan swasta dan awam– negara. *So, we are for national service.*

Saya telah mendapat *blessing* daripada Menteri Kesihatan. Saya telah jumpa dia. Beliau kata, *"Sim, you please help us, help the government. Please proceed dengan segala prosiding dan sebagainya".* Dan dia kata dia akan memberi *full backing* kepada PAC untuk melakukan segala prosiding dan dia kata *he looks forward for a good report.*

Jadi tuan-tuan, puan-puan di sini, apa yang tuan-tuan dan puan-puan beri pandangan ini, akan menjadi *part of the PAC report.* Jadi apa yang direkodkan akan menjadikan *part of the PAC report.* Jadi dia akan dalam *Hansard* dan dia akan menjadi satu laporan yang bersejarah. Jadi tanpa melengahkan masa, saya buka *floor* untuk sesiapa yang ingin memberi pandangan kepada PAC. Sekian terima kasih, *xie xie, nandri vanakkam. Yes please Sir.* Di sana *[Sambil merujuk kepada pembesar suara]*

Encik Murugappan: Selamat pagi YB-YB dan semua hadirin. *Let me just present some points comprising observations, complaints and…*

Tuan Sim Tze Tzin [Ahli PAC]: *Your name Sir, your name Sir?*

Encik Murugappan: *My name Murugappan. I'm a retired government servant and I'm coming here as an individual. Okay, the first point I want to mention is the Competition Commissions should strictly enforce antitrust policy with regard to the healthcare sector, notwithstanding the fact that the two major private hospital groups, IHH Healthcare and* Kumpulan Perubatan Johor, *are government-linked companies.*

Now I noticed that during the COVID-19 pandemic, there was a government-linked company that supplied respirators that were not working. The government-

linked at huge losses and yet the government found it necessary to give them new contracts. It is quite puzzle-lah, *you know why you want to give new contracts to a company that did not perform during a pandemic. Now IHH Healthcare itself controls Gleneagles, Pantai, Island and Prince Court Hospitals. This dominant position gives them undue influence in setting prices and practices in the private healthcare sector.*

My second point is similarly the pharmaceutical industry is also oligopolistic in nature with big pharmacies itself controlling Wellings, Caring and Geroge Town.

Three, medical tourism as promoted by the government, has an adverse impact on the local healthcare sector, as it is lucrative and has attracted a lot of specialists to the private sector to the detriment of the public sector hospitals. A number of years ago, Dr. Jeyakumar Devaraj, the former member of Parliament for Sungai Siput held during a seminar at Penang Institute, publicly stated that 80 percent of specialists are in the private sector, whereas 80 percent of admissions are to the government hospitals.

Fourth, the government could try to prevent this massive outflow of public sector specialists who were probably trained at taxpayers' expense by implementing a more progressive income tax structure whereby all individuals with taxable incomes, all ya. *Not just doctors. I remember Dr. Jeyakumar said doctors should be taxed. But I think it's unfair*-lah. *It should be to all individuals with taxable incomes of more than RM500,000 a year to pay progressively steeper tax rates as it's become higher and higher, the tax rate should be steeper. So that the incentive to move to the private sector is less. This also has the effect of reducing income inequality in the country.*

Fifth, there is absolutely no basis for price discrimination between insured and non-insured patients, with insured patients being charged double the prevailing rates. This practice has the effect of pushing up insurance premiums. The insurance company could also introduce a no-claim bonus for policyholders to avoid frivolous admission to the hospitals. I know of some people who say I have been paid a premium for so many years. I didn't get anything. So, I admitted myself to the hospital.

Sixth, private hospitals also mark up their drug prices tremendously such that they are more than double the prices at the private pharmacy which already marking good margins. This is without taking into account that the hospitals would be receiving discounts for bulk purchases.

Seventh. Since the hospitals invest in expensive equipment, the management puts pressure on the doctors to do unnecessary tests. When I was in government service, I was a nominee director for one of the private hospitals representing my organization. I was the only director who was the most simply telling towards the

patients. The other director always asked, "What was the utilization break for the MRI machine? What was the utilization rate for this?". So indirectly puts a lot of pressure on management and doctors to use the equipment, to give the required rate of return.

Eighth, itemised bills contain a lot of medical jargon and the average patient doesn't know exactly what treatment the patient has paid for. It is suggested that the bill should also include a brief description, preferably non-technical terms of the nature of the treatment provided.

Ninth. In the event of overcharging, the patient has no alternative except to pay. In fact, I remember previously, one private hospital charged my wife for a blood test that was not done. So, I reported to the ministry, I wrote various letters including to Dato' Noor Hisham. I did not get any responses. All they said was our roles in supervising private hospital is limited. You know what the senior officers in jabatan *in Penang told me, the medical director's assistant, "If they did not perform the test, you shouldn't have paid". I told him this is the kind of advice I expect from a friend in a coffee shop. Not from a senior officer of the Ministry of Health. Finally, nothing was done you know. In the event of overcharging, the patient has no alternative except to pay or go to court. It is suggested that the government consider setting up an arbitration council similar to the Consumer Tribunal.*

Tenth. In cases of medical negligence, the patient again has no choice but to go to court. This not only involves enormous legal fees but patients also face tremendous difficulties in getting another doctor to provide expert evidence. To share my personal experiences, my mother had glaucoma, I took her to a famous eye surgeon in Penang in a private hospital. I told him my mother had glaucoma. Can she undergo cataract surgery? She said yes. We will take additional precautions. That's only meant additional expenditure and she went blind.

So, when I approached another big hospital specialist he told me, "You know we do 100 surgeries. Definitely some will go wrong". I said, "Doctor, to you is a statistic. To my mother is a life". And I asked him, whether he could give evidence. Of course, they don't want to give evidence against a colleague because they are afraid in future, they will give evidence against them.

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On the other hand, doctors have the Medical Defence Union to represent them. Again, it is suggested that the government establish a panel of specialist doctors in various fields who can be called upon to provide evidence for a reasonable fee. This will make the playing field a little bit more level between patients and their doctors.

Eleven, it is noted that doctor's charges are regulated. But hospitals are free to charge astronomical advance. Why is this so? One of my doctor friends was previously a professor in Penang Medical College said, it is because the two major hospital groups are government-linked. The government just not want to control their charges. I don't know whether it's true-lah.

Twelve, once a patient is admitted, the patient and/or their family have little say in the treatment except if they choose to discharge the patient. A few examples illustrate this point.

A 91 years old lady who was nearing the end of her life was admitted to a private hospital in Penang with the instructions to provide only palliative care. The family knew she cannot be cured, she is about to die. However, in reality, a team of five specialists visited her twice a day for about a week including a geriatrician, cardiologist, anesthetist, et cetera. Before she passed away about seven days later, the billing in 2012, mind you 13 years ago, came to a whopping RM35,000.

An expectant mother experiencing labour pains was admitted to a private hospital in Penang on Saturday afternoon in 2024. The obstetrician gave an injection to delay delivery presumably because he did not want to work after office hours. However, on Monday morning, he claimed that the fetus was in distress and then an emergency caesarian section was necessary. The bill amounted to whopping RM20,000. Even though the Johor branch of the same hospital— this is the Penang branch ya. The Johor branch of the same hospital has advertised the caesarian package for only RM8,000. There's a difference of RM12,000.

A six-month-old infant was admitted to a private hospital in Kuala Lumpur for an infection of the lymph nodes behind the ear on a Monday in December 2024. Although the infant had been in the hospital for six days prior, the ENT specialist showed up at 7.30 am on a Sunday morning and insisted on performing an operation on the infant involving three separate incisions behind the ear. The mother told the ENT specialist that she would need to get the father's consent.

However, the ENT specialist insisted that she could not wait and walked off. Eventually, the operation was avoided on the advice of another ENT specialist from a different branch of the same hospital. Okay, this is an important question. Did the specialist insist on performing the operation on a Sunday without the father's consent, so that she could earn double the amount? I am told that if they do the operation on a Sunday, they have paid double the amount.

The final point I have here on medical insurance. On the question of medical insurance, the fundamental argument for taking up insurance is to protect the insured against uncertainty. We want to protect ourselves against unforeseen events. If

insurance premiums are going to be continuously increased during the tenure of the policy, then why buy an insurance policy in the first place? It looks like we must take another insurance policy to protect ourselves against insurance premium increased. It makes absolutely no sense. Terima kasih. *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much sir for your comprehensive and very extensive presentation. Yes.* Ya, silakan.

Encik Hazwan Arif bin Hassan [Muqmeen Group]: *Assalamualaikum,* selamat sejahtera, salam Malaysia Madani. Nama saya Hazwan Arif bin Hassan, daripada Muqmeen Group (Prudential BSN Takaful). Saya adalah seorang— antara orang kata, sejumlah besar sebahagian perunding takaful sepenuh masa di seluruh Malaysia ini.

Apa yang saudara itu katakan tadi sebenarnya ada juga *underlying issue* sebenarnya. Kenaikan insurans premium takaful dan juga insurans ini bukanlah salah 100 peratus syarikat insurans dan takaful. Kami sebagai syarikat dan juga agen-agen di sini hanyalah sebagai operator yang menguruskan dana *tabarru*, wang-wang yang telah— caruman-caruman yang telah dikumpulkan, dimasukkan ke dalam satu tabung, menguruskan. Apabila berlaku tuntutan, kamilah yang bertanggungjawab untuk mengagihkan wang tuntutan itu daripada dana *tabarru* ke hospital-hospital untuk membayar tuntutan yang telah dikenakan.

Tetapi apa yang berlaku ialah bukan salah kami, tetapi sebahagiannya adalah caj-caj yang dikenakan. Bayangkan, ini adalah satu *final* GL *[Sambil menunjukkan senaskhah dokumen]* bertarikh 1 Januari 2025 daripada klien saya sendiri untuk sakit tidaklah kritikal, tetapi melibatkan pembedahan membuang nanah di Pantai Hospital Laguna Merbok.

Untuk tiga hari saja daripada 30 Disember hingga 1 Januari 2025. Apa yang mengejutkan saya kadang-kadang ialah *hospital charges* sehingga RM6,000 untuk tiga hari. Bolehlah, tapi saya rasa macam tak berpatutan untuk tiga hari. Sebenarnya bukan penuh tiga hari pun beliau duduk. Beliau masuk pada 1 hari bulan pun bukanlah 1 hari bulan penuh. Mungkin pada malam 30 hari bulan itu beliau baru *discharge* masuk sebab ada proses untuk kata apa, nak memproses GL itu.

Jadi, beliau tak masuk penuh tiga hari. Hanya mungkin dua hari suku, dua hari setengah sahaja. Tetapi, *charges* yang dikenakan kadang macam— RM6,000 untuk *hospital charges*, RM3,000 lagi untuk *surgical benefit*. *So*, semua jumlah hampir RM10,339.20. Ini untuk pembedahan kecil untuk nak membuang nanah sahaja.

Kadang saya fikir kadang buang nanah saja *kut*, takkanlah sampai RM10,000 untuk tak sampai tiga hari penuh. Sebab yang ini dia punya kemasukan dia tak sampai tiga hari penuh, cuma dua hari separuh sahaja.

Kemudian, macam YB cakap tadi, untuk kata caj-caj barang yang telah di-*marked up*, di sini ada ini, *breakdown of excluded amounts. Medical surgical ward and supplies.* Yang ini yang Prudential tak bayar tahu, yang ini Prudential yang tak bayar tahu. Yang dia tak tanggung, dia tak *cover* untuk pesakit. *[Dicelah] Non-payable expenses.* Saya terkejut tengok di sini. *Medical surgical ward and supplies amount not-payable, face mask N95 particulate RM12. This is the real.* Kalau nak salinan saya boleh bagi.

Tuan Sim Tze Tzin [Ahli PAC]: Boleh, boleh. Bagi nanti bagi— *provide* kepada sekretariat supaya kami boleh rekod.

Encik Hazwan Arif bin Hassan [Muqmeen Group]: Okey. *Miscellaneous charges admission,* okey RM26. *Miscellaneous charges administration fee*— yang ini pun sama juga. Caj-caj begini yang patut dipantau.

Juga, saya tak ada *breakdown of itemised bill* sebab saya *duk* tunggu lagi klien saya bagi, tapi tak apa. Cuma kata, yang ini. *Hospital charges surgical benefit* ini. Ini baru satu. Bayangkan kalau ada beberapa pembedahan yang lain? Ini untuk pembedahan buang nanah sahaja, belum untuk influenza.

Influenza kadang tahan empat hari, *boom* RM7,000 dah. Empat hari, influenza, biasa sahaja. Tak tanya apa, doktor datang melawat— ini pengalaman saya, pengalaman klien yang bercerita kepada saya. Klien yang bercerita pada saya, dia cakap, tahan empat hari. Doktor masuk, tengok, *blah*. Nak kata nak *consult*, nak bagi tahu apa keadaan sebenar, tak ada. Itu, di salah satu hospital swasta di Kuala Lumpur. Macam itu.

So, the practices kata kadang-kadang doktor kadang tak bagus juga. Datang tengok, tak cakap apa, *blah and then*, caj. Datang, *blah*, tengok, caj. Yang nak kena bayar bukan *patient* itu, tetapi perlu diingat, pencarum-pencarum dalam tabung dana *tabarru* itu sendiri seperti saya.

Saya 10 tahun— 10 tahun kah? 15 tahun mencarum dalam polisi saya, *medical insurance*. Sepanjang 15 tahun, tak pernah pun *claim*. Tak pernah pun *claim*. 15 tahun. Ada yang 10 tahun, ada yang 20 tahun tak pernah mencarum. Aku dapat apa? Aku dapat apa dia orang cakap. Nak melegakan hati dia orang, saya cakap okey, saya tengok balik *cash value* dalam dia orang punya polisi, okey keluarkanlah sedikit sekadar nak bagi bonus. Orang cakap itu adalah apa orang cakap, *profit-sharing*, perkongsian keuntungan antara syarikat dan juga para pencarum. Itu sahaja.

Macam tadi saudari cakap, perlu *set*-kan satu— PAC perlu syorkan kepada KKM, kawal, *oversee this hospital.* Konsultasi doktor memang dikawal, tetapi perkhidmatan barang-barang *disposable* dia orang ini. Macam jarum, tiub, ubat-ubatan, apa lagi?

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Kalau ada apa-apa tambahan, sila boleh tambah nanti. Sila pantau dia orang punya harga dia orang. Sebab, ikut mana pun, syarikat takaful, syarikat insurans hanyalah membayar tuntutan itu mengikut kos-kos yang telah dijustifikasikan oleh hospital. Itu saja. Kami tidaklah— kami tak bersalah. Komisen yang kami dapat, itu sebenarnya untuk kami beri khidmat balas kepada klien-klien kami. Ini... *[Sambil menunjukkan senaskhah dokumen]* Nak urus ini, tuntutan ini. Semua ini— *actually,* inilah kata dalam bentuk perkhidmatan yang kami beri pada klien kami. Ini *follow-up* apa semua. *Outpatient follow-up treatment.* Kami yang buat ini. Kami yang buat, kami dilatih untuk dibuat dan kami beri khidmat yang paling terbaik kepada klien-klien kami.

Kalau nak tuduh kata syarikat insurans untung, syarikat insurans untung ini, tidak benar sama sekali. Perlu diingat, kalau nampak ejen bawa keluar kereta baru, itu untuk kepuasan diri dia. Itu ejen yang kaya. Yang kamu tak nampak— ejen kena sidai, kamu tak nampak. Ini isu yang berlaku.

Jadi, jangan letakkan 100 peratus kesalahan pada syarikat takaful, syarikat insurans dan juga ejen-ejen. Kami hanyalah yang bekerja dan memberi khidmat kepada klien kami. Itu satu. Tetapi, *the real underlying issue* adalah ini— *charges* hospital yang kami bila nampak, kadang-kadang tak masuk akal. Tak sampai tiga hari tahan, dah RM10,000 dah. itu sahaja.

So, saya harap PAC tolong tekan pihak hospital-hospital swasta ini, kawal dia orang punya *charges* ini. *Scrutinise* balik, teliti balik berapa *charges* dia orang, kenapa mahal sangat ini. Berapa harga pasaran untuk ubat-ubatan, untuk jarum, untuk tiub, alat-alat perubatan, sila pantau.

Tuan Sim Tze Tzin [Ahli PAC]: Okey.

Encik Hazwan Arif bin Hassan [Muqmeen Group]: Okey, terima kasih, *Assalamualaikum.*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, Encik Hazwan. Saya tahu ramai yang ingin berucap. *You* boleh terus *queue* sahaja ya. *Queue* di depan supaya kita boleh tahu berapa ramai ya. *I think ladies first*-lah ya. Tak apa, *you can queue there, so that— okay.*

Puan Kelvinderjit Kaur: *Okay*. *A very good morning to our honorable YB and members of the floor and all attendees, ladies and gentlemen. So, I am Kelly, can*

address me as Kelly, and I am graduate from Universiti Sains Malaysia. *So, I would like to raise dissatisfaction about the rampant raise in medical insurance premiums lately.*

So, firstly, most of us are persuaded to actually take medical insurance by very convincing insurance agents who, of course, receive a big commission and bring young people to take the insurance although still young because the premiums are low. So, at that point of time, we are not told that the premium will actually increase. Alright. So, at this particular period, when we are young, the insurance makes huge profits as not many youngsters have serious health issues unlike the elderly and also the senior citizen, right?

So, then, as we grow older, the premiums actually increase especially after reaching age of 60. So, now, they say that they face high claim— yes, after the age of 60— but don't the insurance companies realised that they have made big profits when the present senior citizen were youngsters, when they first took their policy? Okay, so that the first thing.

Secondly, hospitals do unnecessary tests and procedures when they know that a patient is covered by insurance, unlike self-paying patient whose consent will be obtained before any procedure after also informing the cost of the procedure as hospital also fear that patient may not be able to afford it. Alright. So, that is the second one.

Moving on the third one is that test that actually were not done are billed to insurance company. So, when we questioned the hospital, they say that, "It maybe a mistake but it's okay, you don't have to pay because the insurance is paying." But some may not realize that over yearly, be lifetime, eligibility is being utilised and becomes less every time a claim is made. So, we are actually at the losing end.

So, some hospital say that, "Oh, it is a mistake but we need to send a new bill to the company after they have got the approval and it will actually take more time. Are you willing to wait?" Alright. So, they will actually bring this up, and don't forget, a late discharge from the room will also makes you actually get charged extra. So actually, who wants to wait for that? So, they actually use that reason and like I said earlier, so you if you get discharged later on, they will actually charge you for the room itself. So, that is the issue actually.

So, for the suggestion is that— my suggestion, for those who actually took the medical insurance at a young age, example below 30 or 35, their premiums should not be increased when they reach 60 as the insurance company has made profits from the premiums. So, it is understandable if insurance company charge a high premium for those 60 and above who decides to take a policy.

So, next suggestion is that all test and procedure should obtain the written consent of insured and bills prepared by the hospital should be also signed by the patients to certify that the tests and procedures were indeed done and even the medication given to the patient in the ward before the final bill is sent to the insurance company. So that the client actually knows about the bills and what they were actually charged for.

So, another issue that doctor's consultation is limited to two times a day. Alright. So, doctor only actually comes in once but in the bill, it is stated that two visits were charged. So, all these caused the insurance company to pay high claims, thus the insurance companies have to actually raise their premiums.

So, to conclude, government actually need to monitor and control the prices and fees imposed by hospitals and also doctors. So, that's all from me. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much, Kelly. Very good. Yes, Sir.*

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Encik Poh Hup Lin [Life Planner AIA Berhad]: *Hello. Morning, YBs. I hope that…*

Tuan Sim Tze Tzin [Ahli PAC]: *Your name and your organizations if you have.*

Encik Poh Hup Lin [Life Planner AIA Berhad]: *Can you hear me? I am Poh and I come as a life planner. In this industry for almost more than 30 years. So, we received a lot of complains left and right. In between, we are the intermediary…*

Tuan Sim Tze Tzin [Ahli PAC]: *You are from NAMLIFA, is it?*

Encik Poh Hup Lin [LIfe Planner AIA Berhad]: *No, no, no. As an individual. So, hopefully, we came here not to complain, not to— we have to find a solution. We are all victims. Do you all agree?*

So, first, I think we start from the hospital, the Ministry of Finance— sorry, Ministry of Health (MoH). First thing, they must closely monitor the hospital especially in their billing and what kind of test been done, necessary or just to something like rule out, rule out basis. It happened.

*Only yesterday I heard one complaint. The son admitted for one week fever, all these things and then, "Oh, come. Your son might got cancer, lymph cancer, must do this test." So, you know, patient don't know anything, do-*lah. *RM4,000. Come out result okay, nothing. So, luckily the mother was smart, quickly transfer to another hospital. From mainland go to island. Island say, "Why give you so many antibiotics?*

It's terrible. Your body immunity has gone down." So, I don't think this type of things, if you go and complaint, negligent or wrong test, it is of no use. Very hard. So, the ministry should take action. That is the hospital.

Not only that. Just now first speaker mentions about— and also the lady— those with insurance and those without insurance, different rate. We got one case. This auntie bought an old policy long time ago; 30 years ago, can claim only, I think RM5,000. So, she went for a cataract, the doctor ask, "Aunty, you got policy?" "Ah, no, no, no." Maybe she forgot also. So, in the end, the bill come thousand over only. So, the aunty later come, want to claim, submit a claim. When the claim form was given to the hospital, I don't want to mention the hospital or I might get sue, the doctor says, "Wah aunty, you are not sincere, tipulah, liar. Got insurance said no insurance. Now, want to write, I charge you extra RM1,000." That was long time ago.

So, this trouble created by the hospital comeback to us. How to solve? Then, we have to lie to the hospital. In a way, we got the hospital.

■0950

Okay, you want to charge please give us a bill for what reason. The hospital— I don't know-lah *maybe also the mistake*-lah*. Luckily for that lady, she went and faxed to pay this one. Fax there got the name of the hospital. So, I told her we are going to report this. So, quickly they said the doctor will all— I don't know what discussion being done, they said, "Okay, I don't want to write the claim form for you. I just write a letter for you. It's okay. The letter is good enough". So that, that shows that it's terrible, for nothing simply charged. That was a long time ago. Now even worse. RM2,000 can become RM5,000, double. Please check. Help us.*

During the COVID-19 time, do you know, I think the hospitals made a lot of profit. Pardon me if I'm wrong. It's happened case. It happened to my missus. We went for the COVID-19 test. I think every person they charged the bill because we know how to look at the bill. Apron and everything. I don't think they changed, every new patient they changed the apron but it's charged. It's charged, it's charged. Satu *apron,* 10 orang pakai pun *charged* 10 orang. *100 percent more than 100 percent profit.*

This is— all these are non-payable item (NPI) like the first speaker said. For example, if you look at your bill, if you go there, every time the hospital needs to administration fees, registration fees, for what? Their computer must be lousy. How can you register then you forget again? All these are non-payable items (NPI). So, please check on them. I think the main— this is called the vicious cycle. Hospital charges increased, premiums increased and all these things. That is so far, I want to talk about hospitals.

In fact, we got a tragedy also about hospital, it's my mother-in-law. My missus's mother. She went for a simple appendix operation only but later complications but no ICU. I questioned the doctor. The doctor is from Penang. I don't want to mention his name. Until the Director asked [Tidak jelas] all the nurses who are the ones that take care of my mother-in-law? He asked us to identify. Then I questioned the doctor, "You have how many ICU unit?" They said, "12." Forgotten already but can't tell with the number. Then I asked, "How many patients you operate?". She said, wah, she's very proud so many. I said, "What happened?". Do you think that today goes ICU, tomorrow come out already? Occupied, maybe two, three days still there. So, this patient, no ICU. So, that one is actually a negligence but very hard to prove. That is on hospital.

Now I come back to insurance companies. For insurance companies, I think this is a problem of competition. Last time you got RM30,000 annual limit— RM30,000 confinement limit, then RM60,000, then RM90,000, then RM100,000, then million, million, million. This is really stupid because why, I think insurance companies got a lot of this one they called actuarial. They are smart. You see, if you buy a RM100,000 and you buy a RM1 million from RM100,000 goes to RM1 million the premium is not much different but it keeps on the cost of insurance is there. Claim of my 30 years of servicing, only one case leukemic case spent more than RM1 million. The rest are all lower. But now you see maybe…

Tuan Sim Tze Tzin [Ahli PAC]: *On average how much claim on average, Mr. Poh?*

Encik Poh Hup Lin [LIfe Planner AIA Berhad]: *On average we never keep a record but I only know only one hit RM1 million, more than RM1 million.*

Tuan Sim Tze Tzin [Ahli PAC]: Kita boleh tanya soalan.

Encik Poh Hup Lin [LIfe Planner AIA Berhad]: *Okey, this one now you see there are some companies they introduced high-end plans. Maybe there are competition. Wah, this company A, company this one, B company this one. So, they keep on selling this one to the customer. Most of them, they are not like what the lady said they are not very 100 percent well informed and know about insurance claims. So, high is good. "Oh, I got RM1.5 million, I got RM2 million, I got RM10 million". I tell you after RM5 million, die already.* Belum sampai *RM10 million. But you are paying for it.*

So, we must mandatorily ask the insurance company to market each level. Just like we got PPR, perumahan rakyat*. We got terrace house, we got semi-D, we got bungalow. You cannot sell all bungalow. Bungalow sells to who? We need to take care of all. Like for example you only want to sell Bentley, you don't want to sell Myvi*

and all these things. Who can afford it? Not everybody can afford. Not everyone is maha kaya*. There are lot of people suffering. So, make it— you must have this type of product for people to choose.*

One more thing, this one also on insurance companies especially the investment link. We got two types of investment links and the stand-alone. Stand-alone one is even terrible. I think the main problem is the stand-alone now. The premium rise, the premium revised you don't pay, lapsed. Investment link you don't pay still okey, boleh jalan lagi*. Still can go on. Only they shorten your all coverage.*

Just like today, patrol RM2, okay. Tomorrow or come May, we don't know, we predict RM3 the RON95, you still pump RM100 but you go a shorter distance, still can jalan*. The investment link you still can* jalan*. But the problem with investment link is that we also want Bank Negara. This one is Bank Negara to control. You cannot simply automatically raise the premium or put through or charge the premium. You must get the consent of the policyholder. Because you know or not policyholder comes, "Eh, why my premium goes up by RM80 per month?". Then you know what, they came and complained. What does the agent need to do? The agent goes and delete, delete, delete. Extra work, non-productive and problem. So, must ask the consent. Once the policyholder wants, okay, don't want never mind. It is his problem. He doesn't want the policy lapsed it's his problem. Otherwise, agent has no end of this type of thing.*

I can tell you, for the information of that lady, insurance agent always wishes for the best of their policyholder. A mechanic, harap-harap kereta rosak, ada bisnes. Hospital, harap-harap orang sakit, ada bisnes. *Coffin shop,* harap-harap orang mati. Insurans dengan harapan *people healthy and become wealthy* boleh beli lagi banyak*. [Tepuk]*

Let me tell you again this one, sorry, if anything happens you know everybody come lelonglah semua. *Only the agent comes and helps to settle all these problems if they are well-covered. [Tepuk] This one through my 30 years of experience. And— forgotten too excited.*

One more thing, after the hoo-ha in the Parliament, I think so far Parliament does this is good. Only thing that is productive for us. Otherwise, we hear nonsense there. About the interim measures Bank Negara and companies have to follow. It will be coming on. Some of them have surrendered, cannot afford to pay, policy lapsed. Now they say that you can bring back the policy. Relive, make the hidup semua, *reinstatement.*

■1000

But actually, reinstatement there is a hidden clause there. So please ask Bank Negara *to control it, not reinstatement, restoration. Means that no waiting period in the post, reinstatement waiting period. I hope everyone knows what is the waiting period.*

Encik Hazwan Arif bin Hassan [Muqmeen Group]: *Waiting period 30 days.*

Encik Poh Hup Lin [Life Planner AIA Berhad]: *Eh! Not 30 days, more than that. 120 days and if your policy is less than 2 years. Guarantee letter* tak boleh keluar, *mau* siasat. Siasat tak *tau* bila, sampai bila pun tak *tau*. *If you are lucky, two weeks is very good. Unlucky two months, three months, we don't know. So, this one is an important clause* Bank Negara *must impose it for everybody, for the benefit of everybody because of the hills increase in the premium.*

And one more thing, this one I think is especially for Bank Negara. *Please help us, the SST should be waived on those personal private policies, not business policies. For example, your* kereta kena SST, *insurance? [Dicelah] Yes, this is not called promotion, this one is for our own use. If you buy your house fire policy got SST or not?*

Seorang Ahli: *Yes.*

Encik Poh Hup Lin [Life Planner AIA Berhad]: *Yes. Your personal accident got SST or not? Yes, this is not for business, for our own consumption, for our own good. To the government if the* rakyat *or the policy* selamat*, very good, solves their problem. No need to go and jam the government hospital. But do you know recently, from six percent go to eight percent? If your policy is RM1,000, you have to pay RM80 which I think is a burden. So, please help us. Thank you. [Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, thank you Mr. Poh. I think this Mr. Choo, then okay who else? Mr. Singh at the back and then you, and then Dr. Jaya.* Boleh? *Okay.*

10.02 pg.

Encik Choo Chon Kai [Parti Sosialis Malaysia Pulau Pinang]: Okey, selamat pagi, salam sejahtera. Saya Chon Kai daripada Parti Sosialis Malaysia dan saya sendiri juga seorang pengguna hospital awam sebab saya tak ada insurans kesihatan. Tetapi saya hendak bawa isu ini sebab memang kaitanlah, okey.

Okey, pertama kali saya juga ingin ucapkan terima kasih dan juga penghargaan kepada PAC kerana mengadakan sesi pendengaran awam ini dan harap pihak Parlimen boleh adakan lebih banyak sesi sebeginilah tentang isu-isu yang lain. Okey, ini yang pertama.

Okey, isu yang saya hendak bawa di sini ialah walaupun saya bukan pengguna hospital swasta dan juga tak ada insurans kesihatan tetapi isunya saya rasa berkaitan dan penting kerana kita tidak boleh merawat simptom tanpa mengubati penyakit pada puncanya. *[Tepuk]* Jadi saya sebenarnya tidak bersetuju dengan apa yang dinyatakan oleh YB Sim tadi sebab kewujudan dua sistem ini adalah sesuatu yang terbaik.

Sebab saya rasa ini adalah punca masalahnya kerana dalam berapa dekad kebelakangan ini dalam 30, 40 tahun kebelakangan ini, wujudnya satu kecenderungan pemikiran dalam pembuat dasar kita menganggap bahawa kesihatan itu adalah sesuatu yang boleh menjana keuntungan, kesihatan itu sesuatu yang boleh dijual seperti barangan komoditi untuk dapat keuntungan. Ini adalah masalahnya, inilah masalahnya membawa kepada perkembangan pertumbuhan hospital-hospital swasta di negara kita dalam tempoh 30, 40 tahun kebelakangan ini. Sebelum itu tidak ada. Adanya hospital yang bukan kerajaan tetapi lebih kepada hospital amal, okey. *Charity*. Okey, itu bukan banyak— memang bukan buat keuntunganlah tetapi trendnya dalam 30, 40 tahun kebelakangan ini memang adalah adanya pertumbuhan hospital swasta yang semakin besar dan membuat keuntungan.

Jika tak ada keuntungan tak mungkin syarikat-syarikat itu akan melabur termasuk GLC juga melabur untuk dapat keuntungan. Ini adalah menjejaskan sistem kesihatan kita secara keseluruhan. Bila saya sebagai seorang pengguna hospital awam pergi beratur di klinik-klinik itu, saya rasa ini saya bukan lihat ini masalah dengan sistem kesihatan awam kita sendiri sebab dia sudah dirosakkan, dihakis oleh kewujudan satu sektor swasta yang menjana keuntungan daripada kesihatan kita.

Jadi saya rasa itu adalah satu punca masalah yang harus kita lihat dan harus kita tanganilah, okey. Sebab sistem kesihatan ini— sistem kesihatan awam adalah penting dan sepatutnya kita juga kena buang sebab ada juga sesetengah orang ada pandangan bahawa hospital awam adalah untuk orang miskin. Kalau mampu bayar, ada duit pergi hospital swasta dapat perkhidmatan yang lebih baik. Sebenarnya ini adalah satu tanggapan yang salah. Ini yang menjejaskan akan membawa kepada masalah yang lebih besar.

Sepatutnya hospital awam seperti YB Sim cakap tadi, hospital awam adalah universal. Apa yang maksudnya universal, sejagat? Maksudnya semua orang, kaya, miskin semua boleh pergi hospital awam untuk dapatkan perkhidmatan yang terbaik. Bayangkan kalau golongan maha kaya, YB-YB sekalian semua kita pergi ke wad kelas ketiga hospital sama-sama. Bolehkah— saya boleh bayangkan mungkin kualiti perkhidmatan di hospital awam kita akan meningkat lebih banyaklah.

Okey, okey saya pendekkanlah. Saya ada tiga cadanganlah untuk selesaikan masalah ini. Seperti saya cakap tadi punca masalahnya hospital swasta itu adalah punca masalahnya. Saya tidak salahkan pengusaha ataupun ejen-ejen insurans sebab mereka sebahagian daripada sistem itu. Masalahnya adalah puncanya, sistemnya. Jadi cadangan kami adalah tiga perkara sahaja, satu adalah kerajaan harus bekukan pembinaan hospital swasta berasaskan keuntungan-keuntungan itu segera, bekukan. Tidak membenarkan lagi pembinaan hospital swasta yang baru. Okey, itu *first thing,* pertama.

Yang kedua, kerajaan harus hentikan promosi pelancongan kesihatan kerana itu satu masalah. Hospital awam yang— hospital swasta yang wujudkan bukan sahaja untuk mendapat duit daripada rakyat yang bukan sebenarnya kaya juga banyak M40 yang sebab keadaan sistem hospital awam kita memaksa mereka ada sedikit duit mungkin boleh mampu untuk bayar insurans pergi hospital swasta. Mereka dipaksa pergi ke hospital swasta. Kalau sistem kesihatan awam kita baik, tak mungkin kita pergi kan?

Okey, tapi masalahnya sekarang di hospital swasta melakukan— menjana lebih keuntungan melalui pelancongan kesihatan dan lebih teruk lagi kerajaan kita sendiri khususnya di Pulau Pinang adalah paling banyak hospital swasta yang mempromosi pelancongan kesihatan. Jadi kerajaan yang harus hentikan mempromosi pelancongan kesihatan. Ini bukan impak kepada rakyat Pulau Pinanglah saya cakap sebab rakyat di Kedah, di Perlis, di Perak kes kualiti kesihatan mereka terjejas sebab juga kerana ada wujudnya pelancongan kesihatan di bandar-bandar besar okey, di Pulau Pinang ataupun di Lembah Klang lah.

Okey nombor tiga adalah kerajaan harus lebih fokus kepada meningkatkan kesihatan awam kita dengan meningkatkan peruntukan kepada Kementerian Kesihatan kepada hospital— kepada kesihatan awam kitalah. Daripada cadangan kami adalah kerajaan harus meningkatkan bajet, belanjawan kepada KKM daripada 2.3 persen daripada KDNK sekarang kepada lima persen di mana ini akan banyak membantu dalam mempertingkatkan dan juga memperbanyakkan hospital, meningkatkan kakitangan, menambahbaikkan juga keadaan kerja sebab saya tahu isu tentang KKM itu banyak masalah juga, banyak sudah dilaporkan saya tak mahu juga.

Itu adalah sesuatu yang penting. Tingkatkan peruntukan. Okey, kalau tak ada duit tadi ada juga cadangan bagaimana melalui percukaian semualah, okey. *So*, itu sahaja tiga cadangan saya. Okey.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih.

Encik Choo Chon Kai [Parti Sosialis Malaysia Pulau Pinang]: Terima kasih. *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Choo Chon Kai. Okey *next* tadi— okey *Mr. Singh* ya.

10.09 pg.

Encik Harbhajan Singh: *A very good morning to our YB and the members of the panel and members of the floor. I'm Harbhajan Singh, okay.*

■1010

I'll give you my experience with the insurance. I took an insurance policy, health policy about 30 years ago where the premium was only a few hundreds. For the last four years, it increased to RM3,000. Following year, it went to RM4,000. After that, it straight away jump to RM12,000. And this year, I just received, it's RM15,000.

Now, I'd like to ask. I never did anything except for a cataract operation which I did two years ago. Now the amount I've paid, I think it's much, much more. If I've saved that money, it had come to hundreds of thousands. And I how many spent a little bit for the cataract operation. And the joke is, a friend went to the same hospital, same doctor to do the cataract operation, he was charged RM3,200 but my bill was RM12,000 because I had an insurance card.

And when— before the operation, I asked the doctor is it painful? I haven't done it. "No, no, no. We just put a few drops and your eye will be numb and we'll operate. No injection", I said, "Okay". During the operation, he gave me two painful injections. Next day, I asked him. When I consulted him the next day, I asked him, "Why the operation, the injection? You told me no operations". You know what he told me? You will laugh. Specialist, you know. "You know, it just like you go to a shop, you order dishes, food to eat. If you cannot afford, you take one dish. You can afford, you got insurance card, so I give you three dishes." [Ketawa] Look at that, he can answer like that. So, you just tell me, where are the ethics of these doctors? They don't care for the patients. They only look at the money.

I had a friend. He went for an angiogram. Routine angiogram. He told the doctor, "I would like to see the percentage of my blockage, please". "Yes, yes. During angiogram we don't put you to sleep. You will be conscious". He went in there with the insurance card. Doctor said, "Don't worry, you can claim insurance". Okay, went in. He put that fellow to sleep. When he came out, the whole insurance gone. Used up, RM96,000. He asked him why? He said, "You at risk [Tidak jelas]". He said, "Doctor, why you put me to sleep? I told you don't put me". "No, no, because I was worried it's bit painful. So, I put you to sleep". RM96,000, you imagine.

Nowadays, you ask me, most, many, I won't say all. I think many doctors, the first question when you go there, they will ask you, "Do you have the insurance card?" But if you don't have an insurance card, you go there— you have an insurance card but you don't tell them, the same thing happens. What our friend said just now, I've tried that. They say, "You sure? Because if later you come back and say you want to claim insurance, we won't fill up any form for you". He tells you. So, this is what is happening.

So, imagine I've paid for 30 years, why should they increase my premium? I didn't join now. If I join now, at the age of 60, yes, the insurance might think, "This fella might be having some problem, that's why he's joining now". Okay, you put a high premium. Man, I joined many, many years ago. I didn't have any issue until now. But why the sudden increase of premium? This three, four years was terrible. RM3,000, RM4,000 and then RM12,000, straight RM12,000 you know? And now is RM15,000. So, is it fair? When we took the policy, we were never told that it is going to increase. I took for my child when she was, I think 10 years old. Investment plus medical insurance. Take two years has been going up.

So, I was thinking, no point. This is what going to happen because sometimes doctors will do unnecessary procedures which are not required because they want to claim the insurance. My brother was having some problem. He went in. I was accompanied him, went to the emergency, they admitted him. When the bill came out, they put there, test for blood, glucose, what-lah. *But the test was not done. I was there. I was there, the test was not done. When you asked them, they said, "Never mind, you don't have to pay. The insurance are going to pay".*

But we are losing our lifetime limit. Our lifetime limit is becoming less each time you make a claim. And then, we also have to pay the ten percent co-insurance. You see? So, we are affected. So, these insurance companies should be more strict in the sense, number one, I suggest that government, I mean it will look impossible but I think the impossible will be possible with Madani government, I hope.

Government, for example, place an officer, government officer in each private hospital. Whenever a procedure is done or the person is— the thing is sent to this person, he goes and visits the patient and ask, "Okay, these the procedure is going to be done. Do you agree to it?" or something. Because if you have the insurance card, the doctor won't ask you whether you want to do the procedure because he knows you are not going to pay for it.

But if you are paying, let's say in the case of the stents just now, he wouldn't have put the patient to sleep. He will say, "Okay, you got three blocks, you know. This will cause you RM90,000. Can you afford to pay or not?" He will be worried he won't

get his money. But because he got insurance, put him to sleep and simply do whatever he wants. You, see? So, that is not proper.

So, if— and the money to the pay the salary of these government officer, I think the government can impose a certain— set up a fund and all the hospitals, a certain percentage of their profits to be channeled to this fund and this fund be used to pay the salary of the officer. And before discharge, when the bill is given, these officers go and counter with these— react with these patients and said, "Was this done? Was this done? Are you satisfied with the bill? Which is not done? What is not?" I'm very sure many tests are not done by the— when they go inside. This is not fair.

And then, another thing is those who took medical insurance at the young age, their premium should not be increased because they started when they were not having any illness and insurance company will have made a lot. So, if let's say the officer goes around and they say, "This was not done, this was not done". Okay, fair enough.

Also, in a case where you dispute the bill, they sent the bill to the insurance company. Insurance company takes time to approve. They will tell you, "You cannot get this done until the bill comes back". But when you come out of the room late, they charge you the room for that day.

The room charges for that day, they charge you. Actually, it's not fault of yours. You want to go out. "No, no, cannot. You must wait for the bill". So, when you dispute the bill, they said you have to wait some more. "Then, we will impose charges for the room because you are not discharged".

So, all these is not fair. I think the government— actually is I don't quite blame the insurance company. Insurance companies, they trust the doctors. But the doctors take advantage.

Another thing, why is it when the person pays cash, for example the cataract operation just now is only RM3,00 something. But when a person goes for cataract with the card, it's RM12,000. Why? The same thing is done. Why? Why? Why? I don't see why. Okay, that's one. So, thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much. Thank you very much. So, before that, okay, I saw a lot of attendees sitting at the back.* Saya minta urus setia tambah kerusi di depan supaya mereka tidak duduk di belakang. Tambah kerusi supaya mereka boleh duduk bersama di depan. Okey, silakan.

Dr. Tan Huat Tian: Salam sejahtera dan selamat pagi kepada Pengerusi PAC, Datuk Mas, YB Sim dan YB-YB yang lain, tuan-tuan dan puan-puan yang saya hormati sekalian. Saya Dr. Tan Huat Tian, bekas pensyarah kanan yang telah

bersara. Saya sebenarnya telah mengambil *group insurance, National Union of the Teaching Profession* (NUTP) dan saya pun masih jadi ahli bersekutu supaya saya boleh meneruskan insurans ini.

Sebenarnya, insurans ini saya telah mengambil selama 23 tahun. Pada tahun 2022, premium ialah RM3,221. Kemudiannya— itu di bawah Great Eastern. Kemudiannya, ia berubah kepada Etiqa Insurance, masih lagi di bawah NUTP *group insurance* dan dinaikkan kepada RM4,124. Masa itu kita tidak mempertikaikan sebab amaun yang di-*insured* ialah meningkat daripada RM50,000 kepada RM100,000.

Tetapi, setahun sahaja selepas di bawah Etiqa, tahun 2024, ia telah ditukar kepada Prudential BSN dan ia meningkat kepada RM6,600. Untuk tahun ini, tahun 2025, ia meningkat kepada RM8,000 lebih dan ini adalah satu kenaikan sebanyak hampir 30 *percent*.

Prosiding Parlimen dan juga berita yang dikemukakan di akhbar-akhbar tempatan daripada kenyataan Menteri dan Timbalan Menteri, Menteri Kewangan, ada sebut bahawa *insurance company* boleh naik kadar premium iaitu sebanyak 10 *percent.* Tetapi, untuk tahun ini, 2025, dinaikkan hampir 30 *percent*. Adakah itu tidak melanggar arahan daripada kerajaan dan juga kementerian? Jadi, itu persoalan saya.

■1020

Kedua, iaitu tarikh *dateline* untuk dibayar ialah 28 Februari. 28 Februari— bermaksud, tinggal dua, tiga minggu sahaja. Kalau kita bayar, jadi bermaksud ia akan teruskan. Jadi, adakah kerajaan boleh mempercepatkan tindakan yang diambil terhadap *insurance company* ini?

Saya tanya NUTP iaitu *National Union of Teaching Profession, the Penang leaders was telling me, for group insurance*, boleh naik 30 *percent. There's no issue. So, to me, I feel in a group insurance, we have more bargaining power. Right or not? But I think that is not true.*

Another thing, what they told me, kadar tidak naik, kadar premium ini, syarikat insurans akan *bankrupt. But I think this is really stupid. You can just Google search, "Prudential Assurance Malaysia Berhad reported a new business profit of USD2.35 billion for the first nine month of 2024". So,* bagi rakan-rakan daripada Parti Sosialis dan sebagainya tidak mempertikaikan iaitu *insurance company* tapi saya mempertikaikan *insurance company* yang meningkatkan kadar yang begitu tinggi sekali.

And I am very disappointed with NUTP also to be really frank to you. National Union of Teaching Profession. For 23 years, after 20 years with Great Eastern, pass it to Etiqa and now to Prudential. Prudential BSN. What's happening actually? The

question now is that, adakah ia tidak mengikut arahan kementerian dan juga kerajaan yang naik sampai 30 *percent*? Sepatutnya *10 percent. We can still accept the 10 percent* kalau ada kadar inflasi dan sebagainya. Dan adakah kita patut membayar sebelum 28 Februari? Terima kasih... *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Sir. Thank you, Dr. Tan. I think this— before Dr. Sim, I think we let Dr. Jaya first because Dr. Jaya que earlier. I think on that— after Dr. Jaya, Dr. Sim and then you, okay? I think there's a— we invited Bank Negara Malaysia's officer here. I think they will take note of what you have mentioned and then hopefully they take it up to their officer.*

Dato' Dr. Jayabalan a/l A. Thambyappa [Health & Safety Advisory Centre (HSAC)]: *I must thank honorably YB Sim. I must thank all the rest of you and of course— can you hear me? I have a usual problem. I start softly and then I go up later as I get warmed up.*

Okay, now. The first thing is there's been a lot of anecdotal and micro picture given on this whole scene of the healthcare. To be fair to the government, there's a White Paper done in some 2021 or so, in which we participated. It is a very good White Paper. At that time, the Health Minister was Khairy Jamaluddin and that health paper was a good attempt at reforming the healthcare in this country.

Now, I will give you the gross picture in the country. Now, Malaysia has developed a very impressive healthcare system, complimented by many people about the impressive healthcare that we have developed. The public sector provides a major portion of healthcare through its network of hospitals and clinics and handles about 75 percent of all admissions to hospital. The private sector developed over the past 40 years from providing almost entirely outpatients care to the current situation where private hospital stated to about 25 percent of total admissions. This is all data from the blueprint.

Coverage is good with 92.6 percent of the population living less than five kilometers from the nearest health facility. Childhood vaccination rates are impressive, consistently 97 percent of the target population or even higher.

However, the Malaysia public healthcare system faces several serious problems including congestion of its clinic and larger hospital, long waiting time for certain investigation such as CT scan and MRI which means we do— cannot both of universal health coverage. Because anytime you have delayed care, it means delayed access to medicine, it's equivalent to denial of access to healthcare.

The other thing is you must also understand the migrant population which amounts to a very large number of workers who are doing a lot of work here, they are

denied in the public sector by way, of course, and many other issues. So, it means we do not have universal coverage yet.

Now, long waiting time, as I said, raising cause of co-payments for equipment in— this is in public sector. You have to pay for your lens, you have to pay for some of the services and then sometimes they sent you to the private sector even there, there's some payment involved, co-payment.

Poor access to foreigners, as I told you. Then, these foreigners have a serious problem because medical personal usually informed the Immigration Department, they suspect this worker is overstated. In many cases where these migrant workers have been sent to the— for detention.

Inability to provide adequate supervision and training for large number of housemen joining the service. There was one houseman who had completed her houseman, before she got an emplacement into the government sector, it took seven years before she got an emplacement.

Insufficient medic— another one. Inability to provide adequate supervision and training for large numbers of housemen joining service. The number swell from 1,002 per year to more than 5,000. This is also comes back to the point you have got a lot of private medical institutions, you know, where a lot of entrance get in and when they passed out, then there's a surplus of doctors who come out from universities who have to wait for a long time before they get the houseman emplacement.

Insufficient medical officer post in the service to absorb the large volume of doctors who had completed housemanship. They now given only four years contracts, in facts that's going to be shorten or it's already been shorten for them to specialise.

So, what are the recommendation? The recommendation— more facilities, clinics and hospitals have to be built and equipped with necessary and all that. A moratorium definitely needs to be placed on new private hospital. Very, very unfortunate burdening. You are in Penang. Across the island, the mainland, there's a huge conglomerate, you know. I do not want to mention the name— that has come up there and they're attracting a lot of specialists and a lot of doctors from the public sector to go and join them which means there's an attrition as I told you earlier from— because the pasture is greener in the private sector, doctors most of the time are lured into that the private sector.

There's an important thing that you need to do. A public service commission should be set up for the staff of the Ministry of Health (MOH). See now, I will come back to this other thing. There was a suggestion that we put an officer in every private hospital. A government officer. Do you know, the administrative cost as far as the

Ministry of Health is concerned, overs to about 14 to maybe even up to 18 percent. Bakar Sulaiman and I had the discussion, it could be as much as that and the suggested cost should be less than eight percent.

■1030

So, you know can you imagine to check on how our door size is in a clinic, you have got a setup in Putrajaya which is actually monitors how the door size of a clinic is. How the laboratories are managed? Do you need to have this sort of administrative cost? Now, putting in officers. So, the administrative cost is something we don't seem to realise. A lot of people don't seem may to lead into the global budget meant for the Minister of Health.

If I say, even if you give five percent and if it is 18 percent is an administrative cost, it is going to eat into it. So, you have to cut down by other means. The other thing is mentioned earlier by Chon Kai, increase the what do you called budget to global domestic. The MOH should be raised to at least four percent of GDP over next five years. It is currently only about 2.5 percent of GDP. Phase increase is suggested will give time for the MOH to utilise the increased budget optimally.

The government should implement mandatory insurance or health tax on ordinary Malaysians because wages are already low. Shouldn't, I'm sorry, they shouldn't implement mandatory insurance or health tax on ordinary Malaysians because wages are already low. Even the 1,700 doesn't go. It's a very far from a living wage. That has been suggested recently.

Many in the B40s group are struggling to make ends meet. About 20 percent of our children are stunted, reflecting the inefficiency of disposable income. There is wage separation in Malaysia. Malaysian workers are only getting about one-sixth of the wages in Germany or the US. As Malaysian workers are being underpaid, it's only fair that would be subsidised as far as basic services are concerned.

The mandatory until children will to necessitate the corporatisation of government hospitals much to the detriment of already what is happening. Do you know that IJN is now refusing a lot of our— the pensioners from going there. Many of the pensioners who used to go IJN are told to go the cardiology unit.

You see, this is because you know the function— another interesting is if you do a surgery. A subclavian, when you want to do dialysis. If you do it on the third floor in UKM, in the third floor. You have to wait for about three months. That's the public wing. If you go up to fifth floor which is the private wing, you can get it done in three days. But it will cost you RM5,000.

You see, this sort of tier system is very unhealthy for the country because we are a small population. It's very easy, we are affluent. We are risking our affluent by

way of all these things. Anyway, little bit more. Bear with me. Current practice is likely they they will respond to a whole new set-up— if you do not break this try, and dismantle— earlier, somebody mentioned about cataract operation and glaucoma. I lost my right eye. After having spent nearly RM75,000 in some of the best surgeon, my close friend in a private hospital, a six-star hospital.

The fee for service mechanism for claiming funds leads to overdiagnosis, as already being said earlier, the caesarean section and all diagnosis related DRG Group. The creation of National Health Fund to handle more than RM60 billion annual health budget should be worsened given the deficiency in financial governance in the country.

The scope for mismanagement is large. Right now, please bear with me, just lit bit info. Malaysia should increase tax revenue in a progressive patient. Okay, now. One other thing, I must say that, there are various defects in the country. First, you don't have a policy. We don't have a written policy as far as this government— health policy is concerned. We don't have a written health policy.

Number two, we do not have a healthcare financing mechanism. It's a very poor healthcare financing mechanism

Number three, it's very— another important area is administrative cost as I mentioned. We need to keep the administrative cost as low as possible. And the other thing is to encourage a system as private insurance would be what you have in the US, where the costliest medicine and private sector is the proliferating sector in the US. In short, the management care organisation system that you have in the US is the main thing we need to avoid. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, Dr. Jayabalan. *Before I call Dr. Sim, YB* Dato' Ku ada sedikit nak cakap ya*. Sorry* ya Dr. Sim. Ya, silakan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Assalamualaikum warahmatullahi wabarakatuh,* selamat pagi kawan-kawan rakan Cina *[Berucap dalam bahasa Mandarin], last day is yesterday but extra day* boleh lagilah *[Berucap dalam bahasa Mandarin].*

Okey, Yang Berhormat Datuk Wira Pengerusi, rakan saya Yang Berhormat YB Sim, moderator dan juga ini kampung dia. Bersama dengan kita hari ini TKSU, Timbalan Ketua Setiausaha Kementerian Kesihatan, Dato' Sri Norazman. *So, he's listening. This is good.* YB Tarmizi daripada Sik dan rakan saya, YB Ali Biju *from* Saratok, Sarawak. *So, we are well presented* dalam PAC. Seterusnya, tuan-tuan dan puan-puan sekalian.

Saya mendengar semua yang diperkatakan tadi ya. Cuma ia kita nak dengar juga. Ada tidak doktor pakar dalam *crowd* ini? Ada doktor pakar tak? Juga daripada

private hospital. Sebab kita punya rantaian mengenai perubatan swasta ini, ia merangkumi *private hospital definitely, doctor specialist,* juga dalam rantaian ini, insurans *of course,* swasta dan *suppliers.* Umpamanya macam Pharmaniaga itu *suppliers.* Ia yang memberikan apa juga kesan terhadap kos secara keseluruhan betul atau tidak ini ataupun tepat atau tidak adalah merangkumi semua ini.

Kita dengar tadi daripada pihak insurans Takaful, daripada ejen dan sebagainya. Tapi, elok kita dengar daripada *doctor specialist.* Saya difahamkan, *correct me if I'm wrong,* bahawa kalau tengok dari segi *charges.* Saya ada beberapa contoh yang banyak buat *profit* ini hospital swasta. Insurans tadi ada yang pertahankan tapi ada juga unsur-unsur antara hospital swasta dengan insurans ini. Saya tak tahulah betul atau tidak. Kadang-kadang ada juga pakat-pakat ini. Kita minta tiadalah ya.

Tapi, yang paling kurang mendapat bayaran yang *fair* ialah *doctor specialists* sebab *90 percent of doctor specialists* dalam *private hospitals* ini, *they are not employed by private hospitals,* kan? *They' go on consultant. On consultant basis. I've got many examples; I've got some bill* yang *real thing.* Seorang doktor pakar yang 30 tahun seorang pesakit datang berjumpa, pesakit yang kronik. Dia hanya dapat RM157 sahaja. *Only RM157.*

Saya ada contoh-contoh lain. Bukan saya nak *defend* doktor pakar tapi kita nak dengar secara keseluruhan. Kita dengar daripada doktor *private hospital.* Insurans kita dengar. Dan satu contoh— kejap saya kena cari sikit. *[Merujuk kepada senaskah dokumen].* Saya suka ambil nota-nota, kena cari. Okey, satu bil— ini banyak contoh diberi tadi juga. *This is really high disparity between private hospital and surgeon fees. Surgeon fees* ertinya *fees* pakar-pakar, doktor pakar. Ada di sini di kalangan doktor pakar tak? Angkat tangan boleh tak?

■1040

Tuan Sim Tze Tzin [Ahli PAC]: Ada, ramai.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Alhamdulillah.* Oh, saya punya kawan tadi daripada Pantai. *Charges bill* ini RM110,000. Banyak itu RM110,000 ya. Saya tak tahu sakit apa tapi banyak. Doktor pakar, dia dapat hanya RM10,000, tak sampai 10 persen. Okey. Yang angguk-angguk itu mesti doktor pakar, kan? Jadi orang silap dia kata doktor pakarlah ini punya fasal ini, harga naik ini. Kemudian doktor pakar ini belajar teruk. Tapi *depa* tak ada buat *profit* macam mana pun. Dia dapat sikit *je.*

Hospital, dapat RM70,000 dan— *sorry,* hospital punya RM70,000. Dia dapat RM65,000 campur RM17,000. Jadi berapa? RM82,000 ya. Hospital dapat RM82,000

daripada jumlah RM110,000 ini dan doktor saya kata tadi dapat hanya RM10,000. Ertinya doktor pakar ini dia yang *check* punya macam-macam ini kan. Sebab dia ini bukan di-*employ* oleh hospital. Jadi dia dapat RM10,000 yang— *the most of it is from*— diperoleh oleh doktor daripada hospital pakar.

Satu lagi saya ada contoh ya. Saya tak mahu sebut hospital. Adik-beradik saya ramai juga doktor pakar ini. Saya selalu bincang dengan dia orang, tanya masalah sebenar. Umpamanya sebuah hospital, dia tak ada kepakaran tentang yang *test* untuk kanser itu. Apa nama dia punya mesin itu?

Tuan Sim Tze Tzin [Ahli PAC]: *PET Scan.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *PET Scan* ya dan dihantar kepada satu hospital lain di Petaling Jaya juga yang pakar dari dalam bidang ini. Kos semua RM2,500— RM5,000 dan hospital swasta yang menghantar ke satu hospital lagi itu, daripada RM5,000 dia buat *profit* RM2,300. Dia hanya hantar *je.* Hantar saja, RM2,300. Di samping itu, yang hospital yang betul-betul buat *PET scan* ini, dia dapat RM1,800. *The balance* lagi pergi kepada hospital swasta yang disebutkan tadi, yang menghantar *patient* itu ke tempat itu.

Jadi, sebenarnya kita kena tengok keseluruhan *supply chain.* Saya sebutkan tadi *private hospital, private specialist, they are not necessary employed by the hospital, insurance and then there is another one,* yang saya sebutkan tadi. Ini semua kena… *[Dicelah]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Supplier.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ya, *suppliers. Suppliers* pun sama juga. Tadi YB Sim moderator ada sebut. Saya pun tahu benda ini. Umpamanya *glove* bukan hanya masa PKP, COVID-19 ya, masa bil lain pun, dia ada situ *glove* RM20. Dia pakai *sat* saja*,* RM20. RM20 itu sebenarnya sama dengan kos satu kotak *glove.* Betul? *[Dicelah] So, this is something big wrong going on in our medical system in the country.* Betul tak?

Saya bukan *on any side but we are what we are trying to do as PAC members.* Ya lah, *we have to be fair to all the people here. The last* sekali itu pesakit yang perlu dibela. Kita tahu *private hospital has to make profit, yes but* janganlah *sovereign* sampai keterlaluan *profit* yang diperoleh, itu saja. Ini belum selesai lagi ya. Ada lagi nak *mai* ini, *hearing* kita. *Insya-Allah,* kita akan dapat selesaikan ataupun buat satu *recommendation* kepada kerajaan supaya *everybody get the fair treatment from the whole system.* Terima kasih YB Sim. *Well done, Sir.*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Dato' Ku, MP daripada Kubang Pasu. Okey, sebelum Dr. Sim, *at the back,* siapa-siapa yang tolong kita tambah kerusi

di depan, sila datang ke depan supaya *you are not too far from us*-lah. Silakan Dr. Sim. Dr. Sim, doktor pakar.

Dr. Sim Joo Seng: *Hello. Before I say anything, I've made the disclosure. I'm non-governmental bodies and not representing the government, not representing parties, not representing the hospitals or even patients. I'm just here as a level-headed person who has gone through the whole series as a doctor in government, private and have my own clinic now in— my own clinic doing primary care, okay.*

So, on top of that I am also a patient. Only once only even though I took out the insurance for 30 years, more than 30 years. I only had one admission for an appendix last year. So, I've never used up any of my quota or whatever quota but I'm still paying the insurance.

So, why I'm here is actually to tell you all that before you actually have a meeting, you have a data system to collect from various people, from the patients. Because maybe all of us here still have complaints because we are patients that have been mistreated but maybe you are representing only 20 percent or you are being abused by either the hospitals or the doctors. But there will be 80 percent of people not having satisfactory treatment and also a very good treatment by taken care of very well by the hospitals and also the doctors.

So, I think before we have any meetings, actually we should collect data. These are from patients' data, from insurance data, from private hospitals, primary healthcare. Don't forget about primary healthcare. Your GPs are very important. Don't go straight to the hospital to see the tertiary care. When you are not well especially if you have hypertension, it's actually easy to control, you should see your primary healthcare. It can be in public hospitals, public clinics like government clinics or in our private GPs. That will cut down the cost. The cost you cut down and then maybe your GP or primary healthcare will teach you how to prevent non-infectious diseases.

One of the main costs of increase in your healthcare is non-infectious diseases. Like for some of you said how come I'm 30, my insurance only that amount but when I'm 60, I'm higher because you have a lot of risk factors now. You have hypertension, you have diabetes, you have heart problems, you have heart failure maybe, you are a post-cancer patient. So, these will add on to the risk stratification of your insurance. They will push your insurance higher. So, try to prevent non-infectious diseases. Take good care of yourselves. Don't rely on insurance to take care of your health. You have to rely on yourself to take care of yourself. That will cut down the cost.

Just now somebody says we should provide a free healthcare system. There is no free healthcare system in the whole world. Even the most— the richest country

in the world also relies on personal insurance or insurance paid for by your EPF or CPF.

Okay, so we should have a government public sector health and also private sector health because it's a matter of choice. If I can afford it, I'll go private. If I think I cannot afford it, I go public. In that way, it's called shared healthcare. If everybody goes to public, I think the government will go bankrupt because healthcare is very expensive. What we proposed is that we should have a choice and the choice should be told earlier. If you take up health insurance, the insurance agents should tell your patient that you are buying this amount for this amount. But the prices will increase as you get older.

But a lot of— some I wouldn't say, everybody is a normal curve. So, they will be now – along the way, there will be people who actually out of the normal curve, must abuse a system. Patients also can abuse the system. Insurance agents can also abuse the system. Doctors can also abuse the system because it's a normal curve. What we have to be careful is that we have to make sure that the patient abuses the system like, they like to get admitted because they want everything free. They think it's everything free if I go to the hospital if I'm under insurance. So sometimes they can do the test in a clinic and then pay for themselves but instead, they get themselves admitted to get paid by the insurance. That's itself a form of abuse of the system. Then will add on to the overall cost. So, people like me for 30 years never claim anything. I'm paying for these patients too.

So, I think there must be a system to find out who is these people, who are outliers abusing the system. Try to— okay, hold on to them and then tell them you cannot do that. If you do that, we cannot give you the insurance. Then we cut off this group of abusing the insurance, a patient who abuses it.

■1050

Similarly, there will be 10 percent or 15 percent of doctors who say, "You ada insurans*. I am going to charge you more." So, we have to have a system in a hospital.*

The private hospital should self-regulate these group of doctors. See how they charge and then, all the hospitals to have an ethics committee. Bring them out and ask them, "Why are you charging over this?"

I am questioned the private hospital the one who gets so many complaints from building this system. Okay, they also want to regulate, self-regulate. Then after that, it come to hospital system. I think a lot of time when we are going into hospital, they said the room charges is only single room RM350. But, that doesn't make up for overall cost of the things because there are nurses to take care of you. They are paid

quite a lot now because the salary has increased. You have to have janitor to wash the place. Okay?

When we go to hotel, you pay this amount, maybe RM700, you are provided all these services. But hospital normally will quote the lowest because the insurance said, I can only pay your room at this amount only. So, how the hospital going to recoup the things to maintain the hospital system? So, they have end up charging other components. Okay?

So, I think it has to be transparent. The hospital has to be transparent and say, I think this RM350 for single room cannot cover for all these chargers. So, maybe we will increase a room. So that, upfront you will know that you got to pay RM650. The other things in your room provided like the hotel room. Your glove, your toilet paper will not be charged. Okay? That way everybody knows about it rather than say, hidden costs. You mean it was hidden to subsidised for the maintenance.

The other thing hospital can— just now I was saying about PET scan. I think we are too many PET scan in certain states. Actually, that's actually not a good thing. What you are saying is actually a good system.

Only if you think that this population got two million, we need about three or four PET scans. So now everybody, every hospital to say I have PET scan because they add costs to the running of the hospital.

Then, we also have the [Tidak jelas] and subsidies for this instrument. Instead of having it, have only a few hospitals in certain states. You got PET Scan, other people can buy the service. But what you are quoting now may not be right because the hospital may— initial hospital may charge us RM5,000 while maybe actually help another hospital buy the service, let say I only RM3,500, but you charge RM5,000. That's fair actually because at the end, we only use one PET scan rather than every hospital having many PET scans and that will add-on to the cost.

So, I think, we have to sit together, round and level-headed way to discuss the problem, come up with the policy. Not just anecdotal like what Jaya was said, anecdotal experience. Because all of us have bad experiences. Some people have bad experience, they go into Facebook. [Ketawa] Okay? But when they have good experience, they don't say it loud.

Therefore, whatever I can complaint maybe 20 to 30 percent, but I think majority still have good experience. We still have a good health system which I think most of my friends from overseas will compliment when they come over.

In fact, they come over here for the dental treatment. They come over here from UK, US you know, dental treatment. Excise some of the lesion of the skin in case it's cancers because has to wait even longer. Even they are paid patient, they

have to wait longer for them to remove the mole, a big mole. So, I think we should sit down to that.

Okay, so I think we have to get the people who abuse the system to be regulated. Patient, doctors, hospital and then the ministry. I think we cannot go around putting officers in the hospital. I think that will be intruding into the system and precise them added cost.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You see a private hospital not regulated. Insurance not regulated. But specialist private hospital regulated. This is something that government must look at it.*

Dr. Sim Joo Seng: *Then, the other thing our private hospital is stand when the…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, private specialist already regulated. Only the other two not regulated.*

Dr. Sim Joo Seng: *When the insurance people come, insurance patient come, we actually charge according to the fees in the schedule. Not that we overcharge you. We put in whatever is in the schedule can charge you the amount.*

So, we are still within the legal framework. But when you come as a private, we actually are doing charity. Okay, you can pay yourself, we charge you less. So, in fact, that is the one of the reasons, not the other way. Because we don't say, we are charging more from us— we really got a book schedule of our fees. That's was actually maybe about eight, nine years ago and never increase the fees of the doctors in the schedule.

So, I am not defending doctors, okay. But I know there will be some doctors who abuse a system, admits patient, sometime they doesn't need admission. Then, some patients they ask to be admitted which is strange. Even have met the patient, they said, "I have been admitted already." [Ketawa] So, you have to think of these people that you need to regulate. But, the majority are the doctors and patients are all well-regulated.

So, one message to the insurance agent is that when you sell insurance, try to not to be overzealous to sell. There are people who cannot afford private health system, they just want to buy it to abuse the system. So, they can get to use it.

They will be a group where they actually buy it and then, they think that this shall cover for life. They don't realise that there is a ceiling. You admitted many times, there will be a ceiling that had reached, then cannot be insured anymore.

So, from the beginning must tell them because some of them doesn't know that. They think that, "I buy now and for life I have been getting insured." Okay, we

are not. We all have ceiling. When it hit the ceiling, your insurance agent will say, "Sorry, we cannot serve you anymore."

Encik Hazwan Arif bin Hassan [Muqmeen Group]: *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Sim Joo Seng: *Unlimited is right, but your premium will go up. Okay?*

Dato Dr. Jayabalan a/l A. Thambyappa [Health & Safety Advisory Centre (HSAC)]: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *Wait, wait Dr. Jaya. We take turns, okay? Don't worry. Okay? You will have your say.*

Dr. Sim Joo Seng: *It's good to have a discussion actually rather than having someone saying it. It's good to have discussions so at the end we get different view, different right opinion.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. Thank you very much Dr. Sim. [Tepuk] For full disclosure, Dr. Sim is my uncle. [Ketawa] So, that is good that he—this is nothing personal. But, this is very good that he give a different perspective from the—this is the whole point of public hearing.*

Different from various stakeholders and PAC is neutral. We are open to all views. Okay, the lady and then you, all right. Can I see who wants to talk? Okay, lady, the Mr., then the lady and then, at the back and you, and Dr. Ch'ng. All right.

Dr. Chee Heng Leng [Citizens' Health Initiative]: *Thank you very much* Puan Pengerusi, YB-YB, YB Sim *and* tuan-tuan dan puan-puan sekalian. *We are here to talk…*

Tuan Sim Tze Tzin [Ahli PAC]: *Your name and* ya.

Dr. Chee Heng Leng [Citizens' Health Initiative]: *Sorry. My name is Chee Heng Leng and I am from the Citizens' Health Initiative which was actually established in the 1990s.*

Okay, I just like to stand back a little bit and reflect a little bit on the big picture. After all, the very interesting anecdotes that have been told to us. That's very interesting stories. I think that YB Sim started this session even though we are talking about private health insurance here and private system here. YB Sim started the whole session this morning by pointing out that we have had a very excellence public health system.

I think that a few of this — a few of the former speakers also acknowledge this. Indeed, in fact, our private system is actually built on the success of our public system, our public health training, public medical training all these years.

So, what happened? Why are we now in this room talking about private health insurance? The problem of private health inflation in a private sector? Okay, I

supposed the answer is obvious that health have been many factors of course that contribute to changes in the last 50 years to 70 years.

■1100

But if I were to zero in on this structure of healthcare system financing. If you look at the National Health and Morbidity Survey in the 1980s when the first NHMS was done, very small percentage of the populations buy health insurance because everybody could depend on public healthcare. But now, it has grown and grown particularly in the 1980s— from the 1980s, private sector grew and grew without any government control. Practically no government control. Also, because the general policy from the 1980s onwards was towards privatisations.

So, what happened is that private— the share of the populations buying health insurance, medical insurance has increased. In this trajectory— let me voice a note of caution, because this whole debate about health inflation in our country actually happened very interestingly in parallel with the killing of UnitedHealth CEO in U.S. of A, the biggest health insurance company in United States. So, it is imperative for us to reflect on the way our healthcare financing system is going and make sure we don't go the way of U.S. of A, okay. Because they are out of control. That is a system where private health insurance is dominant. Is dominant everywhere.

Now, why do I say that we have to focus on the structure? We have to focus on the structure because there are certain things that go beyond the individual. So, for example, if your health financing system is dominantly for profit, you cannot escape from that. That is a pressure to get profit. If your healthcare providers are for profit, you cannot get away from it because of the pressures to obtain profit.

The doctors in the private sector are entrepreneurs. I am sure a lot of them are people with integrity and should be respected. But the system in which they operate, they are entrepreneurs and some of them own very expensive machine, they are shareholders in— some of them even own hospital. So, if you own a very expensive machine, you are the doctor, if the patient comes to you, you are wearing two hats. You are doctor and you also have to recuperated the amount of capital you have sunk into the machine. So, the pressure on you is to use the machine. And as a doctor, you are the provider, you can advice your patient to use the machine, right? Whether or not the patient needs it or need it or maybe marginally needs it, but the tendency is there. I am not saying that every doctor does this, of course. But that is the pressure of the system.

So, in that case, control by the government is important. Control can be both direct and indirect. Direct by regulation, but indirect also through the market. For example, why is private sector increasing? Number one, the market demand is increasing. Why does market demand increasing? Size of the market increasing. Size of the market increasing— for example, one small example, medical tourism. We are next to a neighbor that is many times populations is many times of us. Medan alone and you know the populations of Medan is many times the populations of Penang Island. Even if 10 percent or maybe one percent of the population of Indonesia sees the need to come to Malaysia or go abroad for medical care, we will be swamped. The market size for— the market demand will increase. The market size will increase for private sectors healthcare and when market increases, then of course those suppliers are more in control because this is our capitalist system. Demand and supply, right? So, the government has to control the size of the market, the size of medical tourism.

Taxation is important. When the proponents of market tourism argued for increasing medical tourism, they say that it will benefit our public system because in various ways. I have not seen that happen yet. I hope the government can look into the ways and the mechanism by which they can make this happen.

Number two is the floor price…

Tuan Sim Tze Tzin [Ahli PAC]: *Madam Chee, because we are short of time, I think maybe I give you one more minute?*

Dr. Chee Heng Leng [Citizens' Health Initiative]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *...And the subsequent speakers, I think you are limited to three to five minutes. Okay? Because I think we need to finish at 12.* Okey, silakan.

Dr. Chee Heng Leng [Citizens' Health Initiative]: *Okay. One more minute. I would say two points. One is no matter how much you want to use, just use the private healthcare system, you must push the government and push your YBs to argue to put resources into government healthcare. Because a good public healthcare system acts as floor price in this market system. If you have a viable government system, public system, the private system cannot go— the prices cannot go too high because you have a viable alternative in the public healthcare system.*

Number three— the second point I want to make was that, is that there has already been World Bank studies done which has proved that— done in OECD countries which has proved that taxation-based financing is the most cost-effective healthcare financing system. Even more cost effective than social health insurance. We can talk about that in another time if given the chance. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much, Madam Chee. Okay, next is— yes.*

11.07 pg.

Encik Oon Soon Hock: Selamat pagi YB-YB dan saudara, saudari. Saya Oon sebagai individu dan *financial advisor.* Kenaikan— saya nak terima kasih kepada YB yang betul-betul bekerja untuk rakyat. Terima kasih YB di sini. Tepuk tanganlah... *[Tepuk]*

Kenaikan premium insurans kesihatan baru-baru ini memang membawa beban yang sangat berat kepada rakyat terutama sekali untuk warganegara emas. Tadi Encik Sing kata, dia punya premium akan naik sampai RM15,000. Saya nampak ada warga emas di sini juga akan menghadapi masalah yang sama, mungkin premium akan naik sampai RM10,000, dalam lima tahun lagi mungkin jadi RM20,000. Ini memang berat untuk rakyat, untuk saya pun. Saya akan menjadi tua, saya pun rasa risau nanti saya tak dapat bayar premium.

Bila warga emas tak dapat bayar premium, pemegang polisi ini akan putus *(lapse)* dan warga emas ini akan pergi ke hospital kerajaan dan kerajaan akan menghadapi masalah yang besar. Mungkin lain kali saya tua, kena ambil *chem,* beratur di hospital kerajaan. Betul tak?

Di sini, saya harap— saya ada cadangan. Harap-harap kerajaan, Kementerian Kewangan menolong rakyat untuk mengawal premium dan mengawal caj-caj yang lampau yang terlalu tinggi di hospital swasta. Ini cadangan sayalah. Kalau tidak, lain kali kita rakyat Malaysia akan menghadapi masalah yang besar dalam kesihatan. Macam mana kita bila jadi tua, kita tak dapat perkhidmatan kesihatan.

Baru-baru ini, Menteri Kewangan, YB Lim Hui Ying sudah mengumumkan untuk umur 60 ke atas, premium tidak akan naik dalam setahun tapi untuk umur yang lain, premium tidak akan naik lebih daripada 10 *percent* untuk tiga tahun.

■1110

Tapi saya rasa cadangan ini tidak akan betul-betul menolong rakyatlah sebab dia untuk empat tahun sahaja, sementara sahaja. Selepas empat tahun, apa yang terjadi? Premium akan naik lagi, kita akan jumpa di sini lagi. *[Ketawa]* Betul tak? Saya harap kerajaan memang betul-betul menolong kita menyelesaikan masalah kenaikan premium. Yang itu saya punya cadanganlah. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Mr. Oon. *Okey, just for— okay, Madam. Okay before Madam starts, I just want to do some clarification.* Untuk kenaikan *charge insurance* itu 10 peratus untuk tiga tahun. Itu sebab kerajaan

letakkan *interim measure* supaya kita boleh cari penyelesaian, okey, untuk menyelesaikan *cost inflation, medical inflation dan* selepas itu, haraplah dia tidak akan menaik secara mendadak*. So, we have a very short span of two to three years to do all the reforms you need* supaya dia tidak ada *cliff effect.* Kalau kita tidak buat sesuatu*, after three years, it will be disaster*-lah ya. Okey, silakan *Madam.*

Puan Lim Cheng Ean*: Okay, good morning. YB Sim and members of panels and members of floors. I'm Lim Cheng Ean a retiree from one of the GLICs. Okay, for me, what I want to say is, we— with those on this hall, we know the concept of insurance is a pool of a risks and pool of the fund. So, we are the self-responsible people that buy medical insurance for our own financial planning and not to burden the government because we know the public spending on the medical is every year increasing.*

But towards the end, we as self-responsible tax payers, end up paying every year increasing in medical insurance premiums. I mean for me, a lot of us is we take care our own health, we have not made any insurance claims at all for the past, what, for me is 17 years because when you are under employment, your company pays for it also. So, we are willing to share of the risk but the whole thing is where is the share of the reward?

For us, it is like general insurance for motor insurance you have a non-claim bonus. For us, we don't have. By the time we want to upgrade because I think at my age group, most of us is a standalone medical card. So, we have an annual limit and a whole life limit. So, the insurance company forgot our— this group that is a loyalty policy holder without offering us any upgrade. By the time you hit 60, you may have high blood pressure, you may have diabetic problem or you may have cholesterol. So, these are the things that they just say, "Okay you want to upgrade, we'll go through it". They say, "They decline you or they loading you for 100 percent increase".

So, these are the things it ends up to us they say, "Okey, if you want to continue, just for emergency, you have to bear with the cost". But for a retiree, I think mostly you will spend like RM500 per month. Is it a cost? It's a burden to us, alright. I mean it's a choice, we know. Public sector health is the best because you have more up-to-date medical equipment. So, I will always tell my friends in case of emergency, rare case, go to GH. These are the things that even you go to private hospitals, you will have test after test then you will have that escalating or exorbitant medical bill.

So, for me, I feel like we need to— or the insurance companies they have their data analysis. You have to look at the claim range ratio. Okay, it can be only income of certain a group because they have the product that they have

hospitalisation income. So, some people will just— I mean, my personal experience I did see people walking and asked the specialist, admit me. But just happened my specialist say, "No, yours no need admission". Okey. Because they want to be earning the daily income.

So, is it fair to us? It's not. So, we have to be not only I have a good experience, I also have a bad experience too. So, if sharing the doctor— I mean, for me because I actually I'm staying in KL but now I'm in Penang to look after my father. So, the Penang people, I can see is quite fortunate because you have the Kek Lok Si Charitable Hospital. The bill, the itemised is so clear. I'm so happy I will be willing to pay for my father compared to another private hospital. It's like 50 percent higher. So, I move off the dime but I feel comfortable because the doctor there, the nurses there are caring too and they are professional people.

So, it's a choice for us to take but at the same time insurance company have to— I can see why they charged high because I have my experience when I submitted the claim, okay this is under my company's post-retirement medical, the insurance company took two months to reimburse me. A simple claim with so detail itemised they took two months. So, I just called them I said are you going to bear the credit card interest of 18 percent?

I mean these are the things. So, insurance will build in in in order to have for the higher. Why people come in individual without the insurance policy is slower? This may be one of the reasons, okay. Because if you have like I always say it's standard claim or complexity. The specialists also will be— I know they have the schedule like Dr. Sim said if complexity, they will charge you higher. But routine knee cap replacement, they will have a standard rate.

So, it's a like consultative treatment, do you need to do this scope? I mean, I always talk about genuine not basically you don't want to abuse the system so they will ask you, you want the branded drug or generic drug, okay. For us we just say okay. If generic is generic because it's a pool of the fund. So…

Tuan Sim Tze Tzin [Ahli PAC]: *Madam Lim, we need to cut short, sorry.*

Puan Lim Cheng Ean*: Alright. So, for me, I look at it if it's a standalone please give us a no claim bonus. The other one is since we have a group medical insurance like SOCSO actually they are paying for dialysis treatment for their members. What happened to EPF? Last time when I proposed to them, I said why not you do something, you have the members, you have the group bargaining power. Don't do like life insurance critical illness depends on the anti-regal profile. You have the group. So, use the group and you use your cost to pay for us. So, in case anything, if people decide not to take medical insurance, they still have and fall back to EPF. I think this*

one because we did not include EPF but look at it because they have the biggest members, okay. Alright, thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much, Madam Lim. [Tepuk] Okay, next is I think Dr. Ch'ng and then Mr. and then there and then you. Alright. Okey, I think stick to five minutes as the— finally, Dr. Ch'ng.*

Dr. Ch'ng Ewe Seng*: Good morning, I'm Dr. Ch'ng, a pathologist. I'm representing myself okay as the pathologist to a [Tidak jelas]. So, I just want to talk one thing about the unrated items in the bills, there is a laboratory charge. Actually, in Malaysia, we have an act that was enacted 17 years ago, 2007. There is a Pathology Laboratory Act enacted and* diwartakan *di Malaysia, Pathology Laboratory Act. But unfortunately, it's not enforced until today. 17 years. You can see. Go through the act that has been enacted in the Parliament but is not enforced just a few. This is the one.*

In the Pathology Laboratory Act, there is a mechanism to regulate the services of laboratory services in the hospitals, private hospitals. There is a mechanism to regulate the services and including the fee. The Minister of Health has to write to issue a list of fees for laboratory charges but this is not enforced. You have lost 17 years of the mechanism to regulate the one of the important items in the medical bill that is laboratory charges but because I don't know why 17 years being enacted, lulus di Parlimen, diwartakan *but never enforced.*

■1120

So, this is— the medicine already there but unfortunately, if we have that 17 years of experience, this can be expanded to all other services in the private hospital for example [Tidak jelas] charges, all the— other related charges because we have to [Tidak jelas] inside the act but unfortunately is not enforce. That's the thing that I want to bring to this. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much Dr. Ch'ng. [Tepuk] And— ya, I think ya— yes Sir.*

11.20 pg.

Dr. Teo Aik Howe [Hospital Pulau Pinang]: *And thank you YB. My name is Dr. Teo I'm a senior consultant emergency physician in the government hospital. I'm still working at a government hospital; I've been working in a government hospital for 30 years. [Tepuk] Oh! Thank you very much, didn't realise that.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry, your name again?*

Dr. Teo Aik Howe [Hospital Pulau Pinang]: *Dr. Teo.*

Tuan Sim Tze Tzin [Ahli PAC]: *Dr. Teo. Thank you.*

Dr. Teo Aik Howe [Hospital Pulau Pinang]: *Ya I would like just to share an overview about the issue I think we shouldn't also forget some primary problems. I've been working in a government hospital I think we recognized that a significant proportion of outpatients that we see today, came from private hospitals. They come from private hospitals because they are— mostly they are elderly, their payment is not enough, their insurance has expired or more often they are not— they are too complicated for private hospitals to handle and always they end up in government hospitals.*

One of the reasons why government hospitals are too overloaded because we deal with almost all of these patients, okay. So, it is just not I appreciated very much that you said we really have to build up government hospital services and we have not built up government hospital services for many, many years. I give you a very good example, we have not built it up because if we look at that maldistribution of it, I give you a very good example, Penang one government hospital in Penang sitting there.

There is no government hospital in this area, there is 300,000 population in this area. There is no government hospital here. How many, how many…

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much doctor for speaking up for Bayan Baru ya.*

Dr. Teo Aik Howe [Hospital Pulau Pinang]: *There should be a hospital…*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Dato' Sri Norazman. *Thank you.*

Dr. Teo Aik Howe [Hospital Pulau Pinang]: *I'm sorry, I don't represent anybody but there is no government hospital and I just to take note, there are five government hospitals sitting in Putrajaya, five kilometres from each other. [Tepuk] Please understand this. That is maldistribution of that. Why is that? I mean look, we— the problem is this, is not promote administrators, the problem is that when you look at data, you see so many hospitals in Pulau Pinang. But Pulau Pinang sees patients from Medan, from Indonesia, from Kulim, from Kedah, from everywhere but we are overloaded with all patients, okay number okay.*

Number two, if you want to deal with a private hospital, we have to recognise it. A lot of the reason why people go to private hospitals is because they want diagnostic services, they want out-patient care, they want screening. These type of things that are done which are very important for people's care but long delays for this in government hospitals. So, we have to either build up government hospitals or make these not— at the moment, you do this in private hospitals they have to be

done by admission. And when we do this by admission they can charge fully, they get charged fully under your insurance mechanism.

That's why your healthcare cost goes up and then the diagnosis DRG system goes up. Cause the DRG mechanism suddenly gets charged into your mechanism. So, therefore, healthcare costs everything goes up together. So that's not the way to do it. The way to do it is to build public healthcare access to screening mechanisms, to screening testers to get much better so that people have better access, faster access to screening tests like CT scans, like scopes things like that. Which is much what people want but we don't get that. Instead, we spent a lot on access to admissions, hospital beds, really important but is not the primary at the moment.

Next one, last one— thank you my two minutes. We can not forget that one of the reasons why the cost of healthcare increases in Malaysia and also throughout the world is because it ties in hand with medical-legal costs. And it's a big spike in medical-legal costs in Malaysia, in the last few years because medical legal sue against doctors go up very high and when medical-legal sue go very high, doctors have to be very careful what protecting themselves by— how do you protect yourself?

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Teo Aik Howe [Hospital Pulau Pinang]: *No. They are only all the insurance-insurance people talk. The way to protect yourself is to be defensive medicine, you do more and more testing. That's the way to do it and that's what the US does it, Europe does it and the whole world does it that way because the only way to be defensive. And that's not the way to do it because the way to be more, more defensive medicine is to health drive healthcare costs. The way to do it, the way to do it if you look at Singapore that does it, look at Taiwan does it a bit better, they do case-based, case-based payment mechanism.*

That's why DRG may not be really the way to go forward. Case-based management is the way to do it better, to try to control medical-legal costs together with healthcare costs. I think that's the way to look at it. Thank you very much. [Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much Dr. Teo. Yes Sir, and I want to see who else wants to speak. Anymore? 1, 2, 3 okay.*

11.25 pg.

Encik Kwan Nam Poh: Okey, selamat pagi YB-YB, tuan-tuan dan puan-puan sekalian. *I'm Kwan speaking from consumer and I mention lah okay. Here actually— the problem here actually is this, you must find out the main cause of the problem. The root cause of the problem, okay. Actually, there are many strategies that I think*

the government can do. Actually, at least here I got seven strategies, I just want to share one. The rest I think we pass it to one of your people, okay?

Okay number one, strengthen the public healthcare system, especially in Penang. I remember when my wife was pregnant it was 1990, she met with an accident, motor accident. She was sent to GH in the morning at eight o'clock but she was only operated in the afternoon. She was a teacher and she was entitled to class 1, class 1 ward ya, but she was warded in class 3. After one week then she was promoted to class 2. After another week then only promoted to class 1, okay. At that time, we didn't buy any insurance. You know that time in 1990, never heard of insurance for medical.

Okay, then recently I went to visit one of my friend in GH. I looked at the class 1 ward is the same ward 35 years ago. There is no improvement and the number of wards is also the same, the number of wards never increases, where's the population already increased ya. Especially like government servants they are entitled to class 1 but it go to class 3, ward 3.

So, this one I think the government must do something. Reinforce your infrastructure, build more wards for the GH, especially Penang. The ward 1 actually is more than 100 years. Is very old, colonial time. Never improve. Okay, and a government servant or pensioner if you warded in a hospital, government hospital you only warded, first go to class 3.

Recently one of my friends also, she was warded in an emergency ya, went to A&E, long queue you see. The queue is number 30 something. By the time he reached number one and then their only seven emergency bed in the ward. Seven for men and seven for ladies and the bed was also full. He also sleeps on the chair in the corridor. And then the doctor said you must stay, must be warded. Then he said ward 3 is also full. No bed for the patient, for the pensioner. So, you have to stay in A&E for one night. The next day only you can go to ward 3, class 3.

Tuan Sim Tze Tzin [Ahli PAC]: *Mr. Kwan, can you limit to one minute ya?*

Encik Kwan Nam Poh: *Okay. So— also you see when you drive past Cara Residency ya, you see both sides all park the car. Parking also is a problem ya. You see people— if I go to GH ya, I have to go early in the morning seven o'clock although my appointment is at eight or nine, otherwise there is no parking, okay.*

■1130

Then, you see the planning for the infrastructure also very bad. You see the current ward for specialist, only two-storey rather than should build multi-storey, 20, 30-storey. You can ward— I mean, the patient ward upstairs. Ground floor, I mean, the lower floors, clinics. Then it's a waste of land. You know, Penang is scarcity of

land and you make— so, so big piece of land and you built two-storey only. There is no brain. [Ketawa] Okay, thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Mr. Kwan. You speak my mind. Hopefully, MOH TKSU heard your voice. [Ketawa]* Okey, terima kasih. Silakan.

Encik Chew Kean Khoon [Prudential]: *Good morning all YBs and members of the floor. My name is KK. I'm speaking as a public. So, first of all, we would like to thank government to apply the interim to temporary control the increase of premium. This is to buy us some time. But we hope we don't waste this three years' time. So, after all the discussion in the government, what have you all done to monitor the— or the effort you all have done to control the private hospital charges? This is you all need to look into.*

So, and also, I would like to suggest that can government set up a team or provide a channel for the public to— like a whistleblower to inform government that there's an unreasonable charge of the— we found out or something and we also hope that we have action or reply from government if you all have this channel for us. This is important or else, we don't have any channel to tell you all about these things.

So, secondly, also I would like to suggest that can government increase the tax relief for the insurance? Yes, now is RM3,000 for medical, RM3,000 for life. So, maybe you all can increase the tax relief to reduce our burdens. Okay.

So, as one of the doctors suggest just now, there is a list from MOH about the doctor charges. However, there is no enforcement. If— I as an insurance agent, I did see that there's overcharges from private hospital doctors which does not follow the price list by the— set up by the government.

So, what can we do if we face this thing? Because under this method, insurance company only will pay based on the list, the price. But then, there's no channel for us and we cannot do anything.

And also, one cause of the increase in premium also maybe for the report writing. So, sometimes private hospital can charge one report writing for claim or something like that for RM200. That's I think is simple, just one page or two pages of filling up the report. Then, it charged around RM200. Even outpatient, sometimes.

Okay, that's it from me. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Mr. KK. Last one, okay.* Ada *two more* ya. *We still have— okay. So… [Dicelah] Here. Three more. One, two, three. Okay. Last, because I think we need to finish by 12.*

Encik Ambigapathi a/l K.A Samarasan: *Good morning. My name is Ambi. I'm an individual. I'm talking about the discrimination for people above 70 years old.*

MySalam covers until 65. SOCSO covers until you are 60. Insurance company won't accept if you are 70 years old.

So, why all these discrimination against elderly persons? This is age where we really need help for medical conditions but looks like they want you to go before you reach 70. [Ketawa] I think you have to review all these for old people because very soon it's going to be an old aging population. Close to about 10 percent of the population are going to be above 70, around that.

So, please look into it and help all the elderly people. You just have to look at the hospital attendance. Majority cannot afford insurance or— because they don't want to cover people above 70 years old. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you. Sir, yes.*

Encik Ong Eng Ker: *Good morning YB and all. I want to make it short. Actually…*

Tuan Sim Tze Tzin [Ahli PAC]: *Your name, please Sir.*

Encik Ong Eng Ker: *Ong. Actually, I have bought an insurance 20 over years ago. It's an investment-linked. Now, one is that when I bought, it wasn't told to me it's a pool system, there will be increase after certain age, it's a step. These all, not told to me. So, whether it's the insurance fault or the insurance agent fault, or my fault.*

Now, the thing that it keeps on increase and then now I'm engage with the insurance company since December 2023. I wrote to them, they never answer my claim, I mean my charges and my complain. They just said that there is an unsubstantiated allegation. But I wrote back to them, "It's facts, it's not allegation. You've increased my premium. Is it allegation?" Yes, increase. And then, they have increased without my approval, without getting permission by increasing. Just like you said, medical costs has gone up. One of the reasons.

But they increase my overall limit. But yearly limit, there's no change. So, how this yearly limit doesn't change can elevate my increase in medical cost? So, it doesn't go sync, right? So, I think it just to put up the overall limit just to justify your premium charge. So, I think it's wrong.

But my case now— and then, also I've wrote to them and tell them to answer each and individual item I brought up. They took seven months, after every two weeks, your case is still under review. For seven months. So, there is no professionalism. They never answer my question.

Imagine if I'm doing it, what about layman doesn't know and doesn't fight? I still fight. My case now is still with Bank Negara, currently. So, I'm waiting for the insurance company to come back to me. So, if I can be bullied, how about those who are not a bit educated, let's say the public? So, this is wrong.

Another thing is this. You need to monitor, while I was looking at the insurance, our company insurance claim is less than 70 percent of premium charge but other companies, 160 percent. Why? Because they didn't manage. You got to control and manage. You cannot say, "I got insurance company, insurance pay". But in the end of the day, who has to pay? Ourself. So, when the staff come and see me, I give guarantee letter with the help of a nurse. I said how much roughly this will cost? So, I give.

*And also, insurance— I mean, this no bearing. The hospital asks for my insurance company. I mean, for my insurance policy. I said, no go. Because you use my insurance probably then you start— I don't say-*lah. *If I give you, then I'll have problem. You have miscellaneous charge and go according to the schedule. So, I said no.*

We must control by not giving info. If you give info, they will just overservicing and it's—

other company, I mean overseas has proven also they're overservicing. So, this is one of the reasons you must manage, you must control. So, my case is that the insurance policy didn't mention it's not professional. Okay. So, I got— I'm still pending. I don't want to prejudice my case. I'll wait for Bank Negara to look into my case.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much Mr. Ong. Okay, we come to the last speaker. That— okay, and also Dr. He wants to be the last speaker. But we will wrap up a bit of—* nanti semua YB akan cakap sedikit, ada komen sedikit. Ya, silakan.

Encik Oh Ee Teik: *Good morning YB and members of the PAC board and all present. My name is Oh. I'm not representing the private hospitals, the insurance or the insurance agent. But rather I take this as a platform to voice my concern about— my disappointment about the increase in the insurance premium.*

Firstly, I feel that the insurance companies as well as the private hospital themselves has to do their homework rather than simply push the blame and push the additional premium to the premium payers.

■1140

Firstly, I believe the insurance companies they already have a fixed KPI of how much percentage profit they are going to make every year and if that profit cannot be met, then they will probably keep increasing your premium under the disguise that they cannot make money.

At the same time, the private hospitals— because they are buying equipment, and they are going on rapid expansion. I think everybody who's in Penang knows that

there's not a single private hospital in Penang today who has not expanded in size over the last five years perhaps. So, when they have all the investments put in, they must recoup their investments to make a profit and, again, the poor insurance premium payers become the victim.

I feel that, honestly, if the insurance companies and the hospitals work together and do their work together, then this problem maybe solved and the premium need not be increase. Making the whole operation more efficient will be very helpful.

For instance, if you go to the insurance company and you are trying to get the referral or to go admitted in the hospital, the insurance companies actually have doctors on their panels to review through everything to see whether what you are doing is valid according to the insurance policies. So, on the same perspective, why is it that when the private hospitals, as mentioned by the previous speakers, overcharge, the insurance companies do not contest? That is a bit unbelievable. It can be done, definitely, I am sure.

Also, when the hospital submits the claims to the insurance companies, I am quite sure they have all the data copies and all these information can also be checked and verified by the insurance companies to see whether there is any overcharging.

And then also, I feel that when the insurance company increase your premiums like some of the previous speaker has mentioned, they are not transparent. They don't give you the exact increment, why it increases so much or whatever. So, I think that's also not fair. I believe that it should be told to the premium payers earlier why the premium is increased and under what conditions and this is not clear always.

And then, finally, I guess the Health Ministry or any other ministry in the government should have a fixed payment rate where certain standard medical procedures should have a ceiling price, and the hospital could not charge beyond that. So, I think if that is in place, perhaps you may not solve all the problems, but you probably be able to solve maybe a huge significant portion of it.

Okay, thank you very much... [Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you. I invite Dr. Sng from private medical practices.*

Dr. Sng Kim Hock [Hospital Pantai Kuala Lumpur]: Terima kasih kepada Datuk Wira Mas *and* Jawatankuasa Kira-kira Wang Negara, YB Sim *and your amazing team which I believe you will do something for the nation.*

Okay, I speak as the former President for the Association for Specialist in Private Medical Practice. So, we represent the specialist who are in private medical practice. Most of us, like me, I am 25 years in government service, pensioner, now I am in private practice. We want to give the assurance— I came here to hear your

voices, your cries, your problem. I want to give assurance that most, I won't say 100 percent, most of our doctors are good, caring and do charity. I had paid hospital bills for my patients and others have done it, but we don't say it out. So, we hear you and we try to do something.

We know what is going on, but we are, in a way, we couldn't do anything. But now that is come out into open, very good, we'll try our best. We give the assurance that there is the MMC to look after the practice for the doctors. In every hospital, there's also Medical Defence Advisory Committee which would look after the practice. You actually don't know how many doctors have been sacked from private hospital. They were thrown out. In my own hospital, we have thrown out seven doctors. So, there are black sheep. But we need your help.

Complaint. If a test is done and— are not done and charged, this is criminal offense. It's cheating, it's lying. It must be reported. If there's anything that is done that is not right, you report it. I don't know what kind of report. Police report— just report it. We will do our part to monitor, but we cannot police everyone in the country. But doctors are being excluded from insurance company, excluded from corporation and even thrown out from hospital. They're really bad hats.

But actually, most of us are there to earn a living. We are not profiteering with providing a service. We are not selling a product. So, our service— tell you what is our service now. You come and see me with your 10 year problem, I am capped at RM235. Less than a massage kepala *or whatever it is. RM235. A same patient came from Singapore and said, "Wow, so little?". She was charged SGD900. An American patient.*

So, we are not giving any excuse. Something has been done. We will all work together to bring the hospital charges down, insurance premium will be controlled and Minister of Health, our Datuk Seri is here will do something, we have to find money to build a hospital. One hospital in Penang? It's ridiculous. No government hospital in Petaling Jaya. Mana boleh.

Thank you very much all of you. Speak it up. Will do our best. [Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih. Terima kasih, Dr. Sng. *So*, sekarang saya ingin menjemput panel-panel untuk *wrap-up*. Kita akan habis pada pukul 12 dan *closing will be by our Chair, PAC's Chair*, YB Mas. Saya silakan Datuk Ali Biju, Ahli Parlimen Saratok.

Datuk Ali anak Biju [Ahli PAC]: Terima kasih, YB Sim. Kita dah mendengar semua yang hadir ini membuat kenyataan-kenyataan, rintihan, komplen daripada semua lapisan masyarakat yang ada. Kita memang memerlukan maklum balas seperti inilah untuk membuat apa-apa keputusan yang akan datang.

Prosiding *open discussion* macam ini adalah sangat penting untuk kita sama-sama melihat daripada mikro dan makro, daripada pandangan pesakit sendiri dan juga daripada pandangan pihak hospital dan pihak insurans. Dan kita memerlukan data-data di masa prosiding yang akan datang daripada pihak insurans, hospital supaya kita boleh menentukan di mana silap kita. Macam mana *suddenly* insurans ini boleh naik? Kita beli insurans, oh— masa *insurance agent* jual, *"Ini tidak banyak"*, *"Untuk kesihatan"*. Tapi lepas itu dia naik, naik, naik lagi *and then* kita *trapped*. Nak lari tak boleh sebab kita dah bayar. Jadi, benda macam inilah kita kena lihat dengan lebih *details* lagi.

Repot ataupun segala komen yang dibuat oleh masyarakat, kita akan bentangkan dalam laporan PAC kita. Prosiding ini bukan dibuat dalam masa dua, tiga bulan. Dia akan bersambung, bersambung. Kita memang memerlukan maklum balas (*feedback*) daripada semua supaya apa-apa jua keputusan, kita PAC dan juga masyarakat semua dan juga Parlimen nanti, kita sama-sama setuju arah (*direction*) *health service* di Malaysia ini.

Kita tak nak macam di Amerika (USA), *health service* dia macam dah terlampau mahal. Di negara *Western, Europe,* terlampau mahal. Tidak menggambarkan pendapatan penduduk kesemua masyarakat. Jadi, itulah yang kita nak *avoid* dan maklum balas seperti ini memang kita perlukan dan *please, speak up. We need more info, we need more data, and then, we need to share.* Kesihatan adalah untuk semua. Mungkin dulu tahun 80an kita tak berapa peduli pasal kesihatan sebab masa itu *specialist* kurang tapi sekarang *specialist* banyak, *physio* dah banyak. Mungkin premium itu nak naikkan jugalah tapi taklah mendadak dalam masa dua, tiga tahun.

Jadi, *we are concern about this. Then, we PAC bring it up and then* kita nak semua memberi kerjasama, *open up, speak up* semua. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, YB Saratok. Saya persilakan YB Sik, YB Tarmizi. Silakan.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Assalamualaikum* dan selamat pagi. Terima kasih YB Sim dan Ahli-ahli PAC serta tuan-tuan yang saya kasihi, yang saya hormati sekalian.

Kalau di Indonesia, terkenal satu istilahnya, *"Jika kamu miskin, kamu jangan sakit".* Tadi disebut, ada tuan menyebut kalau di Malaysia mungkin kita ubah, *"Kalau kamu tua, kamu jangan sakit."* Kalau kamu sudah menjadi warga emas ya.

■1150

Di India ada satu filem yang sangat— maknanya *box office* saya lihat filem ini dan tuan-tuan juga nanti balik cari dalam Youtube *'Gabbar is Back'* tajuk filem itu

Bollywood 2015. Menceritakan bagaimana sehinggakan sudah menjadi isu besar negara di India, *corruption* di dalam kesihatan khususnya di hospital. Itu kita mengharapkan tidak berlaku di Malaysia. Bagaimana diceritakan dalam filem ini hero namanya Akshay Kumar. Dia melihat ada satu kes di hospital swasta, doktor ini dia membuat *claim* yang pelbagai ini, mengarut ini. Rupa-rupanya pesakit ini sudah pun mati di dalam bilik mayat.

Begitu ceritanya dan keadaan kita ini bukan hanya di Malaysia, bahkan sudah berlarutan di seluruh dunia. Dan saya melihat satu perkara ini ialah ada berlaku ketamakan. Minta maaf mungkin ada sedikit kekerasan. Ketamakan di beberapa pihak untuk mengaut keuntungan yang besar.

Jadi, perkara ini sangat serius untuk kita lihat dan PAC nyatakan ini hal melibatkan seluruh rakyat sama ada kita di *urban area* ataupun di *rural area.* Saya di Sik, orang-orang kampung juga sama. Sebab sakit itu tidak mengira siapa? Orang Melayu, orang *Chinese,* orang India? Siapa parti dia? Kami di sini *interparty.* Saya dari PAS, dari Bersatu, dari PKR semua. Kita sedang menunggu waktu untuk kita ke hospital. Betul, tuan-tuan ya? Kita menunggu masa sahaja. Bila kita akan pergi ke hospital.

Jadi, dapatan daripada tuan-tuan ini sangat bagus dan yang paling penting ialah di pihak kerajaan melihat polisi secara keseluruhan termasuklah kita melihat dari segi perundangan, aktanya yang kita sekarang ini ada keperluan dalam Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 yang perlu dilihat secara menyeluruh bagaimana *regulation* ataupun peraturan untuk kita *control* hospital-hospital swasta ini.

Begitu juga insurans itu sendiri di bawah BNM (Bank Negara Malaysia) kerana dalam kes yang dikaji oleh BNM itu sangat jelas ada 33,815 kes yang melibatkan ada aduan kenaikan premium insurans ini. Jadi, ini bukan perkara yang kecil-kecil tetapi ia sangat serius.

YB Sim mendedahkan kos rawatan untuk radang paru-paru, mungkin dia selesema ataupun dia demam. Kalau dia ada insurans dia kena bayar RM6,800 tapi kalau dia tak ada insurans, dia bayar *cash,* duit sendiri. Dia hanya perlu bayar RM2,600. Betul ya, YB Sim? Jadi bagaimana itu dikira? Jadi, sangat penting dan saya yakin dapatan kita hari ini daripada tuan-tuan semua kita akan perhalusi.

Juga ada dilihat kesungguhan KKM (Kementerian Kesihatan) juga kita ambil maklum. Kalau dilihat dalam bajet untuk 2025 ada peningkatan besar ya, Timbalan KSU kita ada di sini. Ada peningkatan daripada RM41.2 bilion untuk 2024. 2025, kita naik RM45.3 bilion. Namun itu masih lagi belum cukup saya yakin kerana kita nak pastikan bahawa setiap keperluan kesihatan rakyat itu akan diambil kira sepenuhnya.

Kesesakan di hospital-hospital kerajaan ini sudah pun menjadi merebak ke seluruh tempat termasuk saya di Sungai Petani dan sebagainya.

Saya pun, mungkin Dato' KSU ada di sini, saya mohon di Sik itu satu klinik desa. Bumbungnya bocor, sudah dua tahun belum dapat lagi. Saya pun bagaimana ini? Jadi ini perlu dilihat. Tadi saya sangat terkejut bila disebut doktor daripada hospital kerajaan mengatakan sebahagian yang pergi ke hospital kerajaan itu kerana tuntutan insuransnya tidak cukup ketika dia berada dia hospital swasta sebelum itu. Itu sangat serius perkara apa yang berlaku.

Jadi, saya berterima kasih kepada semua yang hadir dan yakin ini suatu usaha besar kita bagi memastikan setiap rakyat kita mendapat kesihatan yang terbaik sebagai seorang rakyat di negara kita.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih YB Sik. Seterusnya saya menjemput YB Kubang Pasu, Datuk Ku Rahman untuk memberi ucapan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey, *Assalamualaikum* kepada semua. Pada pandangan sayalah, kita ini kadang-kadang pandangan sendiri tak sempat nak bincang untuk mewakili kumpulan kita. *We had a very fantastic event today.* Pandangan-pandangan yang diberikan yang kita dengar tadi dari *all walks of life* amat-amat bagus dan menjadi sekurang-kurangnya panduan kepada PAC untuk membawa kepada peringkat yang berwajib.

Kita di sini macam YB Sik cakap, kita dalam PAC tak ada parti. Memang kita wakil parti tetapi bila kita bincang tentang kepentingan rakyat kita letak topi parti di sebelah. *We have to be neutral and the best is* kepentingan rakyat menjadi keutamaan kitalah.

YB Sik, PAS, saya Bersatu. Dua-dua PN. YB Mas, Bersatu PN. YB Sim, PKR. Yang seorang lagi juga PN juga. Tak tahulah kebetulan hari ini PN lebih ramai. Tapi itu tidak mendatangkan masalah.

Ada beberapa perkara dan apa yang kita dengar di sini ini *even though* kita *mentioned certain thing good or bad* daripada pihak PAC. Ia akan bawa lagi ke peringkat-peringkat yang lain. Kita akan bertemu dengan banyak lagi *stakeholders* di peringkat kerajaan, *private hospitals* dan sebagainya untuk kita dapat buat satu rumusan yang terbaik. Akhirnya ia akan menjadi satu rumusan yang boleh dibawa untuk jangka masa panjang.

Ada beberapa perkara yang saya nak sebutkan sekali lagi. Saya pun sendiri saya menyokong tentang *government hospital.* Saya *support* cadangan tadi supaya— siapa yang sebut cadangan tadi supaya bajet untuk kesihatan dipertingkatkan. Sungguhpun kita dah naikkan tahun ini tahun 2025. Betul Dato' Sri Norazman ya? RM40 bilion lebih dan lepas *education,* kesihatan dapat yang tertinggi.

Ini satu saya rasa satu langkah yang baik untuk negara kita. Itu tak mencukupi seperti mana yang disebutkan tadi *we are talking about 2.5 percent of GDP. It should increase further not immediately to five percent, six percent* tapi *staggered 2.5, 3.5, four percent* dan seterusnya. Supaya *public health system* ini, hospital kerajaan dan sebagainya ini ia setanding dengan *private hospital. Easier said than done but that should be our target.*

Sebab hak untuk mendapatkan rawatan perubatan yang *the best* adalah hak semua rakyat. Tak kira dia di kampung, di bandar, dia kaya, dia miskin dan sebagainya. Semua dapat hak yang terbaik.

Kita dengar tadi tentang *expansion of private hospitals* tadi. Saya pun dengar pada tempat-tempat lain. *Who pays for this expansion of private hospitals? At the end of the day,* kita bayar premium itu ada terlibat juga *private hospitals* ini. Bila dia buat itu dia punya *increase* dia punya CaPex naik. Ia punya kos naik. *At the end of the day, private hospitals* kena buat *profit* dan dia kena *increase the cost to the patients and therefore increase the income.*

At the end of the day, for shareholder kena pergi *one day, that's what happening. This is something that maybe* Kementerian Kesihatan dapat melihat perkara ini.

■1200

Lastly what to do, cadangan ya. Ada dengar macam-macam tadi. Mungkin ini sebenarnya *thinking aloud.* Kita dah *regulate the private specialist,* doktor-doktor pakar. Dia boleh *charge only certain amount to certain patient* yang dengan penyakit-penyakit tertentu. Betul tak? Tapi kita tak ada *regulate private hospital and insurance.* Sebab itu ada negara umpamanya United Kingdom (UK), *even* Indonesia *recently this one during Jokowi's time.* Apa yang dibuat *National Health Insurances, then they regulate there. Then you know, they schedule amount for the whole country.*

Lagi satu saya nak bagi satu contoh. Satu, saya sebut tadi— saya dengar tadi tentang *term* DRG. Sebelum saya datang ini— saya doktor juga tapi doktor saya PhD. Bukan doktor *medical*. Jadi dulu bila saya dapat PhD, balik kampung tahun 83', semua orang sakit *mai* jumpa saya. *[Ketawa]* Saya kata saya tak boleh bagi ubat. Saya boleh bagi panadol *je.* Itu masalah juga bila PhD dipanggil doktor. Tapi yang betul-betul *doctorate* ini PhD lah, doktor. DRG ini maksudnya apa? *Diagnosis-related group.* Betul ya? *This one* kadang-kadang dia ada masalah. Dia pergi *private hospital* macam apa, penyakit SLE dan sebagainya. *Private hospital* kadang-kadang dia tak boleh *manage,* nak *handle,* dia *pass back to public hospital.* Betul tak? Semua penyakit serius ini, kalau pergi *private hospital* yang *emergency* ini, dia panggil ambulan dia hantar *pi general hospital* Datuk Seri. *So, at the end of the day, I think*

it's already rational for us to improve the public health system. So that rakyat yang tak mampu, yang dia— ekonominya tak baik, dia kena pergi *public healthcare system.*

Saya ada satu— saya dengar ya, ada hospital di Pulau Pinang. Nama dia Lee Yang Yee kah? *[Dicelah]* Oh Lam Wah Ee. Okey, ini satu hospital yang cukup baik. Kalau banyak lagi hospital macam ini yang *treatment* dia sebagai *private hospital,* tapi dia *charity* ya. Bukan dia tak *charge* langsung.

Saya bagi contoh seorang kawan saya dari kampung saya Yan. Dia punya *valve* dia empat-empat sudah *nearly 100 percent.* Dia boleh mati *anytime. So,* dia pergi hospital ini, buat *medical*, ada orang cakap bagus. *So,* dia dapat itu, dia pun balik. *Then halfway, I think* tak sampai Jambatan Pulau Pinang, doktor itu telefon dia. Dia kata *you* kena datang balik hospital. *You* kena *operation* fasal *you* punya ini *very serious.* Dia pun balik jumpa hospital itu. *Then* dia kata saya tak mampu nak bayar. *Bypass* ini kalau *private hospital* mahal kan RM100,000 dan sebagainya. Doktor ini cakap dengan dia apa, *you* tak perlu fikir fasal nak kena bayar. *Operation* buat dulu. *I would do it for you. You* tak payah bayar cengkeram pun. *So, what happen after that?* Nak kena bayar ini banyaklah, dekat RM100,000. Dia pergi melawat rumah pesakit ini di kampung saya di Yan. Dia *pi* melawat. Dia tengok-tengok rumah dia ini orang susah. Dia takkan mampu bayar. Apa dia bagi kalau saya ingat betul-betul. Dia kata kita *charge you* RM5,000 sahaja. *You* carilah pinjam duit-duit, kita kena *charge* sikit. *This is fantastic* yang berlaku di hospital di Pulau Pinang ini.

Ada juga cadangan yang kita dengar supaya *private hospital* ini dia ada satu *wing.* Dulu IJN ada buat kan. Ada satu *wing.* Dia untuk orang-orang yang tak mampu, warga emas macam semua sini termasuk saya jugalah, warga emas juga. Nampak tak berwarga emas tapi emas. Nak masuk intan dah pun supaya ada *wing* ini, supaya dia ada pilihan. Dia buat *charity.* Saya ingat macam Assunta Hospital, *private hospital* di Petaling Jaya. Dia ada elemen ini dalam hospital itu. Dia takkan *charge* lebih-lebih.

Lagi satu pengalaman kita semua bila kita *pi* hospital. Dia akan tanya *you* bayar dengan insurans ke ataupun peribadi. Kalau insurans, dia *look very happy*-lah. Kalau yang sendiri tak berapa *happy* sebab dia *quote* RM2,500 tapi kalau insurans RM5,000.

So, at the end of the day, terima kasih banyak-banyak dan kita akan dapatkan pandangan dari semua pihak dan PAC *Chairman* akan membuat pengumuman kemudian bila habis selesai kita jumpa dengan *all stakeholders.* Terima kasih banyak-banyak. *Insya-Allah,* kita jumpa lagi di lain masa. Sekian, *assalamualaikum warahmatullahi wabarakatuh. [Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Dato' Ku. Okey, sebelum saya serah balik kepada *Chair,* saya pun nak ulas sikitlah. *I want to tell you a story, a real story.* Minggu lepas, *my mother-in-law,* emak mertua saya dapat *accident. She has been newspaper seller for 40 years. So, she's B40*-lah. Jual surat khabar. *So last week— but recently retired. Drive a motorbike,* pergi makan pagi. Tiba-tiba dilanggar oleh kereta. *Drive* laju, langgar kena dan gelek *run over her body. Critical, still in hospital.* Tunggu ambulan *half an hour.* GH tak sampai, *one private hospital* sampai. *So* pergi ke hospital di Seremban. *So, this hospital— I spent many days there and I observe.* Hospital ini menarik. Kenapa? Dia walaupun satu hospital yang kecil, tapi *patient*-nya ramai. Dia daripada Melayu, Cina, India semua ada. Hospital ini adalah— saya tengok *carpark* dia, yang datang semua Proton Saga, Myvi atau Axia dan sebagainya. *All the very consider B40* punya *level.*

Saya buka matalah ya. Nasib baik mak mertua saya dia ada beli insurans. *As people they protect themselves, they buy. The number one lesson is insurance is important as well. Second,* hospital swasta memainkan peranan. *When the government hospital is overloaded. So, I think we have to be fair as PAC members, as Members of Parliament,* kita bukan mencari salah. Kita bukan *witch hunt or we want to go after anyone or want to strain your leg, or what do you call private hospital* kah, *insurance company, no. We are trying to help, to have a sustainable private healthcare system, private healthcare financing for Malaysians.* Kita semua ini rakyat Malaysia. Kita carilah penyelesaian yang sesuai untuk negara kita. Kita tidak boleh ikut seperti YB Saratok cakap, kita tidak boleh ikut sistem Amerika. Amerika itu *a broken system. I lived in America for six years and know how bad it is.* Sampai insurans CEO kena *was gunned down and became a hero,* yang *assassinated him become a hero. Because people feel is injustice. That's an injustice there.*

That's why saya— *I feel strongly about this and then I want to fight this. I want to fight for a fair system. I'm not fighting for against anyone. I want to fight for a fair system for everyone and I need your help.* Kita di sini *Members of Parliament,* kita nak buat sesuatu tapi kita perlu sokongan rakyat, betul? *[Dicelah]* Hari ini kita adakan prosiding untuk *engagement* supaya benda ini dia akan berlaku, boleh dilaksanakan, mendapat sokongan daripada rakyat. Kerana kita mempunyai *very short window.* Sebab kenapa? Kita hanya ada tiga tahun interim sahaja. Kita berterima kasih kepada Perdana Menteri kerana dia secara tegas, dia telah mengarahkan supaya interim apabila isu besar kenaikan insurans mendadak. Perdana Menteri secara *very* tegas and *very fast did an interim measure. He gives three years for all the stakeholders to come together and find a solution.* Ini mandat dia bagi kepada MOH,

kepada Bank Negara, kepada semua agensi kerajaan untuk mencari penyelesaian. *For three years we have to solve it.*

PAC kita terpanggil untuk membantu supaya kita boleh *engage stakeholders* dapat *feedback* dan kita selepas dua prosiding terbuka. Hari ini di *Penang*. Minggu depan di KL, di Parlimen. Selepas itu *we* akan *go for closed door proceeding.* Banyak prosiding akan berlaku dan *we will go deep dive into the issue* dan *finally we will produce a report and present it to the Parliament and to the government* supaya *action can be taken.*

■1210

Ini proses dia dan kita harap bahawa *the public, the* rakyat *will continue to be vigilant, speak up* sebab kita tak mahu *hoo-ha* dua minggu, lepas itu benda ini *die down. When you die down, meaning is* habislah. Dia tidak akan berlaku perubahan atau reformasi.

Jadi, saya harap bahawa isu ini akan berterusan dan rakyat harus bersama dengan kita dan *continue to come very strongly. If you feel something as strong, speak up and then*, sama-samalah kita bertenang, sama-sama kita mencari penyelesaian— *a full ecosystem.* Daripada *private healthcare* sampai kepada hospital kerajaan, *a full ecosystem*.

Semua-semua— kita semua rakyat Malaysia, ya. Kita sama-sama cari penyelesaian yang bagus. Hospital swasta pun milik rakyat Malaysia. Farmaseutikal pun orang Malaysia kerja di dalam ya. Hospital *specialists* pun rakyat Malaysia juga ya. *Patients, insurance agents*, semuanya kita rakyat Malaysia. Carilah cara Malaysia untuk menyelesaikan. Itu mesej daripada saya. Sekian, terima kasih, *xie-xie, nandri vanakkam*. *[Tepuk]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih saya ucapkan kepada YB Sim. Terima kasih juga kepada semua yang terlibat hari ini yang memberikan buah pandangan, fikiran kepada sesi pendengaran awam kali pertama yang dilakukan oleh PAC.

Saya ucapkan ribuan terima kasih juga kepada sahabat-sahabat Ahli-ahli PAC Parlimen Malaysia yang berkelapangan pada hari ini. Saya ingin merakamkan ucapan penghargaan saya kepada Yang Berhormat Tuan Sim Tze Tzin di atas inisiatif untuk buat di utara ini ya.

Kebetulan di KL— patutnya hari ini di Kuala Lumpur dijadualkan, di Parlimen Malaysia, tetapi malang sekali, kapasiti bilik mesyuarat penuh di Parlimen ini. Bayangkan. Jadi, terpaksa kita lakukan di Penang dan dapat berjumpa dengan tuan-tuan dan puan-puan semua.

Pastinya ini yang diperjuangkan sebagaimana telah pun dinyatakan oleh sahabat-sahabat saya, ini adalah isu rakyat. Isu kita semua. Saya beli polisi, habis belajar dekat UKM, kerja jadi peguam, saya beli mula RM150 polisi. Ia bertambah, bertambah. Hari ini satu *family* tujuh orang, semua ada insurans. Pasti membebankan ya, membebankan.

Saya memang pengguna tegar kad insurans berbanding dengan YB Sim, pernah pakai? Tak pernah pakai. Saya *almost every year* masuk hospital. *[Ketawa]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya pula tak pernah beli insurans. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Dato' Ku Rahman tak pernah beli insurans. Dia banyak duit, dia bayar *cash* ya.

Jadi, apa yang kita nak dengar hari ini adalah bagaimana kita boleh membaiki keadaan dan juga bagaimana boleh kita kawal dan juga kita membuat satu situasi menang-menang kepada semua pihak sama ada pihak hospital, pihak insurans, semua pihak yang terlibat. *Even* dekat Penang ini pun ada juga kilang-kilang yang menjual *medical devices,* kan? Yang mana boleh diguna pakai. Maksudnya, mereka pun sama-sama juga terlibat.

Jadi sebab itu tuan-tuan dan puan-puan, hari ini yang kita lakukan adalah untuk sama-sama kita melihat di masa hadapan dan hari ini PAC, kita ada banyak sebenarnya isu-isu lain selain daripada isu kesihatan awam dengan peningkatan kos perubatan dan sebagainya dan juga premium insurans.

Kita ada banyak lagi isu-isu lain, tetapi kita menjangkakan isu ini akan mengambil masa yang juga panjang kerana banyak pihak juga yang akan dilibatkan. Disebabkan itu, saya harap tuan-tuan dan puan-puan semua akan terus memberikan kerjasama yang baik. Minggu depan, hari Jumaat, 21 hari bulan, kita akan buat di Parlimen, Bangunan Parlimen Malaysia, jam 9.00 sampai pukul 12 tengah hari. Waktu yang sama, minggu depan, hari Jumaat.

Saya suka mencadangkan kita juga boleh buka *Google Form* kepada orang awam kalau siapa yang tak berkesempatan untuk hadir untuk memberikan buah pandangan, fikiran mereka di dalam *Google Form* tersebut supaya kita boleh lebih banyak lagi dapatan-dapatan daripada pelbagai lapisan masyarakat yang boleh memberikan buah pandangan dan juga fikiran.

Sekali lagi ya, saya ucapkan sekali lagi terima kasih kepada semua sahabat yang terlibat. Untuk buat *public hearing* pada hari ini, saya nak bagi tahu tuan-tuan dan puan-puan bukan senang sebab berikan tepukan kepada Parlimen Malaysia. *[Tepuk]* Seramai 25 orang datang hari ini, mereka yang terlibat. Yang ada *videographers, photographers*, yang sekretariat...

Tuan Sim Tze Tzin [Ahli PAC]: *Hansard. [Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Hansard*. Yang apa yang tuan-tuan cakap, tuan-tuan cakap "*eh", "oh",* semua akan keluar dalam *report*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Hansard* Parlimen. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Hansard* Parlimen Malaysia. Jadi, mereka datang semalam naik bas sampai pukul 11 lebih dan hari ini dah datang bertugas, dan petang ini balik terus ya. Jadi, saya ucapkan terima kasih. Bukan mudah nak buat satu pendengaran awam, tetapi dengan kerjasama Parlimen Malaysia, *alhamdulillah* ia dapat dilaksanakan.

Terima kasih sekali lagi kepada Datuk TKSU, datang senyap-senyap, tak bagi tahu. Duduk situ, bagus ya, supaya Datuk KSU sendiri dapat dengar dan juga melihat bagaimanakah keluhan oleh semua rakyat ataupun mereka yang terkesan. Itu sahaja.

Sekali lagi saya ucapkan terima kasih kepada semua tuan rumah dan tuan-tuan semua yang memberikan kerjasama yang baik. Semoga apa yang kita semua perjuangkan ini akan akhirnya nanti akan memberikan manfaatnya dipulangkan balik kepada rakyat Malaysia, *insya-Allah.* Terima kasih. *[Tepuk]* Saya tangguhkan pada pukul 12.15 ya.

[Mesyuarat ditangguhkan pada pukul 12.16 tengah hari]



MALAYSIA

LAPORAN PROSIDING (HANSARD)

Jumaat, 21 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding Pendengaran Awam:
Peningkatan Bayaran Premium Insuran Kesihatan,
Caj Hospital Swasta dan Impak kepada
Kesihatan Awam di bawah MOF, MOH & BNM

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

SESI PENDENGARAN AWAM
JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN MALAYSIA

DEWAN BANKUET, BLOK UTAMA
PARLIMEN MALAYSIA

JUMAAT, 21 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dr. Hajah Halimah Ali [Kapar]

Tidak Hadir *[Dengan Maaf]*
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Puan Vivian Wong Shir Yee [Sandakan]

URUS SETIA

Encik Ahmad Johan bin Mohd Afandi [Ketua Penolong Setiausaha (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

SAKSI

Prof. Dr. John George [Bekas Pengerusi Kebangsaan Doktor Kerajaan, Persatuan Perubatan Malaysia]
Datuk Panjamothy
Encik Ravinder Singh [AQM Insurtech]
Tuan Mohd Del bin Mustafar Azlan [Prudential Life Insurance Agency Association]
Puan Jenny Yee Wai Kwan
Dato Indera Dr. Sha'ari bin Ngadiman [Harm Reduction Action Network
Encik Woo Yuen Seng
Encik Chiu Fook Seng
Encik Rajagopalan a/l Kgr Pillay
Encik Steven Wong Weng Leong [China Construction Bank (Malaysia) Berhad]
Prof. Kehormat Amrahi Buang [Malaysian Pharmacist Society]

Encik Nabil Husni [Mencakna]
Cik Natasha Mohd Sharif [Boleh Space]
Encik Kam Yew Wai
Prof. Dr. Sothirachagon Sinnathurai
Dato' Dr. Mohamed Ibrahim bin A. Wahid [Beacon Hospital]
Encik Cheah Tuck Wing [Chairman Malaysian Coalition on Ageing]
Encik Saravanan Govindasamy [BioCare Group, FOMCA]
Dr. Tan Ai Mooi
Encik Chin Kuan Min
Dr Rashidi Mohamad bin Pakri Mohamed (UKM)
Encik Manir Victor [Vital Signs Asia]
Encik Sathya Kamalanathan [Eximius Medical Administrations Solutions]
Encik Tan Jeck Kan [SBM Agency]
Dr. Noraishah Mydin binti Haji Abdul Aziz [Persatuan Kecanggaan Tiub Saraf Malaysia]
Puan Nur Syimah Izzah bin Abdullah Thani [AstraZeneca Sdn. Bhd.]
Prof. Dr. Nur Aishah binti Mohd. Taib [Together Against Cancer]
Encik Sivakumar Subramanian
Tuan Lim Teng Cyuan [Malaysian Association of Pharmaceutical Suppliers]
Encik Mohanakrishnan Menon a/l CC Menon
Encik Tan Jee Kwang
Puan Minnie Yap [VKA Wealth Planners Sdn. Bhd.]
Encik Koh Eng Huat
Dr. Gunalan Arumugam Palari [Persatuan Perubatan Malaysia]
Encik Raymond Yeoh Huat Hock
Puan Azealea binti Dzulkefflee [Agensi Azealea Dzulkefflee]
Encik Eugene Tan Kok Cheng [Prudential Insurance Malaysia]
Puan Parimalar Nesamany [Ejen AIA Bhd]
Encik Ethan Teh Eng Teck [Association of Financial Advisor Malaysia]
Encik Wong Chun Wai
Encik Woo Yew Seong
Encik Muhammad Sha'ani bin Abdullah [SUSDEN Malaysia]
Puan Alifah binti Zainuddin [CodeBlue]
Encik Andrew Tan Eng Jon [Balai Ikhtisas Malaysia]
Encik Lim Jaan Huei
Encik Nathar Shah
Encik Lim Jack Shen [Persatuan Farmasi Malaysia]
Encik Woon Yu Cheng
Puan Harpreet Kaur a/p Darshan Singh [Persatuan Farmasi Malaysia]
Encik Wooi Yu Thong [PRULIA]
Encik Tan Keng Beng

LAPORAN PROSIDING

SESI PENDENGARAN AWAM
JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

DEWAN BANKUET,
PARLIMEN MALAYSIA, KUALA LUMPUR

JUMAAT, 21 FEBRUARI 2025

Sesi pendengaran awam dimulakan pada pukul 09.00 pagi

*[Yang Berhormat Sim Tze Tzin **mempengerusikan Mesyuarat**]*

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat Jawatankuasa Kira-kira Wang Negara, Parlimen Malaysia]: *Assalamualaikum warahmatullahi wabarakatuh.* Selamat pagi. Terima kasih kepada semua hadirin hadirat yang hadir pada Sesi Pendengaran Awam bagi Prosiding Peningkatan Bayaran Premium Kesihatan Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan Bank Negara Malaysia.

Ini adalah sesi pendengaran awam yang kedua selepas yang pertama diadakan di Pulau Pinang pada 14 Februari iaitu minggu lepas. Seperti yang saya maklumkan sebelum ini, aturannya setiap pengucap akan diberikan lima minit. Jadi sebelum memulakan pengucapan dimohon supaya memperkenalkan diri, nama penuh dan juga daripada mana. Maksudnya sama ada mewakili pertubuhan, agensi-agensi berkaitan ataupun individu. Disebabkan sesi kali ini akan direkodkan oleh tim laporan prosiding dan akan dimasukkan dalam Laporan PAC.

Di atas saya perkenalkan selaku moderator pada pagi ini YB Sim Tze Tzin daripada Ahli Parlimen Bayan Baru. Di sebelah kanan beliau YB daripada Betong, YB Dr. Richard— Betong, Sarawak. Di sebelah kiri beliau YB Dr. Wira Ku Abdul Rahman daripada Kubang Pasu.

Jadi saya tanpa melengahkan masa sebab kita ada sampai pukul 12. Saya persilakan YB Sim untuk memulakan sesi pendengaran awam kedua bagi Prosiding Peningkatan Bayaran Premium Kesihatan Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan Bank Negara Malaysia. Persilakan YB Sim. *[Tepuk]*

Tuan Sim Tze Tzim [Ahli PAC]: Terima kasih Pengerusi majlis, saudara Johan. Yang saya hormati Yang Berhormat Dr. Richard, Ahli Parlimen daripada Betong, Sarawak. Yang saya hormati juga Datuk Ku Rahman, Ahli Parlimen daripada Kubang Pasu, Kedah. Saya Sim Tze Tzin, Ahli Parlimen daripada Bayan Baru, Pulau Pinang.

Hari ini saya amat berbesar hati boleh jumpa ramai yang hadir pada sesi pendengaran awam yang julung-julung kalinya diadakan di Parlimen Malaysia di bawah *Parliament Select Committee Public Accounts Committee* Parlimen Malaysia. Bagi satu tepukan kepada semua yang hadir. *[Tepuk]*

Saya nak mulakan dengan satu pantun.

Pergi berubat di hospital swasta,
Layanan mesra tiada cela;
Kos rawatan, ubat-ubatan dan insurans biar selesa,
Agar rakyat tidak merana.

Hari ini kita berada di sini— terima kasih. Hari ini kita adakan satu sesi pendengaran awam yang di bawah kelola *Public Accounts Committee.* Kita tahu bahawa kita menghadapi satu masalah kenaikan insurans yang mendadak baru-baru ini. *The root cause* adalah disebabkan oleh kenaikan *medical inflation* dan juga caj hospital swasta. Itu sebab rakyat tidak puas hati dan mereka *complaint* dan Ahli-ahli Parlimen ini kita adalah dipilih oleh rakyat. Kita harus menyelesaikan masalah rakyat. Itu sebab kami di bawah PAC kami memulakan prosiding untuk mencari penyelesaiaan yang tuntas dan juga jangka masa panjang. *A sustainable solution*. Kita tidak menyalahkan siapa-siapa. Kita ingin mencari penyelesaiaan. *It is not a blame game*. Kita mahu satu sistem yang bagus.

Tuan-tuan dan puan-puan *I want to share a little bit of my experience. About two weeks ago, my mother-in-law.* Dia menghadapi *accident*. Dia seorang B40. *She was a newspaper seller for 40 years. Recently, she retired. In morning she rode her motorcycle to have a breakfast. But there was a car running at very high speed knocked her down and ran over her. Like a lot of Malaysian, although not a very rich family she buys her own insurance. She's B40 and newspaper seller. She bought her own insurance to cover herself. For 40 years she has never gone into hospital. This is the first time.*

I want to acknowledge here, insurance is important. Mark Odea is here. We say that there's a role for insurance policy and policy holders.

Apabila dia pergi ke hospital, dia pergi ke satu hospital yang kecil. Saya menziarahi beliau saya dapat tengok bahawa di sana hospital itu ada Melayu, ada Cina, ada India *patients* dia. Ramai saya tengok *parking lot* dia. *Parking lot*-nya *patients* mereka bukan daripada orang yang atas. Bukan T20. *They come with Myvi, they come with Axia, Proton Saga* yang lama-lama. Dia datang. *So, I can see that* hospital swasta walaupun pada persepsi kita adalah golongan T20 yang mampu tetapi sebenarnya tidak.

Sebenarnya ramai B40 mereka memerlukan perkhidmatan hospital swasta kerana hospital awam memang *queue* panjang. *We can see that private hospital is*

important to our healthcare system. *So we want now*— sekarang kita tahu bahawa kenaikan *medical insurance* dan juga *medical inflation* dia telah membebankan sistem sekarang. Perlu lah kita mencari penyelesaian yang tuntas dan juga jangka panjang, *a sustainable solution for the future*.

Itu sebab kita adakan pendengaran di hari ini. Kita mahu selepas pendengaran di Pulau Pinang dan juga pendengaran awam di Parlimen kita akan *go into close door, ten sessions of close doors— proceeding* dengan *industry player to go deep dive into the issues and find a solution. We want to listen from the industry players to give us solutions and suggestions.*

Jadi saya tidak ingin panjangkan *today is to listen to you*. Jadi saya nak bagi *rule*. Di Parlimen ini Ahli-ahli Parlimen— saya ingin mengalu-alukan YB Shah Alam. Bagi satu tepukan kepada beliau. *[Tepuk]* dan juga YB Kapar, Dr. Halimah. *[Tepuk]* Hari ini kita akan adakan sesi pendengaran. Walaupun kami Ahli Parlimen, kita di sini dalam Dewan pun cakap lima minit sahaja. *Our speech in Parliament because there are so many Members of Parliaments want to speak. Sometimes our debate is only limited to five minutes. I apply the same rules to everyone. When you speak number one, everything is recorded in the Hansard. You will be part of the history forever. What you say will be recorded and it will be in the Parliament website we call it Hansard, forever.*

What do you do is first you introduce yourself. Nama dan juga dari kalau daripada organisasi mana, silakan cakap. Lepas itu *we go into your complaints or your suggestions or your whatever that you want to say.* Tujuan kita adakan sesi ini adalah untuk mencari penyelesaian. *It is not to blame anyone. It is for a policy change. We need a change for Malaysia and for everyone of us.* Terima kasih. *Xie xie. Nandri vanekkam. [Tepuk]*

Okey kita teruskan, mula*.* Ada dua *mic.* Boleh beratur. Siapa yang nak sila beratur*. I will go one after.* Sekarang sudah ramai di sini*. But I think the fair thing is one here, one here. No issue. Take your time. We have until 12 noon.*

Kita boleh bercakap bahasa Malaysia, bahasa kebangsaan dan juga bahasa Inggeris pun boleh. Silakan

■0910

Prof. Dr. John George [Bekas Pengerusi Kebangsaan Doktor Kerajaan, Persatuan Perubatan Malaysia]: *Good morning. Thank you for this opportunity to share with the PAC. Good morning, everyone. My name is Prof. Dr. John George. I am an ex-professor at the University of Malaya Medical Centre and also, I was also the National Chairman of Government Doctors of MMA (SCHOMOS), prior. So, just to give you a little background just 15 seconds.*

I was— in 2000, as the Chairman, I proposed the formation or the allowance of limited private practice in government which was approved by Tan Sri Samsudin and JPA and the ministry. And, from there, we started the UMSC. The UMSC was started and the main reason was to retain doctors. UMSC has been extremely successful since it started, many of us were retained and stayed back in UM rather than going to private. So, that is the bit of background.

Now, coming to the issues. I have been going to the ground both with insurance companies, with the rakyat *and others to find out some of the major problems and, I have summarised them in a document which I will also give it to you, YB. I will give you the document. So, in this— what I noticed there were, the main issue currently is out-of-pocket expenses, one at the KKM hospitals.*

In some KKM hospitals, the doctors are willing to do procedures— let's say but you need a stent. So, sometimes they may require a patient to pay for the stent which can cost up to RM7,000-RM8,000, even up to RM10,000. So, this is quite a lot of expense for them. They are asked to go to find some tabung, *some* yayasan *or find some family member or themselves to come up with the money. And that's quite a lot of money. That's one.*

The second problem is affordability of the insurance once you are over 65. Once you are over 66, the premiums become probably around RM7,000 to RM10,000 and at 75, around RM14,000. And this is when people cannot afford the premiums no longer. And this means that there must be from talking to the insurance industry, they seem to say that most people are seen to be able to pay up to maybe RM4,000 or RM5,000 and then after that, they find difficulty in paying. So, the question is how do we keep or cap this premium to this amount and until you are of older age, so that as you mentioned, that you can carry on going to a private hospital and getting your treatment and not have to stop. Because if you stop, then you have to go to the government sector.

Now, talking about the government sector, the government sector during the COVID-19, outsourced a lot of operations to the private sector and, these costs millions of dollars. So, my proposal is that which I think many have been talking about and the government is also talking about this having a tabung, *a* Tabung Kesihatan Negara *or social. So, in this* tabung *which comes from taxation or whatever sources, which you can decide how you get this* tabung. *But I have estimated it needs about to pay the KKM payments and also SOCSO. So, what does this cover?*

So, first thing it needs to cover is the KKM out of payments. That means you should be able to claim your stend and everything from the tabung. *Don't forget, not everybody is claiming every year. So, we need to know how much exactly is being*

claimed for this out-of-pocket. Second, the insurance industry might say, "Okay, if you want the premiums to be same, you need to have a co-payment of 10 percent or let's say up to RM5,000, maximum RM5,000. If you can pay that co-payment, we can keep your premium down to RM4,500 or whatever". So, that is another thing. So, this co-payment could also be paid by the tabung.

Next, the insurance industry itself. The hospitals and the insurance industry need to make sure that the hospitals have some sort of standardised premium. So, that it we know. One of the problems today is some insurance companies are not covering the total amount of medical expenditure. So, let's say the medical expenditure came up to RM30,000 but they are saying we will only pay RM20,000. So, how is that possible because in your policy it's written as charged. If you read your policies, it will say, "Surgery as charged" and "Anesthesia as charged". But when it comes to the final bill, they are saying, we are not paying the total amount. This needs to be looked at. How can they get away with that?

So, I think we should form this tabung *and I'm very happy to be part of this national board or whatever looking into this aspect. Thank you very much.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Professor for your insights and your suggestions*. Silakan.

Datuk Panjamothy: Yang Berhormat-Yang Berhormat, para hadirin yang dihormati sekalian. Selamat pagi dan salam sejahtera. Nama saya Panjamothy, asal dari Sentul, individu, *active social worker.*

Seperti yang disebut oleh Yang Berhormat sebentar tadi, *private hospital healthcare is very important. On the other hand, private hospitals are fleecing the poor people, particularly the B40 group. I would like to suggest* Kementerian Kesihatan dan juga lain-lain agensi yang terlibat harus memperkenalkan satu garis panduan kepada semua *private care hospitals* untuk senaraikan kos-kos rawatan seperti *like this coffee shops you have the price list* bagi mengelakkan daripada caj-caj *exorbitant* daripada *poor patients.*

Okay, I am one of the victims. I went to the hospital a few years ago. After producing my medical card, they didn't reveal to me how much the cost was. They said, "No, we will send it to the claim and all that". Since I'm not taking out from my own pocket and I don't feel the pinch, same thing goes to the others. So, we don't feel the pinch. But they are marking up and claiming. This is very wrong. So, you have to check that. Monitor the private hospitals and all that.

The other very important thing is that you see, when a patient dies due to surgery or whatever it is, the private hospitals they are very reluctant to release the body to the next of kin without paying the full amount. I think this one we have to look

into very seriously. You see, after going paying and then, they have lost the life of their next of kin, but in order to retrieve their body from the mortuary or what, the hospital particularly the private hospital they said, "No, we don't release the body until and unless you pay the full settlement". A big amount. How can the poor people while they are grieving the loss of their next of kin?

So, this has to be taken into consideration. As I said just now, the private hospitals they are fleecing like anything. You have to monitor. You have to produce a guideline to all the hospitals. This is what I've got to say. Thank you very much for giving me the opportunity. I feel very proud to be in this Parliament building today. Though we are not MPs, but today we feel like MPs today and thank you for the environment. Thank you to the organiser.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you so much. Thank you* Yang Berhormat Mothy ya. *Thank you so much* Yang Berhormat. *Okay, I think everyone is* Yang Berhormat lah *today. Okay. [Ketawa]* Silakan, Yang Berhormat.

Encik Ravinder Singh [AQM Insurtech]: *Yes. My name is Ravinder. I'm an actuary. I worked 30 years in the reinsurance industry. I worked 20 years in London, Amsterdam, Zurich before I came back. What's happening in the industry worries me a lot. I think as a leader in the insurance industry it's our obligation to find a solution because today, 60 percent of Malaysians don't have insurance. The industry is over 100 years old; 60 percent don't have insurance and these are the people who need it. They don't even have RM1,000 savings. So, we have to do something. I have four points. I hope I can go through all four very quickly.*

The first one is— I have my nephew's bill from November last year from a private hospital in PJ. He was in the hospital for two and a half days for appendicitis. And, the cost RM37,000. This hospital in PJ has a self-playing piano in the lobby and an aquarium takes one-third of the lobby area. We don't need that. What we want is two-star luxury hotels with three-star prices. No more five stars, six stars luxury. We don't need that.

The problem is then my next point, my son is 27. I have his medical insurance premium schedule. I added up the premiums from age zero to age 80. So, what he would need to pay. In reality, he will pay more because after every few years, it will go up. So, this is the lowest he would ever pay and the price from zero to 80, I've never seen any record of this before is RM300,000. RM300,000 premium you pay from zero to age 80. Now what scary is 70 percent of deaths are is from age 60 to 80.

■0920

So, you pay 70 percent of your hospital charges in the last 20 years of your life. That is scary. What that means is when we retire, we don't have the insurance policy from the company. So, we are on our own. Most people after 60 can't afford insurance anymore, we will go to the government hospital. So, YB, the T20— even the T20 after they pass 60, they will be going to the government hospital. Because they are not earning, they can't bear it. So, that is the major problem. I've not seen this mentioned anywhere, any significant part, okay. The co-payment is worth it. My son's co-payment is a thousand, the discount on the premium is 30 percent. So, co-payment makes sense. Okay.

So, my third point, in the insurance industry, we talk about the profitability of insurance companies, RM4 billion is a number I've seen. There is another element that we can change because we have moved on, we are not 50, 60 years ago, where we didn't have internet and we can't do things.

Today, we have internet and knowledgeable consumers who understand. I need to share here, the agents from the conventional insurance and takaful, I sum up and I checked is hard to find this figure but I believe they are earning per year is RM6 billion to RM8 billion. About close to 200,000 agents earn between RM6 billion to RM8 billion every year. We don't need that if we have simple products. On top of that, banks also get commission, it's probably RM2 billion.

So let's not just talk about the RM4 billion savings or the profitability, let's talk about the RM10 billion distribution cost. Today, Bank Negara is open up for digital insurance licenses and this will be for Malaysian organisations, not foreign companies. But the challenge is, there are not enough takers to come and back up our talented Malaysians. There are so many who want to find the solution, but they need capital and it's not big money. Deep seek— it's a kind of deep seek solution. We don't need the big tick, we just need some people who can believe in a solution and it can be a Malaysian solution. That's my third point.

The last point I want to say is, we have a major problem about only doing curative treatment, no preventive. To solve this problem, we need to move into the preventive area in a big way. Nobody is championing this. Hospitals are not championing this. So, we need to find a solution that takes care of this. What can it be? You only get the lowest price of premium if you don't smoke, you don't drink, you exercise and you watch your diet. You'll be mine must be dead.

Otherwise, you're sorry, you have to pay higher. So, when we put a cap of 10 percent, we should have just done it for those who have a BMI, we can do it for fireman and policemen. Why can't we do it also for this? Also, our GPs are not an

example, our GPs are overweight or obese more than the public. Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Ravinder. Thank you very much. Sorry, I have to keep a tap on that because I know everyone wants to speak and it has to be fair, okay. Thank you, Sir.* Silakan.

Tuan Mohd Del bin Mustafar Azlan [Prudential Life Insurance Agency Association]: *Okay*. *Hello, assalamualaikum. Good morning. My name is* Mohd Del bin Mustafar Azlan. *I am from the Prudential Life Insurance Agency Association. This is our suggestion to the government, regulation and policy.*

Number one, price cap and fee schedule. Introduce price control or a fee schedule for medical procedures, consultations and medication to prevent overcharging.

Two, transparency in pricing. Mandate private hospital to disclose their pricing structures for common procedures and services to enable patients to make informed decisions.

Three, incentives for cost-effective care. Provide incentives for hospitals that adopt cost-effective practices and technologies.

Number four, regulate drug price. Control the pricing of pharmaceutical and medical supplies to reduce overall treatment costs.

Number five, personal income tax. Encourage individuals to save for healthcare expenses through a tax-advantaged account. Increase tax relief for medical insurance.

Number six, subsidies for the low-income group. Provide government subsidies of financial assistance to low-income patients to access private healthcare.

Seven, case monitoring and auditing. Which is one, regular audits. Conduct regular audits of hospital finance and operations to identify areas of inefficiency or overcharging. Two, benchmarking. Compare cost and performance with other hospitals to identify best practices and areas of improvement.

Number eight, increase primary facilities to cater for simple diagnosis and treatment. Like just now they mentioned, we don't need a five-star hospital.

Number nine, provide enough general hospital and resources like nurses; and

Number ten, improves public health awareness. Encourage regular health checkups and preventive measures to reduce the need of expensive treatment later. Okay, so that to the government.

So, our suggestion for the private hospital is operational efficiency, which is a streamlined process, adopt technology, prevent over servicing, energy and resource management, outsourcing non-care services, encourage competition.

Number three, public public-private partnership like the government hospital that has become semi-private, like Hospital UITM Sungai Buloh. *It's a very good hospital and a few others that the government starting to do it for the past I think one, two or three years. So, that is good.*

Number four, encourage generic medication, promote generic drugs.

Number five, leverage data and analytics.

Number six, training and workshop management. So, that is our suggestion— from us. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Encik Mohd, okey, daripada Prudential. *Please*.

Puan Jenny Yee Wai Kwan: *Thank you. Good morning, everybody. My name is Jenny. I am here as an individual and also as a policyholder. I just want to raise up my concerns and I find that there are some unfair terms in the policy. I hope the Central Bank and Ministry can look into it to help us as policyholders, as also Malaysians. So, I want to just put up in summary in short form.*

So, the unjustified application of the exclusion clauses. My condition is actually duplication cyst was only confirmed as a congenital disease by post-operation via the histopathology lab medical reports. So, neither I and also my doctor knew it was a congenital beforehand and also inconsistent claim handling by the insurance agency, AIA. My procedure was under— if my procedure is under Letter of Authorisation (LLA) and the AIA would not seek reimbursement.

But somehow, since I paid upfront, my claim was actually denied. This is exactly a double standard and it's unfair. Because of this, I actually applied for a personal loan to settle my RM22,000 bill for that. Similar to the cover condition, my condition is clinically similar to the appendix operations. If the appendix is covered, why not my case?

Fourth, misleading advice from the insurance agent. I've consulted my agent pre-operation and it was assured that the procedure was claimable. I took a personal loan on this advice only within a day later leave me in financial hardships. I want to call for a foul policy terms, I really hope the ministry and Central Bank to review the insurance policy to ensure fairness and clarity, especially when policyholders act is good faith and rely on professional advice. Thanks a lot.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Jenny.* Okey, silakan. *Please*.

Dato Indera Dr. Sha'ari bin Ngadiman [Harm Reduction Action Network]: Terima kasih YB-YB. Saya Dato Indera Dr. Sha'ari bin Ngadiman, berpengalaman 38 tahun dalam perkhidmatan awam dan sekarang saya Timbalan Pengerusi *Harm*

Reduction Action Network Malaysia dan juga *President Epidemic Intelligence Program Malaysia*.

Pertamanya, saya ingin mengatakan tentang perlunya satu konsep pembaharuan fasiliti setiap satu masa tertentu contohnya 10 tahun. Sebagai— saya bagi begini kerana apa? Dalam pengalaman saya, saya melihat banyak fasiliti kita yang mempunyai peralatan-peralatan usang yang *beyond academic repair* tetapi ia ditinggalkan dan ia mengakibatkan pesakit akan bertumpu ramai-ramai, makin ramai. Kerana apa? Alat sokongan bagi membantu pesakit amat berkurangan ataupun tidak dibaik pulih.

Oleh itu, saya mengharap— cadangkan supaya mungkin kerajaan perlu *invest* satu amaun yang besar setiap 10 tahun. Perbaiki semua fasiliti dan sebagainya setahun. Kemudian, kita rehatlah masa-masa lain untuk perkara lain. Pada setiap 10 tahun lagi, semak fasiliti-fasiliti tersebut, ada tak peralatan-peralatan lain yang perlu diperbaiki ataupun ditambah baik? Kerana apa, ada juga peralatan yang telah amat usang *more than 20 years* yang mungkin pada masa ini tidak ekonomi untuk digunakan ataupun tidak ekonomi untuk dibaiki.

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Perkara yang kedua adalah terdapat juga fasiliti kita di kerajaan, hospital-hospital di mana kita mempunyai bilangan dewan bedah yang cukup tetapi dewan bedah itu kosong, tidak mempunyai fasiliti yang cukup. Jadi, kerana itu bilangan mereka yang harus untuk melakukan pembedahan terpaksa ditangguh. Jadi, saya mencadangkan supaya Kementerian Kesihatan, Kementerian Kewangan melihat menyeluruh dewan-dewan bedah yang ada di seluruh hospital kerajaan agar dilihat adakah ia dibangunkan untuk digunakan atau dibangunkan hanya untuk menjadi stor. Saya minta sangat.

Perkara yang ketiga, saya nak bangkitkan adalah tentang pada tahun 2030, negara kita akan menjadi negara tua. Kita semua ini akan menuju kepada fasa sedemikian. Apakah persiapan kita untuk kita menjelang— tempoh tersebut tidak lama, hanya lebih kurang dalam lima tahun akan datang. Oleh itu, kita kena melatih pegawai-pegawai kita sama ada pegawai perubatan ataupun paramedik ke arah memberikan perkhidmatan warga tua berkenaan.

Perkara yang keempat. Kita ada dua YB daripada negeri Selangor dan negeri Selangor adalah satu negeri yang padat. Kalau kita lihat fasiliti kita ada lebih daripada 10 fasiliti di negeri Selangor, klinik kesihatan khususnya, setiap hari lebih daripada 2,500 pesakit yang terpaksa beratur panjang dan sebagainya. *Why?* Kerana apa? Kerana bilangan fasiliti kerajaan yang ada tidak mencukupi.

Namun, fasiliti swasta memang ramai, banyak, lebih 1,500 fasiliti swasta yang ada di negeri Selangor tetapi kemampuan pesakit adalah berkurangan. Sebab itu, saya minta kalau boleh lihat semula bagaimana kita ingin mengimbangkan bilangan fasiliti yang ada di *Klang Valley* ini *compared* dengan mereka yang ada di Pantai Timur. Pantai Timur penduduk tak banyak tetapi fasiliti mereka cukup, itu sebab kita tak dapat keluhan mereka di sana. Tetapi, di *Klang Valley* terdapat keluhan. Kerana apa? Bilangan fasiliti kita tidak mencukupi berbanding dengan bilangan penduduk yang ada.

Perkara yang kelima adalah kerajaan telah menghabiskan banyak duit untuk merawat penyakit-penyakit kronik seperti jantung, buah pinggang, diabetes dan sebagainya. Saya mencadangkan juga ada beberapa *approach* yang dapat mengurangkan kos berkenaan melalui peng-*apply*-an *harm reduction approach* seperti dalam penyakit diabetes, kanser, berkaitan dengan *tobacco* dan sebagainya. Saya mencadangkan supaya kerajaan melihat perkara ini dengan baik. Kerana apa? Ia juga akan melibatkan kos yang banyak sekiranya ia tidak digunakan dengan baik oleh kerajaan. Sekian, terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Dato' atas cadangan. Silakan.

Encik Woo Yuen Seng: Salam sejahtera. Selamat pagi YB-YB dan para hadirin semua. Nama saya Woo Yuen Seng, seorang pesara dari Subang Jaya, Selangor. Saya bersuara dari sektor swasta tanpa punca pendapatan sejak lapan tahun lagi. Saya terkesan kerana kenaikan premium insurans yang tinggi semenjak 2022 oleh syarikat insurans saya. Bagaimana kos peningkatan kos sebanyak lima peratus daripada RM2,108 kepada RM3,163 mendadak mendapat kelulusan *regulator* adalah di luar imaginasi saya.

Pada hari ini, saya akan menyentuh fasal langkah interim Bank Negara Malaysia yang pada pendapat saya tiada membantu langsung mengurangkan beban kewangan orang ramai terutama warga emas berikutan kenaikan premium insurans perubatan. Di antara empat langkah interim, hanya langkah interim kedua boleh dianggap ada kelebihan untuk kita.

Walau bagaimanapun, penangguhan pelarasan premium satu tahun hanya memanjangkan penderitaan beban warga emas, dalam bahasa Inggeris, *prolonging our agony.* Untuk langkah interim ketiga, jika pengembalian semula ditawarkan, bagaimana pula dengan pelanggan yang dengan berat hati telah meneruskan polisi kita atas keperluan pelindungan insurans perubatan?

Semasa saya tanya insurans saya, adakah *refund* untuk kita. Mereka kata tiada *refund* sebab dalam langkah interim Bank Negara Malaysia tiada disebutkan *refund.* Pada pendapat saya, Bank Negara Malaysia tiada mengambil tindakan

secukupnya sebagai *regulator* untuk melindungi pengguna-pengguna yang terjejas. Ia sepatutnya mengarahkan pihak hospital dan IPO untuk menangani caj perubatan yang tinggi antara mereka sendiri, bukan *pass the bulk to the public.*

Untuk jangka masa panjang, adakah BNM serta kementerian dan agensi lain mempertimbangkan perkara-perkara dan cadangan berikut yang boleh mengatasi masalah kos premium insurans kesihatan? Pertama, menawarkan pelepasan cukai untuk premium insurans perubatan yang tadi disebutkan awal tadi, memberikan diskaun tiada tuntutan iaitu seperti insurans NCD kerana tiada tuntutan kos perubatan kepada masa polisi yang lalu, menyediakan pakej insurans yang disatukan dengan premium keseluruhan yang lebih rendah.

Contohnya, saya ada insurans kebakaran rumah, ada insurans kereta, ada insurans kecurian. *So,* adakah pihak insurans mempertimbangkan pakej keseluruhan dengan menawarkan satu pakej di mana bayaran premium ada lebih rendah keseluruhannya?

Memberikan inisiatif untuk meningkatkan ekonomi perak, *meaning, the silver economy,* inisiatif untuk semua warga emas dan melaksanakan Sistem Kesihatan Kebangsaan (NHS) seperti yang telah disahkan dalam Kertas Putih Kesihatan 2023 dalam Parlimen. Untuk makluman saya, saya telah menyelidiki topik mengenai premium insurans perubatan yang tinggi dalam tesis MBA saya pada tahun 2023. Jika sesi awam PAC hari ini tidak mencapai satu penyelesaian, warga-warga emas seperti saya akan menambahkan barisan menunggu panjang di hospital kerajaan tidak lama lagi. *Thank you.*

[Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Encik Woo memberikan pandangan. Okey, untuk maklumat tuan-tuan dan puan-puan sekalian, dalam sesi ini, apabila *you* cakap memang pegawai-pegawai kita akan catat, *Hansard* akan catat. Tetapi, tambahan di sini ada pegawai-pegawai daripada KKM dan juga Bank Negara Malaysia dan juga pelbagai jabatan kerajaan juga akan mendengar. Jadi, apa yang dilontarkan di sini akan *taken into consideration by the government.* Okey? Silakan.

Encik Chiu Fook Seng: *My name is Chiu Fook Seng. I'm a retired man. Today, I come here just to give some information and my idea to public. Now I work as a volunteer, committee member for a— we call it community of public hospital or simple word is it's a charity hospital. If you don't mind, I just give a brief background of the hospital?*

Tuan Sim Tze Tzin [Ahli PAC]: *Yes, within five minutes, everything.*

Encik Chiu Fook Seng: Okey, *very fast. Because this hospital, our yearly income is around RM120 million. That we are the multiracial hospital consist of Chinese patient 50 percent, Malay patient 30 percent, Indian and others 20 percent.*

So, then from there we did a lot of charity work throughout Malaysia. We got 12 kidney diagnosis centre. In KL alone also we got three, one in Seri Kembangan, one in Seputeh, one in Sepang. So, yearly we contribute the 12 in whole Malaysia, we subsidised USD3 million just to help up the patient.

Then, come back, there's something today I want to highlight. Even we are the charity hospital also, you all come to know or not, until today last year, we paid five to 10 percent of we call it we pay-lah, *not commission*-lah, *to insurance company.*

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The sum of almost 6 million dollars. This year they are going to send in their letter request for 15 to 20 percent. This is ridiculous, we cannot accept.

Tuan Sim Tze Tzin [Ahli PAC]: *What is the rebate? What do you mean by rebate?*

Encik Chiu Fook Seng: *The total medical claim. Medical claim for medical card holder. Because almost 50 percent of our income derived from medical card holder or policy holder. It's around RM60 million. They request for five to 10 percent but most of them also 10 percent. That is summed up to be five point something to RM6 million. This year, beginning of the year we receive letter from few giant insurances company that they request for 15 percent and some even 20 percent.*

That if we can fulfil ya *all their request, then this year easily we have to prepare RM10 million for the rebate but it's not repaid to patient, repaid to insurance companies. So, here we don't mind to accept two or three percent or five percent but you know, I mean sometimes patient also they ask for let's say example overstay in hospital or maybe take more medicine, so we have to– not to say who pay lah. End of the day also we don't mind to discount off some of this and bear it because end of the day also all our money also so little out whether to hospital, to patient or to insurance company*.

That to me and there's another article I read in the paper that if shortly, recently government cannot find out a solution to agree on the inflation or agree on the price rising from hospital or insurance company, they will allow a 10 percent. But to me I prefer that every hospital, private hospital or charity hospital, they will have their different rate of increment. Like us just take for us that and also, I forgot to mention I am the auditor for the hospital also. I know every single detail in the account book.

And then for this ya*, the 10 percent to me is very high for us. You see every year we got RM120 millions of sales. Now government allow us to increase 10 percent, this means that we can increase RM12 million. But out of RM12 million, if deducted out the inflation rate or the exchange rate or the import – of imported what do you call it, import duty for medicine or medical equipment, we will easily make another RM10 million. So, if next year another RM10 million top-up, we got RM20 million.*

So, for third year, those increment 10, we got another RM30 million, total up we got extra RM60 million only for three years. But to us we got we don't keep the money, we are the non-profit organization. So, I hope that Bank Negara can step in to look into the matter or I don't mind ya, *even if you want to investigate or if you want to know further information, we don't mind to supply also.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, thank you very much Mr. Chiu.*

Encik Chiu Fook Seng: *Another thing is that I hope that...*

Tuan Sim Tze Tzin [Ahli PAC]: *Injury time one minute* ya. Okey. *[Ketawa]*

Encik Chiu Fook Seng: *Very fast. It's just some suggestion only.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.*

Encik Chiu Fook Seng: *Some measure. That I hope there are now and then you know most of the medicine or medical equipment also imported from western country that now US also try to levy 25 percent here and there. So, I hope that the consideration of purchasing medicine or equipment, they go to the BRICS committee country like China and India.*

So, another easy job for government to monitor the insurance company or our hospital, private hospital. The best is give more power to the ISO to go for regular inspection on the hospital.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.*

Encik Chiu Fook Seng: *Because ISO every year also they do one or twice audit so can take advantage on or set up committee with them to just go on with the inspection or control. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much Mr. Chiu for your input. [Tepuk] Yes, sir.*

Encik Rajagopalan a/l Kgr Pillay: Yang Berhormat Pengerusi, Yang Berhormat Dato', Datuk, tuan-tuan dan puan-puan, selamat pagi. Nama saya Rajagopal dari Subang Jaya yang masih belum mempunyai satu hospital. Pada pagi ini, kita telah pun dengar beberapa *suggestion*-lah atau *proposals* daripada beberapa ahli dalam pembentangan ini dan saya adalah seorang individu juga yang telah bersara dan sedang membayar yuran insurans ya.

Now, the first thing I want to mention is that health like education, human welfare, utilities and security are all basic needs of the people. Therefore, the government has got a very important role in this. Now, providing health services and healthcare, it should be the one of the main important areas that we got to look at.

Now, when the hospital healthcare is being privatized, we should ensure that whatever raise that are being charged should be commensurate with the efficiency and the effectiveness of the delivery system but not at the cost of profiteering and maximizing profit. This should not be an area for private business. It should be an area where the private sector should also assist the government in looking at the basic need of the people.

Now, in my case, I have taken an insurance policy to ING in the year of 2012 and over the past of 10 to 12 years, I've been paying my premiums and I note that initially I paid about RM3,000 and today I'm asked to pay RM14,000 premium a year. Now, this has gone up by leaps and bounds every year and the current increase from last year to this year is 23 percent. At the same time my coverage has been reduced and my rates and my claims to the hospital, the rates are also been reduced. Now, I think this is a serious matter and I have appealed to the insurance company and they have not looked at it and they have stated that, "Now you could look at the new policy if you want to".

Now, I've given – I've made a written application which I will submit to the Jawatankuasa*, hope you can have a look at it. Now, what I am talking at here is that because we are faced with this increasing cost, we find that the affordability to senior citizens becoming less and less and in time to come, the insurance companies may be are having a programme to weed us out from the system*. *When we are young, we can pay the premiums and we don't make any claims and when we grow older, we invariably have to have some health issues and that is when we need some healthcare.*

They talk of all kinds of policies, all kinds of healthcare slogans but at the end of the day, I note that as we grow older, the raise become higher and higher and become unaffordable and we are phased out. That is when we will suffer and we go back to the public hospitals which is already overcrowded and I think the government has got a serious role to look at the participation of private sector in the health area where it is the basic need for the citizens. Thank you very much Pengerusi. *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you* Mr. Ravigopal. Ya, silakan.

Encik Steven Wong Weng Leong [China Construction Bank (Malaysia) Berhad]: *My name is Steven. I would just cut of all the formalities. I go straight that the point. I think following from what he said just now, I think it's very true. By the time*

you are 60, you find that the insurance policy premiums have gone way high up, skyrocketed. The other thing is about the lapses you know when you don't pay your insurance policy for just one or two times you know, they will just consider it as a lapse. When you ask them, they will tell you, "Oh, sorry it has already lapsed.", okay.

So, what happens if somebody is oversea and come back and find that it has lapsed because you never receive any letter, letter has gone into somewhere. You know these are the things that the government has to really look into. I am glad I have to say this, Bank Negara has been very supportive but it's a matter of you finding the right person there. I just found two persons I had lunch, I had dinner with and they invited me for dinner last Friday because I complained a lot and I always get things done, all right, you got things solved. You can read my articles in Malaysiakini, just google for insurance policy. There's a few articles there you know the trick, you know how to get the money back from the insurance policies.

Now, the second point is I think we have been talking about this from umpteen years and when I– Yang Berhormat Sim, *I have actually sent you the copy of the article as well which I wrote sometime in 2006. Hello, 2006 is about 20 years ago.*

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Medicine prices is one of the highest in the region. Okay, let me read you the article ya. *The researcher in the university where I was working with said this. "His team was surprise with this finding that the innovator brand Rosatin used for curing depression the highest medium price ratio is 31.06 that of the IRP. While, the antibiotic ciprofloxacin in the retail price pharmacy has a medium price of 113.63 times of the IRP." Does this shock you? 111 times higher than their IRP. Why was there no control over the last 20 years? When I brought this up Dr. Chua Soi Lek said he will look into this. he will monitor the prices. But after that I'm back here telling the same story.*

So, I'm very glad that PMX has made announcement recently and Dr. Dzul— I have actually communicated this article to them as well and I'm glad that they are talking about dismantling the cartels. I hope this is something that we will do as a nation to support the efforts that the government is doing. Because without that, without dismantling the cartel— I am sorry, all the pharmaceutical companies— without that, we are going to die without a single cent left. By the time you are at risk, warga emas, *that's it. You know you have so high insurance premium to pay and then you have very little savings. That's why I can't retire.*

The other point is this some of the hospitals, they do extra test for you. Four years ago, I went to see a doctor. I had thyroidism, so called thyroidism. Four years later I was actually tested for thyroidism when I actually had no problem with

thyroidism. Does that ring— is that funny isn't it? I told the doctor specifically I don't need the test before the blood was taken. Yet, the test was being done. He asked me, "Are you covered by insurance?" I didn't know about it. All right?

Tuan Sim Tze Tzin [Ahli PAC]: *One minute ya Steven.*

Encik Steven Wong Weng Leong [China Construction Bank (Malaysia)]: Ya. *Wait, just one minute. So, I had to stand up, I had to email to the hospital for nearly three months and Ministry of Health was also involved. They didn't clamp down until I brought it up to Dr. Dzul. I think Dr. Dzul must have put a thing and then finally the doctor admitted, yes. Okay, settle. The money was paid back to the insurance company, not pay back to me* ya.

A quick one, the procedures that sometimes we need to go through because insurance policy have their own standard operating procedures is not a really necessary. For example, when you go to see a hospital— I mean when you see a specialist, what happens to be a relative during Chinese New Year and they checked, they said "Oh, you better go and do something." A specialist telling me that— now, I have to go to the GP just to get a referral letter.

Tuan Sim Tze Tzin [Ahli PAC]: *Ya, Steven. I think the time…*

Encik Steven Wong Weng Leong [China Construction Bank (Malaysia)]: *Yes, okay. So, that's all I want to say. A lot of procedures need to be revised* ya*. All right. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Mr. Steven. Before we continue,* urus setia *managed to get the ring… [Membunyikan loceng] Okay. So, what we do is like this* ya. *Four minutes you speak then the first ring will come in… [Membunyikan loceng] Then, one more minute, the two ring… [Membunyikan loceng] An injury time one minute, okay.* Boleh ya? *[Membunyikan loceng] Ha, that's it. Okay, injury time stop, stop* lah ya*.* Tolong ya. *Okay.*

Because I think because kita ada ramai dan saya sudah *calculate today we have about— we arrange 500 chairs. So, it's almost filled up. I was told,* urus setia bagi tahu 450 orang hadir pada pagi ini. Bagi satu tepukan*. [Tepuk]* Kalau kita hendak semua orang cakap lima minit, kita perlu 37 jam, okey. *So, that will be tomorrow. We still haven't finish. So,* kita hadkan secara lima minit siapa-siapa yang hendak bercakap, okey. Kita bagi adil ya kepada semua. *All right,* silakan.

Prof. Kehormat Amrahi Buang [Malaysian Pharmacist Society]: *Bismillahir Rahmanir Rahim. Assalamualaikum warahmatullahi wabarakatuh and very good morning. I think first of all my name is Amrahi bin Buang. I am the current President of the Malaysian Pharmacist Society. I think the issue that we are*

discussing is of a critical national importance and it affects affordability, accessibility and sustainability of the Malaysia healthcare system.

The main problem with us is actually the current healthcare system which is very, very, very silo. Everybody is doing their own way and it's not connected. The rising cost of private healthcare have placed a significant burden on the rakyat. With reports of sharp increase in insurance premium and private hospital charges. This is further compounded by the spillover effect on public healthcare facilities leading to congestion and longer waiting times in government hospital. As key healthcare providers, pharmacists are deeply concerned about the financial strain placed on Malaysian and the long-term viability of our healthcare system.

Let's talk about transparency and fairness in healthcare pricing. MPS emerges that healthcare cost are rising but any unilateral increase in insurance premiums or hospital charges must be justified and transparent. The exponential rise in healthcare cost should not disproportionately burden the rakyat while private healthcare players continue to report strong profit margins. We urge the government to implement a transparent pricing framework that ensures accountability from all stakeholders. The recent initiative by the government for the display of the price of medicine is a good start to this effect. For healthcare providers to deliver a high-quality, cost-efficient care, they required cleared and structured financing model. MPS urges the creation of a value-based healthcare financing system that ensures spending is tight to measurable patient outcome rather than service volume.

Second point. Strengthening the public-private healthcare synergy. The increasing cost of private healthcare have resulted in higher dependency on public hospital stretching government resources thin. To alleviate this pressure, MPS strongly support the implementation of a national health insurance that integrates public and private healthcare services. A well-structured NHI will ensure financial protection for Malaysian by promoting affordable access to healthcare by creating a sustainable cost-sharing mechanism between both public and private sectors.

Expand the role of community pharmacist and general practitioner clinics to reduce congestion by improving interoperability and resource efficiency between the public and private healthcare sectors. Improve collaboration between public hospital, private hospital, GPs and community pharmacist for better patient outcome and integrating them into one single patient-centered ecosystem. Reduce out of pocket expenses preventing financial hardship due to unexpected medical cost. A structured copayment system can balance patient affordability and sustainable financing.

Third point. Strengthening the role of pharmacist in disease prevention, rational medicine use and cost reduction. Pharmacists are central to medication

affordability and patient safety. MPS advocates for number one, strengthening the rational use of medicine, to reduce unnecessary prescription and overuse of expensive medication. Increase utilisation of generic medicine which can significantly reduce healthcare cost for both insurance and medication. Increased utilisation of generic medicines ya.

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Then, pharmacist-led interventions such as chronic disease management, Medication Therapy Management (MTM) to optimise treatment for effectiveness and prevention of medication waste and preventive care initiatives that can significantly reduce hospital visits.

Expanding insurance coverage for pharmacist-provided services, ensuring better adherence and health outcomes.

The government must act swiftly and decisively to address systemic inefficiencies and prevent further financial strain on the rakyat*. MPS firmly believes that pharmacists, alongside other healthcare providers, must be actively involved in shaping national health financing reforms to ensure a cost-effective and patient-centred healthcare system.*

Lastly, pharmacists remain committed to working with policymakers, insurers, healthcare providers and patient groups to establish a transparent, sustainable and equitable healthcare ecosystem. The one that ensures all Malaysians have access to high-quality, affordable healthcare without financial hardship.

Last point, "Think Health, Think Pharmacist". Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, thank you.* Terima kasih Profesor Amrahi *from Pharmacists Society*. Ya, silakan.

Encik Nabil Husni [Mencakna]: *Assalamualaikum warahmatullahi wabarakatuh* dan salam sejahtera. Terima kasih kerana mengadakan sesi pendengaran pada hari ini. Nama saya Nabil Husni. Saya *data scientist* kesihatan awam daripada Amerika Syarikat. *[Dicelah]* Okey. Saya seorang *data scientist* kesihatan awam dari...

Tuan Sim Tze Tzin [Ahli PAC]: Nama, nama.

Encik Nabil Husni: Nama saya Nabil Husni. Saya seorang *data scientist* kesihatan awam dan saya membuat kajian kebanyakan perkara tentang *healthcare* reformasi.

Satu isu yang saya ingin bangkitkan hari ini ialah penentu sosial kesihatan ataupun *social determinants of health.* Itu adalah salah satu cara untuk mengurangkan kos kesihatan. Kebanyakan tinjauan sistematik dan juga kajian dilakukan di kebanyakan negara jika kebanyakan *investment* dijadikan kepada *social*

determinants of health, ia mampu mengurangkan kesihatan. *Social determinants of health* termasuk perumahan, kesihatan awam, pembangunan dan isu-isu di luar daripada sistem kesihatan. Ini kerana Malaysia merupakan negara yang mempunyai— kebanyakan pesakit kronik dan sepatutnya *social determinants of health* diutamakan dahulu supaya kita mengurangkan bebanan kepada kesihatan awam dan *eventually can reduce the cost of health. So,* itu sahaja.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Encik Nabil. *Very good. This is something extra*. Ya, silakan.

Cik Natasha Mohd Sharif [Boleh Space]: *Assalamualaikum and good morning everyone. I'm Shawn Sharif. I'm from Boleh Space,* OKU *advocacy group.*

So, we've actually presented to the previous Health Minister on our recommendations to the Health White Paper. So, I'm going to read out what we suggested are the pillar trees which is ensuring sustainable and equitable health financing.

So, the first one is to ensure that instead of the government investing in the private sector. Why not channel those investments to public healthcare, make it stronger. So that we don't need to have this conversation with the private sector anymore.

Then, next essentially legislating a ring-fenced element for any and all pro-health taxes which include summonses that are identified as behavioural change agents for the utilisation of MOH in future government budgets.

The second is to improve healthcare budgeting by increasing the tax base especially from the higher-rich through taxes such as property tax, sales and revenue, inheritance tax, capital gains et. cetera. This is very important because essentially all of us who are patients, especially chronic illness patients, we don't want to be in this situation. But as luck has it, we are stuck with our condition that needs to be addressed and it's best if it is taken care of by the government since the government has the biggest budget and power essentially to help our group of people.

So, another one is to ensure that we include persons with disabilities in any and all health financing committees so that the needs of the person with disabilities are always guaranteed.

I would like to also focus our attention on the people who need coverage essentially the people with disabilities pre-existing conditions, mental health issues, people with rare diseases and undiagnosed conditions and people with ongoing non-communicable diseases, those who need habilitation and rehabilitation, the elderly and also palliative care not are excluded from assessing healthcare but and any all

parties that tasked to handle the healthcare financing. So, there needs to be a guarantee, especially from the government that all these different groups that usually wouldn't get access to any insurance coverage are taken care of whatever health financing that we eventually go for. So, it is quite important to make sure that nobody is left behind.

Then another thing that we need to take into account, we need to diversify the universal coverage of health protection and support to all in Malaysia. So, this should include sexual and reproductive health also, mobility, sight and hearing aids. Payment for sign language interpreters, rare disease treatment and medication, medical implants as well as dental rated care, palliative care, habilitation and rehabilitation services. This is very important because if we focus on— if we put a barrier to this kind of health needs, it is going to reduce our quality of life. So, that needs to be taken into account.

So, last— and the last thing is to ensure that all of the MOH facilities are accessible to all by implementing universal design and ensuring that KKM facilities have the information sharing with relevant accessibility features. So, that is why we want more participation from the OKU groups to be at the same table, to talk about all of these health policies that are being formulated and taking place.

So, I hope YB, you can bring our requests to the relevant parties. Okay, thank you so much.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. Thank you,* Puan Sharif daripada *OKU group. [Tepuk] It is very good perspective* sebab kita pun kurang tahu tentang bebanan dan juga kesusahan daripada golongan OKU. *That's a very good perspective*. Terima kasih. Silakan.

Encik Kam Yew Wai: *Good morning, everybody. So, my name is Kam. I've been in the insurance industry for 30 years. Medical repricing for me is not a new issue because for the past 30 years, I come across many, many times of medical repricing but recently, because it is a big issue, so everybody they make noise.*

Okay, what I want to say is most of the time, not most of the time, every time when the medical repricing, the insurance company they will inform us because of the medical pool funds, it bursts already due to the claim high ratio. So, because of that, there are increase. But what I can see is, these medical pool funds there have a problem because it is not the insurance company's fault. It is a system's problem because the system is saying that they are allowed to issue the new rider without control for a certain of period of time. When a medical puts rider, when you just run for five years, then you launched another new rider, definitely your pool fund will be

lower and lower because people will jump to another new fund. Because you are giving more benefit to the new rider.

Okay, for example, I have a study case here from my company. So, the rider A launched in 2009 with the annual limit of RM90,000. Lifetime limit RM900,000. So, this rider discontinued when during I think 2018. So, the premium as today for a 41-year-old man, non-smoker, the insurance charge is RM1,346. But the rider B, there are launched in 2020, RM1 million annual limit. So, unlimited lifetime which is so there are repricing already. So, today is RM978 which is cheaper. Why?

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And the latest one this year, annual limit is RM5 million, lifetime limit is no limit. But the premium is RM979. If you are the customer, which rider you will choose? I will definitely choose the latest rider because you give more benefits and lower insurance charges. That's why the system got the mistake already. When you allow the rider to issue without a certain time to maintain, the pool fund will get lower and lower.

My suggestion is— okay, today is— so, either insurance company they have a basic centre pooled fund which they call a main pooled fund. This means a pooled fund, you don't need a high limit of cover. It may be an RM100,000 cover because based on all the studies said, every claim— okay, the claim, a single claim is lower than RM100,000. All the claims are lower than RM100,000. So, yes, we have some claims that is more than RM100,000 but not all.

When those people their need more higher cover, you can issue the additional rider which is an additional rider like you exceed RM1 million, how much do I need to charge you? That is called the additional rider. So, the basic you need to have is a lower pooled fund is enough already. Because your basic rider, when you control for the 15 to 20 years, it may help you to maintain the pooled fund. So, it won't be dropped. Or the other way, if the insurance company don't do that, the government can do a national centre pooled fund. It's something like the SOCSO. Okay. Or the insurance company— your customer, the first 100,000 insurance charges put into the pooled fund, let the government control. So, you'll get more better.

Okay, this is a pooled fund I would like to say. So, that's why the claim can be prevented. Okay. So, I got all the studies here. But never mind, we can talk later. But the other thing I would like to say is that take-over clauses for the policyholder which is I still remember 25 years ago, when a policyholder they want to change the medical card, there is a takeover clause. But nowadays, it's no more.

All the public, you must understand that. Today, you say you are upgrading the medical rider, but actually, you are not. You've purchased a new medical plan

even in the same insurance company. That's why you have a waiting period. That's why you have a lot of non-disclosure cases in the market because they don't know. They thought, "I bought from their company 10 years ago, today I claim, why am I considered as a new customer?" So, takeover clauses are actually is fair to customers. So, you said to treat customers fairly. That is very important. They should implement back the takeover clauses.

And the third, the policyholder. Just now, a lot of people mentioned they are 60 already. Okay, yes. So, your insurance charges will increase because we get old already. They will get you very high charges. So, when these folks or I can say the senior citizen, we can implement another policy for them is they can opt to reduce or have the core payment which is the core payment. So, like RM5,000 and RM10,000. If you offer this, the premium will be lower immediately a lot and they still have the medical cover.

If today the government is unable to solve the issue, then the government will bear the burden. Why? Because everybody will go to the government hospital. That is my point. Okay, thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Mr. Kam.* Okey, seterusnya kita silakan. Ya.

Prof. Dr. Sothirachagon Sinnathurai: *Thank you, Mr. Chairman. My name is Sothirachagon. I used to be very involved in the insurance industry but I'm actually an academic, retired Vice Chancellor of Perdana University and then [Tidak jelas].*

Very simply put, we are faced to the situation where the insurers claimed that the medical costs have gone up. Therefore, they have to raise their premium. There is a standard way in which the insurance industry which is actuaries to do the job, measures its profits and its losses. If we pay a hundred million dollars in premiums, what percentage of these premiums is returned as claimed to consumers, to the policyholders? That is referred to in the industry as the claims ratio.

Number two, we also want to find out how many claims are declined or how in terms of numbers and in terms of the quantum payout. How many are declined? That is referred to in the industry as the claims settlement ratio. Now, if the claims ratio is high, very high, then of course, the industry cannot payout. Let's see what the data is. We cannot get this data from the industry. We are told it's being compiled, it's difficult to compile, et cetera. That is a hold lot of bull crap. The fact is, the insurance industry operates from basic data of this kind.

Now, I would invite everybody here to take their handphone to punch in Google, Malaysia medical and health insurance claim ratio data by Statista. Statista is a reliable statistics provider. I have checked with them whether their data has been

challenged and it has not. Statista shows that the claim ratio in the medical and health insurance in Malaysia in 2023, that's when they have the latest data, was 65 percent. That means, for every RM100 that is paid as a premium, only RM65 is returned to consumers in terms of claims.

If you compare with the data in other countries, let's take Obamacare. Okay, that is the collective effort. In Obamacare, you have to return 80 percent. If you do not, the following year, you have to give a rebate to the insurer. So, all I'm saying is we need this kind of data. Data for claims ratio and data for claims settlement ratio for each company that is offering healthcare insurance. If we get that, I ensure you will not be able or need to have such a session for the next 10 years. Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Prof. Sothi, for your insightful comments.* Ya, silakan Dato'.

Dato' Dr. Mohamed Ibrahim bin A. Wahid [Beacon Hospital]: *Hi, my name is Dato' Dr. Ibrahim. I'm a clinical oncologist, the former President of Malaysian Oncologist Society and the Asia Pacific Cancer Society, as well as the Southeast Asia regional Oncologist Society. I'm here to talk about exactly what was printed up there, "Peningkatan Bayaran Premium Insurans dan Caj Hospital Swasta".*

Can I first introduce, talk about the charge hospital swasta? People are blaming private hospitals for high charges and everybody is pointing out to the private hospitals. Yes, I work in a private hospital but can I just say something? In 1995, when I first came back to Malaysia to start the cancer centre, I was given a budget of RM17.3 million to buy equipment. For RM17.3 million in 1995, I managed to buy six to seven machines for the treatment of cancer. In 2019, when I wanted to upgrade the machine in my hospital, the cost of upgrading just one machine was almost RM20 million.

So, you look at the cost of treatment and the cost of buying equipment, the last 20 to 30 years, have increased substantially, you know. So, the cost of cancer treatment in the 1990s, RM6,000 accounts for buying chemotherapy was considered very, very expensive. Today, the cost can easily be RM30,000, RM40,000, RM50,000 even RM100,000 per month and that is sometimes not considered as the standard treatment.

Can you blame the private hospital for charging them? You know, it is what we pay for the drugs. We pay a lot more for equipment. So, how are we going to control the cost? I mean, if you want to cut down the cost, yes, one of course, generics. If we can fast track generics treatment, that will help to certainly. But not all

new innovative treatments have got generic. It also takes a long time to register generics. So, I think generic is important.

But like I said, it's not the cost of a private hospital overcharging. The doctors' charges are being regulated. For the last 10 to 15 years, our charges have not increased. My consultation fee for patients has not increased. It costs a lot more to pay for a plumber to come to your house to repair your bill than to pay me for my consultation fee. Okay…[Ketawa]

So, I mean, you know these are facts.

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So, they are regulated. It's not that healthcare is unregulated. But, you know they have modest percentage. So, some of the insurance company unrealistically asking 20 to 30 percent discount from private hospitals.

We don't make that much profit, you know and a lot of profit that we make are ploughed back into development of more hospitals, building more facilities, buying more and new equipment and these are very high expenses, that's number one.

So, you know please don't blame private hospitals' charges. It is the cost overall. Today you buy nasi lemak RM2, RM3 or RM5 or whatever, last time you only buying for 20 cents. Overall things have increased. What I'm worried, concerned here is not only— we are addressing about the bayaran *of premium. You know, but also what is important like Professor [Tidak jelas] just now mentioned is the rejection, the decline rate.*

My concern here is I have to fill up insurance form every time and my worry is the increasing number of rejection cases now. I'm seeing so many patients. They pay premiums, they pay a lot they still got a lot they promising RM10 million insurance coverage, RM1 million coverage and then to pay for you know a drug that cost RM100 per month, declined because it doesn't suit their— you know they have their own definition what they want to pay, what they don't want to pay. So, they decide what they want to pay.

So, the main issue here now is the decline rate. That is going up and up and up. So, you are going to pay a lot for your insurance premium but what is going to happen tomorrow when you want to claim for your hospital charges, you look at the decline rate. So, I think the government has to address the decline rate.

In Singapore, some of the neighbouring countries, the decline rate is very low. Why? Because in Singapore they insist you have to pay standard of care medical treatment. As long as the medical treatment is following the guidelines standard of care, insurance have to reimburse.

Here, no. They define their own reimbursement. They define what they want to pay. So, I think you need to look at the decline rate and all I'm asking for is please pay standard of care medical treatment.

That's all we are asking for and our private hospital charges the last thing you said you know that compare to neighbouring countries, we are not that high. Why do the Indonesians come to Malaysia? Because our costs is cheaper and we have better quality healthcare. They pay RM7,000 for a PET scan. In Malaysia they pay RM2,000. So, compared to our neighbouring countries, our healthcare is not that expensive. Compared to Singapore of course it's non-comparable. Thank you. [Tepuk]

Tuan Sim Tze Tzin [Bayan Baru]: *Thank you Dato' Dr. Mohamed Ibrahim for your input. Yes, please.*

Encik Cheah Tuck Wing [Chairman Malaysian Coalition on Ageing]: *Good morning. Thank you. I thinks it's the first time the public is allowed to speak and I mean from what I understand, I hope this is not the last time a voice is given to the* rakyat *and not just on the insurance matter but on other matters that is of prime importance to seniors. I mean to the people in general.*

Okay, I'm Cheah, Cheah Tuck Wing from the Malaysian Coalition on Ageing. We represent— we have nine founding members who are the most active civil societies involved in ageing. So, I'm very thankful that there are quite of member of seniors here speaking about their grievances affecting them. You don't mind if I take out the mic, it's easier for me to speak.

Yes, it is easier for me to speak this way. Okay, so, I think all the suggestion given here today is well and good but the only thing that I felt that a there's we miss the elephant in the room and the elephant in the room it is that there's a failure in the regulatory bodies. I think everybody agreed to this. [Tepuk] [Ketawa]

Okay, nowadays not just Bank Negara, not just PIAM, not just Ministry of Finance, if it's a regulatory body you can consider but Parliament itself. [Tepuk] Now I think as what YB Sim has said just now you— I mean the YBs here represent the people but yet the voice of people are not heard. I mean sessions like this should be organised earlier not when there's a backlash from the public. [Tepuk]

It is always the case you know, it is always the case. When there is something wrong after they implement something then the public make a lot complaints then only something is taken action about and this should not be the way. We should not be reactive. There should be PAC for example I just throwing the idea, a PAC maybe to look at problems major issues that may affect rakyat *and then organise sessions*

like this to engage the rakyat *and not you know— not only when the problems come. Be more proactive not reactive.*

I'm trying to say this. And I think only then— I mean real and sincere engagement and not just to say that we have already engaged the public and we have already done our job. That should not they should not be the case. Seriously engage to public, get their feedback and then you find the policies will be more easier to implement and people are more happy. [Tepuk]

Now in the case of medical insurance today I'm not speaking on behalf of this Malaysian Coalition of Ageing. Actually, I'm speaking on my personal behalf as consumer, as an insurance member. So, I think I speak on behalf of many that the interim measures provided by Bank Negara, is just not good enough-lah, *I would say because it's only prolonging the thing only.*

I just want to point out two. I think just now the gentleman pointed out four interim measures but I just want to highlight two interim measures mentioned by Bank Negara. All right, one is that they say that those above 60 years old their repricing will be suspended for one year, correct? That's right.

But my insurance company telling me, I don't want to name it but is one of the biggest on medical insurance in Malaysian. My insurance company telling me, it's only applied for those with the lowest plan meaning to say lowest lodging and lowest you know. So, it's only for lowest spend.

Is this what Bank Negara interim measures all about? I do not know the details but this is not right, you know. If it suspended for those who above 60 then it should be suspended irrespective for low plan or high plan. [Ketawa] That's number one.

Okay, the second one is regarding the so-called repricing over three years. Now, it's not going to solve the problem. After three years you still got to pay a very high insurance premium. As simple as that.

So, are you solving the problems? No, this interim measures to me is like what the Professor says 'crap'. [Ketawa] You know, sad to say-lah *I don't want to use this sort of language but seriously we have to sit down. If this has been brought up earlier, if this townhall session has been brought out earlier than this problem would have been anticipated and then resolved rather than you know now we don't need to have this session now, right?*

So, another thing I can foresee another major problem is vaping. I don't know why this country just not want to ban vaping. [Tepuk] When Singapore, Thailand has already banned it and if you are coming out with a reason that we need the money from tax and all and the expense of the health of the rakyat, *I think it's very bad. You know, is very bad. I think it should be banned you know, things like this.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thanks.*

Encik Cheah Tuck Wing: *Cost of living is very, very high now, you know?*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.*

Encik Cheah Tuck Wing: *So, more problems will crop up. So, please have the PAC to identify the major issues effecting the rakyat and have more session. Thank you very much.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you so much.* Terima kasih, Encik Cheah. *Thank you very much for pointing our failure as a Member of Parliament. Actually we have been, this is actually one of the most— this is the what you call? I would say we are very proactive. This the first time we engage the public in this massive way. Yes, almost 400 to 500 people turned up. [Tepuk]*

So, we will continue to work harder, point taken. We admit some of our shortcomings but we will continue to work harder. Okay, just to response a little bit on this interim measures, interim measures is only for three years. But after three years we have a cliff effect.

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We might have a cliff effect if we don't do something. That is the reason why we have this public engagement, we listen to every one of you. After this, we will go for ten closed sessions, very, very long sessions, many, many hours. We'll deep dive and drill into all the problems and we will come out with suggestions to the government and we have already got the undertakings from the government to reform.

The Prime Minister is committed to reform. Yes, he announced it in Parliament. The Health Minister is very committed to reform, the Bank Negara also very committed to reform. I can assure you. So, this is very positive things happening now.. [Tepuk] because of your outroar. It's because of your complaint, things are rolling. This is good for the country because democracy is at work. Okey? All right, I don't want to take too long time. Please, sir.

Encik Saravanan Govindasamy [BioCare Group, FOMCA]: Salam sejahtera. Nama saya Saravanan, mewakili *Federation of Malaysian Consumers Associations (FOMCA). Now, I woukd like to highlight certain point. Of course, we need to acknowledge self-regulation by private healthcare or even insurance has failed. We need to understand that. Now, why I am saying that is under FOMCA, we have National Consumer Complaint Centre which we handle a lot of complaints in a year and basically, we received complaints on insurance hike or even private hospital charges and so on. Now, when we brought out this issue to – I don't want to name the enforcement agency* lah ya.

Any agency we are pushing the complaint to, they said, "Oh, we don't have any jurisdiction", "Oh, there is no regulation on this", "There is no enough policy on this", "There is no regulation", "No, we are not covering this sector. You need to go to that agency, that enforcement unit".

So, here we need to make understand that regulation has failed. Now, another thing is lately we've been reading in newspaper, a lot of healthcare industries are coming saying, "Please don't regulate the private healthcare". Why? All right, we need to ask that question. Are they exclusive? Why they should be exclusive? All right. So, here, government must play their role in providing the fundamental in basic human rights which is healthcare, must be provided by the government. Make sure to regulate private healthcare even insurance industry.

Now, what is saranan FOMCA? *Please allow me to speak in* bahasa. Gabungan Persatuan-persatuan Pengguna Malaysia (FOMCA) menyatakan kebimbangan serius terhadap peningkatan kos premium insurans dan perkhidmatan-perkhidmatan insurans kesihatan swasta. Untuk menangani isu ini, FOMCA menggesa kerajaan mengambil langkah-langkah berikut:

(i) *very important. We need to have oversight body* di bawah *Prime Minister's Office which to oversight private medical healthcare and also the insurance industry. Why? Number one, they can monitor and* mengawal inflasi kos perubatan bagi memastikan kenaikan rawatan, ubat-ubatan dan perkhidmatan kesihatan adalah munasabah dan wajar;

(ii) mengawal premium insurans perubatan dan memastikan syarikat insurans perlu membuktikan kewajaran kenaikan serta mendapatkan kelulusan sebelum menaikkan harga;

(iii) mengawal caj perkhidmatan kesihatan swasta dengan menetapkan harga siling untuk mengelakkan caj berlebihan;

(iv) memastikan ketelusan dengan mewajibkan hospital dan syarikat insurans memberikan butiran penuh kos rawatan serta anggaran harga awal sebelum rawatan dilakukan;

(v) kawalan lebih ketat terhadap kenaikan premium insurans perubatan. Di sini, FOMCA ingin menggesa Bank Negara Malaysia untuk menentukan, melaksanakan pemantauan ketat terhadap kenaikan premium insurans bagi memastikan ia berasas dan telus;

(vi) memastikan syarikat insurans mendedahkan asas penetapan harga. *This we need to highlight. There's no benchmark, there's no data justifying medical inflation currently*;

(vii) mengelakkan keuntungan berlebihan dengan memastikan insurans perubatan berfungsi sebagai perlindungan pengguna dan bukan sekadar produk komersial untuk keuntungan syarikat;

(viii) meningkatkan ketelusan kos insurans dan penjagaan kesihatan. Di sini, FOMCA menuntut penjelasan yang jelas mengenai kenaikan premium di mana syarikat insurans perlu menerangkan secara terbuka sebab-sebab kenaikan kos. Memang *there's some justification but there is no data to support that;*

(ix) penghapusan caj tersembunyi bagi mengelakkan pengguna dikenakan bayaran tambahan yang tidak dijangka. Yang terakhir, *sorry*. Nombor empat;

(x) kawal selia lebih ketat terhadap perkhidmatan kesihatan swasta. Di sini, kami ingin menggesa Kementerian Kesihatan, *please come out. We don't see you anywhere, all right*. Kementerian Kesihatan perlu memperkenalkan mekanisme kawalan harga bagi perkhidmatan kesihatan swasta untuk mencegah peningkatan kos yang tidak munasabah dalam konsultasi, ujian diagnosis dan prosedur rawatan;

(xi) menetapkan struktur harga standard bagi caj hospital dan pakar perubatan swasta untuk mengelakkan ketidakseimbangan harga; dan *last but not least*

(xii) *here, as MP's, we'd like to request* meningkatkan perbelanjaan kesihatan awam kepada lima peratus daripada KDNK.

Itu sahaja, *thank you*. *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih wakil daripada FOMCA. Okey, sekarang dah 10.30. *I saw 25 people standing waiting to speak. So*, kita akan *reduce* sedikit ya *the time. So now, we give three minutes one ring and then the fourth minute, one ring and then we only give 30 seconds injury times. Okay? So, you have four and a half minutes. By eleven o'clock, we will reduce* lagi ya. *Okey,* silakan. *Yes, sir.*

Dr. Tan Ai Mooi: *[Bercakap tanpa pembesar suara] Why don't —stay back and stay? And then — so much efforts have been — suara rakyat sepatutnya didengar. Let us ... [Tepuk].*

Tuan Sim Tze Tzin [Ahli PAC]: *Okey, okey. Point taken.* Boleh.

Dr. Tan Ai Mooi: *[Bercakap tanpa pembesar suara] [Tepuk].*

Tuan Sim Tze Tzin [Ahli PAC]: Ini suara rakyat, demokrasi. Boleh. *So, four and a half minute. Okey?* Kita *continue until cows come home. Is it? [Ketawa]. All right,* silakan. Terima kasih. Ini bukan senang nak jadi Speaker ya. Bukan senang nak jadi Speaker. Speaker *means the* Tan Sri Speaker *you know? The* Dewan Rakyat.

Encik Chin Kuan Min: *Ladies and gentleman, may I request a big clap to our YB Sim and also the team because this is a first ever… [Tepuk] first time ever you know, let the public to speak about this insurance raise, about the premium raise. This is the first time. Not easy. I think YB has made a lot of efforts, you know? We should congratulate him for the courage and also the effort. Not easy to organize this. First in Penang, second in Parliament, here.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.*

Encik Chin Kuan Min: *Okey.*

Tuan Sim Tze Tzin [Ahli PAC]: *Your name, please.*

Encik Chin Kuan Min: *Chin. I'm speaking on my behalf* lah, *myself. So I think, from my point of view, I think we should look at this issue from the root problem. Root problem is actually is actually behaviour. I would like to know, can you see your neighbour? Anyone wearing sandals? Anyone? Put up your hand. Sandals? No, right?* Pakar selipar, ada tak? Tak ada ya? *Why? Because we know that when you come to Parliament, we should wear correctly, right? So, you cannot wear sandals. So, same thing goes to this issue you see. Because, behaviour. Human behavior, nature, human nature.*

I was working in Singapore for a few months when I was younger, young. I crossed the border to Malaysia. In Singapore, we cannot throw rubbish, you know? We must queue up. Go to bus also queue up but after Johor Bahru, Tebrau, everybody throw rubbish and also squeeze into the bus, you see? What happened? What's the problem? Behaviour.

Because in Singapore, the rules, regulations are very strict. Rules means rules. So, here also the same. I'm not blaming anyone. Just like YB Sim said just now is we need to have a r&r, rules and regulations and also law and the law must be executed. It's not only law. In Malaysia, sorry ya*, a lot of thing we say law but sometimes we got U-turn one, you know? Always U-turn. So, I don't think this is good*

for our future of next generation. You see, just now our gentleman talking about the enforcement, about this BNM, Bank Negara Malaysia you know. Yes, I truly agree. We have to gather all of them, you know? Bank Negara, BPM, hospitals, insurance companies, you know, together, sit down together and come out with a solution. So far very good, already started but sudah *very serious or else you won't be here. You know? Very serious already. 40 to 70 percent of increment of the insurance premium.*

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My suggestion solution is one word only, courage's. Just our problem is human nature, you know human nature. So, you need to have courage's to collective solution from all parties and transparent. The bill— like charges, list down the bill before doctor charge, we need to write down. We do have to listen to everybody. We need to enforce this and also the look out policy. Last time, Dr. Mahathir dasar pandang ke mana? Timur*, east. Now, I think we should* Dasar Pandang Ke Selatan.

You know, if they are doing well, they are economy is good. Why not we just learn from them. I think recently our YB— another YB what's her name, went to Singapore, right? What's her name— and I think it's good to learn something good from them, you see. So, the last things is execution. No point with talking so much here, you know but yet the execution none. So, Parliament, MPs very important. We need come out with a law. Thank you so much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Mr. Chin for your input. Yes*, silakan. *Yes sir.*

Dr Rashidi Mohamad bin Pakri Mohamed (UKM): *Assalamualaikum and good morning,* Yang Berhormat *and esteem guest. I'm Dr. Rashidi Mohamad Pakri Mohamed, Consultant Family Medicine and also a senior lecturer from* Universiti Kebangsaan Malaysia*.*

Yang Berhormat, *insurance premium rates paid by Malaysian who have disposable income. The hike in the premium will increase the possibility of common Malaysians unable to afford to pay and will utilise the public healthcare services with the influx of patients. So, it does affects both healthcare systems, both public and private. We certainly do not want the underserved population such as elderly persons with disability, unemployed and poor to be neglected, as there must be a mechanism to overcome the possible influx in the public healthcare system.*

Yang Berhormat*, more emphasis should be given on disease prevention of NCDs which is the main course of morbidity and mortality in the country. How much emphasis is given is very important. As we have the national strategic plan for non-communicable diseases and the government has already allocated RM32.4 billion for the Ministry of Health.*

While this budget covers all aspect of healthcare system, some of this funding is earmarked for chronic diseases prevention and related initiatives. I would like to suggest to further expand the primary healthcare, services and increase in the allocation to primary care as it will cut the cost of treatment and procedure due to emergency conditions and complication related to chronic diseases and research and data collection funding may also be directed towards research into the prevention and treatment of chronic disease as well as collection of data to monitor trends in NCD prevalence looking at the ever involving lifestyle trends and the risk of disease. Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Dr. Rashidi. Very short and sweet and straight to the point. Thank you so much. Yes sir.*

Encik Manir Victor [Vital Signs Asia]: *Good morning. My name is Manir Victor. I am WHO Patient Advocate for Malaysia. I am also a media practitioner with Vital Signs Asia. We serve nine countries around Asia. So, we talk about public private health system best practices, innovation and ideas and as a transplant recipient right here in Malaysia, in a public system that goes to both public and private hospitals, we want to talk about something that is very important.*

Malaysia is at its crossroads whether we agree with it today or ten years from now, we are still be that same space of being at a crossroads. First of all, we have a great public system in Malaysia. We have to applaud them KKM for doing a great job [Tepuk] because it has been underfunded over the past 20, 30 years and we have very, very, very good doctors and I'm saying this because I work that with several different countries.

So, we have quality in this country but we have a system that is quite archaic and old and need some help. Part of that system is if you look at our neighbors on either side of Malaysia and across the world as well, you see that there is political hot potato. Right now, that is our funding and we need a national health and social insurance policy. [Tepuk] We absolutely need that because every country does that ensures that people like Profesor Amrahi was talking about, like Dato' Soldi was talking about and Shawn here who has talking about. We cannot afford to leave people behind. That is an absolute fact. If the chain is strong, the weakest link of that chain are the aged and the sick people in this country.

So, we not only talking about being very siloed in talking about as insurance but we have to look at health in its entire sphere of that ecosystem and one of the things that absolutely necessary we just look to the south like Chin was saying you just look to the south and you see that we have a neighborhood who has a fantastic system. They try to make sure that everyone is covered. We need to look at a public

national health and social insurance to move this country forward. So that, we don't have this same conversation that we are doing today three years from now. Thank you very much. [Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Mr. Manir. Yup*, silakan.

Encik Sathya Kamalanathan [Eximius Medical Administrations Solutions]: *Good morning YB and everyone. My name is Sathya. I'm from eMAS. We are TPA in KL. We administer employee health benefits. We facilitate cashless treatment at hospitals. So, we sit right in between the hospitals and the insurance payers. So, we have full transparency and we see everything that's happening with the bills.*

I think firstly I agree our healthcare in Malaysia is very affordable and that's why we able attract a lot of people to coming into Malaysia but at the same time, our inflation is also the highest in the region. So, I think just maybe five, ten years down the road where we going to be equal with our neighbor's. Bank Negara has been talking about medical inflation since 2016. They publish articles in The Star, in The Sun talking about the reasons for medical inflation. Now only 2024, we talking about it.

So, I think one of the first things that we need to look into is the regulations of the hospital services and supplies. So, I just put up a few bills on my phone just now to take look at it. Medicine cup, right? Some big hospitals or just large chain hospitals, they charging RM1.50 for a plastic medicine cup that they put two or three tablet inside. The cost price is hardly 2 or 3 cents. Why do they have to charge RM1 for it?

Sure, in the grand scheme of thing the bills only cost RM6, RM7 out RM10,000 but the small things add up. The vital signs monitoring, the machine that goes beep, beep they charge RM15 per day/ Why do need charge that much? They probably recover the cost of the device in two or three patients? Right? So that why need regulations apply to all these things and also regulations on what can and cannot be charged. [Tepuk] Doesn't make sense to me for them to charge bed sheet, to charge under pad, to charge medicine cup when these things all cost is negligible to the hospitals? They should be able to absorb it.

Secondly, every item that used in the hospital is regulated, it has to be controlled, it has to be registered either with MDA or NPRA. So, the cost of this item should be made visible to KKM as well and KKM should then use that to regulate the prices. I implore that in the next ten sessions that you all going to have YB, the close sessions that the PAC or the PSC look into something like an NCD model or no claim discount model or a cashback model to prevent people from over using their

insurance because the mindset that Bank Negara has highlighted is the buffet syndrome where people think I have insurance so I better go to the hospital, right?

I went to the hospital for my one and half year-old daughter. She had a fever of 40 degree celsius. I declared myself as a cash paying patient. The doctor said, the specialist said never mind, she very good mood, she doesn't need to be admitted. But for all my clients, anyone whose one and half, they automatically get admitted and then the specialist didn't even charge me the consultation fee just because I was a cash paying patient. So there is a double standard it doesn't make sense. [Tepuk]

We need a mechanism to regulate medication prices. In one of my dialogue session with Minister of Health I was told that the Big Pharma is opposing all efforts to regulate medication prices. This doesn't make sense. If countries like India and so many other countries around the world are able to fix the price of medications, why can't we? All admission and surgeries into hospitals must be subject to an open peer review that is published on MMC website.

Right now, when I go to MMC website, I have to dig through the website to find out who are the doctors who have faced disciplinary action. Previously just two years ago, it's right there, front and center on the website. Now I have to dig. Why is MMC try to hide this information and MMC committee should also be open to individuals who are not doctors. Not just to limited doctors because then there's a huge conflict.

■1050

Finally, we have to address what I think is the biggest elephant in the room which is the conflict of interest. All the largest hospitals in Malaysia have significant shareholding by government investment agencies like EPF, like KWAP. [Tepuk] Sorry, please don't clap it, please don't clap it because whenever EPF announces a six percent dividend, we are so happy. But we have to accept that the dividend is coming from what I call blood money. So— we have to think about that as well. Thank you so much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you so much. What's your name again? Sorry.*

Encik Sathya Kamalanathan: *Sathya.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sathya. Thank you Sathya for your input.*

Encik Tan Jeck Kan [SBM Agency]: *Good morning, Yang Berhormat Tuan Pengerusi, MPs and all the guests. I am Tan and in the insurance line for more than 30 years. I have four points but I am going to go for fast one. The first one is regarding the interim measures that were announced last December by Bank Negara. In January, our company have an internal briefing and the company told us that if the*

company wants to go beyond 10 percent, then they just need to put up the application once they got the approval, then they can go ahead. My company has planned to go for 20. I would urge Bank Negara please don't do that because we cannot announce publicly maximum 10 but privately, we go for 20. Because nobody is able to handle the query and the angriness from the policyholders, right?

The second thing is the tremendous increase in the medical cost. I have a very solid case here. In 2010, I had a client going for sinusitis removal to remove a small node here. The doctor only took 35 minutes in the operation theatre and the patient can go back after three hours, after resting at a lobby sofa. The bill comes to RM1,700. 13 years later 2023 the same thing, in a private hospital and you know what is the charges? RM23,700. It comes to almost RM24,000 and the patient is put up two nights in the hospital.

The third thing. The government has asked the insurance company to sit down with hospital to seek for solution to lower down the premium. I will think that this will come to a dead end. Because you cannot put the rabbit to talk to the tiger. They have been slaughtering the insurance company for 20 years. There's no way they will sit down and talk.

The last thing is my humble suggestion. I think that the only exit to stop this issue for once and all and also— I agree that more than half of the audience here would agree that it is a human right to receive treatment. So lastly, I would urge the government to put the product under controlled goods regulations including the medical cost from the hospital and also the insurance premium from the insurance company. Thank you. [Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Mr. Tan. A lot of very shocking information from you. Okay.* Silakan.

Dr. Noraishah Mydin binti Haji Abdul Aziz [Persatuan Kecanggaan Tiub Saraf Malaysia]: *Assalamualaikum* dan selamat sejahtera kepada semua. Nama saya Dr. Noraishah Mydin binti Haji Abdul Aziz. Saya hanya ada tiga poin pada pagi ini. Saya harap tuan, puan dapat mendengar betul-betul.

First and foremost, I am not going to pretend that I am representing anyone other than patients with spinal bifida. There are about 7,000 patients with spinal bifida in our country now, Semenanjung as well as Sabah dan *Sarawak. I am going to be 50 years old on the 3rd of May 2025. I have had 14 surgeries. Alright? Without there being private hospitals in Malaysia to commensurate for whatever problems our government healthcare is facing, I would effectively be dead. I would not be alive. Okay? Make that very clear.* 14 pembedahan. Tanpa doktor-doktor pakar yang hebat di Malaysia ini, *and we have many of them. Many dedicated. Many good people.*

Tanpa doktor-doktor pakar di Malaysia ini, kanak-kanak *birth defects* tidak akan mendapat pembelaan. *Alright? We would effectively be dead.*

The issue here is insurance. There is no insurance for OKU. Most of us depend on OKU cards. But birth defects children need to be operated on. With no doubt, I will not be here. I am 50. I am not even on any medication. Not even pain medication. If I don't look at social media, my blood pressure doesn't go up. Okay? That is one. Who I am, what I do and who I represent?

Now second, I am going to tell you about what this country is facing, whether we want to believe it or not. Our future generations of Malaysians, our beautiful Malaysian children who should be healthy are now facing a situation where they will be born unhealthy. 91 percent of my mothers in Malaysian neural tube defects or Persatuan Kecanggaan Tiub Saraf Malaysia, *91 percent of the mothers between the ages of 25 and 35 are either diabetic, pre-diabetic or they have gestational diabetes. Okay? Something needs to be done there because these mothers are definitely not going to get their insurance. The bell has rung. Just going to end it with one last thing.*

You have pharmacists here. You have people here in medicine. We are talking about medicine here. The argument is generic medicine, all sorts. But the issue is do you know what's actually entering the mouths of mothers in this country? Alright? I will tell you, facts. If you look at the paper, I published in 2018, cranial neural tube defects and trimethoprim. Trimethoprim is an antifolic antagonist. Okay? Antifolic antagonist. Most of my most severe patients with spinal bifida are in Johore. That one area in Johore there is a dumping ground of trimethoprim in the water waste. So, YBs you need to look at interministerial cooperation here. There must be a route for whistleblowers. A safe route for whistleblowers. So, that everyone can reach out to you and give facts. Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Dr. Aisyah. Dr. Aisyah was formally a* calon *for PKR in Putrajaya. Almost become YB. Thank you, YB. Alright,* silakan*.*

Puan Nur Syimah Izzah bin Abdullah Thani [AstraZeneca Sdn. Bhd.]: Salam sejahtera dan *assalamualaikum*. Saya Syimah*, representing pharma association means Pharmaceutical Innovator Associations.*

Actually, I have three questions I want to ask. The statement I have on behalf of my pharma colleagues one is on transparency and diversity of insurance. I think resonating what many people say here is we need more transparency because we notice there is a lot of transparency as consumer myself and as a pharma member, we notice a lot of transparency in claiming of the medical insurance and even the insurance policy itself. Do we know actually what is written in the policy, the hidden

clauses? It comes back to when I wanted to claim for something, then I can't afford to claim it. It was denied or declined.

This is a personal point of view. Recently my mother was submitted. 60-ish. The insurance is like very high premium that we pay. The GL said that okay approved for this operation. Towards the end, we have to 90 percent of the total all cost. I have to back and forth to just get the 10 percent paid. Where is the— there is a lot of hidden clauses because it was not given to us, right? The clause is like very general. Everything is covered. But when we wanted to pay, claim, then I have to pay 90 percent of the bills. I think a lot of— no transparency in the insurance clauses as well.

The second is what is that extra, extra insurance that we pay? I think kalau macam insurans ejen datang *to us, then we were like okay this is the premium dot, dot, dot and okay I take it. And then towards the end like "Eh, actually for health only this portion". Can we actually really look into these basic insurance needs and then if you need all the riders right you can actually add on. If you want to go to the five stars hospital maybe there should be another additional rider for that.*

■1100

So, maybe we need to be able to cover the basic and the National Health Insurance probably will take time. I know MOH has been working on it but as like you know, what can we do for this to diversify our insurance plan as well.

On my second point, it's a bit more on statistics. It's about the balancing of FDI and DDI. We understand a lot of questions are prone to us as well but on the map based on pricing, right? But I want to actually just put some statistics for the committee to actually consider. The Edge actually reported a profitability of about RM8.1 billion only in H1. For life insurance and Takaful, this 2024 data.

How about Pharma sales? In 2022, is about RM11.2 billion. Pharma total, not only innovator. From the hospital, I think last year Q3 is about RM1 billion from one hospital, half a billion from another hospital. That was reported, right? In the media. But for Pharma— Innovator Pharma company, we also contributed to significantly to clinical trials, 80 percent of clinical trials in Malaysia are contributed by MNC's.

And, you know what is our revenue bag? Investment bag from our revenues about 15 to 20 percent goes to clinical trials. And Malaysia, honestly speaking, has a good platform for us, Pharma company, to actually invest in clinical trials. So, it has you know, progressed significantly. So, Malaysia is a very good market actually for clinical trials. So, it opens up in early access to more and more patients in Malaysia.

How about employment? So, total Pharma is about 95 percent high-skilled job employment. And, talk about medicine pricing, 14 percent of the total medical bill in Malaysia, it was reporting Code Blue, only 14 percent goes to max and pricing. In

Taiwan, 12 percent. So, I think it's something for the committee to consider as well. And then, to answer to some of the medicine cost right, for pharmaceutical innovator pharmaceutical companies, we— some have, some don't have but we also have a patient's scheme. Either is being transferred to the patient, I think it's a question mark.

Thirdly, on the consumer's right…

Tuan Sim Tze Tzin [Ahli PAC]: Syimah, Syimah.

Nur Syimah Izzah binti Abdullah Thani: *Yes?*

Tuan Sim Tze Tzin [Ahli PAC]: *The time is up.*

Nur Syimah Izzah binti Abdullah Thani: Okay.

Tuan Sim Tze Tzin [Ahli PAC]: *30 seconds. Finish it. Thank you.*

Nur Syimah Izzah binti Abdullah Thani: *Okay, 30 seconds. I think lastly is the consumer's right. For us, actually to have, like you know, a consumer's right. In February 2025, it was— there was a letter given to a hospital to cut costs but we as consumers, do we actually know that it was actually given to the hospital directly from the hospital. That would actually potentially steer the decision of the physicians to treat the patients and last but not least, we as pharma members want to request to actually have a session with you. So, you will know what actually we are facing in this market as well.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yeah, yeah. I understand. Yeah, I think we have invited the Pharmaceutical association but you feel free to give your contact. So that we can invite your Pharmaceutical Innovation Association, right?*

Nur Syimah Izzah binti Abdullah Thani: *Okay.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. Thank you very much.*

Nur Syimah Izzah binti Abdullah Thani: *Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih. Silakan. *[Tepuk]*

Prof. Dr. Nur Aishah binti Mohd. Taib [Together Against Cancer]: *Thank you. Assalamualaikum warahmatullahi wabarakatuh. I am the other Dr. Aishah. I'm Professor Dr. Aishah from University of Malaya. I'm a breast surgeon and I am representing Together Against Cancer, an advocacy group that is made up of patients, carers, health care providers and supporters. So, we have two main points that we would like for you to consider and four recommendations that we would like you to consider.*

First of all, I think in terms of insurance not responding to the reality of cancer diagnosis and treatments. So, what we see is that people, healthy people with benign pre-existing illnesses, are being excluded from coverage. For example, a normal breast ultrasound that shows a breast cyst in a 25-year-old will be excluded from breast cancer coverage.

Secondly, cancer treatments. Some are denied treatments, especially those that were deemed to be preventive in nature. So, I think Dato Ibrahim mentioned this earlier but we have patients who need treatments for five years or 10 years for treatment, not for prevention of recurrence are denied having claiming the insurance for this medication. And, these treatments are also being done in the outpatient setting and therefore, cannot be claimed.

Okay, the third one is that cancer patients have the right to be forgotten. That means that pre-existing conditions can be forgotten. So, for example, in the European countries, there are legislation that protects cancer patients that have survived eight years or 10 years and they are no longer considered as pre-existing illness. Therefore, having— availing the ability to have insurance coverage after the diagnosis.

Alright, the second point here that we would like to say is that I'm also a professional, right. So, I do know that our medical fees are fixed. It has been fixed for decades now and it is legislated. However, medical fee from the hospital side is not legislated or controlled. We know there's a Transparency Act for the drugs but it is not really available for the other things. So, we also agree with the conflict of interest point there that most of these hospitals that do not really is tell the markup of prices are actually GLC's, okay. So, therefore we have four points that we would like to recommend.

Number one, we have to improve the insurance instruments that respond to people's needs and it is not for insuring the healthy;

Number two, we should be moving towards fairer community-rated insurance instead of personal risk-rated insurance to respond especially to the silver economy because we know that private personal insurance is non-sustainable;

The third point is, I think the main thing is that I don't think we are spending enough for public health issues. We need to increase the GDP for public health spending. We are actually one of the lowest, if not the region, the world for our class of country that we are in which is the upper middle-income country;

The last one is, we should review the transparency of hospitals' fees, the markup's and so forth and we should be providing financial counselling upfront to guard catastrophic spending among patients and their families in the private sector. And, all these need to be regulated.

So, that's all from me. So, we are from Together Against Cancer. So, we will be very happy to contribute in any way we can to the Ministry of Health and also the government. Thank you, YB. [Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Professor Dr. Aishah for your input. Thank you.* Ya, silakan.

Encik Sivakumar Subramanian: *Hello. Our respected YB Sim and all the YB's on stage and ladies and gentlemen. A very good morning.* Salam sejahtera, *Zǎoshang hǎo* and *Vanakkam. So, let me introduce myself. My name is Sivakumar Subramaniam. I am a district manager representing one of my companies, I mean the business of 30 years. Okay, so over these 30 years, I am experiencing the medical pricing almost like you know, 15 to 10 times, even for my personal policy. So, but today there are few— I mean feedback which I would like to put it up here. This is my personal— one or two questions that I would like to put up here.*

Okay. So, as you know, every human being has three necessities, as you know food, shelter and clothing and this is a very important necessity. So, just in case of anything, if it were to happen, rise if we need insurance especially the medical. All right? So, without medical insurance, all our hard-earned income will just wipe out. So, that's the main reason why you will be having insurance. So, basically, insurance— when you talk about insurance, is a transfer of risk, okay? So, when you are talking about this insurance right, when I mentioned just now, without insurance, if anything were to happen, all our income will be wiped out.

When we are talking about the current situation right now, looking at if let's say there is no medical repricing was regulated, we worry in future, all our hard-earned income will be wiped out as well, okay? So now, I have a very important question here, okay. Do the number of foreigners coming to our country, Malaysia, under the Malaysia My Second Home Program? A residency through investment concept that allows foreigners to invest and reside in Malaysia for at least, for example 20 years.

As we all know that, Malaysia is a heaven for many foreigners and their living standard compared to our local citizens a much more better, especially be comparing our B40 group.

■1110

For example, for those who are earning income of USD3,000. If let's say this USD3,000 candidate come to Malaysia under this program and they convert this money, easily they can get about RM12,000 to RM13,000. When they talk about the currency exchange.

With this RM12,000 to RM13,000 in Malaysia, this person can able to have T20 lifestyle. Now, as you know, many foreigners come in to Malaysia under this program called Medical Tourism to cater this group of people— and I am sure all medical centres and embraces with the latest technologies, okay. They come out with the robotic operations, this and that. Okay.

Now, this is the need for this group of people so that they can able to get a better medical treatment down here in Malaysia with cheaper cost compare to their own country. Okay. Now, due to this right, the medical cost gone up and eventually it will be impacted all of our local citizens with medical repricing. This is question number one. The second one, are there charges at the medical centres in Malaysia different for local citizens compared to foreigners or foreign patients?

So, we wouldn't know. So, if you go to a medical centres, if let say the charges is standard, we supposed to charges for the foreigners, if let say we as a local paying the same price which we will feel it's not fair for the locals, okay. So, eventually this would able to impact on our medical repricing. So, just the information I would like to highlight here. So, thank you.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Okay. Thank you for your input. Next, to our gentleman on the right.*

Tuan Lim Teng Cyuan [Malaysian Association of Pharmaceutical Suppliers]: *Good morning. My name is Lim Teng Cyuan. I am the President of the Malaysian Association of Pharmaceutical Suppliers. Healthcare cost has many components. Seeing that there are many stakeholders today, MAPS as an association representing importers and suppliers of generally low-cost high-volume pharmaceutical. For today, I would like to limit our input to the questions of cost of medicine towards the overall cost of healthcare.*

My colleague from Pharma mentioned that the contribution of healthcare medicine is about 14 or 15 percent. So that is the most impact that we would have on the overall cost. We thanked the PAC for the closed-door session invitation scheduled for next month and we are pleased to accept. We are already preparing some slides for that purpose.

As part of the joined World Health Organisation and Health Action International project on medicine prices and availability, a series of in-depth reviews have been in published. These are actually studies done in different countries, they've look at the models and they've come up with some recommendations.

Specifically, the WHO/HAI review series on pharmaceutical pricing policies and *interventions working paper two, there are six papers. So, this is basically from working paper two. The role of health insurance in the cost-effective use of medicine*

is referred here. It's a long paper but I am just going to pick the important points, the four points. The working paper is available as a download resource on the HAI website. You can just try it yourself.

To be brief, the papers state that insurance system are likely to need to use a combination of policies and management strategies then they include, number one, selection. Defining a formulary or a reimbursable list, requiring generic substitution for some medicines and prior authorisation from some medicines, designing co-payments to encourage use of preferred cost-effective medicine.

Second purchasing, negotiating prices and setting quality and other conditions for medicine supply. The part of about setting quality if defunct because of our MPRA sets the quality which is equivalent to all. Negotiating volume rebates, conducting competitive bidding.

Number three, contracting. Setting the terms and conditions for payment of health service providers to influence prescribing and dispensing. Example capitation payments for budget that include medicines' cost, performance-related pay, contracting with a preferred pharmacy network.

Fourthly, utilisation management. Implementing programmes to educate patients and prescribers and audit and give feedback to prescribers. We see today, that policies and strategies are only partially adopted by the insurers. We hope for a more holistic approach to cost-effective use of medicines. We hope that effective adoption of tried and tested policies can stamp the need for hikes in healthcare premiums.

Finally, love your innovators and your biologics but please use generic and biosimilars. Thank you.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Okey. Terima kasih kepada Mr. Lim. *Next, we go to our gentleman on the left.*

Encik Mohanakrishnan Menon a/l CC Menon: *Good morning to you, YBs. Thank you for your patience and for your concern. You mentioned, I* think *YB Sim mentioned the earlier that he's quite encouraged with about 400 plus people here today. But I think, I got to know about this from reading the newspaper and there was a link that said "isi borang". There is a problem with the link. I don't know if anybody else faced that. I could not get into that link and I had to go into multiple newspapers and finally when I got to The Edge, that's when I got a good link.*

I realise where the problem is because the link had Parlimen Malaysia, but because it's a very long link, the newspaper puts a hyphen to overlap. So, I think if you have the link correctly, you probably have three times of number over here.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Okey. Ya.

Encik Mohanakrishnan Menon a/l CC Menon: *Because, this is a very hot topic.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Sorry about that.*

Encik Mohanakrishnan Menon a/l CC Menon: *Its being debated everywhere. So, please I hope the Parliament would spend a significant amount of time considering this issue.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Noted.*

Encik Mohanakrishnan Menon a/l CC Menon: *Now, I want to go into my own experience. I started with an insurance policy paying about RM2,600 about 15 years ago, RM2,600 per year.*

According to my age bracket, this year, I should be paying about RM8,000. But last year I was already paying RM15,000 in premiums. It has already increased once and then a few months later I got another letter saying its going to be RM22,000 per year. That's my premium.

I am in my retirement age and I am being forced to work actually just to support my insurance premium. Now, because we couldn't get all these fancy policies, 15 years ago this million-dollar policies that you see going around these days, it was only covered by about a few hundred thousand.

I took a second policy about 12 years ago. So, that's second policy has not going to help much. This first policy I just mentioned, the premium is going up by 200 percent based on my current age, what it should have been at my current age has gone up by 200 percent.

But the other insurance policy, has only gone up by 100 percent. So, I am giving you some data, there is no consistency across insurance companies as to how much they are raising. They are doing it arbitrarily, I think. Because based on my own data that is, I have two policies.

Now, the other thing that I want to bring up is this so-called blacklisting of hospitals by insurance companies. It's not really been publicised. I happened to find out from my agent accidentally that my insurance company will not cover Thompson Hospital, all right?

Because of some dispute they are having. By the way, this is not communicated to us. Sorry, let me correct myself here, when I said they don't cover, what I mean is they don't provide a guarantee letter, all right? They don't provide a guarantee.

So, what if there's an emergency and I have got to go to the hospital? Am I supposed to be calling to say— is my family member suppose to call my agents and

say, "Who's the compatible hospital that will accept me with the guarantee letter?" I think these kinds of things need to be communicated.

Now, I welcome what the previous speaker said about medical tourism. That was also my point. A medical tourism is probably why we have the five-star lobbies in the hospital and I don't think we should be having that, okay. Maybe this is a government's policy or strategy and all the healthcare industries' strategy that they want to make more profits by bringing in foreigners. Fine. Have a separate charging system and also for Malaysians, we're happy to have a separate entrance with three-star facilities and leave the five stars for the foreigners. All right?

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I think another speaker said that we should have department under the Prime Minister's Office, that's very good. Because right now you just have Bank Negara and branching over here you just have Bank Negara for insurance. But, we need one body that regulates the hospitals, the insurance companies and the pharmas, all one-stop shop and also an easy process for a normal citizen to register a complaint with this arbitration body. This is something that we need.

Medical care, just like the government regulates – this is just my last point, 20 seconds. You, the government regulates the price of rice, it regulates the price of petroleum. Medical care is equally as important, government should step in, it's high time, the government steps in to regulate all these people and get them into coordination, synchronise them and make sure we get affordable healthcare. Thank you.

[Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you sir, thank you sir.* Ya, silakan.

Encik Tan Jee Kwang: YB, *thank you for having this public hearing for us. I'm Tan Jee Kwang, I'm a 64 year old retiree. I started to purchase this insurance for 26 years since 1999. The insurance changed twice, two times. The insurance A didn't increase much the premium, insurance B increased twice. But, while increasing, while adjusted, they upgrade our – this coverage. But, come to 2016, the insurance C is started to go up but I didn't complain, I didn't write a complaint. But, it go up 21 percent, 2017 – Oh, sorry. The past few year, for the 16, 2016 before is they maintain three years, four years, three years, four years at the same premium. But, after 2016, they either increase alternate or every year. Now, started 2022, they increased. 2022, I actually attained 60 years old. So, they gave me this rerating, okay fine, 39 percent. But, repricing is 30 percent.*

I asked them, "How you calculate out?". They said, "You just, you just..", this is their what – "You just refer to the FAQ lah". FAQ means Frequently Asked Question

or answered questions. Item five, I asked them, "Whether you get the approval from BNM or not?". BNM got akta. *You have to follow the* akta, *the* akta *is FSA 2013. So, I asked them, "Whether you follow or not?" They said, "No". This is a commercial decision made by – I don't want to.. [Tidak jelas] the insurance, please. After careful consideration of factors like medical inflation. How you calculate out we don't know. Only the regulatory body know, that's BNM.*

BNM akta *is already there for 2013. But did they enforce it or not or they just put it for show? I also communicate to BNM, BNM after reading the complaint letter, it says, "Why not you work together with the insurer?" How to work together with the insurer?* Okey.

Another thing is the private hospital, okey. *Previously, private hospital, there is a regulatory body also. But, where is the regulatory body? Independent. They're actually formed by the independent doctor, they call it MDAC. MDAC stands for Medical and Dental Advisory Committee. Where are they? They're already removed. So, nobody monitor the charges or the fee. They're supposed to have an independent regulatory body actually formed by all this doctor. When the bill go to the patient or policyholder, they have to check, they have to check each by each whether different or not, various standard or not.*

Then, first they have to report to the hospital, the hospital itself. Then, if the hospital don't want to adjust back, don't want to how to say justify back, then you have to report to the MOH. This is the regulatory body.

But, I think the failure is there. The two regulatory body. There is one is our financial body, there's BNM, another one is Medical and Dental Advisory Committee (MDAC). Please put it back. So, you will solve all the problem.

Tuan Sim Tze Tzin [Ahli PAC]: Ya, Mr. Tan.

Encik Tan Jee Kwang: *So, another thing is very scary. So, you see now every year...*

Tuan Sim Tze Tzin [Ahli PAC]: Mr. Tan, *can you finish in 20 seconds, please?*

Encik Tan Jee Kwang: Okey, okey. *20 seconds. Every year alternate year, you got to increase. Now, I'm retired aready. I just pay from my saving. I pay for four members of my family member – now, I could not afford. I just pay for myself and pay for my wife. So, the premium rate is more than 10 percent. Hopefully, it would be five percent. So, I see one of my – three of our this premium, for 2026, 9.5 already. My daughter who actually pay earlier still stick to the same. Thank you very much.*

[Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much* Mr. Tan. Okey, *like this. I think we – because today is Friday and then there's a Friday Prayer. So, we have to finish it if possible by 12. So, I think I need to reduce a bit of the time. So, now everyone three minutes.* Okey? Ya? *Sorry* ya, *sorry. I know everyone want to speak, we want to give chance to you for you to speak. Yes,* silakan.

Puan Minnie Yap [VKA Wealth Planners Sdn. Bhd.]: *Okey. Hi, good morning. My name is Minnie Yap. I'm a financial planner from VKA Wealth Planners. I'm in insurance industry for around eight years. So, here some of my point of views. So, I suggest actually we should have the flexibility to choose whether to remain the premium or top up according to our affordability when it comes to the medical repricing because there is cash value in the policy for investment-linked medical plan. So, when the medical rider is having a repricing, can the latter stated the sustainability of the plan such as like initially the plan is sustained until 70 years old. So, right now due to medical repricing maybe reduce until to 65 years old or 67. So, can the insurance company provide that so that we can make a choice whether we want to top up or top up according to our affordability?*

So, second thing. Hospital bill actually didn't reveal to patient before discharge. So, policy owner actually doesn't know the total amount of the bill and also the amount need to self-pay. Some private hospitals ask the policy owner to do some test or assessment which is not necessary and not covered by insurance company. So, at the end the policy owner have to pay the bill from more than RM1,000 for unnecessary test.

One of my clients actually charged by one of the private hospitals. The details there written, "Nursing assessment or admission or discharge", which is cost RM332. So, when we ask the private hospital what is the charges about, the nurse actually told us that is for sanitizing the room everyday. So, my client is actually staying for four days. So, four days cost RM322 which is ridiculous. You are hospital, we are not Airbnb right? Airbnb also even charge one time for the cleaning fees only. So, at the end I actually help my client to file the complaint to hospital then only they refund the money to my client. So, imagine those who didn't complaint then they have to pay loh.

So, lastly I want to say that adjust the commission for agents to yearly like generate insurance instead of six year commission once they closed the deal. Because some agent actually after successfully close the deal, they no longer provide service to the policy owner such as assisting clients in handling the claims. So, when the policy owner request to transfer the servicing agent, the commission is actually

still received by the previous agent instead of the new agent who provides a good service. This is actually unfair to agents who is doing a good job.

So, and then I found out that in last year, one of the insurance company which is introduced medical plan whereby there is a claim, the following year premium is increased. So, I think this plan is fair enough for client who doesn't make a claim. Because many people feel that, "Oh, I pay for the premium but never claim before. So wasted. Rugilah". So, I think this way can actually help to manage the insurance pool fund. So, that's all from me. Thank you.

[Tepuk]

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, thank you Minnie. Thank you Minnie.* Ya, *sir*. Silakan.

Encik Koh Eng Huat: Okey, salam sejahtera YB. Saya ada beberapa persoalan dan saya mohon lebih masa. Sebab ulasan saya, saya perlukan juga YB sebagai penggubal dasar untuk akta semua. Jadi, saya perlukan satu ulasan daripada YB berhubung dengan hujahan-hujahan saya sama ada berasas. Sebab dalam isu ini saya nak beritahu – ada tak wakil daripada Bank Negara? Sebab saya lebih suka berdepan.

Kalau tak ada, saya cakap dia tak berminat dengan isu yang sepatutnya dikawal selia. Sebab itu YB cakap dia komited. Daripada langkah jangka pendek yang diambil, dia tidak berminat langsung. Sebab dia hanya tahu berunding dengan pihak insurans dengan tidak menjemput pihak FOMCA ataupun PPIM.

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Adakah keputusan yang dicapai itu bernas dan memihak. Kenapa FOMCA tidak...

Tuan Sim Tze Tzin [Ahli PAC]: Tuan boleh beri nama, nama.

Encik Koh Eng Huat: Siapa dia? Koh Eng Huat, Koh Eng Huat.

Tuan Sim Tze Tzin [Ahli PAC]: Koh Eng Huat, okey. Koh Eng Huat *you* ada tiga minit saja... *[Ketawa]*

Encik Koh Eng Huat: Okey. Dalam isu ini...

Tuan Sim Tze Tzin [Ahli PAC]: ...Jadi singkatkan ya.

Encik Koh Eng Huat: Bukan, kalau boleh kasi masa sebab saya banyak fakta. Hujahan ini untuk membela rakyat.

Tuan Sim Tze Tzin [Ahli PAC]: Betul, betul.

Encik Koh Eng Huat: Okey. Antara hujahan yang saya nak cakap ialah saya nak jaminan daripada ini PAC sama ada, ada kekebalan tak apa yang kita berhujah ini. Sebab satu ialah kita nak mempertahankan kerajaan, satu ialah institusi penguasa membuat satu keputusan... *[Loceng dibunyikan]* ...Yang tidak memihak

hala tuju kerajaan. Di mana PMX menyatakan kita kena merasionalisasikan subsidi bersasar supaya tidak bersasar.

Dalam isu ini kalau pihak penguasa membuat keputusan, keputusan komersial memang apa yang tadi saudara apa cakap, keputusan Bank Negara selama ini— saya ada sembilan keputusan Bank Negara dan untuk pengetahuan YB, aduan ini telah dibuat semenjak 2023. Sembilan keputusan Bank Negara dan rumusan keputusan Bank Negara adalah kami akan memastikan pihak PPK menjalankan perniagaan secara adil, saksama dan profesional. Saya dah boleh hafal. Tapi itu yang dia janji, tapi apa yang berlaku, tak ada.

Dalam isu ini dia menyatakan keputusan pihak PPK... *[Loceng dibunyikan]*

Tuan Sim Tze Tzin [Ahli PAC]: Encik Koh, kita kekurangan masa...

Encik Koh Eng Huat: Bukan, bukan. Maksudnya ini ialah untuk demi rakyat.

Tuan Sim Tze Tzin [Ahli PAC]: ...Jadi ada— mungkin nanti *you* boleh...

Encik Koh Eng Huat: Bukan. Ini sebab saya nak satu daripada jaminan supaya sebab media pun takut nak ambil kenyataan. Satu, dia takut apa yang kita buat ini tidak menyokong Bank Negara, tapi bukan Bank Negara salah, salah ialah penguasa. Penguasa yang tidak bertanggungjawab. *[Loceng dibunyikan]*

Tuan Sim Tze Tzin [Ahli PAC]: Jadi, boleh rumus dalam satu minit Mr. Koh.

Encik Koh Eng Huat: Okey. Dalam isu ini dia cakap dia akan pastikan PPK. Lepas itu dalam aduan saya kenapa premium boleh dinaikkan. Sebab bila *you* cakap premium boleh dinaikkan, dia cakap ada terma menindas. Dia cakap premium tidak dijamin terletak dalam terma. *So*, dalam akta— penggubalan Akta Perkhidmatan Kewangan di mana dinyatakan objektif akta ini. Boleh tengok muka surat 31.

Tuan Sim Tze Tzin [Ahli PAC]: Encik Koh, nanti *you provide* kepada urus setia, *written, written...*

Encik Koh Eng Huat: Bukan, bukan. Ini satu penerangan yang bagus supaya saya nak ulasan daripada YB sebab dalam dia punya pernyataan saya hanya nak cakap objektiflah. Objektif Akta Kemudahan— sila lihat muka surat 30 ke 31. *[Loceng dibunyikan]* Okey. Objektif pengawalseliaan utama akta ini adalah untuk menggalakkan kestabilan kewangan bagi mencapai objektif berikut. Memupuk keselamatan dan kekukuhan, kecekapan— semualah.

Tuan Sim Tze Tzin [Ahli PAC]: Ya.

Encik Koh Eng Huat: (b) Berusaha untuk melindungi hak kepentingan pengguna perkhidmatan dan produk kewangan. Dalam isu ini bila dia cakap hak komersial... *[Loceng dibunyikan]* Bermaksud keputusan komersial apa yang berlaku.

Tuan Sim Tze Tzin [Ahli PAC]: Ya.

Encik Koh Eng Huat: Jadi, dia mengaku terma menindas— terma tidak dijamin adalah polisi. Jadi, saya ada buat sesi libat urus dengan Bank Negara, Prudential dan juga UOB. Dalam ada 50 orang, saya hanya seorang dibenarkan. PPIM kalau ada wakil dia tak dibenarkan masuk. Dalam isu ini saya cuba memartabatkan tapi dia tak mahu, martabat.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Mr. Koh.

Encik Koh Eng Huat: Bukan, bukan sebab ini penting apa yang saya cakap.

Tuan Sim Tze Tzin [Ahli PAC]: Saya tahu, saya tahu. Kita pun *deal* dengan isu yang penting juga.

Encik Koh Eng Huat: Bukan nak malukan, bukan nak malukan. Kita nak Bank Negara penguasa dia sedar di mana dalam jaminan...

Tuan Sim Tze Tzin [Ahli PAC]: Tak, nanti kita akan bagi keterangan...

Encik Koh Eng Huat: *Wait, wait.* Bukan— dalam ikatan. Bukan sekarang. Maksudnya saya nak cakap, dalam perjanjian dia masih boleh menghalalkan ikatan yang menjanjikan premium yang tidak jamin sedangkan polisi Bank Negara, *fair treatment of financial consumer*, layanan adil dan disebabkan itu dicerminkan dalam piagam pengguna yang dinamakan...

Tuan Sim Tze Tzin [Ahli PAC]: Okey, baik.

Encik Koh Eng Huat: ...*You* boleh tengok itu Prudential nya...

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih banyak ya.

Encik Koh Eng Huat: *...To treat customer fairly, openly, honestly.*

Tuan Sim Tze Tzin [Ahli PAC]: Faham, faham. *Point taken.*

Encik Koh Eng Huat: Bukan. Saya nak sikit. Jadi ulasan adakah berasas? Sebab dalam dia punya keputusan, kami juga mendapati pihak tuan telah mengeluarkan beberapa kenyataan atau ulasan yang tidak berasas. *[Loceng dibunyikan] No, no.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey macam ini Mr. Koh. Nanti kita minta seorang urus setia...

Encik Koh Eng Huat: Bukan, adakah ulasan...

Tuan Sim Tze Tzin [Ahli PAC]: *...Attend to your complaint*, boleh?

Encik Koh Eng Huat: Maksudnya saya sebagai...

Tuan Sim Tze Tzin [Ahli PAC]: Seorang, seorang...

Encik Koh Eng Huat: Maksudnya sebagai pengawal selia, bila dia cakap akan memastikan tetapi dia mengapa dia boleh cakap itu menindas.

Tuan Sim Tze Tzin [Ahli PAC]: Faham, faham. Boleh...

Encik Koh Eng Huat: Bila saya cakap, Prudential ada buat tawaran, tawaran untuk saya kekallah.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, faham.

Encik Koh Eng Huat: Lepas itu arahan penerimaan tetap yang dia panggil *sign* tak ada nilai. Saya letak nilai dia cakap tak boleh. *So*, saya cakap biar Bank Negara buat keputusan, Bank Negara tak putuskan. *[Loceng dibunyikan]*

Dr. Tan Mooi: *[Bercakap tanpa menggunakan pembesar suara]*

Encik Koh Eng Huat: *No, this one...*

Tuan Sim Tze Tzin [Ahli PAC]: Ya. Nanti kita akan *assign* seorang urus setia dengan Mr. Koh ya, Mr. Koh.

Encik Koh Eng Huat: *No, no. This for public interest.*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih.

Encik Koh Eng Huat: *No. I know is for public interest.*

Tuan Sim Tze Tzin [Ahli PAC]: Kerana ramai lagi, ramai lagi sebab kita kesuntukan masa ya. Minta maaf ya, minta maaf. Terima kasih, terima kasih. Baik, silakan.

Encik Koh Eng Huat: *So*, adakah berasas, adakah ini boleh kenyataan macam ini kita dianggap ugut? *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: Kita nanti urus setia tengok ya, terima kasih banyak ya. Kita mengalu-alukan Yang Berhormat Teresa Kok daripada Seputeh, Kuala Lumpur.

Dr. Gunalan Arumugam Palari [Persatuan Perubatan Malaysia]: *Okey, thank you YB Sim and all the rest of the Parliament. My name is Dr. Gunalan and I actually the Private Specialist Affairs in charge of the Malaysian Medical Association. Glad to see quite a number of my familiar faces and all of previous discussion as well. First of all, thank you for the opportunity to actually represent the doctors. I think the main thing that I get from today's discussion, there a lot of demonisation of the role of doctors and private hospitals that is actually grossly misrepresented here today. I think a lot of time people do not understand what takes place behind the scene in the private hospital in the work that is being done by the private doctors as well.*

Second thing, our partners in the medical insurance industry— I call them partners because if not for their presence as this moment in time, the health of the nation will be in a crisis. KKM would not be able to sustain the delivery of healthcare. Now, that is very important understanding, we must acknowledge their role. Are they perfect? No. Is private hospital perfect? No. Are doctors perfect? No. But this is where the forum has to be put in place where we engage with the relevant stakeholders.

And I thank YB for actually having the courage to take it by the bull by its horn because next month we going to have a meeting with all the stakeholders again

where we have actually prepared a very detail analysis and proposal that we will shares as well with YB. The interest of time I'm not going to do what it was done previously but I'll just go straight to the point in terms of what we find as the demonisation of private healthcare which is not fair.

Because today in a small district hospital, you have a private hospital. At 20, 30 years ago there is no private hospital, what happened? People are going to Singapore, India and UK for treatment. Now, we have brought cardiac surgery, neuro surgery to your doorstep, oncology treatment to your doorstep. This is not with the investment of the government. Government facilitate, yes, but the GLCs were pumping at investing the money, allowing people like me, I am a private specialist as well. Allowing people like to me actually provide the service to people and we are actually doing it based on regulated fees.

Doctors are not simply marking up the prices or simply charging based on what we feel like charging because it's all regulated. Now, are there outliers, are there people who are unscrupulous? Yes, there are. But that is where the role of the public is come into play. [Loceng dibunyikan] Malaysian Medical Council is there. We need to put all the complaints and stuffs there.

I now want to focus about the life insurance industry. I think Mark is here as well, to their credit. Their annual report are published alright. So, Bank Negara has got detail. It's all available on the website. Now, there is one component of this that is actually not being spoken about at all. RM5.5 billion is actually the agency commission. Now, we need to look at that. Is the total provision of healthcare in Malaysia was RM7.7 billion, that has been paid for to the hospital and the doctors. [Loceng dibunyikan]

But RM5.5 billion is actually the agency commission which is quite steep almost two third of the total cost. Now, instead of possibility of changing some of this policy delivery or the distribution mechanism to what was mentioned earlier, the online system. Singapore has got about 40 percent of their delivery is direct policy purchase online as well. Some of the savings can actually be passed on to the consumers as well. They are many highly, savvy, sophisticated customers who can do that.

So, I think there is a lot of improvement and innovation that can be done by the private insurance themself. [Loceng dibunyikan]

Tuan Sim Tze Tzin [Ahli PAC]: *Yes.*

Dr. Gunalan Arumugam Palari: *Now, final point that I want to make is with regards to MOH proposal of DRG. Now, diagnosis relative groupings— please get all the stakeholder's involvement into the process and discussion. Because the way*

things have been proposed, we fear that it is going to destroy private healthcare as we speak. Now, what is going to be happen is you are going to limit access to healthcare of certain group of patient.

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Because, they are high risk— they then end up being channeled from the private hospital to the public hospital as well, further delaying treatment. So, these are a lot of things that we need to look at carefully. Thank you Yang Berhormat *for your time. We'll see you [Tidak jelas].*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Dr. Gunalan. Thank you very much for your input very much.* Okey, silakan tuan.

Encik Raymond Yeoh Huat Hock: *Good afternoon. My name is Yeoh. Everyone knows the complexity of healthcare coming back to private hospitals. My personal experience is one private hospital diagnosed me where the situation which will cost RM90,000. I went for a second opinion, I got it all done for RM23,000. So, this is a very clear-cut case. That was two years ago. I'm walking fine today, L4-L5 operation.*

Now, next thing is on age for senior citizens when they hit 70, even though you have not claimed your lifetime limit and when you try to get the renewal, they will tell you because of other histories, we are not going to renew your policy. Since the last five months, my wife and I, at age 70, we have approached a few insurance companies but they are willing to give policies until age 100. My question is why the existing company is not willing to extend the policy like new policies now that have been offered? This I believe is because Bank Negara has lately started to look into all this.

There is another thing about Bank Negara, I must give my comments, compliment is they are doing a good job because when they look at certain claims when they get into a picture, the insurance company will then process the claims. So, the question is for senior citizens, all policies hitting 70 very difficult to get a renewal policy even though the new companies are willing to look at your policy but they will always say depends on the underwriter.

For 20 years I've paid my policies and my claims have not been even 50 percent of the lifetime limit. So, the question is at this age when you have retired, no income, you are going to end up queuing up government hospitals. 20 over years insurance companies have taken premiums and now you are left in the cold. So, you'll be starting to queue up in government hospitals. That's all I need to say. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Mr. Yeoh. Okay, I think we have to stop people from queuing already. This is the last* ya, *okay*. Ya, silakan.

Puan Azealea binti Dzulkefflee [Agensi Azealea Dzulkefflee]: *Bismillahir Rahmanir Rahim. Assalamualaikum warahmatullahi wabarakatuh and a very good day to everyone here. Very caring people and to our respective leaders from the respective field, I am very sorry you have to* tahan perut *for lunch for this. All right. I am Azealea Dzulkefflee. I've been in the insurance industry, having my own takaful agency, for now 16 years and also married to an accountant who has an accounting firm for 17 years now. So, I believe I'll be bridging the gap between the seniors and also the young ones. And coming from a medical background and also political science background. I think I understand the socioeconomics of what's the issue here.*

So, basically my petition is consideration to increase and separate tax relief allocation for both family takaful or life takaful, insurance as well for medical, education, retirement section, since insurance has multipurpose, not just for medical card and hibah or life insurance. But it serves as a highly reliable and most importantly syariah-compliant wealth creation and preservation tool for individuals and also corporations in order to have a holistic peace of mind and lifestyle.

Separate the medical tax relief allocation for individuals, corporations, providing not only for spouse and children but also for elderly parents. Imagine me, I am also paying for my parents, their insurance but I cannot claim tax relief, all right. This will also ease the cost for public hospitals in treating elderly patients since medical cards for elders will be seen as more affordable for their working-class next of kin.

Now, providing such as in Singapore, they provide more working chances for senior citizens in servicing sectors. So, they are kept busy, stay sociable in society and active. They have ample income to sustain their living in this current demanding economy as what public service in Singapore has been practicing. More healthy seniors mean less medical costs and sustainable medical inflation. This will create a good domino effect on our current society and nation-building, hence gives a good reference for our young generations to follow suit, stay active and retire actively.

Now, I blame the social media on all the good viral food. Would you agree that everyone is eating— easily eating bad food. So, especially in schools. You see what they feed our kid? So, this is one thing that we should also remind ourselves and also our next of kin to stay active, jaga diri, jaga makan, *so less demand in medical assistance and sort of that. So, with that I hope everyone would cooperate and work together in ensuring our socioeconomics in medical treatment and also*

insurance will be given a proper attention. So, I really hope to the leaders up there, you help us. This is a cry for help for all pharma, medical, hospital, and insurance. Thank you so much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Puan Azealea. I can see that you are really* jaga makan juga ya. Silakan.

Encik Eugene Tan Kok Cheng [Prudential Insurance Malaysia]: *Good afternoon. I think about afternoon. So, I say good afternoon. My name is Eugene, I am an agent from Prudential. So, actually I have been in the business and for quite some time and still surviving. So, a few things that in read from the media and a newspaper, I guess the only thing that they missed out is education. They should imply more as financial planning to the youngster, young generation, what is insurance about. Is insurance a commitment or what? Actually to us insurance is a contract. So, why— based on contract, what are the insurance company should provide?*

What things you should do to preserve your benefit is like the waiting period, contestability period, the medical card coverage and what should you do when got hospitalise and what should you do before you leave the hospital? So, all these are the small things are we train the young one from of they are young. That's why we see our seniors here they are making noise saying that not doing renewal for you all things like that because it based on contract. So, not everything can be renewed as per what our hearts want.

So, second thing about medical inflation. Actually, a few days ago I met up with a doctor because my client got admitted. I was being informed by the doctor that he's not very happy because some insurance company is pressing them or controlling them in terms of the type of medicine that can be used. So, this is affecting the recovery stage of the client. So, I need the— I hope the authority will take note about this thing. You hendak *control cost* boleh tetapi buat cara yang betullah. Janganlah masuk hospital asyik makan ubat, tidak baik. *On the doctors, I feel you all. I checked back the claim documents. The charges* cuma 80 sampai 120 sahaja. *So, you guys are not charging a lot. Doctors are not to be blamed here.*

Another thing finally is your medicine cost. I don't know whether that the medical is being imposed tax or not. If it's being imposed tax, I do hope that kastam *or* kementerian, *whatever* kementerian, *please make medical products to be tax free so that when you tax free, the cost reaching us as an end user because even I am an agent, I also policy holder. So, I won't* kena caj *kaw-kaw here. So, that's all from me. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you sir, thank you sir.* Ya, silakan.

Puan Parimalar Nesamany [Ejen AIA Bhd]: Salam Malaysia Madani tuan. YB-YB, *thank you for this opportunity. A lot I have learned from here from all the speakers, thank you. My name is Parimalar. I am an insurance practitioner for over three decades. So, during the first decade what I've experienced is medical insurance premiums go up due to age, due to age. There was no medical repricing. But along the way especially like most of them shared here from the 2016 onwards and especially after the pandemic, the medical insurance premium has been going up very much between 30 to 40 percent.*

The reason I am here today is because I would like to plead to all the stakeholders. There's a lot of blame game going on here. So, whether it's the medical insurance companies or whether it's Bank Negara or Ministry of Health or Ministry of Finance or pharmaceutical companies, private hospital practitioners, please, we are in a very serious situation now. We take Malaysians— we are categorised into three financial categories, B40; M40; and T20.

So, what happens to B40? B40 because of their income bracket, they are given a lot of benefits in the public hospitals free. They have a lot of freebies because they are entitled to it.

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The T20, they can afford it. So, I'm now focusing on that M40. The M40 especially after the pandemic, we have been really [Tidak jelas] in between. You see, some would be remaining in M40, some a small amount would move to T20 but with a lot of things going around us, especially with the medical insurance premium hike, we are going to drop into B40.

So, there are going to be a lot of people queuing up in the public hospitals to be treated. Is the government prepared for that? Is our public hospital are or our public hospitals prepared for such a long queue there? We can't even manage the current situation now.

I'm one— very, the fear factor I've now is I keep on hearing this phrase. Oh, medical insurance is going to be only for the rich. I don't think the way the premiums are going up is not going to be affordable for the common man. This is a very, very serious situation.

So, all the stakeholders I pleaded to you, come together and put the premium on hike because I've been a proud practitioner of doing claims all my life and you know a lot of people who couldn't afford decent and immediate healthcare were able to get it because of medical insurance. Today, we are losing sight. So, I pleaded to all the stakeholders.

Thank you YB, for this opportunity.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Puan Parimala. Now this is the exact spirit. We are coming here to solve the problem. It is not to blame anyone* ya. Okey, silakan.

Encik Ethan Teh Eng Teck [Association of Financial Advisor Malaysia]: *Okay, just in time for good morning. I'm Teh Eng Teck from Association of Financial Advisor Malaysia or* Persatuan Penasihat Kewangan Malaysia. *So,* saya balik ke Parlimen Malaysia.

Okey, soalan pertama saya adalah satu soalan kerana pengalaman saya sendiri pada tahun lepas bila mak saya dimasukkan— untuk menjalani pembedahan di Hospital Sungai Buloh. Apabila discaj, bil yang ditunjukkan, ia adalah kos sebenar. Kemudian, selepas subsidi kerajaan.

Okey, soalan saya ialah kos sebenar yang ditunjukkan, kalau dibandingkan dengan hospital swasta, hospital swasta adalah 15 kali ganda lebih tinggi. Itu adalah kos sebelum subsidi kerajaan. *So* apakah KKM boleh lakukan untuk membantu harga di *private hospital?* Sebab ada saya tanya dengan kawan, kawan kata mungkin sebab *bulk purchase* daripada kerajaan lebih besar. *So,* mungkin kos dia akan lebih rendah. Itu saya bukan pakar.

Kedua, ramai yang sudah mengutarakan perkara ini yang membimbangkan di mana warga emas semua kata nak *let go,* lepaskan insurans. Masa itu akan melumpuhkan pusat kesihatan awam. *So,* seperti yang dinyatakan tadi, *so* mungkin lihat kembali kepada pelepasan cukai kepada anak yang membayar untuk ibu bapa dan amaun yang— had yang ada sekarang RM3,000 untuk satu keluarga. Tanpa kenaikan kos insurans pada hari ini, RM3,000 untuk satu orang saya sendiri pun sudah tidak cukup. Dengan isteri, anak dengan ibu bapa memang tidak munasabah lagi.

Ketiga ialah ramai juga menyatakan mungkin pada zaman sekarang IT, celik kewangan tapi agak membimbangkan saya sebab daripada apa yang saya dengar tadi daripada pemegang-pemegang polisi, ramai yang tidak betul-betul faham dengan insurans. *So,* ini adalah satu penyelesaian jangka panjang yang di mana perancangan pengurusan kewangan diri perlu diterapkan di dalam sistem pembelajaran kita secara formal. Ramai yang masih tidak faham apa yang tengah berlaku.

Akhir sekali, berkaitan terus dengan apa yang berlaku sekarang. Saya rasa langkah interim yang dicadangkan, ia ditafsirkan secara berlainan oleh *insurance company* yang berlainan. Setiap *company* ada tafsiran dia sendiri berpandukan *guidelines* yang diberikan. Sebab kita berurusan dengan semua *insurance companies, so* ada yang cara yang jawapan yang kita dapat tidak sama dengan

jawapan yang kita dapat daripada *insurance companies* yang berlainan. *So,* mungkin satu perkara ini perlu diseragamkanlah. Itu sahaja. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Encik Teh kerana input yang bagus. Ya, silakan.

Encik Wong Chun Wai: Salam sejahtera, selamat tengah hari. *My name is Wong Chun Wai,* pesara baru, 62 tahun dari Shah Alam.

Hanya satu poin. Rayuan saya adalah *urgent point of action* untuk jawatankuasa yang menangani masalah ini. Ini kerana kalau dilihat carta ini, *[Sambil menunjukkan sekeping kertas]* premium saya dari tahun 2014 sehingga kini, ia dah naik 143 peratus. Maksudnya, saya bermula dengan lebih kurang RM420. Sekarang kalau saya membayar apa yang diminta oleh pihak insurans, setiap bulan RM1,160 bersamaan dengan lebih kurang RM14,000 setahun. Dengan itu, saya mengambil pilihan untuk mengekalkan premium yang sedia ada, RM580 satu bulan. Itu mengehadkan *benefit* kepada saya.

Nampak tak garis berwarna oren itu *[Sambil menunjukkan sekeping kertas]* menjunam? *Right,* menjunam. *Cantonese says "Hong ham mah". It is a red cliff, you know. So* boleh dilihat menjunam daripada 40 tahun *coverage* sehingga 80 tahun. Sekarang hanya 68 tahun.

Saya dimaklumkan pihak insurans, *"Oleh kerana Encik Wong mengekalkan premium pada RM580, maka adequacy itu hanyalah sehingga 68 tahun".* Jadi bagi golongan seperti saya yang merancang untuk *retirement* kita kan, dah fikir 10 tahun kita beli insurans, sekarang senang-lenang. Kalau *back to inflation* pun kita boleh *afford* kan? Tapi kalau macam ini, kalau saya bayar mengikut apa yang dicadangkan syarikat insurans sehingga ke akhir hayat saya pada 80 tahun, katakanlah, saya akan membayar RM310,000 kepada pihak insurans. Itu pun tak termasuk *interest* kan yang saya— premium yang saya bayar sebelum ini.

Jadi bagi golongan kami, YB, *urgent point of action* kepada kami yang akan *time out,* saya dah 62 tahun, premium saya pada tahap ini hanya boleh *last until* 68 tahun. Jadi hanya ada enam tahun lagi. Jadi, itu rayuan saya dan bukan untuk saya sahaja, saya rasa kalau kamu melihat laporan daripada data, ramai, mungkin berpuluh ribu seperti saya. Terima kasih. *[Tepuk]*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Encik Wong kerana memberi input yang bagus. Silakan.

Encik Woo Yew Seong: *Okay, good afternoon YBs. Another three minutes to 12.00 noon. So good afternoon.*

I'm a self-paying patient.

Tuan Sim Tze Tzin [Ahli PAC]: *What is your name, please?*

Encik Woo Yew Seong: *My name is Peter Woo,* daerah Segambut. *Now, what I want to share with you is my own personal experience recently and I've mind-boggling finding. My own experience tells me this, a self-paying patient like my case in a private hospital, I actually pay more than what the insurance company pay. That, of course, a lot of people are like "What? It cannot be true".*

To my knowledge— to everybody's general knowledge, an insurance company will always be paid, pay more than a self-paying. But my experience tells me that we are— let me illustrate a real case. I think you should listen to ya.

Okay, my son was diagnosed with acute appendicitis three weeks ago. Of course, then before that I enquired with the general surgeon, approximately how much would be the cost because it is acute which means you have to be operated on immediately. He told me, based on his experience, of all past cases, it should be about RM25,000. Of course, in my mind, that was pretty steep for an appendicitis operation, RM25,000. I was thinking more like maybe RM15,000, RM20,000 but because it is still urgent, I said "It is fine, let's go ahead and do it here".

But the general surgeon was kind. He told me if RM25,000 is something you cannot afford, I can write you a letter immediately and you can go to the government hospital and I think a lot of people are doing that. But that operation wouldn't happen today ya. *It might happen the next day or the day after. So anyway, I agreed to RM25,000. I said, "It is okay. I'm fine with RM25,000". Anyway, he stayed there for three nights. It is a normal laparoscopy appendicitis operation, no complications whatsoever.*

Now, prior to my son being discharged, the general surgeon was in my room, we were in the ward, so to speak in the room together with my son. Then their account assistant came in with the bill and guess how much for the bill. RM33,000. That is for three nights of appendicitis operation. Of course, I was shocked. Even the general surgeon himself was shocked. He said this cannot be RM33,000. So anyway, I told him, please do me a favour. Go through the list of six pages long, tell me whether these things are real or not. I don't understand you know medical things and all those stuff, long stuff things. He went through. The general surgeon was very good. He went through item by item. I think you should listen ya. *Item by item by item, he said this bill is in order. He says, "Anyway, fine". I say, "Fine, I will pay. If it is in order, I will pay". So, I paid the bill, right.*

So, the general surgeon said, "Fine. I'm going to have a meeting with the hotel management" – hotel management pula. *[Ketawa] Because the place is really like a hotel maybe, you know. Just kidding.*

■1200

You always think about three-night stays Three night stay, you know. So, anyway I going to have a meeting with a doctor of hospital management and I find out why. It should be about RM25,000. I saw the doctor again the next day. He told me I found out the reason why. Why is the RM33,000? Is because you are self-paying. Insurance people pay only RM25,000. I said wow.

Then, he told me this you know, "By the way, it is not complications. Standard operations," and the general surgeon was telling me, "I also cannot understand why self-paying is paying more than the insurance companies." Then, he said, "There is a patient just next to you just discharge today as well. She is paying. Everything is the same. She's paying RM26,000 but she's the insurance covered."

So, here is my questions to the PAC. I think I have the important questions for you to think about. How is it possible that the self-paying patient has to pay a huge premium of about 25 percent…

Tuan Sim Tze Tzin [Ahli PAC]: *You have about 30 seconds.*

Encik Woo Yew Seong: *…More than a medically insured patient at the private hospital, when common logic tells you otherwise? Two, how is it the insurance companies with the annual corporate profits deemed to have a less abilities to pay then a self-paying patient? Is it because the insurance companies have the bargaining power? Was self-paying patients like me has no negotiations power?*

Three, a self-paying patient paying more, is it prevalent pricing policy for private hospitals? Is it because they are trying to get profit maximised to meet the shareholders revenue targets and is this fair on self-paying patients when there is no bargaining power?

Lastly, if medical doctors fees are regulated, how is it hospitalisation charges that cost much more than the doctors' fees are not subjected to some form of guidance or regulations? As a matter of fact, I just tell you how much is the cost in Mahkota Cheras Hospital. They published it.

On the website they can go for Mahkota Hospital Melaka. It tells you the cost of the same operations. 25 percentiles. That means the lower 25 percent, they pay RM10,250. 15 percentiles, they pay RM11,010. 75 percentiles, they pay RM13,400 but I paid RM33,000. Less resident discount of RM800. So, there was RM32,000.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.*

Encik Woo Yew Seong: *So, this much for you PAC.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much Mr. Peter Woo for your real-life story. Yes. Thank you.*

Encik Woo Yew Seong: *I want to leave a letter for you to subset what I am saying.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.* Silakan.

Encik Muhammad Sha'ani bin Abdullah [SUSDEN Malaysia]: Salam sejahtera. Syabas Yang Berhormat dan Jawatankuasa Kira-kira Wang Negara kerana mengadakan sesi pendengaran awam ini. Saya Muhammad Sha'ani Abdullah, Merdeka *boy*. 68 tahun dah. Tak ada insurans tetapi saya sejak MCE terlibat dalam NGO. Bila mula kerja, saya dah aktif dalam NGO, *permanent* 40 tahun. Terlibat dalam pelbagai majlis jawatankuasa untuk advokasi dasar awam.

Bagaimanapun cara dan corak libat urus dasar awam dan penggubalan undang-undang harus diperbaiki. Bukan sekadar *tick the box event. So, then* saya cuba cari peluang nak jumpa YB-YB. *I mean* semalam ada orang muda itu sindir sayalah. Itu menjadi satu yang mencabar. Apa keberhasilan tindakan kita? Saya tak percaya ini kita bersara-bersara ini. Selama kita bernafas, kita mesti menjadi Yang Berhormat, yang berkhidmat.

Okey, tentang isu Skim Pembiayaan Perkhidmatan Kesihatan telah mula dibincangkan oleh Kementerian Kesihatan lebih 20 tahun dahulu. Saya terlibat ya. Dua minit *already*. Cadangan sekadar menangani isu premium insurans kesihatan tidak akan mengatasi masalah. Mesti ada satu skim pembiayaan kesihatan nasional untuk mengimbangi atau pun satu saingan kepada insurans kesihatan swasta. Barulah tindakan-tindakan pesaing itu akan memberi kesan yang adil kepada pengguna.

So, maka cadangan satu adalah penubuhan skim insurans kesihatan sosial nasional. Mekanisme pembiayaan, kerajaan perlu menubuhkan skim insurans kesihatan nasional yang mewajibkan sumbangan berasaskan pendapatan dengan subsidi untuk golongan berpendapatan rendah. Perincian rawatan dan harga skim harus memperincikan semua jenis rawatan dengan menetapkan harga yang telus dan memastikan perkiraan premium yang adil.

Dengan adanya skim ini, ini akan mewajarkan pihak swasta dan juga hospital swasta telus dengan perkadaran harga rawatan. Kawal selia ini. Persaingan harus digunakan untuk kawal selia kualiti dan juga harga yang dikenakan. Selanjutnya, perkara kos sara hidup ini harus berkaitan dengan dasar-dasar seperti gaji wajar dan juga rasionalisasi subsidi yang dilaksanakan.

So, ini harus ditangani secara keseluruhan daripada menangani satu-satu aspek yang menjadi beban kepada sara hidup rakyat Malaysia. Sekian, terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Encik Sha'ani. Okey, sekarang 12.06 tengah hari. Kita akan— kalau saya kiralah *we will finish about* 12.25 tengah hari *or something like that. So, after that we will wrap up a bit*. Saya cakap sedikit

and YB Teresa Kok sebagai Timbalan akan cakap sedikit *then we will wrap up*. 12.30 tengah hari, *we will have a little bit of press conference over there.*

Then, kalau ada sesiapa yang ingin masih nak jumpa dengan kami, masih. *I will stay until* 1.00 tengah hari. *You can continue to engage us*. Okey, silakan.

Seorang Ahli: *Can we ask the Yang Berhormat to pay attention because the people came all the way but you all are on the phone. So, I just want to... [Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *We are recording. We are* mencatat. *We write everything in here. We are not watching the phone. Don't worry. Taking notes. Taking notes okay, yes.*

Puan Alifah binti Zainuddin [CodeBlue]: *Hi YB. I am Alifah. Journalist from Health news site CodeBlue.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry again*?

Puan Alifah binti Zainuddin: Alifah *from*…

Tuan Sim Tze Tzin [Ahli PAC]: Alifah.

Puan Alifah binti Zainuddin: *Health news site, CodeBlue YB. I just have one question of point which I hope you can respond to or discuss in the closed-door meeting. CodeBlue reported yesterday that AIA— and I am sure other insurance companies are also doing this, is seeking to limit coverage for advanced tests and pushing its panel hospitals to switch from innovator drugs to generics. I know there has been a lot of advocacies today to move from innovator to generic drugs. But it is important to note that not all branded drugs have generic equivalents.*

For example, certain subtypes of breast cancer— I think Prof. Aishah can vouch for this. You can only access these branded drugs with private insurance at private hospitals. So, perhaps PAC can suggest regulations to only allow this shift from innovator to generics for drugs that only have equivalents and not a blanket no-innovator-drugs policy. Thanks.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much Alifah. I think just a quick response. Maybe it's not proper for us to respond now because we are in the proceeding. So, we have to be neutral and above board*-lah ya. Okey, silakan.

Encik Andrew Tan Eng Jon [Balai Ikhtisas Malaysia]: *I am Andrew Tan, [Tidak jelas] Pharmacy. One is I want to emphasise on the primary care setting. It is very important in Malaysia. Primary care setting such as GP clinic and now community pharmacies. So, here I would like to suggest that individual medical card can be extended to GP when you visit GP or we go to the community pharmacy. All this we can help the patient to save cost.*

The other thing is whether the government under the Madani Government can help to subsidise the B40 and M40 in terms of the insurance. Just now my president from Malaysian Pharmacy Society, he mentioned about the national health insurance scheme.

So, whether it's time for Malaysia to transform the national healthcare system to have this national health insurance scheme. So that everybody includes the baby when you are born, you enjoy the insurance until you age. The other thing is car maintenance. We have NCD right?

■1210

Okay, so whether our dear colleague insurance here whether can you give medical insurance to all the people with these NCD also? Hence, the other point is prevention is better than cure. So, I think it's time for government to encourage people to go into healthy to achieve fitness and healthy.

So, I think committee pharmacy as a primary care provider can provide this service to all the people in Malaysia to achieve a healthy society and community. So, thank you. [Tepuk]

Tuan Sim Tze Tzin [Bayan Baru]: *Thank you Andrew for your feedback.* Sila.

Encik Lim Jaan Huei: *Afternoon YB and ladies and gentlemen. I just want to share my real case for my father…*

Tuan Sim Tze Tzin [Bayan Baru]: *What's your name, what's your name?*

Encik Lim Jaan Huei: *Oh, sorry. My name is Lim Jaan Huei. The real case of my father. Okey last year, his medical insurance premium, he's 71 last year, 72 this year. Last year his medical insurance premium is RM15,583. It's not a fancy product, not very high limit, okay. Nothing change for the past 22 years since his buying this insurance and we check back the archive document and we found that in the policy schedule back in 2011 when Tokio Marine acquired Asia Life, they revised the insurance premium, the premium schedule. The premium for the same age band okay for age 71 band to 75 is only RM5,026.00.*

What I wanted to point out here, I don't see this RM5,000 to RM15,000 in 13 years time is true reflection of inflation. More or less is due to their marketing strategy or— also to remind that the PAC and Bank Negara, in year 2000 onwards, there is a lot of merger and acquisitions take place in this country. We have a lot of small incorporated insurance now become I would say 100 percent of them become MNC company. So, what if that time, pricing was wrong?

They are aggressively for the marketing and place the premium very low to attract the customer and today 20 years later they come and punish the customer by

changing the pricing from RM5,000 to RM15,000. I seriously don't think that is a right way of doing things. So, and if that the pool of their fund or their premium is inadequate, they should be applied for their new policyholder rather than the existing policyholder.

I also want to highlight over here that life insurance policy is a long-term commitment to all of us and especially for my father, I think his intention is for the purpose of mitigate the financial planning comes to this age instead of now become a burden to the family members who need to bon RM15,000 for the premium for him. That is not a true intention. Thank you very much. [Tepuk]

Tuan Sim Tze Tzin [Bayan Baru]: *Thank you Mr Lim for your input.* Silakan.

Encik Nathar Shah: *Assalamualaikum and morning. My name is Shah. So, I'm an academic, so thank you for having this session. I think we need another session like this for scam issues, another mess we're having in this country. Ya, PAC take care of that. Okey, first point I have is one is that for insurance buying, we have to— we cannot buy it through online, only for the small coverage we can do it. For bigger coverage, we cannot buy it from online.*

Point number two, why are we not having staggered consultation fees based on experience, doctors' experience. Lot of doctors, junior doctors are leaving their hospitals to set up their own clinics with no experience and the poors, they will be benefitting if they have staggered fees based on that experience.

Third point, why are we not consolidating the consultation fees and procedures fees? For example recently I had [Tidak jelas]. It's just a small touch-up at my eye. The doctor charged me for consultation and also for procedure, it comes to hundreds and I have to do it several rounds. So, we should actually put consolidate as one.

Then, point number four, why are we not giving a given what we call rebate for good lifestyle in insurance? Why don't we make it mandatory?

Point number five, why are we not taxing heavily those profiteering hospitals and insurance companies and put back the money back to the premium of the poors?

Point number six, why not we are making it mandatory to have prescription and then all the doctors must give prescription and then we can have competition in the medicine pricing?

Point number seven, why are we not having quota for not-for-profit hospital, normal hospital and health tourism hospital? We should maximize the quota for the not-for-profit hospitals and then those health tourism hospitals, we need to put into bidding, ask them to pay more and government get more money.

Point number eight, we need to have public rating for clinic and hospital as part of self-regulation. Just like we buy products online, we can give comment and rating so that we can make wise decision.

Point number six, why are we not limiting the junk foods? Why is it so widely? We need to limit this, we need to make the restaurants to sell healthy foods. We need to tackle the obesity problem. Thank you. [Tepuk]

Tuan Sim Tze Tzin [Bayan Baru]: *Thank you, Encik Shah for your input.* Silakan.

Encik Lim Jack Shen [Persatuan Farmasi Malaysia]: *Hi, I'm Jackson Lim from— I'm a pharmacist, I'm the General Secretary of the Malaysian Pharmacist Society but I'm speaking as a pharmacist and also as the constituent of the weirdest shape constituency in Malaysia which is Damansara.*

Okay, so, I just want to highlight three points. First of which is the we have been talking about hospitals the whole day. So, such a centered hospital, hospital-centered care system that we have in Malaysia and like what my colleagues from pharmacy as well as the medicine have said, we need to have a stronger primary care system. We need to have inter-operability, we need to be able let patients move from one to another, from primary care to private hospital to public hospital back to primary care. Then, we can have a specialization, we can have better use of resources. Because right now we have a dual system and it does make it very hard to move within systems and that's something we need to address and one of the ways to do so I think was mentioned a few times already, it's the national health insurance system. This is where we can move patients from A to B and so on and so forth.

To date also insurance do not cover services in pharmacies. They are limited coverage with GP as well and that's something we need to address as well so that we can actually allow primary care to take the precedence instead of my mum saying I got the card, I need to go to the hospital and see a specialist. I should go to GP and have a proper referral system that refers from the GP straight to the correct specialization. So, it's the infrastructure that we need to look at and that is actually one the big problems.

The second one is actually to include more pharmacies and GP-less services in health coverage like chronic disease management, vaccination services in company pharmacies like recent MYSejahtera, coverage from influenza vaccine is great for the seniors but we need cover younger adult as well because the other one travelling and the other one passing the disease back to the seniors at home that do not have the vaccine. So, these are things that we need to look at and people are

actually dying from influenza and other diseases, younger and younger as the case of very famous Thai [Tidak jelas] actress lately.

Also point-of-care testing. We are also urging the government to consider we can have claims and allow tax relief for digital items. We need to expand it to other things like point-of-care testing— for allow tax relief for point-of-care testing at home and also all the services that are related to that as well.

On top of that, prescriptions. I also want to urge the government to consider that our consumers will get prescriptions, so they actually understand the medication they take and be able to actually look into what they are taking, so they are sure. Last but not least although I'm not the right person to… [Tidak jelas] I'm very well rounded, we need to put more into prevention NCD, things like the root cause. I'm really enjoy the teh tarik this morning but I really shouldn't have it, just to want to highlight that point.

So, lastly just to conclude, we need to address the root cause or not we will be here 10 years time talking about the next increase in premium, the next increase of hospital charges. Ya, thank you very much. [Tepuk]

Tuan Sim Tze Tzin [Bayan Baru]: *Thank you Jackson and don't drink teh tarik anymore ya.* Okey, silakan.

Encik Woon Yu Cheng: Pertama sekali, salam sejahtera kepada PAC. Selamat tengah hari dan Yang Berhormat dan para hadirin. Saya datang hari ini sebab tercetus insurans premium yang meningkat mendadak.

Tuan Sim Tze Tzin [Bayan Baru]: Nama?

Encik Woon Yu Cheng: Woon.

Tuan Sim Tze Tzin [Bayan Baru]: Woon.

Encik Woon Yu Cheng: Meningkat mendadak di mana saya bandingkan data yang 10 tahun dengan yang berlaku kepada saya, jadi saya ambil *average* pada lima tahun yang baru ini, tercetusnya kenaikan pada tahun 2020 di mana nilai yang saya dicaj kepada saya adalah lebih RM500. Tahun yang kedua pada 2021, ia meningkat kepada RM809 okey. Jadi, saya pun buat kompelin kepada syarikat insurans di mana tahun yang ketiga, ia masih naik lagi. Pada tahun 2022, RM1,001.

■1220

Tahun keempat, dia tidak naik di mana saya buat kompelin terhadap *insurance company* dengan ejen tetapi yang malangnya, kontrak yang kita sain dengan syarikat insurans, dia telah bagi tahu kepada kita orang, masa kita sain, kenaikan atau penilaian yang akan dibuat setiap empat hingga lima tahun. Tetapi disebabkan COVID-19 yang melanda, dia bagi tahu saya, kontraknya telah dibatal dan mereka mempunyai hak untuk membuat kenaikan. Ingat?

Tuan Sim Tze Tzin [Ahli PAC]: Dia batalkan you punya kontrak? Dia batalkan?

Encik Woon Yu Cheng: Dibatalkan. *Alright.* Jadi pada tahun 2024, dia naik lagi, RM1,203 dan pada hari ini, sebelum dua minggu yang lepas, mereka menulis kepada saya melalui portal bahawa mengikut *interim measure* Bank Negara, nama Bank Negara dipetik, di mana dia kata dia akan naik polisi saya pada 1 Mac sebanyak RM1,469.

Tuan Sim Tze Tzin [Ahli PAC]: Berapa peratus?

Encik Woon Yu Cheng: Kalau banding dalam lima tahun, lebih kurang 300 *percent*.

Tuan Sim Tze Tzin [Ahli PAC]: Tak, tak. Berbanding tahun lepas.

Encik Woon Yu Cheng: Tahun lepas, RM1,203 di mana sebanyak lebih kurang 18 hingga 19 persen dia naik. Yang itu hak dia, dia kata. Jadi masalahnya sekarang, kalau saya tengok daripada sana, *alignment* di antara bank dengan insurans, tak bersama. Mengatakan bahawa 10 persen tetapi saya terima 19 persen. Itu saya seorang. Ahli keluarga saya ada lima orang, semua kena. Okey? Jadi, satu sebab yang saya tertanya-tanya dah lama dah sebab saya keluar hospital, masuk hospital sebab ramai juga keluarga.

Jadi, apabila saya nak jawab soalan di sini, caj hospital— ini berlaku yang sebenar, kes benar. Ini fakta.

Tuan Sim Tze Tzin [Ahli PAC]: Ya, dalam satu minit ya.

Encik Woon Yu Cheng: Fakta daripada satu hospital A swasta dengan hospital B swasta, bandingan harga yang saya buat semakan adalah beza dengan 100 persen. Maksudnya, RM24,000 daripada hospital swasta A kepada hospital swasta B, RM12,000. Kenapa? Apabila saya tanya balik sebab banyak perkara yang berlaku di mana mungkin caj-caj tertentu, mungkin doktor atau pakar-pakar yang lebih pandai *present, colorful presentation.* Mungkin bezanya harga daripada sana. Jadi, apabila kita tengok benda ini, macam mana kita hendak selesai? Sebab ini impak bukan daripada satu kawasan, daripada seseorang tetapi kesemua industri ini terlibat. Jadi, mereka mempunyai hak untuk batalkan kontrak yang dahulu dan naik dengan harga premium yang dia orang berasa betul. Itu masalah yang kita terima sekarang. *[Tepuk].*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih.

Encik Woon Yu Cheng: Okey, baik.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Mr. Woon.

Encik Woon Yu Cheng: Okey, *thank you Mr. Sim.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, silakan.

Puan Harpreet Kaur a/p Darshan Singh [Persatuan Farmasi Malaysia]: *Hi, good afternoon. My name is Harpreet, I'm from the Malaysia Pharmacist Society. First, I would like to put out a question which I hope is answered maybe in the minutes or in another way. For the national health insurance system, what is the plan and how will the financing be done? So that is my question. There is one proposal which is if you look at* peningkatan bayaran premium insurans dan caj hospital swasta, *the main impact to* kesihatan awam *is of course congestion because people may not be able to afford so they will prefer to go back to government and if you have a congestion there, you are going to end up having the similar problem which is shortage of staff and everything just escalate and snowballs.*

So, we would like to suggest the current team, you know, get together with the Ministry of Human Resource and put in a consideration that for primary care, for minor ailments, a pharmacist note can be used by HR. If that is possible to be done, it would actually already reduce the burden of cost on many of those who are in the category where they need to get a MC either from government hospital or they need to get a MC from a GP. Because minor ailments actually most of the times, they can just recover at homes.

Finally, a comment. Doctor's fees have not been changed over I think what, 20 years and community pharmacist don't even charge any fees to see them. So, it is very curious that insurance premium rates keep on going up and are not regulated. I think this is something that everybody has to take note of that the private primary sector are actually not been remunerated in the way that they should be but insurance premiums keep going up. Thank you, that's all. [Tepuk].

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you very much. Yes. Next.*

Encik Wooi Yu Thong [PRULIA]: *I'm Wooi Yu Thong, President of Prudential Life Insurance Association. My college just now has already address some of the point for government and also private hospital. I'm just to add on one more point on this insurance.*

The medical repricing happened. The reason given is the cost is more than the expectation. So, it's fine for one. This is business rule. It's fine for company insurance to make certain profit to retain the profit for the product sustainable. However, the cost, the claim has up and down. One factor they forgot to put in was the previous years where has lesser claim which contributed more profit to the company. So, to be fair, we are proposing to have actually a clear mechanism where a method of average profitability hitting threshold must be applied. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Mr. Wooi. Okay, you are the last man standing. Let's give everyone a big applause* ya*. Okay.*

Encik Tan Keng Beng: *Thank you very much YB. – YB.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yes.*

Encik Tan Keng Beng: *I want to thank the frontliners especially doctors and nurses who working in all the government hospital.*

Tuan Sim Tze Tzin [Ahli PAC]: *What's your name? What's your name?*

Encik Tan Keng Beng: *I'm Leonard Tan. I'm a general practitioner insurance agent for 35 years. I have seen a lot of claims and talk to a lot of claims manager and recently I just brought, I'm going to submit these two documents for you. One is the same sickness of one person and then the other person who went to KKM in Shah Alam and then another person who went to private hospital in Petaling Jaya, one of the famous hospitals.*

Their fees on the private hospital cost RM85,000 for a bacterial meningitis but in KKM, it only states there RM15,000. There is 500 percent increase. Why there is big margin between the private hospital and the government hospital? You take away RM6,000 for his ward charges, the rest are all hospital charges that excessively charged. This is a document I surrender to you and you can read it. Of course, my friend you say, is above 55 years and he get a bigger discount. Okay? He only pays RM500. Okay?

So don't worry about going to a public hospital, I've been going in and out and helping customers, to facilitate them to go to KKM in any Shah Alam hospital or in town. Only one thing I have to say is please upgrade your facility. You know? Shah Alam hospital such a new public hospital but their MRI machine is out of order or something is wrong somewhere and this poor patient has to wait for their turn to either going to Klang or go to Sungai Buloh to have it done but what to do? If you want to go to private hospital, you pay for it. You don't have the medical insurance? So, you just have to wait and wait and wait.

So, these two bills are for the almost identical stay in the hospital. Alright? But one is RM75,000 and one is only RM15,000 but the government give us subsidies. Now, earlier on this morning, we heard of people and just now also asking the government to come out for the national health insurances program. If you compare to our Singapore, they had provided in MediShield Life. Okay? MediShield Life is governing by the Ministry of Health in Singapore and it is being regulated in Parliament. Definitely.

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And it is also is a basic health insurance scheme that protects all Singapore citizens and permanent residents against large medical bills regardless of age or health conditions. There you are you cannot get any cover from anywhere. You go to

MediShield Singapore. It is now, mandatory. Our government here tell us to go buy SOCSO. Yes, we buy SOSCO but they don't have this medical coverage if you are to be hospitalised for meningitis and for all those poorer, M40 groups, where do we go if you don't have a plan? We don't know where to go.

So, a national health policy is very matter for the long term okey. Collect the premium yes. It is a very low premium. It covers housewives at all and all your children and you be assured, you get the best and I also asked MOH, please do something for your specialists. Your specialists are all leaving your government hospitals, alright. Many all them have left and so certain of the government hospitals supposed to have these kinds of operations,, they can't do it, they all have to be centralised. Yes sir, very big concern. Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Mr Tan, thank you Mr Tan.*

Dr. Tan Ai Mooi: *Thank you. Last question one minute. Alright, I just one to go straight.*

Tuan Sim Tze Tzin [Ahli PAC]: *What's your name? What your name?*

Dr. Tan Ai Mooi: *Dr Tan Ai Mooi. I've been working for the government for the past 30 years as a government policy formulator researcher as well as we have— forwarded goal, I have engaged through with the Malaysia Education Blueprint, I Education Blueprint include a lot of policy feedback for the earlier governments including Anwar Ibrahim's government okey. But we are sad because a lot of things so much effort we may work for years, for months but once go up to the top, things whether it's executed, is always history repeated, that history repeat itself.*

Okey, now I'm going straight to the point very straight. Number one, as for I'm going to do this in three ways. Number one, what is my issue. Number two, challenges. Number three, what is the policy enforcement which we have a law in place emplace going to be executed or it has to be executed by the government, be the Bank Negara, be the MOH or together with YB Mr Sim here, how we facilitate the things to be done. Okey.

Number one, as for the teacher's industry. Alright they have this policy plan NUTP, National Union Teaching Profession that has worked with insurance companies beginning with the Great Eastern later on the Maybank, Etiqa and then finally, it's presently Prudential BSN Takaful. So, all these policies they have raised the premium that is fair enough under Maybank until the past two years taken over by Prudential. If their premium has raised already, let's say in the year 2023, more than 40 to 50, 40 percent in less 2,000 to almost 3,000 for the medical card for people who are in at the age of 64 and in this year, present year is 65. The premium raised again okey in such a short duration. The government has stated saying they can't

and for senior people, senior citizens, they have to restrict it gives a grace period of one year. The premium raised is from 2023 for RM100,000 medic card, RM300,330 premium raised to RM420,000, 28 percent and it's going to be commenced in April.

Let me finish. If we are serious and we are sincere or else let us forget all this talk. Okey, this is the first point and I think this has been raised by so many last illustrations here. Number two, as for hospitals, private hospitals they simply charged to that ridiculous amount, many illustration have been done. One thing may be just six cents, you charged RM1. I think there is kind of logic they are working on. I have a patient they have worked, that were engaged with the endoscopy and colonoscopy.

Could you believe that I did it three years ago, in two years ago, in Sunway was RM3,000 and presently RM6,000 insurance company also refuses to pay. I agree with that. We pay more than 10 percent and on top of that still charging even complain the bottom line does not take note and the upper management is up there. Ridiculous charges including registration RM50. Scan, report comes up, again in less RM100 range. Hospitalisation that ward I'm not warded or admitted and the nurse tacking care of me RM380, tut, tut, tut. That is from A to Z some of the illustrations, that is enough.

Number three, pharmacy drug charges A drug that costs RM222 for 30 tablets as charged in the hospital they are charging RM379. That is 67 percent. We understand the private pharmacy, we buy pharmacy, drugs from, we buy drugs from all these Caring or AA. They have a really charge to 30 to 50 percent extra and in other words are they charging 100 percent? That needs to be taken note and there have violated the law and it's a very clear cut.

Health care is it going to be a marketplace or is it to be a health care for all? I needed the government to address this issue during the talk.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you.*

Dr. Tan Ai Mooi: *Okey lastly. As for those the premium they have violated the law, right and how this policy enforcement going to enforce and how to us, as clients or Malaysians in general, how I'm going launch a complain? I don't think it's logic to complain. I am suggesting the government should take action and hold them back and do not ask them to call them up to discuess, negotiate. I think this a very flimsy and suggestion that without the mind. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you Dr Tan and sir, I will attend to you later okey because in the interest of everyone's style…*

Encik Koh Eng Huat: Bukan, bukan. Saya nak. Yang Berhormat, Yang Berhormat, saya hanya nak umum mengetahui ada persoalan yang saya nak, dua. Sebenar isu yang berbangkit dua. Satu ialah kenaikan premium, satu ialah caj

perubatan. Bermaksud dalam isu ini adakah jaminan sekiranya dikawal selia kos perubatan, premium tak naik? Itu soalan yang perlu dijawab.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih banyak.

Encik Koh Eng Huat: Dalam isu ini, Bank Negara tidak menjawab soalan saya. Jadi, kalau boleh PAC tolong. Soalan saya adalah berhubung dengan premium tidak dijamin yang dinyatakan ada dalam …

Tuan Sim Tze Tzin [Ahli PAC]: Nanti saya minta Bank Negara *officer approach* encik.

Encik Koh Eng Huat: Tak ada, dia sudah kasi sembilan keputusan.

Tuan Sim Tze Tzin [Ahli PAC]: Tak apa, nanti kita dengar…

Encik Koh Eng Huat: Dia cakap terma menindas sedangkan peranan dan kuasa kawal selia ialah untuk memastikan pembelaan sewajar kepada pengguna kewangan. *So*, macam mana tak ada garis panduan yang membolehkan kontrak meletakkan premium tak dijamin dan premium tak dijamin ini diletakkan bahagian manfaat?

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih.

Encik Koh Eng Huat: Nombor satu. Nombor dua, pihak …

[Pembesar suara dimatikan]

Tuan Sim Tze Tzin [Ahli PAC]: Okeylah. Minta maaf, minta maaf, minta maaf okey. Ya, okey. Kita kena rumuskan. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Nanti saya jumpa encik, nanti saya jumpa encik.

Encik Koh Eng Huat: *[Bercakap tanpa pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: Faham, faham, faham. Nanti kita jumpa *you*. Okey, sila. *Alright*, terima kasih kepada semua yang bertahan selama berjam-jam di sini. Okey, saya ingin mengumumkan di sini tadi kita ada rekod urus setia telah beritahu kepada kita bahawa seramai 578 telah daftar dan hadir pada pagi ini. Bagi satu tepukan kepada semua.

Kedua adalah seramai kalau saya ikut rekod saya 51 orang yang telah bercakap ya. Jadi, kita telah mendengar semua pandangan dan juga aduan dan juga semua cadangan daripada pelbagai sektor, pelbagai pihak.

This is what public hearing about ya. *We want to listen as wide as possible okey and then we are all here because we belong the same ecosystem. The ecosystem is called Malaysia, Malaysian. We are Malaysian, we are born, we will get old, we will get sick and we end up in the hospital someday, one way or another.*

Jadi, *it is important that the nation must come together to find a solution because of raising prices or medical health inflation and also medical charges in hospital insurance and also* ubat-ubatan.

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And then the doctors are not paid enough, they are leaving the service. There are also the doctor's fees have not increased for the past 15 years. There are a lot of challenges. That's why we have a public hearing to hear everyone's view. Today, we meet and we listen, we concluded the public hearing. For Monday onwards, we will have 10 very intensive, very long closed-door sessions with all the stakeholders including government officers and also government agencies. That's where we drew down to find good solutions for everyone.

This window is closing. We cannot wait too long to reform because the window of opportunity, the Bank Negara has set an interim for three years. It will start revising in 2026. If it opens up again, there's a cliff effect which if we don't find a solution these one or two years, the whole medical insurance cost will go up. We will have a disaster. That's why PAC is working frantically and very urgently tried to find a solution and engage with all the stakeholders.

Hopefully, we can conclude this proceeding in three months. We will submit our report in the next Parliament sitting which is in June. Hopefully, the government will then take up the reform, our laporan *and do the necessary reform and bring up all the bills, the regulations, the* akta *to be debated end of the year, if possible. We can pass the law either end of the year or next year, or early next year if everything goes to plan. So, this is where you are playing a very important role which is to keep pressure and speak up. Because we are all in together. If you want us to fight, you fight together with us. Okay? [Tepuk]*

We cannot fight without you. We want to go forward, we want to fight for this issue, we need public support and public engagement together.

Seorang Ahli: *It seems to be done. [Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *It has to be seen to be done. Today is the first step. Today is the very first beginning, the new beginning and we fight together.* Itu sahaja daripada saya. Sekian, terima kasih. *Xie xie. Nandri vanekkam. I give to YB Teresa to conclude.*

Puan Teresa Kok Suh Sim [Ahli PAC]: *I think I am not going to make a long speech. I just want to say that some of you have made really good points*. Boleh saya cadangkan supaya apa yang anda bentangkan dengan poin yang panjang lebar itu boleh bagi *black and white* e-mel kepada sekretariat *because your three hours here,*

just these ladies going to record every word that you say. But you know, if you want to give a more comprehensive one, just pass it to them in black and white. We hope that, like YB Sim said, we are going to do something hopefully can have an impact to bring some changes in the laws, in the policies. Thank you very much.

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you. We have—* sediakan *QR code. If you want to give your whatever email or whatever comment, you can continue to— You scan the QR code and fill in all your comments.* Itu sahaja. Sekian, terima kasih. *Xie xie. Nandri vanekkam.*

[Mesyuarat ditangguhkan pada pukul 12.43 tengah hari]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Isnin, 24 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Kementerian Kewangan (MOF)
Datuk Johan Mahmood Merican
Ketua Setiausaha Perbendaharaan

(ii) Bank Negara Malaysia
Dato' Seri Abdul Rasheed Ghaffour
Gabenor Bank Negara Malaysia

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

ISNIN, 24 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] *- Naib Pengerusi*
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]

Tidak Hadir *[Dengan Maaf]*
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] *- Pengerusi*
YB. Puan Vivian Wong Shir Yee [Sandakan]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Cik Jackie Mary Fernandis [Penasihat Undang-undang II, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Puan Rusnida binti Muhammad Radzi [Timbalan Pengarah]
Encik Amiruddin bin Abdul Karim [Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Encik Wong Yun Fui [Timbalan Pengarah]
Suzana Binti Alias [Ketua Cawangan]

HADIR BERSAMA

Kementerian Ekonomi (KE)
Che Kodir bin Baharum [Pengarah]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) (Bahagian Perkhidmatan Sosial)]
Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah Makro]

Jabatan Akauntan Negara (JANM)
Encik Shaleh bin Hussain [Akauntan]

SAKSI

Kementerian Kewangan (MoF)
Datuk Johan Mahmood Merican [Ketua Setiausaha Perbendaharaan]
Encik Abdillah bin Azizudin [Ketua Penolong Setiausaha [KSID(P)1 (Bahagian Pelaburan Strategik)]
En. Muhammad Fitry bin Hussin [Penolong Setiausaha (Bahagian Pelaburan Strategik)]
Mohd Saiful Sungkih bin Abdullah [Timbalan Setiausaha (Bahagian Pelaburan Strategik)
Cik Shairah binti Dzul Khair [PTTK kepada YBM MK II [Pejabat Menteri Kewangan II]

Bank Negara Malaysia
Dato' Seri Abdul Rasheed Ghaffour [Gabenor Bank Negara Malaysia]
Datuk Jessica Chew Cheng Lian [Timbalan Gabenor]
Aznan Abdul Aziz [Penolong Gabenor]
Suhaimi Ali [Penolong Gabenor]
Madelena Mohamed [Penolong Gabenor]
Lau Chin Ching [Pengarah (Jabatan Pembangunan Dan Inovasi Kewangan)]
Ang Jian Wei [Timbalan Pengarah (Jabatan Komunikasi Strategik)]
Surannit Chit [Timbalan Pengarah (Jabatan Pembangunan Dan Inovasi Kewangan)]
Hoo Hon Shiong [Pengarah (Jabatan Penyeliaan Insurans Dan Takaful)]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

ISNIN, 24 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 11.30 pagi

[Yang Berhormat Puan Teresa Kok Suh Sim
mempengerusikan Mesyuarat]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Salam sejahtera, selamat pagi dan selamat datang saya ucapkan kepada Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas, ahli-ahli ex officio PAC yang terdiri dari Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, Suruhanjaya Pencegahan Rasuah Malaysia, Kementerian Ekonomi, Jabatan Akauntan Negara dan Penasihat Undang-undang Parlimen selaku wakil Jabatan Peguam Negara (AGC).

Yang Berhormat ahli-ahli mesyuarat sekalian, hari ini PAC Parlimen akan memulakan prosiding peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam di bawah Kementerian Kewangan (MoF), Kementerian Kesihatan (KKM) dan Bank Negara Malaysia (BNM). Seperti mana semua sedia maklum, tajuk ini tidak dilaporkan dalam Laporan Ketua Audit Negara.

Sehubungan dengan itu, PAC menggunakan punca kuasa seperti berikut.

(i) Peraturan Mesyuarat 77(1)(d) Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat;

(ii) PM Peraturan Mesyuarat 83(2);

(iii) Arahan Perbendaharaan 12 dan 300(1) 2023; dan

(iv) seksyen 5(3)(d) Pekeliling Am No.1 Tahun 2024 Organisasi Kementerian-kementerian, Jabatan Perdana Menteri.

Prosiding ini diadakan bagi tujuan mendapatkan penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan caj hospital swasta. Ini termasuk kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan faktor luar seperti pandemik.

Untuk makluman semua, PAC telah pun mengadakan dua sesi pendengaran awam berkaitan isu ini iaitu sesi satu, di Pulau Pinang pada tarikh 14 Februari 2025,

Jumaat, daripada 9 pagi hingga 12 tengah hari di Hotel AC Marriott, Pulau Pinang. Sesi kedua di Kuala Lumpur pada tarikh 21 Februari 2025, Jumaat dari 9 pagi hingga 12 tengah hari di Dewan Bankuet, Blok Utama, Bangunan Parlimen Malaysia.

Sesi pendengaran ini, telah mendapat sambutan yang amat menggalakkan di kalangan agensi, syarikat, pertubuhan dan individu dengan jumlah penyertaan melebihi 700 orang. PAC berpendapat bahawa terdapat keperluan untuk mengadakan sesi pendengaran awam berhubung ini bagi mendapatkan pandangan dan maklum balas daripada orang awam serta kesan daripada isu yang berbangkit khususnya kepada rakyat sebelum prosiding diadakan.

Melalui kedua-dua sesi ini, PAC telah mendengar dan mendapatkan pelbagai maklum balas, pandangan dan cadangan telah diperoleh khususnya daripada orang awam berkaitan isu yang telah dibangkitkan. Yang Berhormat, ahli-ahli mesyuarat sekalian, hadir bagi memberi penjelasan di hadapan PAC dalam prosiding pada hari ini ialah Yang Berbahagia Datuk Johan Mahmood Merican, Ketua Setiausaha Perbendaharaan; dan Yang Berbahagia Dato' Seri Abdul Rasheed Ghaffour, Gabenor Bank Negara Malaysia (BNM); dan Yang Berbahagia Datuk Jessica Chew Cheng Lian, Timbalan Gabenor (BNM).

Terima kasih saya dan PAC ucapkan kepada semua saksi kerana sudi hadir di hadapan jawatankuasa ini bagi memberikan penjelasan pada hari ini. Sebelum saya menjemput saksi untuk memulakan pembentangan dan memberikan penjelasan, ingin saya maklumkan kepada semua ahli mesyuarat sekalian bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 [*Akta 88*] dan Peraturan Mesyuarat 85, Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat (PPMMDR) sehingga prosiding selesai dan laporan dibentangkan di Dewan Rakyat.

Tanpa membuang masa, saya mempersilakan Yang Berbahagia Datuk Johan untuk memulakan pembentangan. Sebelum itu, saya ingin minta ahli-ahli mesyuarat pada hari ini biarlah kita dengar keseluruhan pembentangan daripada saksi selepas itu baru kita keluarkan soalan. Sekian, terima kasih.

Datuk Johan Mahmood Merican [Ketua Setiausaha Perbendaharaan (MoF)]: Terima kasih YB Pengerusi. *Bismillahi rahmani rahim. Assalamualaikum warahmatullahi wabarakatuh*. Salam sejahtera dan salam Malaysia Madani. Yang Berhormat Puan Teresa Kok, Naib Pengerusi PAC selaku Pengerusi PAC pada hari ini; Yang Berhormat-Yang Berhormat Ahli PAC, Dato' Seri Abdul Rasheed Ghaffour, Gabenor Bank Negara; Datuk Jessica Chew, Timbalan Gabenor Bank Negara; rakan-rakan daripada kementerian ahli ex officio PAC.

Pertama sekali, ingin saya mengucapkan terima kasih kepada pihak PAC kerana memberi peluang kepada kami daripada Kementerian Kewangan dan Bank

Negara Malaysia untuk tampil memberikan penjelasan berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam.

Seperti mana sedia maklum, sememangnya industri insurans dan takaful merupakan di bawah seliaan Bank Negara Malaysia. Namun demikian, seperti mana pun YB Pengerusi mesyuarat telah maklumkan isu berhubung dengan insurans kesihatan dia saling berkaitan dengan banyak faktor yang menyumbang kepada tahap premium kesihatan. Ia mengambil kira antaranya ialah seperti mana yang disebut daripada segi demografi yang dari segi peningkatan *non-communicable diseases* yang juga berkaitan dengan trend penuaan *or ageing population* di Malaysia. Ia juga berkaitan dengan inflasi yang berkaitan dengan harga ubatan, harga teknologi perubatan yang kian meningkat.

Ia juga berkaitan dengan inflasi secara umumnyalah*. So,* dengan itu pelbagai faktor menyumbang kepada isu yang dihadapi berhubung dengan kos insurans kesihatan yang dihadapi rakyat. Namun demikian, dari kerajaan, pihak Kementerian Kewangan bersama dengan Bank Negara Malaysia telah bersama dengan Kementerian Kesihatan dah mula kerjasama untuk merangka pelan tindakan bagi menangani isu peningkatan premium insurans dan takaful. Beberapa langkah jangka pendek telah diumumkan dan terdapat perancangan dengan beberapa cadangan juga dalam jangka masa sederhana dan panjang untuk menangani isu tersebutlah.

So dengan itu untuk memberi perinciannya, saya ingin menjemput Yang Berbahagia Dato' Seri Abdul Rasheed sebagai Gabenor untuk membuat pembentangan. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [Gabenor Bank Negara Malaysia (BNM)]: *Bismillahi rahmani rahim*. Terima kasih Datuk KSP. Yang Berhormat Puan Teresa Kok, Timbalan Pengerusi PAC Parlimen selaku Pengerusi Mesyuarat PAC pada sesi ini; Yang Berhormat-Yang Berhormat Ahli PAC Parlimen, Yang Berbahagia Datuk Johan Mahmood Merican, Ketua Setiausaha Perbendaharaan; pegawai-pegawai kementerian dan jabatan serta sekretariat PAC. *Assalamualaikum* dan salam sejahtera.

Terima kasih Yang Berhormat Pengerusi dan Ahli-ahli Jawatankuasa Kira-kira Wang Negara di atas peluang untuk hadir dan memberikan penjelasan mengenai perkara yang akan dibentangkan pada hari ini. Sejak tahun lalu, ramai di kalangan rakyat termasuklah Ahli-ahli Parlimen telah menyuarakan pandangan dan cadangan terhadap isu kenaikan premium insurans ataupun MHIT. Ini juga termasuk orang ramai yang telah hadir kedua sesi pendengaran awam di Pulau Pinang dan Parlimen baru-baru ini.

Sebelum kita memulakan perbincangan hari ini, izinkan saya mengambil sedikit masa untuk menjelaskan bahawa isu ini adalah isu yang kompleks dan melibatkan banyak pihak berkepentingan. Oleh itu, saya amat menghargai inisiatif yang diambil oleh PAC dengan membawa perkara ini untuk dibincangkan secara mendalam dan juga teratur. Saya juga menyedari kegusaran pelbagai pihak dan mengambil maklum pandangan dan cadangan yang telah diutarakan.

Untuk 20 dan 30 minit ini, pihak Bank Negara Malaysia telah menyediakan satu pembentangan bagi memberi konteks yang lebih jelas mengenai isu-isu yang dibangkitkan serta tindakan yang akan diambil oleh pihak kami bersama-sama pihak Kementerian Kesihatan Malaysia dan juga pihak industri insurans dan takaful serta hospital swasta. Cabaran yang kompleks ini memerlukan dengan izin, *a whole of nation approach.*

■1140

Saya juga memohon jasa baik Ahli-ahli PAC Yang Berhormat sekalian untuk membenarkan saya membentangkan keseluruhan perkara ini terlebih dahulu bagi memberi gambaran dan konteks yang jelas kepada semua Ahli Yang Berhormat sebelum kita membuka ruang untuk sebarang pertanyaan dan juga maklum balas. Saya dan rakan sekerja saya bersedia untuk mendengar pandangan, cadangan serta sebarang persoalan daripada Yang Berhormat selepas pembentangan dibuat. *If we can move to slide number one.*

Seperti yang saya maklumkan, inflasi perubatan yang tinggi di Malaysia merupakan isu yang kompleks. Ia memerlukan kerjasama pelbagai pihak melalui pendekatan *whole of nation*. Peningkatan permintaan untuk perkhidmatan kesihatan didorong oleh pelbagai faktor makro termasuk pertamanya, cabaran kesihatan seperti peningkatan kadar penyakit berjangkit dan tidak berjangkit. Kedua, penuaan populasi di negara Malaysia. Ketiga, kemajuan dalam teknologi perubatan. Oleh yang demikian, adalah penting untuk semua pihak berkepentingan termasuklah KKM, hospital swasta, ITO dan Bank Negara sendiri untuk terus berkerjasama dalam memastikan ekosistem penjagaan kesihatan terus mampan. *If you can move to the next slide? Okay, this is the one.* Betul.

Selain faktor makro, jumlah tuntutan insurans perubatan kesihatan yang terus meningkat juga disebabkan oleh isu inflasi kos perubatan serta peningkatan kekerapan tuntutan MHIT. Sebagai perbandingan, berdasarkan laporan pihak ketiga, *Aon's Global Medical Trend*, Malaysia telah mencatatkan kadar inflasi yang lebih tinggi berbanding purata Asia Pasifik dan global sejak tahun 2018 lagi. Ada beberapa pihak yang kurang bersetuju dengan angka ini, kami ambil maklum dan berusaha untuk bersama-sama dengan pihak-pihak tertentu termasuklah Jabatan Statistik

Negara, World Bank dan juga industri insurans untuk melihat perkara ini dengan lebih mendalam.

Kekerapan tuntutan MHIT juga telah meningkat melebihi dua kali ganda dalam tempoh enam tahun kebelakangan ini. Pada tahun 2017, secara purata, 11 tuntutan dibuat bagi setiap 100 pemegang polisi berbanding 25 tuntutan pada tahun 2023. Berdasarkan kajian tuntutan MHIT dari tahun 2013 sehingga 2018, antara faktor lain yang menyumbang kepada kenaikan kos tuntutan MHIT adalah pertama, caj bekalan dan perkhidmatan hospital yang tinggi dan juga tidak dikawal. Caj ini merangkumi di antara 59 peratus hingga 70 peratus daripada jumlah bil di hospital swasta. Kedua, perbezaan caj rawatan di hospital swasta yang menggunakan surat jaminan ataupun GL berbanding bayar dahulu dan tuntut kemudian daripada *ITOs.* Terdapat kes-kes di mana pesakit yang menggunakan GL dikenakan jumlah caj yang lebih tinggi tanpa justifikasi yang jelas untuk perbezaan caj.

Isu ini bukanlah isu yang baharu. Bank Negara Malaysia telah pun menyuarakan kebimbangan mengenai isu ini hampir sedekad yang lalu dan telah berusaha mencari jalan penyelesaian dengan bekerjasama dengan pelbagai pihak. Langkah-langkah advokasi juga telah diusahakan dengan membangkitkan isu ini di pelbagai forum termasuk beberapa penerbitan berkaitan isu inflasi kos perubatan sejak tahun 2019 lagi. Kemajuan usaha ini turut dipengaruhi oleh faktor-faktor di luar kawalan pihak Bank Negara Malaysia. Oleh itu, penyelesaian kepada isu ini memerlukan komitmen yang teguh dan berterusan daripada semua pihak.

Ahli-ahli jawatankuasa sekalian, pelarasan premium insurans dan takaful sebenarnya merupakan simptom akibat peningkatan inflasi perubatan. Jadi, punca utama ataupun *root cause* inilah yang perlu kita tangani secara kolektif. Namun, dalam mengawal selia pelarasan premium MHIT, Bank Negara Malaysia mempertimbangkan tiga faktor utama iaitu pertamanya, kemampanan jangka panjang ITO tersebut. Kedua, amalan perniagaan yang adil kepada semua pemegang polisi. Ketiga, daya kemampuan pengguna.

Pertama, pelarasan premium berlaku apabila pengalaman tuntutan merosot sehingga tidak lagi mampan untuk menampung tuntutan dan perbelanjaan masa hadapan. *So, this is the first factor the we look at*. Ini adalah penting untuk memastikan ITO kekal mampu untuk membayar tuntutan yang diterima. Kerugian yang berterusan boleh menjejaskan keupayaan ITO untuk membayar tuntutan dan ini berkemungkinan mereka akan berhenti menawarkan produk MHIT yang merugikan. Ini seterusnya akan menambah tekanan ke atas sektor perkhidmatan kesihatan awam. Ingin ditekankan di sini bahawa ITO tidak dibenarkan sama sekali

untuk menggunakan pelarasan premium untuk meningkatkan margin keuntungan mereka.

Kedua, dasar pengumpulan risiko bertujuan memastikan subsidi silang ataupun dengan izin, *cross subsidisation* adalah adil kepada semua pemegang polisi. Oleh itu, keuntungan portfolio lain tidak wajar digunakan untuk menyerap kerugian portfolio MHIT kerana langkah ini boleh menjadikan premium produk lain, contohnya insurans hayat dan insurans pendidikan juga akan menjadi lebih mahal.

Ketiga, ITO perlu menyediakan pilihan alternatif serta bantuan lain yang bersesuaian kepada pengguna yang terkesan bagi membantu kemampuan mereka untuk terus dilindungi.

Untuk beberapa tahun kebelakangan ini, kadar peningkatan tuntutan jauh mengatasi kadar peningkatan premium. Jika kita lihat dari slaid yang dipaparkan pada masa ini, sebagai contoh, pelarasan premium MHIT bagi tahun 2021 sehingga 2023 masih belum setanding dengan kadar tuntutan yang jauh lebih tinggi iaitu jumlah tuntutan yang meningkat sebanyak 73 peratus berbanding kenaikan premium MHIT yang naik sebanyak 21 peratus. Berdasarkan polisi MHIT yang diselaraskan pada tahun 2024 sebelum langkah-langkah interim dilaksanakan, 91 peratus polisi mengalami kenaikan premium kurang daripada 40 peratus dan lebih daripada separuh ataupun 60 peratus daripada polisi mengalami kenaikan premium kurang daripada 20 peratus sebenarnya.

Kadar pelarasan premium yang dialami oleh seseorang pemegang polisi akan bergantung kepada beberapa faktor. Pertama, dari segi kitaran pelarasan premium. Setiap ITO mempunyai kitaran pelarasan yang berbeza seperti setiap tahun ataupun setiap tiga tahun ataupun kitaran yang lebih panjang. Kitaran pelarasan yang lebih panjang boleh mengakibatkan pelarasan yang lebih tinggi disebabkan inflasi kos tuntutan perubatan yang terkumpul.

Kedua, saiz dan demografi kumpulan risiko. Berdasarkan prinsip pengumpulan risiko ataupun *risk pooling,* premium pemegang polisi dengan profil risiko yang serupa, contohnya dalam kumpulan umur yang sama digabungkan untuk menampung kos tuntutan bagi pemegang polisi yang memerlukannya. Premium mencerminkan risiko kumpulan berdasarkan *credible data* pengalaman tuntutan dan digunakan untuk membayar tuntutan bagi setiap tahun polisi. Polisi tanpa sebarang tuntutan masih boleh mengalami kenaikan premium akibat inflasi tuntutan kumpulan risiko mereka.

Faktor ketiga, kumpulan umur pemegang polisi. Premium akan meningkat mengikut usia kerana risiko kesihatan dan kebarangkalian tuntutan meningkat dengan penambahan usia. Penetapan premium mengikut usia adalah merupakan

satu amalan lazim dalam pasaran MHIT swasta dan bukan sahaja di Malaysia. Dengan cara ini, pemegang polisi yang lebih muda dan sihat juga dapat dan akan digalakkan untuk membeli produk MHIT serta tidak menangguhkan pembelian sehingga mereka memerlukannya. Ini juga boleh meningkatkan pengumpulan risiko.

■1150

Sejak tahun 2022, Bank Negara Malaysia telah pun memperkenalkan pelbagai langkah-langkah di bawah tiga strategi utama untuk menangani inflasi kos perubatan dan memastikan perlindungan MHIT kekal mampan. Pertama, mendorong perubahan tingkah laku yang positif dalam penggunaan perkhidmatan kesihatan. Ini termasuk pengenalan ciri pembayaran bersama ataupun *co-payment* dan program pendidikan pengguna. Langkah ini boleh memberi lebih banyak pilihan alternatif pada harga lebih mampu milik kepada pengguna.

Kedua, pengurusan kos yang lebih baik dan telus melalui penubuhan pangkalan data tuntutan berpusat serta penerbitan kos prosedur perubatan yang lazim. Ini bertujuan untuk menyediakan penanda aras bagi kos perubatan terutamanya rawatan di hospital swasta.

Ketiga, penetapan piawaian yang lebih tinggi untuk amalan perniagaan dan penjualan produk MHIT. Ini termasuk menambah baik lembaran penzahiran produk ataupun dengan izin, *product disclosure sheet* bagi memudahkan kefahaman pengguna. Maklumat penting seperti jangkaan premium masa depan dan juga produk alternatif juga tertera dalam lembaran ini. Amalan jualan juga dipertingkatkan melalui perluasan pengumpulan risiko dan panduan untuk *ITOs* menilai kemampuan premium pengguna.

Langkah-langkah untuk mengekang impak kenaikan premium juga telah dilaksanakan untuk pemegang polisi terkesan bagi tempoh 2024 sehingga 2026. Ini adalah merupakan langkah-langkah sementara yang telah dilaksanakan pada awal tahun ini. Saya juga ingin mengucapkan terima kasih kepada Yang Berhormat sekalian dan juga Ahli-ahli PSC Kesihatan dan juga Ahli-ahli *backbenchers* yang telah memberi banyak cadangan kepada kami dan kami telah mengambil cadangan-cadangan berikut dalam melaksanakan *interim measures* berikut. Namun, langkah-langkah ini hanya bersifat sementara dan tidak mampan untuk jangka masa panjang.

Slaid ini adalah agak penting, ia amat penting sekali Yang Berhormat-Yang Berhormat sekalian. Untuk menangani inflasi kos perubatan dan memastikan ekosistem penjagaan kesihatan terus mampan, Bank Negara Malaysia dan juga Kementerian Kesihatan Malaysia telah pun bersetuju untuk melaksanakan sembilan inisiatif pembaharuan ataupun *reform* sektor kesihatan berdasarkan lima teras utama.

Teras pertama Yang Berhormat, untuk meningkatkan ketelusan kos di perkhidmatan kesihatan swasta. Untuk KKM dari segi penerbitan harga ubat dan kajian semula Akta 586. Untuk Bank Negara Malaysia dan KKM, mekanisme mengukur kadar inflasi perubatan dengan lebih tepat dan juga penerbitan julat harga rawatan yang lazim.

Teras kedua, KKM akan melaksanakan model pembayaran kesihatan *diagnostic related group* ataupun DRG dengan izin, untuk menentukan caj kos rawatan secara menyeluruh bagi menggantikan sistem *fee for service* yang diguna pakai sekarang dan menggalakkan rawatan berasaskan nilai.

Teras ketiga, transformasi reka bentuk produk MHIT melalui pembangunan produk asas dengan ciri-ciri yang lebih mampan di samping mengutamakan penjagaan kesihatan berasaskan nilai. Ini akan dilaksanakan secara bersama oleh pihak Bank Negara Malaysia dan juga Kementerian Kesihatan Malaysia.

Teras keempat, KKM dan kementerian berkait akan meluaskan pilihan mampu milik perkhidmatan kesihatan seperti Rakan KKM dan juga perkembangan hospital tanpa keuntungan.

Teras kelima, pelaksanaan rekod kesihatan elektronik atau dengan izin, *electronic medical records* bagi menjimatkan kos melalui pengurangan pertindihan ujian diagnostik dan juga meningkatkan kecekapan operasi.

Pelaksanaan inisiatif berdasarkan lima teras utama yang disebutkan tadi bertujuan memberi kesan-kesan berikut. Ada tiga kesan:

(i) peningkatan ketelusan kos serta pelaksanaan DRG akan menggalakkan persaingan yang sihat dan penetapan harga yang lebih adil;

(ii) membendung penggunaan rawatan kesihatan yang didorong oleh manfaat yang tinggi atau tanpa had di bawah pelan MHIT sedia ada. Penyedia perkhidmatan kesihatan dan pemegang polisi akan memberi pertimbangan yang lebih mendalam, justeru mengurangkan pembaziran ataupun dengan izin, *over-prescription;*

(iii) Ketiga, memperluaskan pilihan penjagaan kesihatan yang berkualiti dan lebih kos efisien serta meningkatkan kecekapan operasi.

Melalui lima teras ini kami menyasarkan tiga petunjuk prestasi utama atau dengan izin, KPI yang perlu dipantau secara berterusan iaitu:

(i) kadar inflasi perubatan yang lebih perlahan dan sejajar dengan trend global;

(ii) pelarasan premium MHIT yang lebih perlahan dan juga terkawal dan;

(iii) penjimatan kos perubatan melalui pembelian secara strategik dan juga DRG.

Sebagai usaha tambahan, Bank Negara Malaysia juga akan terus meneliti dan menambah baik sektor MHIT seperti berikut dan ini adalah komitmen kami:

(i) menambah baik pengurusan pengumpulan risiko bagi produk MHIT terutamanya bagi produk yang tertutup ataupun *closed block* yang tidak lagi menerima pemegang polisi baharu. Ini penting untuk memastikan premium kekal stabil dan pelarasan premium pada kadar yang munasabah;

(ii) menangani inovasi produk yang tidak mampan;

(iii) menambah baik *structure* insentif penjualan produk MHIT untuk membendung inflasi kesihatan serta;

(iv) memperkasakan pengguna dalam membeli insurans melalui penerbitan panduan pembelian produk MHIT dan menambah baik lembaran penzahiran produk MHIT.

Izinkan saya untuk menyentuh sedikit berkenaan dengan produk MHIT asas. Antara aspirasi prinsip utama produk MHIT asas ini adalah premium yang lebih mampan dalam jangka masa panjang serta perluasan skala perkongsian risiko. Produk asas ini juga akan disokong oleh langkah pengawalan kos yang lebih menyeluruh dan penggalakan penjagaan kesihatan berasaskan nilai contohnya melalui pelaksanaan mekanisme pembayaran DRG secara berfasa, pembelian strategik yang diguna sama oleh pihak swasta dan juga kerajaan dan juga kawalan-kawalan lain untuk penggunaan perkhidmatan kesihatan yang lebih berhemah seperti keperluan rujukan dari doktor perubatan umum ataupun *reference from GP,* dengan izin.

Produk ini juga akan mempunyai reka bentuk yang lebih mampan seperti had tuntutan tahunan dan juga ciri pembayaran bersama yang bersesuaian. Namun, reka bentuk ini akan dimuktamadkan setelah diperhalusi dengan lebih lanjut dan setelah mendapat maklum balas dari pihak-pihak yang berkepentingan.

Slaid terakhir saya Yang Berhormat sekalian. Memandangkan pelaksanaan inisiatif-inisiatif ini melibatkan pelbagai pihak, struktur tadbir urus yang jelas dan kukuh adalah penting untuk memastikan kelancaran dan juga keberkesanan jangka panjang. Bagi tujuan ini, Bank Negara Malaysia telah mengesyorkan kemajuan pelaksanaan inisiatif ini diterajui oleh Menteri Kesihatan dan juga Menteri Kewangan II.

Laporan kemajuan dan prestasi akan dibentangkan pada mesyuarat berkala yang akan diadakan. Kedua-dua Menteri telah pun bersetuju dengan cadangan ini dan KKM dan BNM akan bertindak sebagai penyelaras utama pembaharuan perkhidmatan kesihatan bagi membendung inflasi kos perubatan berdasarkan inisiatif-inisiatif yang telah digariskan.

Kerjasama daripada semua pihak juga adalah penting untuk memastikan pelaksanaan keberkesanan inisiatif tersebut dalam tempoh tiga tahun ini. Perkembangan dari segi *progress* inisiatif ini juga akan dilaporkan secara berkala kepada *PSSC Health, PSSC* Ekonomi dan juga PAC. Sekian, terima kasih Yang Berhormat sekalian di atas perhatian yang telah diberikan dan dengan ini kami membuka ruang untuk persoalan dan kami bersedia menjawab segala persoalan ataupun sebarang penjelasan yang diperlukan oleh Yang Berhormat sekalian. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, terima kasih kepada Dato' Seri Rasheed. Okey, ada apa-apa soalan daripada Ahli-ahli PAC?

■1200

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, Pengerusi dan terima kasih juga kepada KSP, Dato' Rasheed dan juga Datuk Jessica. Saya rasa ini adalah satu pembentangan yang sangat komprehensif. Tahniah kepada BNM dan juga MoF kerana melakarkan satu respons yang cepat dan komprehensif terhadap isu yang sangat *affecting the people seriously.*

Daripada apa yang kita dapati daripada pendengaran awam, *people are very concerned* dan kita nampak bahawa *the turn up is very overwhelming.* Kita tidak jangka bahawa hampir lebih daripada 700 orang, hampir 800 orang telah menghadiri kedua-dua sesi pendengaran. Maka ini adalah satu isu yang *burning and very important* dan perlu mengambil tindakan.

Jadi, *first,* saya tahu bahawa Bank Negara Malaysia ini memang mengawal selia syarikat-syarikat ITO. Dan saya ingin mulakan dengan— ada banyak soalanlah, kita *slow*-lah. *We go slow.*

First is that, kenapa— apakah proses Bank Negara Malaysia mengawal selia kenaikan *their premium?* Sebab kita nampak bahawa daripada apa yang dilaporkan oleh kami kepada Ahli-ahli Parlimen dan juga sesi pendengaran, sememangnya mereka— premium berjalan bukan bahawa setiap tiga tahun— ada yang setiap dua tahun ia naik, okey. Lepas itu selepas mereka masuk satu *age* sahaja selepas 60 ia akan naik mendadak.

Apabila *bracket* 70 tahun ke atas ia akan naik lagi mendadak. Kita tahu bahawa mereka ini adalah pesara. *Then,* yang lagi menyayat hati adalah ada yang

cancer patient. Mereka telah beli setia dengan syarikat insurans puluhan tahun. Tetapi apabila mereka paling memerlukan insurans itu mereka dikenakan insurans yang begitu tinggi naik mendadak dan ada yang *cancer patient* yang tengah mengalami perubatan dan mereka terpaksa *surrender policy* tersebut. *So,* boleh respons bagaimana kawal selia daripada Bank Negara Malaysia?

Dato' Seri Abdul Rasheed Ghaffour (BNM): Terima kasih Yang Berhormat di atas soalan tadi. Mungkin kita boleh *go to one of the slide on the* cara-cara kita mengawal selia.

Pertama, Yang Berhormat, saya ingin merujuk kepada mandat Bank Negara Malaysia untuk memastikan *financial stability* dan juga ITO kekal *solvent* dan mampu membayar tuntutan kepada pemegang polisi apabila mereka melakukan tuntutan. Itu adalah mandat dan juga objektif utama dari segi pengawalseliaan penyelarasan premium oleh insurans.

Ini adalah kerana apabila kita lihat produk MHIT memang semakin tidak mampan disebabkan oleh inflasi dan kos perubatan yang meningkat. Bank Negara Malaysia meneliti setiap permohonan penyelarasan premium untuk memastikan kemampanan produk. ITO juga perlu mengambil kira pertamanya kemampuan dengan mengehadkan kenaikan premium berdasarkan dasar dalaman mereka yang diluluskan oleh Lembaga Pengarah mereka, pertamanya.

Mereka juga tidak dibenarkan untuk menyelaraskan premium untuk meningkatkan margin keuntungan mereka. Itu memang tidak dibenarkan oleh Bank Negara Malaysia. Penelitian juga dibuat untuk memastikan mereka menyediakan produk-produk alternatif bagi memastikan pihak-pihak tertentu yang mana pengalaman pembayaran premium akan meningkat, mereka mempunyai pilihan sama ada untuk beralih kepada produk yang lebih asas ataupun lebih murah setanding dengan keupayaan mereka dan juga keperluan perlindungan perubatan mereka.

Keempat, soalan Yang Berhormat tadi dari segi peralihan umur. Sebagaimana saya sebut tadi Yang Berhormat memang apabila kita beralih umur kebarangkalian sakit dan kebarangkalian tuntutan memang meningkat. Ini adalah pendorong utama dari segi peningkatan premium bagi individu-individu yang beralih *brackets* umur tertentu.

Namun melalui usaha kami dari segi melihat semula dari segi *risk-pooling* dan sebagainya kami akan cuba menangani isu ini dan juga kedua dengan adanya produk MHIT asas yang saya bentangkan tadi, ia juga memberi peluang kepada pemegang-pemegang polisi untuk memilih produk ini yang bersesuaian dengan keperluan perlindungan perubatan mereka. *So this is what we will do.*

Then, sekiranya kita dapati ada penyelarasan premium yang tidak mengikuti peraturan-peraturan yang telah ditetapkan oleh Bank Negara Malaysia tindakan akan diambil ke atas ITO tersebut. *You want to add anything Jess? Let me invite Jessica to also* tambah.

Datuk Jessica Chew Cheng Lian [Bank Negara Malaysia]: *Slide 15. [Merujuk kepada pegawai].* Izinkan saya untuk menjelaskan serba sedikit mengenai penetapan premium berdasarkan umur itu Yang Berhormat tanya tadi.

Jadi kalau kita tengok slaid ini. *[Merujuk kepada pembentangan slaid].* Yang sebelah kanan ini kamu boleh perhatikan itu trend tuntutan mengikut umur. Jadi bagi jurang-jurang umur yang lebih tinggi memang nampak trend itu ketara. Ia nak secara ketara.

So, berdasarkan konsep *risk-pooling* ini sebenarnya premium yang dikumpulkan adalah untuk membayar tuntutan bukan untuk *pre-fund, future claims.* Ia bagi membayar tuntutan pengalaman sekarang, masa kini untuk *risk pool* itu. Jadi bila kita ikut trend ini kalau umur naik memang tuntutan makin tinggi. Jadi ini akan menyebabkan premium yang dikumpulkan itu pelarasan akan dinaikkan sedikit juga.

Ada opsyen juga seperti yang ada pihak telah ketengahkan opsyen untuk apa dipanggil *community rating* jadi *flat rate* untuk semua. Ini memerlukan skala yang besar. Itu yang sebab itu kita nak *pursue* produk asas ini. Sebab kalau ada skala mungkin boleh *moderate* premium kepada semua pemegang polisi. Kalau tidak, kalau kita menetapkan premium yang rata untuk semua pemegang polisi, ada kemungkinan yang muda yang sihat juga akan mengalami premium yang sangat tinggi.

Kalau macam itu kita akan menggelakkan daripada membeli insurans pula. Itu juga menjadi masalah. Jadi itu yang masalah yang kita nak tangani sekarang ini untuk mengkaji semula *risk-pooling* ini dan penting itu produk asas yang akan memberi skala yang besar yang boleh membuka opsyen untuk kita *moderate* pelarasan premium. Terima kasih.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi...

Tuan Sim Tze Tzin [Ahli PAC]: Kalau boleh saya nak buat sedikit soalan tambahan. Contohnya saya nampak dekat sini, saya dalam kategori 40 hingga 49. *You see that is still quite flat on that score.* Tetapi pengalaman saya adalah saya dikenakan 50 peratus *my premium* naik sebanyak 50 peratus. *Is it fair?*

I don't think it's fair to me because I feel that based on your graph, it's still quite flat. The worse is the people who are 60 and above. They're pesara. Saya rasa adalah *insurance company is forcing them out to surrender because they don't want to take that kind of cases. Okay.*

Satu lagi ialah isu *pooling. Pool* mereka. Saya difahamkan syarikat-syarikat insurans ia banyak *pool. They're created the new product; they're create one pool. So, pool* yang lama itu ia tak ada orang baru masuk. Maka premium mereka akan naik.

Jadi isu adalah *the structure of their product* dan mereka ini sebab mereka nak bersaing, dia nak *market shares* dan sebagainya dia *create all kinds of new product to get market share.*

Saya rasa itu adalah sesuatu yang tidak sihat. Maka apakah mekanisme atau intervensi daripada Bank Negara *to consolidate those pools* sebab saya rasa ini adalah satu ketidakadilan. *It's a great injustice to those people who have been loyal to the company for so long and they're just let them— they just want to kick them out.*

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What kind of company is this? [Dicelah] It's the heartless. To me, it's heartless ya. Jadi minta pandangan.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. *I think* atas pandangan tersebut apabila kita kaji semula dari segi *risk pooling, so that is one of the area* di mana kita akan menambahbaikkan. Saya ambil maklum, data yang dikongsi oleh Yang Berhormat tadi *in terms of* seorang yang berumur atas 49 hingga 50 tahun, *so* saya rasa dengan kajian semula di atas *risk pooling* ini kita akan dapat menangani masalah-masalah sebegini, pertama.

Keduanya Yang Berhormat, saya juga ingin menyentuh tadi dari segi kenaikan sebenarnya premium oleh pemegang-pemegang polisi ini kebanyakan daripada mereka mengalami kenaikan di bawah 40 peratus sebenarnya. Kalau ada yang lebih 40 peratus adalah mungkin merupakan golongan minoriti. Di sini, saya ingin menyarankan kalau boleh mereka datang ke Bank Negara Malaysia *to our link* dan kita akan melihat secara rapi apakah masalah yang dihadapi *and then* kenapa mereka dikenakan premium yang melebihi apa yang sepatutnya.

Kalau kita tengok Yang Berhormat tadi dari segi peratusan peningkatan lebih 90 peratus mengalami tuntutan tidak lebih daripada 40 peratus. Lebih daripada 60 peratus ataupun 61 peratus mengalami kenaikan kurang daripada 20 peratus. Sekiranya ada yang lebih daripada itu mungkin daripada golongan minoriti tersebut dan mungkin ada sebab-sebab tertentu. Di sini kalau kita ada maklumat yang penuh kita akan dapat melihat dengan sebenarnya.

Contohnya, Yang Berhormat *mentioned* tadi ada *cancer patient* itu. Dia pun telah datang berjumpa dengan Bank Negara dan kami telah berjaya menyelesaikan masalah pesakit tersebut. Di sini kita perlukan kerjasama dan juga bantuan daripada

Ahli Yang Berhormat sekalian sekiranya ada mana-mana pihak yang rasa tertindas ataupun tidak adil, kami memang mengalu-alukan supaya mereka datang dan kita dapat tahu apakah masalahnya dan kita akan cari jalan penyelesaian. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Minta maaf ya Dato'. Saya rasa data yang diberikan oleh syarikat insurans, *they are giving you a general view which I think is may not be the real case* sebabnya kita tahu semuanya *bell curve* yang *extreme cases manning* ada. Tetapi *generally*, saya rasa katakan— tadi saya katakan *because* apa yang pengalaman saya adalah dia bagi satu *chart, very clear chart* umur berapa, *increase how many percent*, umur berapa *increase how many percent* dan saya masih ada *chart* tersebut. Nanti saya boleh hantar. Tetapi *generally* 30 peratus hingga 70 peratus *the increase.*

For a normal— saya di tengah-tengahlah ya, 40 to 49 dia naik *50 percent.* Saya rasa bukan *minority, actually its majority*. *This is a big demographic who is paying for this. So, I think the insurance company is not telling the truth to Bank Negara* ya. Saya haraplah Bank Negara *go deep into this because we cannot allow them to tell you one thing and do another* ya*.*

How about the pool itu? Bagaimana Bank Negara boleh reformasikan *pool* supaya dia tidak menindas orang-orang yang susah dan *loyal* kepada syarikat?

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Okey, pertamanya dari segi maklumat berkenaan dengan minoriti tadi itu, kami akan lihat, kami akan pastikan kami akan lebih lagi— kami telah pun, kami akan lebih lagi meneliti segala data yang diberikan oleh ITO kepada kami. Pada masa ini, memang kita *validate all the data that is given by the insurance company*, dengan izin dan kami akan teruskan usaha ini. Biar saya jemput Datuk Jessica untuk menambah sikit lagi berkenaan dengan cara bagaimana kita hendak mengkaji semula *risk pooling.*

Datuk Jessica Chew Cheng Lian [BNM]: Terima kasih Gabenor. *So*, pertama sekali dengan *pooling* ini kita akan— sebelum itu saya ingin menekankan lagi yang penyelesaian isu ini sebenarnya kita hendaklah melaksanakan itu produk asas yang sedang dibangunkan ini. Itu penting sebab kalau tidak, kita tidak dapat mencapai skala yang besar susah. Macam mana pun kita nak memperluaskan *risk pooling,* akibatnya kalau kita tengok satu-satu penanggung insurans memang susah nak *flatten to curve* tadi itu. Jadi pembangunan produk asas itu memang penting.

Tetapi bagi *risk pooling* yang sedia ada sekarang ini dengan penanggung insurans dan takaful, kita akan memperhati— tengok macam mana kita boleh memperluaskan lagi *pool* itu juga kita boleh *spread the risk to more and dampen the premium increase*. Itu yang kami sedang melaksanakan sekarang, sedang meneliti data yang Gabenor *mentioned* tadi. Kita akan tengok— sebenarnya kita sebelum ini

pun telah melaksanakan satu kali kita telah memperluaskan *risk pooling*, parameter *risk pooling*. So, kita akan cuba sekali lagi tengok macam mana kita boleh membuat ini secara adil. Sebab yang penting juga kita kena adil juga kepada pemegang polisi yang lebih muda yang baru masuk kerja, baru nak beli produk insurans kan. *So*, itu pun penting. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Kita juga ingin mencapai matlamat *being inclusive* supaya produk insurans ini dapat dinikmati oleh semua rakyat di Malaysia ini. Kita ingin juga menggalakkan golongan yang muda untuk mula membeli insurans, kerana apa? Kerana kita tidak mahu memberi *pressure* ataupun tekanan ke atas kesihatan kerajaan, awam.

Dr. Hajah Halimah Ali [Ahli PAC]: Sedikit apalah nak tanya BNM kah, Datuk Johan kah. Perkara yang *basic* lah*,* slaid nombor tiga, Kadar Inflasi Perubatan Malaysia 2025. Kalau ikut global *11 percent*, Asia Pasifik lagi kurang. *Why is* Malaysia lebih daripada orang lain *15 percent*?

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. Ada beberapa faktor yang mendorong kepada tingginya kadar inflasi perubatan di Malaysia. Pertamanya, dari segi peningkatan penggunaan perkhidmatan hospital swasta. Sebab pada masa ini kita lihat lebih ramai orang mempunyai produk insurans dan takaful dan juga apabila mereka mempunyai produk insurans dan takaful ini, mereka lebih menggunakan perkhidmatan hospital swasta. Jadi ini telah meningkatkan penggunaan.

Kedua, dari segi peningkatan harga oleh penyedia hospital swasta. Peningkatan harga dari segi pertamanya rawatan. Kedua dari segi perubatan. Ketiga dari segi kos membuat segala ujian dan *test* dan sebagainya.

Ketiga, apa yang kita perhatikan juga Yang Berhormat adalah terdapat juga situasi di mana apabila seseorang itu mempunyai insurans, harga yang dikenakan adalah lebih tinggi berbanding dengan seseorang yang membayar sendiri ataupun dia bayar dulu *then* dia *claim* selepas ini. Ini adalah hasil daripada kajian kami berasaskan kepada data-data yang diberi melalui tuntutan yang diterima oleh insurans. Itu juga mendorong kepada peningkatan kadar inflasi perubatan di Malaysia.

Keempat, ada juga disebabkan oleh kenaikan harga ubat dan juga alat-alat ujian. Contohnya, mesin-mesin x-ray dan sebagainya, mereka perlu *invest* dan ini telah di-*translate*-kan kepada kos kepada mereka.

Kelima adalah disebabkan pada masa ini tiada kawalan harga dari segi perubatan dan juga dari segi caj sektor hospital swasta. Di sinilah kerajaan telah menyatakan hasrat untuk *to amend* Akta 586 untuk memberi kuasa kepada KKM

supaya boleh mengawal selia kenaikan harga oleh hospital swasta. Itulah pendorong-pendorong utama kepada meningkatnya kadar inflasi perubatan di Malaysia.

Faktor terakhir adalah kita perhatikan selepas daripada pandemik, lebih banyak orang telah menggunakan perkhidmatan hospital swasta. Inilah kerana pada masa tempoh pandemik itu mereka mungkin *delay* tidak nak pergi buat *certain-certain treatment* yang mungkin tidak terlampau meruncing sangat, dia tunggu, lepas pandemik baru dia buat. Itu kita nampak kenaikan yang agak ketara kadar 25 peratus pada tahun 2023 Yang Berhormat.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Yang Berhormat Pengerusi, boleh?

Dr. Hajah Halimah Ali [Ahli PAC]: Kejap, kejap. Saya nak sambung apa yang disebut tadi, okey. *[Dicelah]*

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Dalam *public hearing* yang lepas, hari Jumaat yang lepas yang mana *the specialists are telling us, you* pergi hospital swasta kah apa, *the rates— consultation rate* itu, bayaran bagi kepada pakar-pakar ini, perubatan ini tidak meningkat langsung, dah berpuluh tahun mungkin. *So,* yang meningkat ini apa *the business part of it* kah *what because the specialists* yang susah-susah nak belajar ini, nak *training* ini tak cukup tidur *and all that, all the work-life balance* tak ini, *they don't benefit from it, it's the other people*— kalaulah, ikut lah *that why you just saying* yang saya faham itu kan, *is benefitting from it.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat...

Dr. Hajah Halimah Ali [Ahli PAC]: Buat duit.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Memang betul dari segi bayaran kepada *specialists* memang dikawal oleh pihak Kementerian Kesihatan. Yang tidak dikawal oleh Kementerian Kesihatan adalah bayaran hospital swasta. Tapi memang kita dapati dari segi fi kepada *specialists* dan konsultan memang tidak naik. Memang terkawal. Memang tidak menyumbang kepada peningkatan inflasi.

Yang menyumbang kepada peningkatan inflasi ini adalah kalau kita tengok tadi *about 17 percent, 60 to 70 percent* daripada jumlah komponen bil adalah merupakan caj bekalan dan perkhidmatan hospital yang tinggi. Contohnya, penggunaan alatan x-ray dan sebagainya, CT *scan* dan sebagainya, kedua ubat-ubat dan juga ketiga, contohnya bila ada *surgery,* penggunaan barang-barang untuk *surgery* tersebut. Itu yang meningkat dengan lebih tinggi Yang Berhormat, bukan *specialists* di hospital.

Dr. Hajah Halimah Ali [Ahli PAC]: *So, who is the controlling body? Is it the* Kementerian Kesihatan *or who?*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Pada masa ini untuk produk-produk hospital tidak ada pengawalseliaan.

Dr. Hajah Halimah Ali [Ahli PAC]: Tidak ada? Okey, sebab yang *the blame goes to—*

I am a medical doctor. So, I kesian lah *I* punya *colleagues* itu *tau,* okey. Bila sakit *you* pergi ke hospital, *you* kena habis duit *and all that, who gets blamed?* Itulah doktor ini, apa ini, nak makan duit orang, *getting money out of people illnesses. So, the doctor gets the blame. Better set* apa dia punya ini betulkan dia punya *situations* ini.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: YB, *we are with you* Yang Berhormat *on these issues. So, that's why* kita membangkitkan isu-isu ini di mana kita nyatakan *about 70 percent* daripada komponen di hospital adalah caj bekalan dan perkhidmatan. *So,* di sini merupakan faktor utama dan tumpuan harus diberi kepada faktor ini dan di sinilah kita dapat sekarang ini usaha dengan pihak Kementerian Kesihatan di antara enam inisiatif yang kita *identify* tadi, salah satunya adalah untuk memastikan kita dapat kawal kos-kos berikut melalui DRG dan sebagainya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Yang Berhormat Pengerusi. Pertama, saya nak ucap tahniah Dato' Seri Gabenor Bank Negara kerana memberikan taklimat yang begitu menyeluruh, *I am sure you put a very deep thought into this before you come up with the presentation.*

Pertama, saya nak minta pencerahan Dato' Seri mengenai lima teras untuk membendung kadar inflasi. Satu benda yang saya tengok itu ialah pelaksanaan DRG ataupun *diagnosis-related group.* Boleh Dato' Seri berikan lebih banyak sikit maklumat atau pencerahan? Itu pertama.

Keduanya, banyak diperkatakan bahawa kenaikan insurans premium ini adalah disebabkan oleh kenaikan kos perubatan oleh hospital swasta. *I think that is what people have been saying. So*, ada juga kebenarannya kalau kita dengar banyak daripada *public hearing* yang diberitahu kepada kita ada kebenaran tapi kita *have to be fair to both sides, we have to listen to both sides and see how do we rationalise all these things*. Perlu ada satu ketelusan daripada pihak hospital swasta mengenai kos perubatan ini sebab dia punya *charges* pun *it varies from one hospital to another hospital. I don't know how insurance can come out with what kind certain percentage of premium insurance* yang berbeza-beza.

Just sebenarnya kesan terhadap kenaikan premium insurans ini, dia akan memberikan kesan lain yang lebih besar iaitu kesan di mana orang yang tidak mampu lagi untuk membayar premium insurans yang kian meningkat sehingga begitu tinggi. Umpamanya daripada 2014 hingga 2024, *10 years* kenaikan *more than 143 percent, that is an average of 14 over percent per year, that is too high, much higher than inflation of yearly inflation. That is very high* dan kesan besar sekali yang kita nampak sedang berlaku dan akan bertambah teruk lagi ialah orang yang tidak mampu bayar kenaikan ini akan pergi ke hospital kerajaan yang kita sedia maklum hospital-hospital kerajaan ini memang dah *very crowded,* orang sakit kena tunggu dulu dua hari, duduk katil tak keluar, sebelum masuk ICU dan sebagainya. *This is a very serious matter* sebab itu PAC mengambil inisiatif ini untuk mencari penyelesaian yang terbaik bagi isu kenaikan insurans ini.

Dalam sistem kita hari ini Dato' Seri dan juga Datuk Perbendaharaan, kita ada— *I mean specialists public* hospital tadi disebut, dia *it's regulated, it's regulated.* Dia punya gaji dia, dia punya elaun dia *regulated by body, so* dia tak boleh naik ikut suka dia. Umpamanya saya bagi contoh seorang doktor *specialist* bagi tahu saya, kos total perubatan bagi hospital swasta RM110,000, hospital pakar ini dapat RM10,000 *je*, *not even 10 percent and this* pakar ini dia yang akan menentukan *live and death of* pesakit itu.

Ini satu perkara yang perlu dilihat, *fine* kita boleh *regulate specialist* hospital punya *pay, but at the same time* kita tak ada *regulations or not regulated* hospital swasta tidak di *regulated*, ia tidak ada ketelusan dan insurans juga kita tak *regulate* sebab itu dia naik sesuka hati *even though* Bank Negara ada juga *control here and there but at the end of the day, they just* naik saja lepas itu orang dapat surat yang sakit yang teruk-teruk ini, kanser, jantung, kalau dia tak tahan tengok itu dia terkejut, dia boleh mati yang sakit jantung ini dia terkejut, mati pasal terkejut itu *je*. Betul tak, YB? So, *this is something very serious* lah, mungkin ini patut dilihat oleh kerajaan, *maybe not the* Kementerian Kewangan, Bank Negara tapi *something related.* Kerajaan *as a whole must look into this to regulate* hospital swasta *and also insurance* supaya ketiga-tiga ini *to be regulated* barulah mungkin kita akan dapat suatu kesan yang lebih baik dan positiflah. Itu buat sementara, terima kasih Dato' Seri, terima kasih Datuk.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. Kami sebenarnya bersetuju dengan apa yang dikatakan oleh Yang Berhormat. Memang isu ini merupakan isu yang serius dan kami mengalu-alukan langkah PAC untuk memanggil kesemua pihak berkepentingan untuk membincangkan perkara ini dan juga untuk mencari jalan penyelesaian yang baik.

Sebagaimana saya katakan tadi untuk menangani isu ini, kita memang memerlukan pendekatan *whole of nation* dan juga semua pihak berkepentingan perlu sama-sama berganding bahu untuk menangani masalah ini. Kos perubatan yang meningkat memang satu yang memang yang kita akui dan kita perlu tangani dan inilah sebabnya kita telah menggariskan sembilan inisiatif-inisiatif ini untuk menangani isu peningkatan kos perubatan ini secara holistik. Ia melibatkan bukan saja Bank Negara juga KKM, hospital swasta, pihak *ITOs* dan sebagainya.

Untuk makluman Yang Berhormat sekalian, kami juga telah mengadakan mesyuarat dengan kesemua pihak. Kami telah berjumpa dengan pihak KKM dan bersetuju *on* beberapa perkara. Kami juga telah berjumpa dengan pihak ITO dan mengarahkan mereka melakukan beberapa perkara. Kami juga telah berjumpa dengan pihak hospital, APHM dan berbincang dengan mereka dan mereka juga bersetuju dengan langkah-langkah yang kita telah *identify* dan kita akan ambil untuk tempoh tiga tahun ini supaya kita dapat bersama-sama mengurangkan inflasi kos perubatan.

Kedua dari segi ketelusan. Memang kita telah pun menggalakkan dan mengarahkan pihak *ITOs* dan juga hospital untuk lebih telus dari segi caj mereka. Hospital contohnya, apabila kita dapat pada dua, tiga tahun yang lalu kurang sikit sambutan daripada pihak hospital untuk memberi bil yang lebih telus. Kita telah menggunakan pihak ITO untuk mereka mengeluarkan maklumat tersebut, menzahirkan maklumat tersebut, jadi pihak pesakit boleh melihat hospital ini macam ini *charges* dia, hospital ini macam ini *charges* dia.

■1230

Jadi ia juga bertujuan untuk menggalakkan persaingan di antara mereka supaya mereka tidak *come together* dan meningkatkan harga kos hospital, itu telah dilakukan oleh Bank Negara Malaysia. Tapi di bawah spesifikasi inisiatif yang sembilan ini kita akan dapat sama-sama menangani isu ini. Ketiga, memang dari segi *regulation* adalah amat penting. Dari segi mengawal selia peningkatan harga kos perubatan adalah amat penting dan juga dari segi ubat *itself,* dari segi farmaseutikal juga perlu pengawalseliaan. Di sinilah pihak KKM akan memainkan peranan di bawah inisiatif yang kita ambilkan melalui sembilan inisiatif utama ini.

Dan ketiga dari segi soalan Yang Berhormat berhubung dengan DRG, DRG ini dia akan memperkenalkan kadar tarif tetap untuk setiap kumpulan berkaitan diagnosa masing-masing. Contohnya kadar diagnosis untuk penyakit yang A contohnya di mana ia tidak melibatkan sebarang kerumitan ataupun kompleksiti, lebih kurang harganya sedemikian. Jadi ia boleh jadi macam *benchmark* kepada

semua orang dan semua hospital. Mereka tidak boleh mengecaj lebih tinggi daripada harga yang dia telah tetapkan di bawah inisiatif DRG ini.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey lah contohnya macam *appendix* semua lah, SLE, penyakit SLE dan sebagainya.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Ya betul. Betul, betul.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Sekarang ini dia *different* hospital caj.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Ya *exactly, exactly.* Tapi memang DRG ini memerlukan banyak data dan banyak juga *pre-condition* yang perlu diadakan terlebih dahulu sebelum kita boleh melaksanakan DRG dengan jayanya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Dato' Seri.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sik mahu tanya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Terima kasih Timbalan Pengerusi. Di pihak BNM sendiri adakah konsep skim takaful kesihatan dengan insurans konvensional ini dari segi peraturan itu adakah standardnya sama ataupun ada perbezaan dari segi *condition* dia itu ketika mana takaful ini dia melibatkan konsep dalam syarak, dalam syariah *compliance* ini termasuk soal konsep *ta'awun* itu— untuk dia orang membantu dalam mengambil risiko peserta yang *join* takaful ini.

Sebab dilihat kalau takaful di dalam peraturan itu dia mesti ada kaedah-kaedah yang tidak boleh melanggari lah di antara peserta, orang yang mencarum dengan pihak takaful itu sendiri. Jadi bagaimana BNM melibat ia dipatuhi oleh syarikat-syarikat takaful ini sendiri lah. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. Dari segi *regulation* berhubung *prudential*, dari segi modal dan sebagainya sama, seragam antara pihak konvensional dan juga takaful. Tetapi pihak takaful juga mempunyai elemen dari segi pematuhan syariah. Mereka perlu mematuhi setiap keperluan syariah dan mereka juga mempunyai syariah *advisory council* masing-masing tersendiri untuk melihat produk-produk yang diperkenalkan supaya ianya selaras dengan konsep syariah yang diperkenalkan.

Contohnya *risk pooling* pun sebenarnya adalah salah satu daripada bantu-membantu konsep syariah dalam Islam juga dan juga untuk tidak membebankan kepada pemegang-pemegang polisi. Dari segi itu memang ada Yang Berhormat, kita pantau dari segi pematuhan melalui polisi ataupun dasar yang dikeluarkan oleh syariah *council* di pihak insurans tersebut dan juga oleh SAC pada *national level* yang dipengerusikan di Bank Negara.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, terima kasih. Saya sebelum saya mula saya pun perlu— *we have to congratulate BNM also.* Tadi saya lupa cakap *for your very fast interim measures* lah, *okay? That actually cool down the whole country or else it will become a big, big problem for the government. Congratulations ya. Okay I want to go into this ITO,* ITO dia selalu kata dia tak boleh *sustain,* dia rugi dari segi *medical* dan dia *threatened, so called softly threatened that it will pull out for Malaysia because of they cannot make money here so they will not provide service. I think first I think we want to call them a bluff* lah *okay.*

Number one Malaysia is what you called young nation, our economic is growing, people are the income is growing as well. So, this is a very good market for any ITOs to come in, okay. The way I see that ITOs dia tidak boleh *sustain is because themselves because they give product yang* macam-macam, *promise the sky dan all kinds of incentive, they give big bonuses to their own staff okay* dan akhirnya yang bayar itu adalah polisi-polisi *holders.* Jadi adalah *are very doggy and very— what do you call business practices to me lah. I feel that, that's why* itu sebab ada ramai terutamanya di Amerika Syarikat*, the CEO United Health Insurance* itu dibunuh oleh seorang *and then the suspect become instant hero because his has done justice for everyone else.*

So, I think this is what is going on with what do you called this insurance company. Dan saya tidak kata Malaysia *insurance company in Malaysia is like Amerika ya because we have a very strong Bank Negara Malaysia to monitor them. But I am afraid that we are going towards that, okay.* Jadi saya rasa adalah perlu *go deep into their how they make their money okay, how do they pay bonuses to their CEO's, to— you know to all kind of expenditure including agent-agent fees. Sometimes some of the people in public hearing, they raise up issue* katakan okey setelah mereka jual insurans itu, *six years* ejen itu akan dapat walaupun tak servis pun mereka dapat apa ini dia punya *fees, agent fees.*

Ada orang yang pergi servis pula tidak dapat *fees* tersebut maka ini ada isu-isu yang ketidakadilan di kalangan ejen juga lah ya. Jadi itu saya rasa perlu ada *what do you call a system that is sustainable because the first six years* sememangnya dia— duit itu tidak masuk pool pun. Kebanyakan masuk ke ejen. *I think* majoriti lah *60 or 80 percent* duit itu adalah kepada ejen, kepada *service fees,* kepada syarikat insurans tetapi duit itu tidak masuk *pool for six years.* Jadi ini adalah menyebabkan pool itu tidak boleh *sustain.* Okey *so I think that's number* one.

Isu kedua adalah *claim ratio* sebenarnya semua pool ada *claim ratio* dia okey dan dikatakan lah *claim ratio* Malaysia ini adalah antara yang terendah di Asia Tenggara. Dan *Singapore have a claim ratio of about 80 percent but their pool are*

still surviving and can sustain. Why are claim ratio that insurance Malaysia which is 65 percent cannot sustain the pool. So, this is something that I think Bank Negara should look details into it.

And then the 3rd issue adalah *co-pay.* Bank Negara baru-baru ini bagi kelulusan untuk *co-pay, I want to cautious here co-pay* ini dia sebenarnya adalah satu yang ketidakadilan kepada orang yang susah. *Let say— I lived in America for 6 years; I know the co-pay system is a huge problem* kepada orang yang miskin. Mereka orang yang miskin, mereka tidak mampu beli insurans maka mereka beli insurans yang *co-pay* yang paling tinggi, yang paling murah. *So* apabila berlaku sakit atau *accident,* mereka masuk ke hospital katakan mereka dikenakan USD100,000 punya *whatever medical operation* dan sebagainya, mereka perlu bayar sehingga *50 percent co-pay.*

Okey katakan *even a 15 percent— Malaysia allows until 15 percent* adalah 15,000, bayangkan seorang yang sudah miskin mereka tak mampu beli insurans, mereka kena *fork out 15,000* untuk *co-pay*, mati mereka. *So, I this co-pay system is stacked against poor people.* Kalau kita hendak laksanakan *co-pay,* dia kena ada hadnya. Dia tak boleh lebih daripada *five percent.* Kalau— *of course* saya tahu *co-pay* itu *address buffet syndrome* tetapi kalau *you* lebih daripada *five percent orang* itu susah. *And* sebenarnya *Malaysia the medical bill* ini *is about maximum* pun *on average, maximum* pun *RM100,000. Ya there is nothing that more than RM100,000.*

■1240

So, five percent, RM5,000 I think masih diterima. Kalau *co-pay* itu *50 percent, RM50,000*, tak ada orang boleh bayar tersebut. *So,* saya harap komen sedikit daripada Gabenor.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. Saya akan komen sedikit berkenaan dengan beberapa isu yang dibangkitkan dari segi produk yang tidak bersesuaian dan juga dari segi *co-pay* dan juga beberapa isu-isu pengawalseliaan oleh ITOs. Jadi di situ, kami *in terms of the claims special* dan juga isu berhubung dengan pengawalseliaan ITO, contohnya dari segi *bonus payment* dan sebagainya.

Saya setuju apa yang Yang Berhormat sebut. Memang semua pihak termasuklah ITOs juga mempunyai peranan untuk memperbaiki cara kita beroperasi dan cara mereka memperkenalkan produk dan cara mereka menjualkan produk. Kita akui Yang Berhormat. Di sini kita sama-sama perlu mengambil tindakan bersama untuk menangani isu-isu ini.

Contohnya, *if* kita tengok di slaid inilah, di mana kita berkomited untuk meneliti dan menambah baik semula pertama, dasar pengumpulan risiko. Kedua, dari segi

reka bentuk produk mereka supaya memastikan produk yang dikeluarkan adalah sesuai dengan keperluan pihak-pihak pemegang polisi dan tidak pada harga yang terlampau tinggi.

Juga ketiga, dari segi amalan jualan produk mereka dengan penggunaan ejen dan sebagainya. Kami memang akan mengkaji. Ini adalah antara langkah-langkah yang kami akan ambilkan. Ada lima langkah akan kami ambilkan Yang Berhormat, untuk menangani isu yang Yang Berhormat sebutkan tadi.

Kedua, saya ingin menyentuh sedikit berkenaan dengan keuntungan ITO. Sebenarnya kalau kita tengok Yang Berhormat, *just to put the point to acknowledge*. Di bawah dasar-dasar interim yang kita laksanakan pada masa ini, ia melibatkan kos kepada insurans sebanyak RM2.6 bilion sebenarnya. Ini ialah untuk membiayai langkah-langkah interim, namun *of course* kita akui ini bukan langkah penyelesaian. Tapi, mereka telah ambil *hit* jugalah. Kita pastikan mereka ambil *hit*.

Kedua, kita dapat lihat banyak produk MHIT semakin mengalami kerugian. Bila kita tengok dari segi portfolio dan sebagainya. Jadi, ini memang tidak menyumbang kepada keuntungan mereka.

Keuntungan mereka datang mungkin dari produk-produk lain. Sebagaimana Datuk Jessica ada *mentioned* tadi, mungkin tidak adil untuk kita *cross subsidising of their product* sebab produk lain juga akan mengalami peningkatan harga walaupun prestasi mereka adalah baik. Itu dari segi kedua.

Ketiga, dari segi *co-pay*, saya akui *co-pay* bukanlah merupakan penyelesaian yang ideal. Tetapi, kita *come in* pada masa tersebut untuk memperkenalkan *co-pay* ini adalah kerana tidak ada usaha-usaha yang sembilan ini. Tidak ada usaha yang betul-betul holistik untuk menangani peningkatan inflasi kos perubatan.

Jadi, *co-pay* adalah satu cara untuk memperlahankan peningkatan kos perubatan di mana kita menggalakkan kebertanggungjawaban oleh kesemua pihak termasuklah pihak hospital dan pihak pemegang polisi supaya kita berhemah dalam kita menggunakan tuntutan insurans kita.

That was the only reason why we have it. But co-pay we see has worked in other countries. But perhaps, co-pay as part of the nine initiatives that we have undertaken, then perhaps as well we'll be able to achieve a more effective…

Tuan Sim Tze Tzin [Ahli PAC]: *Can you limit the co-pay to only five percent?*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Okay. At the moment,* kita tak *limit*-kanlah.

Tuan Sim Tze Tzin [Ahli PAC]: Dia tak *limit*-kan, tak ada *limit,* kan?

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Belum sebab kita ingin melihat *the performances* dulu. Kita ingin melihat data-data dulu macam mana, *then we*

memang ada *intention* untuk mengadakan had limit. *Maybe let me invite Datuk Jessica to come in, please.*

Datuk Jessica Chew Cheng Lian [BNM]: Okey. Terima kasih Gabenor. *So*, sekarang ini kita tak mengehadkan *co-pay* ini sebab makin tinggi *co-pay, the premiums will be lower. So*, kita nak bagikan pilihan untuk pemegang polisi yang dari *different background, different income levels and all that.* Sebab ada juga pemegang polisi yang suka *co-pay* yang tinggi.

Contohnya mereka yang mampu, kalau *co-pay* mereka boleh menanggung contohnya RM10,000 kalau kena masuk hospitalkah, RM10,000 dalam *out of their own payment, out the pocket*. Jadi kalau dapat produk itu, memang pun pemegang, penanggung ITO pun menyediakan produk macam itu, premium dia sangat rendah. *For that group of policy's holders, they preferred that kind of product. In fact, that takeout for that group is actually higher.*

So, kita nak menyediakan pilihan bagi pemegang polisi daripada *different walks of life.* Tapi yang penting, yang produk asas yang kita akan bangunkan ini, itulah yang kita boleh *regulate co-pay* itu. Jadi, dia bagi sasaran pemegang polisi produk itu, kita akan menetapkan had *co-pay* yang sesuai untuk *group* itu, kumpulan golongan pemegang polisi itu. Itu kita akan meneliti.

So, sekarang ini kebanyakan polisi yang ada *co-pay*, had dia RM500 *deductible*. Dia *co-pay* itu dalam bentuk *deductible*. Jadi, dalam satu tahun polisi itu, jumlah yang akan ditanggung oleh pemegang polisi hanya dihadkan kepada RM500. Itu yang kebanyakan polisi yang ada dalam pasaran sekarang ini.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Kuala Pilah. *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Adnan bin Abu Hassan [Ahli PAC]: Terima kasih Yang Berhormat *Chairman*. Terima kasih. Saya ingin merujuk perhatian Yang Berhormat Dato' Seri lah, Gabenor, tentang pelaksanaan *diagnosis-related group* (DRG).

Soalan saya Dato' Seri, adakah model ini telah di-*implement* di mana-mana negara— DRG ya, pelaksanaan DRG ini dan— kerana ada daripada bacaan saya ada negara yang melaksanakan kaedah ini dan gagal. Jadi, mungkin di Malaysia ini mungkin akan ada sedikit pengubahsuaian.

Oleh kerana itulah tadi soalan saya bertanya kepada Dato' Seri, adakah ini dirasakan model yang paling terbaiklah untuk Malaysia? Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat, saya rasa soalan berhubung dengan DRG, mungkin lebih baik diperjelaskan oleh pihak KKM. Saya difahamkan ada juga sesi dengan KKM, mungkin mereka boleh memberi penerangan yang lebih baik berkenaan dengan pelaksanaan DRG. Tetapi apa yang

kita lihat, memang ada negara-negara yang telah pun melaksanakan DRG dan juga memang berjaya.

Contohnya di Indonesia dan Thailand. Mereka telah mengamalkan DRG dan kita dapat lihat dari segi keberkesanan dasar DRG tersebut. Jadi, ada banyak contoh yang kita boleh ambil dan banyak pengalaman yang kita boleh belajar daripada negara-negara tersebut, bagaimana kita hendak memastikan DRG ini mencapai matlamat yang kita inginkan.

Contohnya, satu *precondition* yang paling penting pada pandangan pemahaman saya adalah *database*. Kita perlukan data-data dari segi kos mengikut *diagnostic group* tertentu dari pihak swasta, pihak *government* dan juga mungkin pihak ITO juga boleh berkongsi *database* mereka.

Jadi bila ada data berkumpulan sebegini, *then that's where we have a very good data point* untuk memastikan kita dapat pada kadar yang bersesuaianlah dari segi DRG kita. Mungkin pihak KKM akan dapat memberi penjelasan yang lebih baik akan perkara ini. Terima kasih, Yang Berhormat.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Shah Alam. *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Haji Azli bin Yusof [Ahli PAC]: Terima kasih Yang Berhormat Timbalan Pengerusi, Datuk KSP dan juga Dato' Rasheed. Saya tertarik dengan sebab kenaikan kos perubatan yang antaranya menyatakan tentang perbezaan jumlah kos rawatan antara pesakit GL dan juga yang *pay and claim*.

Saya rasa ada satu lagi kategori yang juga terkaitlah dengan perbezaan kos ini iaitu yang mendapatkan rawatan perubatan, tetapi yang tidak *claim* pun. Maknanya dia memang bayar sendirilah. Itu kadang-kadang saya termasuk dalam kategori itu juga walaupun ada insurans, tapi kadang-kadang contoh macam isteri kah anak, dia pergi, dia tak nak masuk dalam— tak nak *warded*-lah *so to speak* kan. *So, I have to pay*-lah. *Warded* itu leceh lagi, macam-macam sebab duduk dalam dan sebagainya. Tapi, *rate* dia itu memang berbeza.

Hari itu bila ada pembentangan daripada— *no*, bukan pembentangan, taklimatlah daripada Persatuan Perubatan hospital, mereka menyatakan dia kata yang kadar rendah yang diberikan kepada penerima rawatan yang membayar sendiri ini adalah macam dia orang kata macam bagi *sort of charity*-lah. *But the charity should not be obtained or taken from those who are paying the insurance.*

Makna *if you want to make charity, you should contribute from your profit or whatsoever, CSR* lah kan. *So* dalam hal ini, macam mana Bank Negara dalam inisiatif yang dicadangkan tadi boleh meng-*regulate*-lah, *so make sure that the* kadar itu tidak terlalu jauh berbezalah antara satu sama lain.

■1250

Dan yang mendapatkan rawatan perkhidmatan secara membayar sendiri ini, tidak *claim* ini pun dapat juga pembelaan sebab mereka juga membantu hospital kerajaan *because* dia mengurangkan kebergantungan orang ramai pergi ke hospital kerajaan.

Keduanya, berkenaan dengan *rebate*. Ada juga cadangan dari orang ramai yang hadir pada masa *public hearing* itu juga mencadangkan supaya ada *sort of* macam *rebate* kepada pembeli insurans ini yang memang tidak pernah *claim for at least 25, 30 years.* Saya antara yang tak pernah *claim* lah, *alhamdulillah.* Tak *claim* itu maknanya baguslah, sihatlah kan kita. Kita tak nak *claim because* bila kita *claim* kita tak sihat. *So...*

Tapi bila kita tidak *claim* itu *actually there is a cost to it. Number one, either you maintain your healthy lifestyle meaning you* pergi *gym, you* beli alatan sukan dan sebagainya, *so that is a cost to it to maintain a good health* kan. Akan tetapi dalam masa yang sama, *you still want the protection. So, you still continue to buy the insurance and pay the premium.*

Nombor dua, kalau *you have been prescribed by the doctor,* ada lah darah tinggi, macam-macam lagilah kan, *so, you* pun nak *maintain your health, so you buy drugs and* macam-macam lagilah.

Contoh sayalah, *I maintain about— I, myself and my wife, I maintain about RM500 a month to maintain a good life* lah dengan *pressure*, dengan Parlimen dan jumpa rakyat dan sebagainya memang lepas itu bila jumpa rakyat ini dia dengan jamu satu hari dengan 10 kali makan ini, memang tak boleh kontrollah, gula makan kan. *So, I have to buy drugs prescribed by the doctor, so I maintain that lifestyle. So,* dua bayar, bayar premium bayar *this one.*

Akan tetapi *at the end of the day,* nanti kalau dah umur katakan dah gaji Parlimen pun dah tak ada, *I have to— how do I continue* kalau premium itu dinaikkan *because of the aging factor* tadi itu kan, *and the pool is getting lesser and the cost of* tuntutan itu bertambah. *So*, bagaimana cadangan itu yang *rebate* itu? Sekurang-kurangnya mereka yang tidak membuat *claim for a certain period of time at least* boleh *top-up* lah maksudnya *at the later age something like that.* Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. Ada dua perkara, pertama dari segi perbezaan caj itu. Memang saya bersetuju malah dari segi penelitian kami pun dengan menggunakan data-data daripada *claims* punya data *from the ITO* dan juga *from a few studies undertaken* memang ada perbezaan dari segi sekiranya seorang itu pergi dengan GL ataupun pergi bayar dahulu *claim* kemudian ataupun bayar sendiri, memang ada perbezaan. Akan tetapi data kami

adalah agak terhad, kami terima daripada pihak insurans sahaja. Memang ada pihak juga yang *question our database.* Akan tetapi secara kasarnya, memang kita perhatikan terdapat perbezaan. Jika kita pergi dengan GL harga lebih tinggi dari segi kalau bukan setakat dari segi caj kalau masuk hospital, caj penggunaan peralatan pun sama, berbeza harganya.

Kalau bayar sendiri dulu *and claim* kemudian, kurang sikit. Kalau bayar sendiri memang lagi kurang. Saya bersetuju dengan apa Yang Berhormat sebut tadi sekiranya mereka nak buat CSR, tidak bolehlah juga membebankan pihak yang mempunyai insurans.

Kedua, kenapa kita amat menekankan kemampanan dari segi kos perubatan? Ini adalah kerana kita nak pastikan supaya insurans dapat terus beroperasi dan kedua, kita menggalakkan mereka untuk memperkenalkan produk asas kerana kita nak memperluaskan *inclusivity of* orang ramai atau rakyat yang mempunyai insurans-insurans perubatan dan juga boleh mendapat perkhidmatan hospital swasta dengan mudah. Jadi ini juga akan mengurangkan bebanan ke atas hospital kerajaan. Memang selaras dengan apa Yang Berhormat sebut tadi.

Kedua, dari segi *rebate*, memang ada banyak cadangan dari segi *rebate. Rebate* ini ada dia punya *positive side* dan juga ada dia punya *downside. Downside* dia kadang-kadang bila kita nak pertahankan, nak dapatkan *rebate* atau NCD itu kita akan cuba elak daripada pergi hospital. Kadang-kadang apabila kita pergi hospital, mungkin dah terlewat dan kos lebih tinggi kepada *patient* tersebut dan juga kepada *insurance company* dan juga sebagainya. Itu yang kedua.

Akan tetapi kita telah menggalakkan malah ada banyak *insurance company* telah mula pun membuat— contohnya, *incentivize provide* insentif *for people* yang *goes to the gym* atau mengamalkan pemakanan yang sihat dan sebagainya, mereka memang ada insentif-insentif yang diberikan kepada pemegang polisi insurans yang menuju ke arah tersebutlah. *That is something that I think* memang dah ada dan kita akan lebih galakkan perkara-perkara inilah. *Jes, want to add?*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Timbalan...

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, ya Timbalan, ya.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *...Vice Chair.*

Datuk Jessica Chew Cheng Lian [BNM]: Terima kasih, sekejap saja. Yang produk yang menggalakkan *healthy lifestyle* itu memang dah ada tapi dia tekankan *healthy living rather than no claim.* Sebab *no claim* itu kadang-kadang pun ada dia punya *adverse consequence,* orang mungkin *delay treatment* kah kan dan dia juga akan mengurangkan *risk pooling*. Jadi orang yang *claim* dia punya pelarasan premium lagi tinggi pula. *So*, yang kita menggalakkan produk yang ada sekarang

dalam pasaran itu menggalakkan *healthy livings. So*, kalau *you* buat *exercise* semua itu *then your premium* dia boleh kurangkan sikit. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Sik *you* nak tanya tadi.

Datuk Ali anak Biju [Ahli PAC]: Pengerusi, saya tadi.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Hajah Halimah Ali [Ahli PAC]: Betong, Betong.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Okey, terima kasih Timbalan Pengerusi. Terima kasih Sik kerana memberi laluan. Saya hadir pada *public hearing* yang diadakan di Parlimen pada hari Jumaat yang lepas. Antara isu yang ada dibangkitkan ialah daripada individu yang menjangkau usia warga emaslah yang disebut oleh Bayan Baru tadi. Jadi kerisauan mereka ialah apabila melepasi umur 60 tahun dan berpencen dan mereka yang telah membeli insuranslah daripada ITO ini.

Jadi saya sendiri juga memang membeli insurans daripada ITO dan *last week,* saya ada terima surat daripada ITO dan memberi dia punya perubahan amaun premium tahunan yang perlu dibayar. Apabila sekian-sekian umur 60, 70 memang dia punya peningkatan— maaflah saya lupa nak bawa itu. Daripada semalam saya teringat tapi hari ini saya lupa nak bawa dia punya surat daripada ITO itu. Jadi memang peningkatan itu amat tinggi dan bagi julat umur 70 tahun itu memang kalau tak silap saya *more than 100 percent* lah. Jadi bayangkanlah kalau pada umur warga emas yang tidak ada pendapatan yang tetap dan tidak ada simpanan, maka dia tidak dapat membayar lagi premium itu. Maka polisi itu akan *lapse*. Jadi apabila dia *lapse,* memang tidak ada *coverage* lagilah.

Jadi persoalannya, adakah ada kaedah-kaedah ataupun pendekatan lain yang di negara luar yang dapat kita ikut? Supaya ada satu kaedah yang dapat membantu warga emas ini iaitu satu sistem macam *life time insurance policy* ataupun insurans kesihatan universal di mana apabila kita menjangkau umur warga emas, dia punya premium itu *at least maintain*-lah tidak membebankan *you* untuk *maintain* sampai umur *you* mencapai 80 tahunlah. *So,* adakah terdapat apa-apa kaedah di negara-negara lain yang dapat kita *adopt* dan sebagainyalah? Sekian, terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. Memang kami prihatin dari segi peningkatan premium khususnya kepada pemegang polisi yang telah berumur.

■1300

Inilah salah satu cara kata yang kata ingin menangani masalah ini adalah dengan memastikan produk yang diperkenalkan adalah mengikut keperluan individu

tersebut. Jadi, apa yang kita nyatakan tadi dari segi produk asas kesihatan ini dengan beberapa prinsip panduan dan juga penjagaan kesihatan berasaskan nilai dengan beberapa parameter tertentu ia akan memenuhi keperluan pihak yang mungkin dah berumur sekiranya mereka tidak mampu untuk membeli premium insurans sebelumnya.

Contohnya, Yang Berhormat katalah pada masa muda, produk yang dipegang mungkin produk yang *medical insurance* yang ada kaitan ataupun ada juga berunsurkan elemen-elemen pelaburan dan sebagainya, *investment-linked* contohnya. Apabila kita beralih umur mungkin kita tak perlu lagi *investment-linked,* kita cuma perlu *basic medical product* sahaja. *So, this product* asas ini akan memberi kemudahan tersebut kepada pemegang-pemegang polisi tersebut.

That is why kita beri banyak penekanan untuk kita mengeluarkan atau memperkenalkan produk insurans asas yang seragam kepada semua pihak. *This is* usaha yang kita lakukan. *Insya-Allah,* kita akan dapat menangani masalah ini menerusi produk asas ini, Yang Berhormat.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Saratok.

Datuk Ali anak Biju [Ahli PAC]: Terima kasih Sik. Terima kasih Timbalan Pengerusi. Saya tertarik dengan *page* nombor sembilan tadi. Cuba balik *page* nombor sembilan. Item nombor lapan itu. Inisiatif pembaharuan sektor kesihatan. Mungkin BNM boleh menerangkan apakah sebenarnya langkah-langkah tersebut iaitu hospital tidak berasaskan keuntungan. Adakah itu *new hospital* ataupun *existing* hospital swasta? Dan macam mana pandangan BNM yang hospital swasta sekarang ini, adakah mereka ini *too much capitalist approach?* Dan *profit* dia orang macam mana tiap-tiap tahun, adakah ia terlalu banyak ataupun *just enough for expenses* dia orang?

Sebab kita nampak sekarang ini makin ramai *foreigners* yang pergi ke Malaysia untuk berubat. Malah kadang-kadang hospital itu lebih daripada 50 peratus adalah *foreigners.* Jadi, macam mana *charges* dia orang ini, sama kah tidak dengan *local?* Itu satu.

Tapi yang menarik perhatian saya adalah hospital tidak berasaskan keuntungan. Mungkin *can you explain a bit more?*

Dato' Seri Abdul Rasheed Ghaffour (BNM): *Thank you,* Yang Berhormat. Contoh hospital tidak berkeuntungan ini adalah contohnya seperti Hospital Lam Wah Ee di Pulau Pinang, Hospital Tung Shin di Kuala Lumpur dan juga Hospital Assunta di PJ. Di mana mereka beroperasi berlandaskan setakat memenuhi kos operasi mereka sahaja bukan bermotifkan keuntungan langsung. Kita akan menggalakkan

lebih banyak hospital-hospital sebeginilah di mana mereka bertujuan untuk memberi perkhidmatan dan sebagainya.

Ada tiga contoh yang baik dan inilah merupakan idea daripada Kementerian Ekonomi untuk memperbanyakkannya lagi hospital-hospital sedemikian. Itu dari segi hospital tanpa keuntungan ini.

Dari segi keuntungan pihak hospital. Memang pada pandangan kami berasaskan kepada *charges* ini, kita rasa mungkin tinggi tetapi *of course I think we may not be in the position to comment on this* sebab apabila kita berbincang dengan pihak swasta mereka mengatakan ROE mereka dalam 10 peratus *which is actually* lebih kurang sama dengan apa yang dilihat di negara-negara lainlah.

Namun, *this is of course, I think something that we need to validate and we need to discuss and see what is the best level of appropriability or reasonable level of appropriability of the private hospitals.* Terima kasih.

Datuk Johan Mahmood Merican [MoF]: Izinkan saya tambah. Berhubung dengan hospital yang tidak berasaskan keuntungan. Sebenarnya macam yang contoh yang diberikan, sebenarnya bukan sahaja ia punya tahap hasil *revenue* hanya mencukupi, memadai hanya untuk operasi tetapi ia perlu lebihan sikit supaya boleh digunakan untuk pelaburan untuk meningkatkan *infrastructure,* peralatan dan sebagainya.

Tapi berdasarkan hospital tidak berasaskan keuntungan. Biasanya antaranya ialah dia distrukturkan supaya dia tiada pemegang saham. *So,* tiada isu dividen yang disalurkan dalam pemegang saham.

So, dengan itu antara galakkan yang diberikan kerajaan memberi pengecualian cukai tertentu atas keuntungan yang dibuat oleh hospital tersebut supaya keuntungan itu dapat dilaburkan semula untuk meningkatkan prasarana dan kemudahan ia lah sebab seperti mana yang dikongsikan kos peralatan perubatan semakin meningkat dan seperti mana yang Dato' Seri Gabenor sebut dalam hospital swasta perlu juga memastikan bahawa keuntungan ini mencukupi juga supaya prasarana dan perkhidmatannya masih dapat di tahap yang sepatutnya.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry Datuk,* saya nak tanya macam yang tiga hospital ini *you* kategorikan sebagai *non-profit* punya hospital? *Is it* dia orang yang beritahu kah? Kah macam mana itu? *How is it? They apply* kah apa?

Datuk Johan Mahmood Merican [MoF]: Sebab ada layanan cukai yang tertentu untuk hospital yang tidak bermotifkan keuntungan. *So,* mereka perlu memohon kepada Kementerian Kewangan dan LHDN untuk mendapatkan status tersebut.

Tapi antara syaratnya ialah hospital tersebut itu tidak ada pemegang saham individu ataupun syarikat. Biasanya *they normally held under trust structure.* Macam Tung Shin ia ada Lembaga Pemegang Amanah yang dari segi tata kelola bagaimana ia beroperasi.

Tuan Sim Tze Tzin [Ahli PAC]: *On this point,* kalau boleh Pengerusi, saya nak tanya sebab kami difahamkan apabila *we did research, some of the country* dia tidak membenarkan hospital mereka *list on their Bursa.* Contohnya di Korea. Mereka tidak membenarkan syarikat hospital untuk *list* kerana mereka rasa itu adalah satu perkhidmatan. *Our health is not for profit. The principle is health is not for profit.*

So, untuk kita di Malaysia ini, kita ada IHH, kita ada KPJ, dan sebenarnya Khazanah dan juga EPF, *they invested in this companies, okay. So, at the end, it's a vicious cycle because this is for profit organisation. Their objective is to maximise the profit. I'm not saying that they're profiteering but they maximise to the max. So, if I can— if you read the newspaper, their profit is 10 billion, one billion. The smaller one is one billion. Bigger one 10 billion profit. Okay.*

So, saya rasa ini adalah sesuatu yang kita sebagai satu negara, *we have to think of whether health is for profit or not?* Bolehkah kita *you know, I think we should think about this and not to make money out of other people's misery, especially our health.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Doctor gets blame, you know?*

Tuan Sim Tze Tzin [Ahli PAC]: *Doctors another issue.* Tapi saya rasa *is matter of principle we shouldn't let our hospitals to be listed.* Itu soalan nombor satu kepada KSP.

Kedua ialah tentang *I* nak bagi satu contoh *even— okay, we talked about Lam Wah Ee. We talked about Tung Shin. But another model that I think I want to present to this committee and also Bank Negara* dan KSP adalah satu model lagi *for profit but a charitable hospital. Which I think it exists in* Negeri Sembilan.

The hospital is called CMH. It is run for profit but their profit is very minimal and then they return most of the profit back to the patients. I think that model is quite good because it used to be loss-making hospital and then this group— siapa nama dia, dia masuk, *they turned around the hospital, now its profitable. They made RM12 million a year but they returned 80 percent which is about RM9 million to RM10 million back to what do we call to help the poor, a charitable fund to help the poor and they don't maximise the profit.*

Which I think the model we should look into details, whether how to make it. Okay. Kalau bolehlah. Kita *apply* juga kepada IHH dan juga KPJ *and Sunway* lah. *I*

mean this. For example, one of the public hearings mereka bangkitkan bahawa ada satu hospital mereka ada *grand piano, a*da satu akuarium, tiga tingkat akuarium itu.

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This is excessive. Hospitals, go back to the basic lah*. Basic is to provide healthcare, provide healthcare. We are not like asking for a six-star hospital. We want a three-star effect, three-star facility but five-star punya healthcare* punya *delivery. I think this is what people want.* Terima kasih.

Datuk Johan Mahmood Merican [MoF]: *I think YB…*

Dr. Hajah Halimah Ali [Ahli PAC]: Tambah sikit *about* ini. *Do you— who says that this hospital can be a tourism product?* Makna yang tadi yang ada akuarium yang ada *swimming pool* adakah? Apa itu, kan? *Who decides? Is it KKM or you all the finance part* kah macam mana? *Then become* jadi hotel. Macam hotel. Ada *six-star hospitals*, ada yang sebut macam *six-stars hotel, six-stars hospital.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya lah tapi kalau ada market, ada orang yang mahu itu, macam ada sesetengah hospital kita yang mana presiden di luar negara datang sini untuk dapat rawatan. *So, there is a niche for certain market for certain as medical tourism.*

Dr. Hajah Halimah Ali [Ahli PAC]: *That's the question that I'm asking them. Do you have that kind of category or anybody can become six-stars?*

Datuk Johan Mahmood Merican [MoF]: Yang Berhormat, *I'm not— I know YB quoted there's a country where they don't allow for listed companies but* seperti mana Yang Berhormat sedia maklum setiap negara ada dia punya model tersendiri dan kebanyakan negara ada dari segi perkhidmatan awam-swasta, perkhidmatan awam *and models in between. So, whether it's a private-public and there are also models in between whether they are not for profit or charity-based.*

I think the current model that we have akhirnya *in many industries you do need profits in order to generate a return so that there will be sufficient investment in that. I think some of these hospitals they cater for a market that there is there, there are some who are— desire that level of services and able to afford it.* Hanya isu ialah dari segi dasar kerajaan ialah supaya memastikan bahawa rakyat secara amnya yang tidak mampu mempunyai perkhidmatan yang sebaiknya lah.

Mungkin dari segi kejayaan negara Malaysia untuk menarik pelancong kesihatan masih menunjukkan bahawa terdapat perkhidmatan kesihatan swasta yang masih kompetitif dan berkualiti yang menjadi satu tarikan. *So*, isu yang dibangkitkan yang kita nak percapai *what is the right balance. So, I think that's why there are some things that we should regulate and there are some things which we*

should leave to market. It's a continuing challenge I think for government to always find the right balance to achieve the best outcomes.

Tuan Sim Tze Tzin [Ahli PAC]: Untuk poin itu Datuk KSP, saya tidak pertikaikan *free market sometimes is better so that the industry grow.* Tapi sekarang kita nampak bahawa dia bukan— dia *excessive profit.* Dia mungkin dah sampai ke *excessive profiteering* di mana keuntungannya berbilion-bilion ringgit tetapi dia masih caj *you know— what do you call this inflation continue to hike the price. It makes, it's drives out the M40.* Hanya *T20* mampu, yang lain dia *push them to the government hospitals. I think this is crumbling the general hospital (GH), government hospital. So, I think government has to come in where there is excessive profiteering.*

Okey, contohnya kalau berlaku macam ini, kalau *if we want to let them to continue the lease, maybe can we impose a windfall tax on them and then take the money to subsidise certain health initiative or something or go back to our government hospital? I think the government must actually address* isu yang *excessive what you call— a bit maximizing the profit* dari segi itu.

Datuk Johan Mahmood Merican [MoF]: *Again* Yang Berhormat dia mesti cari apa yang— imbangan yang betul lah. So, pada masa ini seperti mana yang telah dibincang, kerajaan pun ada kuasa kawal selia atas caj atas doktor, *so specialist fees and all that has already regulated. The issue that we are trying to content with is what is the— how to control the general charging of the other hospitals services whether they are excessive procedures or whether it is— so, I think we are not yet in a position where at the moment we are not looking yet at any form of windfall tax. I think what is put here is the initiatives that we are doing to ensure that there is a reasonable charging for healthcare services.*

But let us work on this approach which is something that has at least achieved some alignment all the relevant stakeholders— whether it's Ministry of Health, Ministry of Finance also the insurance companies and hospitals. This is at least the approach that we approve.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *I think maybe if I can a little bit into what KSP has said. I think it's really* sebab *striking the right balance between I think profitability and also providing services because we also want them to make some profit. Because profit is very important for them to also invest in term of new equipment, new technology, new ways of doing surgery and everything. I think* Yang Berhormat *you are right, striking the right balance there.*

Kedua*, I think I like the point you raised just now in terms of hospitals that has public motivation plus charitable as well. I think it's something a model that we can also look and how do we encourage this kind of establishments in the future. Third, I*

think as KSP mentioned these are the nine key initiative that we believe may not be the best but this is something that we believe can achieve the matlamat kita untuk menangani dari segi peningkatan kos perubatan yang tinggi ini, *insya-Allah*. Saya rasa dengan sokongan dan juga kerjasama dari pelbagai pihak dan juga Yang Berhormat sekalian memberi sokongan kepada kami, kami akan cuba sedaya upaya untuk mencapai melaksanakan sembilan inisiatif ini untuk mencapai objektif yang kita inginkan. Terima kasih.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Pengerusi, sikit sahaja mungkin mohon penjelasan berkaitan perkara empat inisiatif ini— penerbitan jurang harga perkhidmatan kesihatan. Jadi adakah ini juga bermaksud kita ingin meletakkan harga syiling caj rawatan *(price cap)* ini. Adakah itu yang dimaksudkan? Dilihat ada kewajaran maknanya kalau di-*explore* ada rawatan-rawatan itu dia sudah, maknanya kita boleh lihat secara jelas kosnya itu contohnya macam konsultasi doktor pakar. Jadi caj rawatan bilik. Jadi, itu mungkin boleh dibuat satu harga syiling dia.

Ada beberapa negara yang kita tengok dia menggunakan kaedah harga syiling ini termasuk kalau di *Singapore* itu dia sebut *fee benchmark*. Itu maknanya sudah ada syiling yang sudah ditetapkan dalam *certain-certain* perkara dalam rawatan itu. Dia mungkin juga ada *relate* dengan DRG itu bagaimana ada yang sudah pun ditetapkan harga dan tidak boleh melebihi dari mana kita telah menetapkan harga yang dikata syiling itu. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. *I think* memang betul apa yang kita inginkan di sini adalah julat, *it's a range*. Julat kos rawatan berdasarkan kepada data-data yang kita kumpulkan daripada syarikat insurans, daripada hospital dan sebagainya. Jadi, dia sebagai sedikit gambaran ataupun *benchmark* kepada pesakit dan juga kepada insurans dan hospital, *this is the range of cost* yang kita dapati secara amnya lah. *It's more for that objective.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Yang Berhormat Pengerusi, terima kasih Datuk Wira dan Datuk KSP. Ada yang meminta kerajaan untuk mempertimbangkan penubuhan *national health insurance as one of the mechanism to diversify healthcare financing. What is your opinion on this? Thank you.*

Datuk Johan Mahmood Merican [MoF]: Yang Berhormat, terima kasih atas soalan tersebut. Mungkin soalan ini lebih sesuai dituju kepada pihak Kementerian Kesihatan. Pada satu masa dahulu, Kementerian Kesihatan sememangnya pernah melaksanakan kajian dari segi pembaharuan sistem kesihatan secara amnya dengan cadangan untuk mewujudkan satu sistem seolahnya yang, seperti mana

yang mungkin ada di negara seperti UK lah— diwujudkan satu *national insurance.* Ada mungkin ada *pro and con* nya. Tapi antara mungkin isu.

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Mungkin antara sebab mungkin perkara ini tidak dilanjutkan ialah isunya sesuatu *national health issue* mungkin mewujudkan satu cukai barulah yang dikenakan atas semualah dan sama ada penerimaan ramai berhubung dengan dikenakan satu cukai baru. Ia juga satu— *it is a very fundamental change in our system where there will just be— [Tidak jelas] one purchaser of all health care across public and private health care which is a very big change from our current system. So,* mungkin itu juga dalam pertimbangan kenapa Kementerian Kesihatan tak lanjutkan cadangan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Cadangan ini dah ditutuplah? Tutup buku?

Datuk Johan Mahmood Merican [MoF]: Itu yang sekadar saya tahu fasal ia pernah dikaji oleh Kementerian Kesihatan tapi tak— *it was not progressed.* Mungkin nanti bila berjumpa dengan Kementerian Kesihatan, mungkin mereka boleh menjelaskan dengan lebihlah pertimbangan berhubung dengan kajian tersebut.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ini *financial.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I mean, just on this question— is this something like a national health insurance?*

Datuk Johan Mahmood Merican [MoF]: *What you have in UK*-lah*, it's a separate tax which is used to pay for health care but then where the funds are then used to buy services on both public and private healthcare. It's a very different model from what we have now.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Is it possible? I* tahu pada lebih kurang 15 tahun yang lepas di Parlimen, *I* ingat Kementerian Kesihatan pernah bangkit idealah tapi itu idea sahajalah untuk ada macam *national health insurance.*

So, waktu itu saya masih ingat kerana saya di Dewan, saya dengar perbahasan. *Is* that sama ada model apa, lepas itu kita tak dengar apa-apa lagilah. Tapi saya rasa mungkin kita boleh ada *national health insurance* bagi mereka yang membayar EPF, KWSP.

So just take out two percent or five percent daripada apa yang mereka sumbang kepada KWSP dan kita ketepikan, *aside to be...*

Seorang Ahli: *From employees? [Bercakap tanpa menggunakan pembesar suara]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *…From employees* walaupun kita ada SOCSO-lah*, you know. It's a kind of health insurance for— I do not know. This is just throwing ideas.*

Okay, actually I want to ask— tadi saya dengar yang mana sekarang kerajaan memang tidak ingin *regulate,* menyelaras *insurance premium* tapi macam tak ada satu badan untuk mengawal selia, kan? *So, is* Bank Negara *the body that can play this role* kerana saya rasa *since half a year ago*, semua *insurance companies* mereka naikkan premium mereka dan ini jadi satu masalah.

So, how come they can pakat *among themselves and based all this premium, suddenly with high— some of them like what YB Sim* kata yang dengan *percentage* yang sangat tinggi. *So,* adakah bila mereka buat semua ini perlu dapat kelulusan daripada Bank Negara ataupun kita sekarang mungkin perlu wujudkan satu badan untuk lihat yang kesemua permohonan daripada syarikat insurans ini bila mereka nak naikkan premium?

So maybe mungkin kita juga boleh lihat sama ada kita *set up* satu tribunal bagi mereka yang ingin mengadu. Kita dengar pada hari Jumaat yang lepas, *500 over people* punya *complaints*, macam mereka tak ada saluran untuk mengadu, membentangkan aduan mereka. *They do not know what is a channel? Can they write to* Bank *Negara or write to whom? They only write to* wakil rakyat *and we cannot do anything.*

So, whether the government can consider to set up some sort like tribunal and also this— a body that oversees insurance companies' premium.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Saya dulu *and I will invite Jessica to come in as well.* Memang pada masa ini kita *regulate*. Apabila kita memberi panduan dari segi penyelarasan premium, memang ada beberapa elemen untuk memastikan mereka mengambil kira dari segi kemampuan dan juga *affordability of the* pemegang polisi dan juga sekiranya harga naik dengan mendadak, mereka perlu memastikan ada produk pilihan kepada pemegang polisi ini.

Sekiranya ada berlaku di mana mereka rasa tertindas dan sebagainya, memang mereka boleh pertamanya berhubung dengan ITO tersebut. Kedua, mereka boleh datang ke Bank Negara juga melalui *link*. Mereka boleh *complain* kepada Bank Negara dan kami akan lihat. Sekiranya penyelesaian pun tidak memihak kepada mereka, mereka boleh pergi kepada— *is it OFS, Jess?*

Datuk Jessica Chew Cheng Lian [BNM]: FMOS. *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: FMOS, *now* kita *called it*— kita dah *combined* dengan SIDC, *it's financial mediation oversight…*

Datuk Jessica Chew Cheng Lian [BNM]: *Ombudsman [Bercakap tanpa menggunakan pembesar suara].*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *...Ombudsmen. So* ada, memang ada *this kind of tribunal where they can go there to also complain and we will look into this matter.* Memang dah ada.

Tuan Sim Tze Tzin [Ahli PAC]: *On this point*-lah kalau boleh Pengerusi, *I received complaint* daripada— *you know I have a platform, people complain. They told one of the complain that they told us is first,* kepada ITO. ITO memang memihak mereka sendirilah, ITO.

Pergi ke Bank Negara, mereka rasa Bank Negara tidak memihak kepada mereka walaupun ada *all these very strong evidence. And then* pergi ke *ombudsmen, ombudsmen* pun— *the ombudsmen is funded by ITOs.*

So, they feel that ombudsmen pun side kepada *ITO because it is not independent. The funding for ombudsmen by the ITOs. So,* mereka rasa itu adalah tidak adil dan *on Friday,* seorang *complain* begitu panjang *and they drag me on the side and then— you know that guy, I tried to stop him from speaking but he continued to speak to me for half an hour, okay.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Kalau ada *those kind of complaints, I think we will be very happy to see it. We will be very happy to know I think the complaint and see what we can do* Yang Berhormat. *I think that— I'm giving my commitment and that we will look into that matter.*

Tuan Sim Tze Tzin [Ahli PAC]: *No, you have to address the issue of the independence of the ombudsmen because the funding comes ITO. It doesn't carry— it doesn't give confidence to the* rakyat *that it is independent.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *It supposed to be independent maybe Jess wants to explain it? The set up.*

Datuk Jessica Chew Cheng Lian [BNM]: *Thank you, Governor. So YB, since December actually, we have received 12 cases.* 12 kes yang dirujuk kepada Bank Negara *and we have helped to facilitate* dengan pihak ITO dan kesemua 10 daripada 12 kes itu sudah diselesaikan *and you know both parties came together and managed to find a solution.* Yang dua kes lagi *we are still helping to facilitate. So,* memang *we will help* seperti mana yang Gabenor dah cakap.

On the financial mediation ombudsmen service, although the funding is industry-funded, but we have— we regulate the setup of the FMOS together with ACN, it has independent— it is subject to independent board of directors. Majority independent board.

The fees also are set in a way that does not influence the outcome. The ombudsmen semua *are independent within the organisation. And every year FMOS will be given enough to sustain its operation. So they are not subject to any influence from the industry. That is all regulated. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *I mean principally the ombudsmen must be seen to be— must be fair and seemed to be fair. Is should be independent and seen to be independent. I think the money should not come from the ITOs. The way I see it*-lah *because …*

Datuk Jessica Chew Cheng Lian [BNM]: *In fact, the— just very quickly, the fee structure in such that it setup in the way in encourages the ITOs to settle it themselves because they pay of flat fee, they all pay a flat fee regardless of outcome or whatever cases. But if they have more cases, they pay higher fee.*

So, that is to encourage them to settle the case at their end instead of ding-donging and then going to the FMOS. So, we set it up in a way to encourage swith resolutions of complaints. Thank you. The Chairman is independent chairman as well as board members.

Datuk Johan Mahmood Merican [MoF]: Yang Berhormat, saya nak menyentuh balik kepada soalan daripada YB Teresa berhubung dengan KWSP. Seperti mana YB sebut sememangnya pada tiap masa memang ada banyak cadangan untuk mengeluarkan wang daripada KWSP tetapi ingin ditegaskan objektif utama KWSP untuk memastikan bahawa simpanan persaraannya mencukupi. *So,* dengan itu, itulah dari segi prioriti memandangkan ramai ahli KWSP yang tidak dapat mengumpulkan simpanan persaraan yang mencukupi.

Namun demikian, seperti mana YB mungkin sedia maklum di bawah KWSP, pada masa ini ada satu skim i-Lindung di mana terdapat lebih kurang— *I think* sekurang-kurangnya lima syarikat insurans di mana ahli dapat buat pengeluaran daripada Akaun Sejahtera ataupun akaun dua untuk membeli insurans hidup dan penyakit kritikal.

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So, mungkin itulah satu perkara tertakluk kepada— terdapat produk yang sesuai dan mungkin itulah yang sesuai dikaji untuk ditambah baiklah dari segi bagaimana kita dapat tambah baik kemudahan untuk menggunakan sebahagian

daripada Akaun Sejahtera untuk membeli insurans. *I think if we get the right design then it will be suitable to look into using part of account two, especially since when you do that approach sometimes it helps save distribution and hence to get a better advantage for the EPF members.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *But I think the— you see, now I think some of us only know that it such a thing as called ombudsman on this healthcare thing. But I think all of us know about that is the tribunal, housing tribunal. So,* kalau ada apa masa— isu pertikaian dengan perumahan, mereka akan pergi dekat sana dan dia ada *benchmark* ada *below 50,000.*

So boleh saya cadangkan mungkin *the outcome of all this … is* Bank Negara *should alert come out with the statement, alert public* kalau mereka ada apa-apa aduan tentang premium yang mereka bayar ataupun *hospital bill*, mereka boleh rujuk ke sana. *So, I think is a kind of awareness that you need to inform the public*-lah*. You see* wakil rakyat juga datang, semua orang bising dekat wakil rakyat sahaja *[Ketawa].*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *We will do that, we have been doing it, I will do that* Yang Berhormat.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ada apa soalan lagi?

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]* Habis dah. Ada lagi.

Dr. Hajah Halimah Ali [Ahli PAC]: *Last* sahajalah fasal ubat, kos ubat kan. *Do you all regulate the suppliers of* ubat *or is it the KKM?*

Datuk Johan Mahmood Merican [MoF]: Yang itu ialah di bawah KKM. Setiap ubat yang boleh dijual di negara Malaysia perlu di— *there is a registration process* Yang Berhormat untuk setiap ubat yang dibenarkan dijual...

Dr. Hajah Halimah Ali [Ahli PAC]: Bukan ada yang *big, big pharma industry* itu dia apa— dia *import all the expensive medicines*, dia yang akan *supply cause* dulu dia ada kecil-kecil dah*. There were a lot of competitors. I don't know how,* macam mana dia punya apa itu kan*. Because that will affect the price of* ubat *because* kalau dia seorang jadi raja, *everybody got to pay* ambil daripada dia.

Datuk Johan Mahmood Merican [MoF]: *I think* Yang Berhormat— seperti YB sedia maklum, produk yang masih di bawah paten itu memang dia yang dapat kuasai harga dia dan mereka pun akan menetapkan harga yang berbeza mengikut negara berdasarkan dia punya perancangan mereka. Tetapi pada masa yang sama, untuk ubatan yang tiada lagi paten ataupun generik sebab kerajaan ada dasar untuk mengutamakan pembelian ubatan generik.

So, dengan itu, daripada kontrak perolehan kerajaan, ubatan-ubatan generik tersebut akan juga didaftarkan untuk dibenarkan untuk pasaran tempatan dan

hospital-hospital swasta punya boleh juga mengambil kesempatan daripada ubatan generik yang memang dibeli dan dengan itu didaftarkan untuk kegunaan di Malaysia.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Bayan Baru *last one* ya,. *After that we have to end.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, saya akan *combine* semua soalan saya. Tapi semua berat-beratlah. Nombor satu adalah isu tentang— disebabkan oleh *we take actions on this insurance company.* Sekarang *insurance company* mereka tengah *consider* bukan paniklah tapi mereka ada banyak yang mereka cuba buatlah. *So*, nombor satu adalah dari segi *rejection of claim* ya. Ada ramai yang saya terima bahawa mereka mula *denied claim* tidak— walaupun dulu dapat, sekarang tak dapat.

Then doctor's pun mereka *dictate doctors okay,* boleh pakai ubat ini, tak boleh buat prosedur ini. Walaupun ada kes yang contohnya mereka perlukan *PET scan* untuk kanser tapi insurans kata tak perlu atau katakan mereka kata perlukan ubat ini, mereka— insurans kata tak perlulah macam itu. *So,* ada isu-isu ini bagaimana Bank Negara *while there still try to maximise the profit*-lah, *okay. Their profit companies what. So, how does Bank Negara intervene into this? Because this involved technical and MOH and Bank Negara didn't have a joint committee to look into all these complaints, all right.* Dia tak— *you manage on the financial side, MOH manages on the clinical side.* Tapi tak ada platform untuk *address this kind of complaints. So, what is your solution?* Soalan nombor satu.

Soalan kedua adalah tentang *investment linked*. Ramai kata *investment linked* ini sebenarnya *a scam* lah. Sebab walaupun dia kata *investment linked* tapi *fees*, *their actually promote their— let's say* katakan Prudential kah*, Great Eastern. They have their own fund. So, the money they take, they promote their product*-lah*. The money goes to the product. And then the financial services are quite high, the fund manager gets a card. Okay.*

Eventually is— they just added into— then the agents got a lot of cards also ya. The agents got— The first six years, they got a lot of money. So, a lot of people promote investment linked. So, can Bank Negara look into the issue of investment linked?

Okey, isu ketiga adalah— *this one I feel very strongly. I feel very sad*-lah sebab *during the public hearing,* ada ramai OKU datang dan juga ada orang yang *born diseases*. Saya ada satu perkataan, ada satu persatuan.

Datuk Johan Mahmood Merican [MoF]: *Congenital, is it?*

Tuan Sim Tze Tzin [Ahli PAC]: *Haa yes. They say they were born with this disease, okay. They have no choice. The mother is like crying. I have a child like this, I want to buy insurance, we cannot buy insurance.* OKU pun kata*, they cannot buy*

insurance. There's no one who they can buy any insurance. So, how are we going to help this kind of marginalised community? This is not their fault, they were born that way. Okey, OKU pun bukan di pilih, dia ini takdir.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Dia di lahir macam itu.

Tuan Sim Tze Tzin [Ahli PAC]: Di lahir macam itu. Jadi, *they have no way to buy insurance. How to address this issue?*

And last sekali adalah isu *Financial Services Act from all this 'huu huu haa' about insurance,* MHIT, ITO dan sebagainya. *What are the things that we should be— do anything that we need to amend the law to give more power to BNM to regulate? Because this is an opportunity.*

If you want to reform, we reform total-lah. *Cannot be telling, Okay, what you call MOH to reform but Financial Services Act* tak payah. *I mean if we can do are comprehensive one, once and for all this one year, we do all the necessary for. Last, very last is your basic— can you tell us more about your basic care* itu? *Basic insurance, how are you going to implement it?* Lima soalan. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. *I will try to answer some of the questions. I was saying but there just coming to answer some of the questions that you sent it. There're a lot of questions* yang semuanya memang penting. Pertamanya daripada segi *rejection* dan juga sebagainya. Memang apabila ITO melaksanakan *interim measure*, sebagaimana saya sebutkan tadi Yang Berhormat, memang dia melibatkan kos kepada mereka dan juga menjejaskan juga *profitability* mereka.

Apabila ia menjejaskan *profitability* mereka, dia mempunyai impak ke atas kapital mereka. Dari segi dasar, modal yang mereka perlu pegang. Akibatnya Bank Negara telah mengarahkan syarikat insurans untuk mengamalkan kos *containment*. Mereka perlu melaksanakan usaha-usaha untuk mengurangkan kos mereka. Cara yang diambil adalah untuk memastikan keadilan dari segi bayaran kepada pesakit dan sebagainya ataupun insurans sebagainya. Contohnya, memastikan hospital tidak *overcharge* dan sebagainya. Itu pertama. Itu bila kita lihat contohnya ada hospital-hospital memang caj mereka terlampau tinggi dan mereka tahu *charges* ini adalah lebih jauh daripada apa yang di caj oleh orang-orang lain. Jadi *that's where they want to— they also need to discipline the hospital. So that's why they take that kind of action.*

Kedua dari segi menangani kos-kos penjualan produk juga. Kita telah mengarahkan mereka untuk mengawal kos-kos ini. Ini adalah salah satu daripada inisiatif yang kita ambil untuk memastikan mereka dapat mengawal kos mereka.

Sekiranya ada berlaku sebarang *unintended consequences* contohnya ada *rejection* tidak— tidak sepatutnya di-*reject* dan sebagainya, mereka boleh datang ke Bank Negara. Kita akan lihat kes itu.

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Sebagaimana Jess *mentioned* tadi, daripada 12 kes dihantar kepada kita, 10 telah pun diselesaikan. Tetapi kalau macam alasan mereka adalah kukuh, memang sepatutnya kes macam ini, rawatan sepatutnya macam ini sahaja, bukan untuk melebihi dan sebagainya. Mereka boleh membuktikan yang rawatan yang diberikan ataupun *test* yang dijalankan memang melebihi daripada apa yang diperlukan. Sebab ITO juga ada doktor. ITO juga ada *professional practitioners that they can know that this kind of diseases* tak perlu buat *tests* yang tidak sesuai ini. Jadi, mereka akan *reject those kind of applications* lah. Itu pertama.

Kedua, dari segi *investment-linked* dan sebagainya, memang kita akui *that's where* kita akan menuju ke arah produk insurans yang berasaskan nilai, sesuai dengan keperluan individu tersebut dan juga kemampuan individu tersebut. Ini akan beralih. Kita ingin melihat peralihan kepada produk sebegini.

Ketiga, OKU. Memang agak sukar untuk mereka mengambil risiko ini. Tetapi, ini mungkin ada cara lain kita boleh menangani masalah ini di mana pihak kerajaan boleh datang *come in* juga dan juga dari segi *welfare*. Kita perlu mengambil kira kepentingan OKU dan sebagainya. Tetapi, kalau daripada penyakit-penyakit tertentu yang mereka perlu perlindungan yang boleh diberi perlindungan, insurans akan terus memberi perlindungan kepada mereka.

Keempat, dari segi FSA. Pada masa ini Yang Berhormat, kita mempunyai cukup kuasa untuk kita bertindak. Kita telah pun menggunakan kuasa-kuasa kita untuk mengawal selia industri insurans ini dan juga memastikan kemampanan produk. Juga kedua, dari segi memastikan keadilan kepada pemegang polisi. Tapi, kita memang akan *review from time to time regulations* kita dan juga perundangan kita. Sekiranya perlu, memang terima kasih kepada Yang Berhormat dan juga Ahli-ahli Parlimen untuk menyokong kami apabila kami pergi ke Parlimen untuk memohon pindaan kepada akta kami untuk memberi kami kuasa dan sebagainya yang berpatutan.

Akhir sekali, *basic products I think we explained just now*, ada tiga perkara. Satu, *in terms of product* berasaskan nilai. Memastikan harga lebih mampan dan juga memperluaskan skala pengurusan risiko. Kedua, mempunyai mekanisme DRG. Ada juga pembelian strategik oleh *government* dan juga swasta di mana kita dapat mengurangkan harga pembelian. Ketiga, termasuklah memperkenalkan keperluan mendapat rujukan daripada GP dulu sebelum pergi ke hospital. Sebab kita nampak

pada masa kita kadang-kadang walaupun seseorang itu tak perlu masuk hospital, bila dia pergi ke hospital sama ada *patient request* sendiri atau doktor yang *suggest* kata kalau you masuk hospital, kita boleh *claim*.

Jadi, dia duduk hospital sehari dua, kita boleh *claim*. Kita nak elakkan masalah sebegitu, jadi kita mungkin akan cadangkan pergi melalui GP. Bila GP rasa memang perlu kes ini untuk dimasukkan ke dalam wad, baru kita masuk wad. Ketiga, dari segi *parameter product* lah. Mungkin had yang tertentu dan sebagainya. Juga jika sesuai, ciri *co-payment* di mana yang berpatutan. *Jess, you want to add?*

Datuk Jessica Chew Cheng Lian [BNM]: *Maybe just one thing* dalam perkara pengamalan insurans untuk *reject claims* semua itu, kita pun sudah menubuhkan satu macam jawatankuasa kecil yang dipengerusikan oleh Bank Negara dengan pihak hospital swasta dengan industri insurans dan takaful sekali. *So*, kes-kes macam ini boleh dibincangkan di sana bagi mencapai penyelesaian. OKU juga, kami juga giat menemui pihak-pihak berkepentingan untuk memahami isu-isu mereka dan mencari penyelesaian. *So*, itu kita akan meneruskan. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Pengerusi, *last question about this interim measure.* Selepas *interim measure* itu diumumkan, walaupun— itu baguslah ya. *We have to give the credit*. Cuma, masih ada orang-orang yang dalam *public hearing,* dia kata, walaupun insurans sudah diumumkan, tapi tafsiran bermacam-macam. Ada orang yang katakan *60 and above* tidak boleh *increase* kan *the moratorium, no increase*. Tapi ada yang kata, mereka terima adalah terima daripada ITO bahawa ia hanya untuk *apply* untuk *the lowest band, the upper band* masih *increase*.

Ada yang pula kompelin kepada kami, walaupun umum 10 peratus, tapi balik-balik *20 percent, 30 percent* pun ada. Ini adalah dibangkitkan semasa *public hearing.* Jadi, tafsiran yang bermacam-macam oleh ITO dan walaupun kita katakan *start 15th of January,* tetapi ada yang umum kata mereka hanya akan laksanakan *1st of March.* Contohnyalah, ini adalah yang dibangkitkan. *So, how do you address these issues?* Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat *for raising those issues*. Memang betul, *I think we hear that as well. So, this is where* pada peringkat ini *it's still in the early stage* lah*. As I said, I still think there is still issues there that we need to also address* lah*.* Sekiranya ada kompelin-kompelin yang macam ini, kami ingin tahu dan kami ingin nak berhubung dengan *insurance company* itu kenapa mereka tak boleh laksanakan. Kami ingin menggalakkan pihak-pihak tertentu kalau ada aduan sebegini, kemukakan kepada kami.

Kedua, dari segi yang ada lebih daripada 20 peratus itu, mungkin ada sebab-sebab tertentu. Jadi, elok juga *if* mereka dapat berhubung dengan kami, kita boleh faham apakah sebab-sebabnya. Adakah sebab umur dan sebagainya dan kita boleh tangani masalah ini dengan ITO tertentulah.

Ketiga, dari segi *those above 60,* sepatutnya tidak ada pelarasan premium penangguhan. Memang *that was the* dasar yang kita persetujui. Sekiranya ada kes-kes tertentu yang berlaku di mana mereka dikenakan juga pelarasan, elok untuk kita memahami kenapa mereka diberikan pelarasan tersebutlah dan cuba untuk menangani tersebut.

Tuan Sim Tze Tzin [Ahli PAC]: Contohnya yang baru saya terima 16 hari bulan Februari, dia kata *interim measure 10 percent*, tapi dia dicaj *increment 47 percent.* Nanti saya serah kepada Bank Negara. Okey? Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Please, yes. We want to know.* Ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. *So,* saya nak umum kita tangguhkan prosiding kita pagi ini pada jam 1.46 minit. Jadi, kita akan bersidang semula pada pukul 2.30 yang mana Menteri Kesihatan akan datang berjumpa dengan kita. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih.

[Mesyuarat ditangguhkan pada pukul 1.46 tengah hari]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Isnin, 24 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Kementerian Kesihatan Malaysia (KKM)
YBhg. Datuk Seri Dr. Haji Dzulkefly Ahmad
Menteri

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

ISNIN, 24 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] *- Naib Pengerusi*
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Datuk Ali anak Biju [Saratok]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]

Tidak hadir *[Dengan maaf]*
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] *- Pengerusi*
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat Jawatankuasa Kira-kira Wang Negara, Parlimen Malaysia]
Encik Mohamad Tarmizi bin Ahmad [Penasihat Undang-undang I, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia]
Cik Jackie Mary Fernandis [Penasihat Undang-undang II, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit Pejabat Jawatankuasa Kira-kira Wang Negara, Parlimen Malaysia]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Puan Rusnida binti Muhammad Radzi [Timbalan Pengarah]
Encik Amiruddin bin Abdul Karim [Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Encik Wong Yun Fui [Timbalan Pengarah]
Suzana Binti Alias [Ketua Cawangan]

(samb/-)

Kementerian Ekonomi (KE)
Che Kodir bin Baharum [Pengarah]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) (Bahagian Perkhidmatan Sosial)]
Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah Makro]

Jabatan Akauntan Negara (JANM)
Encik Shaleh bin Hussain [Akauntan]

HADIR BERSAMA

SAKSI

Kementerian Kesihatan Malaysia (KKM)
YBhg. Datuk Seri Dr. Haji Dzulkefly Ahmad [Menteri]
YBhg. Dato' Sri Suriani binti Dato' Ahmad [Ketua Setiausaha]
YBhg. Datuk Mohd Fauzee bin Abd Majid [Setiausaha Bahagian (Bahagian Perolehan dan Penswastaan)
YBhg. Dato' Dr Mohd Azman bin Yacob [Pengarah Perkembangan Perubatan]
Dr. Davis Johnraj [Timbalan Pengarah Kanan I, Bahagian Perancangan]
Dr. Harshinderjeet Singh [Ketua Penolong Pengarah Kanan Bahagian Amalan Perubatan]
Dr. Yap Wei Aun [CEO, Health Transformation Office (HTO)]
Dr. Peter Gan Kim Soon [Pakar Perubatan Kesihatan Awam, HTO]
Encik Dinash Aravind Radhakrishnan [Ketua Penolong Pengarah Kanan, HTO]
Puan Fatkhiah binti Haji Khalil [Timbalan Pengarah Program Perkhidmatan Farmasi]
Encik Ahmad Fadhli Umar bin Aminolhuda [Pegawai Tugas-tugas Khas (Parlimen) Kepada YB Menteri Kesihatan]
Dr. Mohamad Farhan bin Rusli [Pegawai Khas YB Menteri Kesihatan]
Encik Mohd Syazli bin Yahya [Pegawai Khas YB Menteri Kesihatan]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

ISNIN, 24 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 2.34 petang

*[Yang Berhormat Puan Teresa Kok Suh Sim **mempengerusikan Mesyuarat**]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Salam sejahtera. Selamat petang dan selamat datang saya ucapkan kepada Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas, ahli-ahli ex-officio PAC terdiri daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, Suruhanjaya Pencegahan Rasuah Malaysia, Kementerian Ekonomi, Jabatan Akauntan Negara dan Penasihat Undang-undang Parlimen selaku wakil Jabatan Peguam Negara (AGC).

Yang Berhormat ahli-ahli mesyuarat sekalian, petang ini PAC Parlimen akan meneruskan prosiding kedua berhubung isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam di bawah Kementerian Kewangan (MoF), Kementerian Kesihatan (KKM) dan Bank Negara Malaysia (BNM).

Pada sebelah pagi tadi, jawatankuasa ini telah mendengar penjelasan dan keterangan daripada Kementerian Kewangan dan Bank Negara Malaysia berhubung isu ini. Seperti mana semua sedia maklum, tajuk ini tidak dilaporkan dalam Laporan Ketua Audit Negara.

Sehubungan itu, PAC menggunakan punca kuasa seperti berikut iaitu satu Peraturan Mesyuarat 77(1)(d), Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat (PPMMDR). Yang kedua, PM 83(2) (PPMMDR). Ketiga, Arahan Perbendaharaan 12 dan 301 (2023) dan yang keempat, seksyen 5(3)(d), Pekeliling Am No. 1 Tahun 2024, Organisasi Kementerian-kementerian, Jabatan Perdana Menteri.

Prosiding ini diadakan bagi tujuan mendapatkan penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan caj hospital swasta. Ini termasuk kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan faktor luar seperti pandemik.

Untuk makluman semua, PAC telah pun mengadakan dua sesi pendengaran awam berkaitan isu ini iaitu satu sesi di Pulau Pinang pada tarikh 14 Februari 2025, daripada

9.00 pagi hingga 12.00 tengah hari di AC Marriott Hotel, Pulau Pinang. Sesi kedua di Kuala Lumpur pada 21 Februari 2025, dari 9.00 pagi hingga 12.00 tengah hari di Dewan Bankuet, Blok Utama, Bangunan Parlimen Malaysia.

Sesi pendengaran ini telah mendapat sambutan yang amat menggalakkan di kalangan agensi, syarikat, pertubuhan dan individu. Pihak KKM turut hadir di kedua-dua sesi tersebut dengan diwakili oleh Timbalan Ketua Setiausaha (TKSU) Kewangan KKM iaitu Yang Berbahagia Dato' Sri Norazman Ayob.

PAC mengucapkan ribuan terima kasih di atas komitmen dan kerjasama yang diberikan oleh pihak KKM. PAC berpendapat bahawa terdapat keperluan untuk mengadakan sesi pendengaran awam berhubungan ini bagi mendapatkan pandangan dan maklum balas daripada orang awam serta kesan daripada isu yang berbangkit, khususnya kepada rakyat sebelum prosiding diadakan.

Yang Berhormat ahli-ahli mesyuarat sekalian, hadir bagi memberikan penjelasan di hadapan PAC dalam prosiding pada petang ini ialah Yang Berhormat Datuk Seri Dr. Haji Dzulkefly Ahmad, Menteri Kesihatan Malaysia dan Yang Berbahagia Dato' Sri Suriani binti Dato' Ahmad, Ketua Setiausaha Kementerian Kesihatan Malaysia. Terima kasih saya dan PAC ucapkan kepada Yang Berhormat Menteri Kesihatan kerana sudi hadir di hadapan PAC bagi memberikan penjelasan pada hari ini.

Sebelum saya menjemput saksi untuk memulakan pembentangan dan memberikan penjelasan, ingin saya maklumkan kepada semua ahli-ahli mesyuarat sekalian bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 iaitu Akta 88 dan Peraturan Mesyuarat 85, Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat (PPMMDR) sehingga prosiding selesai dan laporan dibentangkan di Dewan Rakyat.

Jadi, tanpa membuang masa, saya menjemput Yang Berhormat Datuk Seri Dr. Haji Dzulkefly Ahmad untuk memulakan pembentangan. Dipersilakan, Yang Berhormat Datuk Seri.

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [Menteri Kesihatan, Kementerian Kesihatan Malaysia]: Terima kasih. Terima kasih, Timbalan Pengerusi PAC, YB Teresa Kok. Seluruh Ahli PAC, Ahli-ahli Yang Berhormat sekalian, sahabat-sahabat saya daripada pengurusan tertinggi KKM, Dato’ Sri KSU dan rakan saya, Dr. Yap Wei Aun selaku CEO, Health Transformation Office, semua

pengurusan tertinggi daripada KKM dan rakan-rakan yang menjadi— yang turut bersama dalam mesyuarat pada petang ini.

Saya mulakan dengan lafaz yang mulia, *assalamualaikum* dan salam sejahtera semuanya. Salam Malaysia Madani. Izinkan saya, Timbalan Pengerusi PAC untuk pertama-tamanya merakamkan setinggi-tinggi penghargaan kepada PAC atas inisiatif dan keprihatinan terhadap isu yang amat penting ini.

■1440

Inflasi perubatan ataupun *medical inflation* dengan izin, atau lebih khusus lagi dalam agenda mesyuarat ini adalah peningkatan premium insurans adalah isu yang amat dekat sebenar-benarnya di hati saya dan warga Kementerian Kesihatan. Saya yakin kita akan bersama-sama berkongsi *insight* dan perbincangan ini dan juga berkongsi kebimbangan yang sama.

Keprihatinan awam yang meluas, Kementerian Kesihatan juga sangat peka dengan mengikuti perkembangan perbincangan awam ataupun *in the public domain* dengan izin, berkenaan perkara ini. Termasuk sesi yang dianjurkan oleh yang dikatakan sebagai pendengaran awam ataupun *public hearing PAC* di Pulau Pinang dan Kuala Lumpur baru-baru ini. Penghargaan terhadap perspektif pelbagai pihak, KKM menghargai kesediaan PAC untuk mendengar suara rakyat serta perspektif KKM dalam mencari penyelesaian yang terbaik untuk semua.

Saya telah membangkitkan isu— sebenar-sebenarnya saya telah membangkitkan isu inflasi perubatan atau *medical inflation* ini yang sememang tinggi diakui sejak pertemuan pertama saya dengan Jawatankuasa Pilihan Khas Kesihatan (PSSC) pada 2 April 2024 yang lalu. Ini seperti yang direkodkan dalam prosiding laporan Parlimen, laporan PSSC. Susulan daripada itu, KKM telah mengemukakan penyelesaian melalui Pelan Transformasi Pembiayaan Kesihatan secara komprehensif di mana ia juga merangkumi langkah-langkah pembendungan kos melalui kerjasama bersama-sama dengan Bank Negara Malaysia. Pelan ini telah pun dibentangkan oleh Pejabat Transformasi Kesihatan kepada Jawatankuasa Pilihan Khas (HTO) kami, Dr. Yap Wei Aun dan *team* membentangkan kepada JKPK Kesihatan pada 27 Ogos 2024 tahun lalu.

Kerjasama KKM yang berterusan dengan Bank Negara Malaysia dan agensi-agensi yang terkait, yang berkaitan telah berjalan sejak beberapa bulan yang lalu. Malah sebelum isu kenaikan premium perubatan ini menjadi tumpuan, kita telah pun mencari pelbagai pendekatan dan penyelesaian dan merancang transformasi sejak awal. Kalau boleh saya sikit lagi menyebutkan. Saya perlu merakamkan bahawa inflasi perubatan merupakan isu yang kompleks, sangat rumit dan rencam sifatnya yang dihadapi oleh banyak negara di seluruh dunia. *This is a global challenge for*

now. Terdapat pelbagai faktor yang menyumbang kepada inflasi ini. Sebahagiannya adalah munasabah dan wajar, namun ada yang memerlukan intervensi yang agak segera.

Dalam kesegeraan kita menangani isu inflasi perubatan ini, kita perlu— saya ingatkan berhati-hati, cermat dan teliti dalam mengaplikasikan amalan terbaik global dan *global best practice* dan tidak mengambil tindakan yang dilihat seperti agak tergesa-gesa yang mungkin saja boleh mengakibatkan kesan yang tidak diingini atau dengan izin, *the unintended consequences* yang akan pastinya menjejaskan kualiti dan akses kepada penjagaan kesihatan baik pada masa ini mahupun masa depan yang diistilahkan sebagai *primum non nocere* ataupun yang dikatakan ini adalah *Hippocratic Oath* utamakan ataupun "*First, do no harm".* Dalam usaha kita mencari penyelesaian, jangan pula kita mencetuskan atau apa yang dikatakan sebagai kemudaratan. *This seems legal magazines* ada dalam Islam sebenarnya, *[Berucap dalam bahasa Arab].*

Kementerian Kesihatan mencadangkan penyelesaian yang holistik dan menyeluruh secara kolaboratif seperti yang dibentangkan nanti dan kami akan— Dr. Wei Aun akan membentangkan perkara ini. Namun saya ingin menegaskan kepada semua bahawa penyelesaian komprehensif sebegini memerlukan waktu, memerlukan sedikit masa untuk dilaksanakan dan untuk kita capai tahap kematangannya. Justeru, langkah-langkah sementara, jangka pendek yang diumumkan oleh Bank Negara adalah bersesuaian untuk tempoh terdekat ini.

Kesimpulannya, saya ingin merakamkan sekali lagi setinggi-tinggi penghargaan kepada Ahli-ahli PAC atas keprihatinan terhadap isu kritikal yang mendepani negara hari ini dan rakyat. Kementerian Kesihatan juga mengharapkan kefahaman semua Ahli Parlimen sepanjang fasa perlaksanaan jangka panjang dan dengan langkah-langkah interim yang sedang dilaksanakan.

Dengan itu, Kementerian Kesihatan memohon sokongan Ahli-ahli Yang Berhormat saudara sekalian dalam usaha kami melibatkan semua pihak berkepentingan untuk menggerakkan sistem kesihatan negara baik awam mahupun swasta ke arah satu yang saya selalu sebutkan sebagai berganjak kepada *paradigm value based healthcare and system of care delivery.* Itu saja ringkasnya yang dapat saya sebutkan sebagai pengantar Pengerusi PAC dan saya menyerahkan pembentangan ini, kalau dengan izin kepada Yang Berusaha Dr. Yap Wei Aun selaku *Chief Executive Officer of our Health Transformation Office.* Sekali lagi, jutaan terima kasih. Sila Dr. Aun.

Dr. Yap Wei Aun [CEO, Health Transformation Office (HTO), Kementerian Kesihatan Malaysia]: Salam sejahtera Yang Berhormat Puan Teresa

Kok, Naib Pengerusi PAC; Yang Berhormat Ahli Jawatankuasa Kira-kira Wang Negara yang lain, Yang Berhormat Datuk Seri Dr. Haji Dzulkefly Ahmad, Menteri Kesihatan; Yang Berbahagia Dato' Sri Suriani, Ketua Setiausaha Kementerian Kesihatan Malaysia.

Terlebih dahulu, saya ingin merakamkan terima kasih juga kepada PAC kerana mengambil inisiatif untuk memperhalusi dan mendalami isu inflasi perubatan. Pihak kami amat peka terhadap kebimbangan rakyat tentang isu yang penting ini. Malah isu ini telah pun dibangkitkan ke Jawatankuasa Pilihan Khas Kesihatan tahun lepas bersama dengan strategi awal pembendungan. Kementerian Kesihatan amat menghargai peluang untuk mengkongsikan strategi seluruh negara yang diusahakan bersama kementerian dan agensi yang lain termasuk Bank Negara Malaysia. Inflasi perubatan adalah suatu isu yang membangkitkan emosi dan agak serius kerana berkenaan dengan liputan kesihatan yang berkait dengan nyawa manusia. Namun, ia adalah suatu isu yang kompleks. Kita perlu menerapkan amalan terbaik antarabangsa dan memperkenalkan rangka penyelesaian yang komprehensif untuk membendung inflasi perubatan. Tetapi penting untuk ditekankan, kita mesti mengelakkan daripada tindakan reaktif, tergesa-gesa yang boleh membawa kesan sampingan yang tidak diingini. *Primum non nocere, "First, do no harm".* Boleh saya minta slaid kemudian.

Pembentangan petang ini akan meliputi empat perkara. Pertama sekali punca inflasi perubatan swasta. Kedua, *is* pembendungan harga perubatan swasta secara menyeluruh. Ketiga, *is* strategi seluruh negara untuk membendung inflasi perubatan dan akhirnya inti pati kritikal. Saya mahu meminta maaf terlebih dahulu disebabkan perkara inflasi perubatan adalah suatu perkara yang agak teknikal. Jadi saya menjemput soalan klarifikasi daripada Ahli Parlimen pada bila-bila masa untuk setiap slaid yang dikemukakan. Izinkan saya juga untuk menggunakan dwibahasa disebabkan penggunaan istilah teknikal yang banyak. Slaid yang kemudiannya. *[Merujuk pada pembentangan slaid]*

Secara am, ada dua punca inflasi perubatan. Dekat kiri punca yang munasabah dan dekat kanan punca yang tidak munasabah dan sesuai untuk intervensi. Yang punca-punca munasabah, antara yang paling penting adalah pertama sekali adalah mengenai perkembangan teknologi perubatan. Ini adalah satu perkembangan yang positif di mana skop rawatan amat meningkat. Jadi *people with cancer or cardiovascular disease* yang masa dulu kita fikir, *"I'm sorry, tak ada banyak rawatan untuk anda. Just balik rumah dan sebagainya".* Sekarang kita ada *option* untuk merawat mereka tetapi rawatan ini mungkin lebih berharga.

Kedua *is* kita juga meningkatkan hasil kesihatan, *the outcomes are better.* Dulu bila kita rawat seseorang mungkin dia hidup enam bulan. Sekarang mungkin dia hidup lebih lama. Jadi hasil kesihatan juga meningkat. Yang penting *is* kita patut memastikan bahawa bila kita cuba membendung inflasi, kita tidak membendung punca yang munasabah yang akan menyebabkan kesan yang tidak diingini.

Kedua adalah penuaan masyarakat dan peningkatan penyakit yang tidak berjangkit yang akan meningkatkan keperluan penjarakan perkhidmatan kesihatan dan juga permintaan untuk perkhidmatan tersebut sambil meningkatkan kompleksiti penjagaan tersebut. *When there are a frail elderly patient, they may need a longer time in hospital. They may need a multidisciplinary team* untuk menjaga mereka secara rapi.

■1450

Mereka mungkin lebih kecenderungan untuk masuk lagi kepada hospital. *I think we can see that in our families*.

Faktor ketiga adalah kos input seperti gaji *including* gaji bagi jururawat kami dan tenaga kerja yang lain yang makin meningkat. Saya rasa ini adalah satu punca yang munasabah. *I hope that we do not want to reduce the salaries of our health workers. Related to that* juga peningkatan kos input seperti kelengkapan, infrastruktur, komoditi kesihatan yang kebanyakan daripada mereka dipanggil *internationally traded and the price is usually in US Dollars*. Jadi, kita terbuka kepada *the global market issues as well.*

Faktor keempat yang munasabah saya rasa *as our country becomes more economically develop*, pendapatan kami makin meningkat, ekspektasi rakyat juga makin meningkat. Dulu bila saya pertama sekali kerja dekat hospital, ada satu wad yang lebih *better described as a hall* daripada satu wad. Tetapi sekarang *we want better quality services and we expect better outcomes.*

May I draw attention kepada punca dekat kanan yang tidak munasabah dan sesuai untuk intervensi. Pertama sekali adalah bahaya moral ataupun *moral hazard* ataupun dalam bahasa yang lebih *familiar,* sindrom meja bufet. Ini adalah dalam konteks insurans swasta.

Bila kita dalam satu situasi di mana liputan pembiayaan bermula daripada ringgit yang pertama, di mana pesakit sebenarnya tidak terdedah kepada hanya harga sebenar, pembekalan dan permintaan untuk perkhidmatan, ujian, prosedur, akan kurang selaras dengan keperluan klinikal yang sebenarnya. Jadi, masalah ini sudah pun ditangani oleh Bank Negara melalui *co-payment* dengan *deductible* yang mereka sudah mengenalkan. *So, I think that is quite important*.

Faktor ketiga adalah tokokan harga khasnya seperti farmaseutikal yang berlebihan *and* apa yang sedang dilaksanakan oleh Kementerian Kesihatan bersama dengan agensi yang lain adalah pemaparan harga dekat klinik dan hospital swasta supaya pengguna boleh melaksanakan satu keputusan yang lebih termaklum bila mereka memilih tempat untuk menerima perkhidmatan dan ini akan mewujudkan persaingan yang lebih bagus di sektor kesihatan swasta.

Faktor ketiga adalah kekurangan persaingan untuk membekal opsyen yang lebih mampu milik dekat— ini, *we are talking about hospitals here*. Kebanyakan hospital lebih menekankan *hoteling experience* yang lebih meningkatkan *five stars, six stars* dan sebagainya tetapi kita kurang membekalkan opsyen yang lebih mampu milik.

Ada dua inisiatif yang kita sudah laksanakan. Pertama sekali adalah inisiatif Rakan KKM dan juga untuk mengembangkan hospital yang tidak berasaskan keuntungan *or non-profit hospitals*. Tetapi *the fundamental issue* iaitu yang keempat adalah penggunaan kaedah pembayaran *fee for service* atau fi untuk perkhidmatan yang jelas difahami secara global adalah satu kaedah pembayaran yang pro inflasi, yang kurang cekap dan sebagainya.

Jadi, *the key point from this slide is at the bottom*. Ini adalah satu isu yang kompleks. Saya faham bahawa kesemua Ahli Parlimen memang menerima tekanan kuat daripada *constituency* mereka untuk mengenalkan satu penyelesaian bagi inflasi perubatan. Tetapi yang penting sekali adalah bahawa kita patut elak daripada penyelesaian yang akan membawa kesan yang tidak diingini ataupun *unintended consequences.*

May I pause here for soalan klasifikasi atau *I can move on to the next slide*? *Just klasifikasi* sahaja.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Can he move on*?

Dr. Yap Wei Aun [HTO]: Kalau tak ada soalan klasifikasi, saya boleh teruskan kepada slaidnya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Boleh saya tanya soalan sedikit, Datuk Seri?

Dr. Yap Wei Aun [HTO]: Silakan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya bersetuju dengan apa yang disebutkan dalam sebab-sebab itu berpunca daripada inflasi perubatan swasta ini, Datuk Seri. Tetapi apa yang diperkatakan ini betul. Tetapi dari segi praktisnya Datuk Seri, punca kenaikan premium insurans ini banyak orang memperkatakan bahawa disebabkan oleh *private hospital charges* yang tinggi, maka insurans kena naikkan premium, Datuk Seri.

Hospital charges ini Datuk Seri dari segi apa yang penyelidikan saya yang taklah menyeluruh, kita dapati ada *charges* yang *exorbitant*, terlalu tinggi dan juga hospital swasta ini dia caj benda-benda yang tidak sepatutnya dicaj. Kalau kita tengok Datuk Seri, saya pernah tengok saya punya pun. Saya selalu pergi *Assunta Hospital*. Saya tak pernah beli insurans Datuk Seri sebab saya rasa selama ini pun saya jarang masuk hospital. Jadi, kalau duit yang sepatutnya saya bayar ke insurans 10 tahun sudah, kalau *accumulated* pun saya boleh bayar *charges* yang ini, kan?

Umpamanya, *very classical example*. *Depa* caj *glove,* Datuk Seri ya. *Surgeon glove* ataupun *examination glove*. *One pair,* RM20 tetapi sebenarnya kos itu satu kotak *glove* RM20. *I mean,* benda-benda macam ini hospital *shouldn't charges the patient*. *You make profit in other things,* kan Datuk Seri? Banyak benda lagi dia boleh buat *profit*.

Kemudian, satu kes. *One* hospital swasta. Orang nak pergi buat PET scan, Datuk Seri. Dia tak ada *equipment* ini. *Equipment* ini dia perlukan kelulusan daripada Jabatan Nuklear dan sebagainya. *So, what happened* ini dia— doktor ini tulis, hantar *patient* ini ke *another* hospital yang ada *that specialisation*, yang ada *equipment* itu. Apa yang terjadi? Caj, jumlahnya RM5,000. *And the* hospital yang buat *examination PET scan* ini, dia caj hanya RM1,800. Jadi RM5,000 tolak RM1,800, RM3,200. Jadi, hospital yang hanya tulis hantar *patient* ini ke *that* hospital yang ada *specialisation PET scan* ini, *they make* RM3,200. *This is a real case*. *Real case.* Doktor itu dia tunjuk pada saya. *This is a real case*.

So, there are many other examples, Datuk Seri. Jadi, okey kita kena lihat benda ini daripada *a fair view*. Hospital swasta Datuk Seri, dia ada tanggungjawab dia. Dia tak boleh caj yang— *charges* yang *so unreasonable*, maka menyebabkan insurans *company* pula caj *unreasonable also*.

Masing-masing caj, maknanya jadi *double unreasonable to the patient which is bad. That's why* kita lihat apa yang saya baca *somewhere*. Dalam masa 10 tahun antara 2014 ke 2024 Datuk Seri, kenaikan premium insurans ini ada yang lebih daripada itu iaitu 143 peratus.

Jadi, maknanya kalau kita ambil *average per year is about 14.3 percent increase per year. That is too much and* ada yang dia orang beritahu kita masa *public hearing*, naik pada RM300, naik RM500, naik pada RM1,000, naik RM3,000. *Every year,* dia naik makin tinggi, makin tinggi Datuk Seri. Jadi, saya rasa kita kena lihat— yang ini betul, perkembangan teknologi sebagainya. Itu pun masalah juga.

The charges mungkin— umpamanya MRI. MRI itu dah— *some* dari MRI itu dah orang kata RM1 *book value* dah pun. Tak ada *depreciation* lagi. Dia caj lagi. Tak payahlah caj. Dah tinggal RM1 *book value* kan. *This kind of things*, tak rugi hospital

pun tetapi kita kena prihatin juga kepada pesakit yang beli insurans, yang kadang-kadangnya pula kalau sakit yang tak boleh dibuat *private* hospital dia hantar pergi *government* hospital. Dia tak boleh buat. Jadi insurans, bayar sahajalah. Itu *for the start* Datuk Seri. Terima kasih banyak.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya, terima kasih Yang Berhormat Kubang Pasu. Okey, saya ingat kalau kita teruskan jawapannya itu ada dalam slaid-slaid yang seterusnya, *insya-Allah*. Sila, Dr. Yap. Terima kasih Yang Berhormat Dato', Kubang Pasu.

Dr. Yap Wei Aun [HTO]: Terima kasih Yang Berhormat. Slaid yang seterusnya. *For this one, maybe I use a bit more English. Maybe it's important for us to walk through the different components of a hospital bill which is in yellow in this diagram. [Merujuk pada pembentangan slaid]*

So, what I hope to describe in this slide is to start with the different components of a hospital bill in yellow, followed by how the government is currently controlling each of these different components in red. The private sector also imposes their own controls in blue and finally on the right-hand side is our suggested holistic approach.

■1500

Allow me to talk it through starting from the box which is yellow on the top left. This is professional doctor's fees. Professional doctor's fees take up is one of the key components of a hospital bill and if you look on the right-hand side this is covered under price regulations in the form of a ceiling of the price under Akta *586. Moving down to the bottom left of pharmaceuticals, this is also a large component. This also a large component of the cost of a hospital bill. This particular one, we are imposing a retail price transparency in the form of a* pemaparan harga *based on* Akta 723.

Then, if we move down and we are talking now about all different medical supplies, medical devices, services, imaging, OT, nursing services, miscellaneous and room and board. The overall bill if you look on the red side in the vertical bar is covered under Akta 586 *as itemised hospital bill. There are also certain commodities such as gloves and masks especially during the pandemic which are covered under* Akta 723 *for the price controls. The private sector also plays some role with the blue on the right of that. Many of them negotiate discounts on the total bill and some also negotiate some pre-negotiated prices and discounts for example on the room and board. This is just indicative only, different private insurance companies have different practices but this is just to provide an indication.*

But, I think most people are wondering why is there a white empty space below retail price transparency? Kenapa ini macam tidak terkawal? *I think that's a*

key question that you want to ask us. Many have indeed asked and suggested why don't we just extend the price regulation applied to professional fees to cover every single possible item in a hospital bill including all possible supplies, medical devices, nursing services, imaging, laboratory test et cetera. Let me just remind you all, medical services are extremely complex.

We are not talking about managing the price of let say eggs or chicken. There are potentially many thousands of different items and understanding the real cost and appropriate price for each and every of this item as well as the administrative cost imposed to manage and enforce this would be very substantial. And often may I remind you if we do set a price ceiling for each of these individual items, the hospitals would treat that as the price. It may even increase inflation in the short run. But, most importantly is to remember that this exercise may not be effective and it may even result in unintended consequences.

The reason why is because hospitals may response in several ways including in ways which blunt the effect of this price mitigation intent or it may, even worse affect the quality of patient care. Let me give you some examples. They may do so by increasing the quantity of supplies and services. So, if you say that "Oh, it just reduces the markup on the particular glove." They might decide "Well, okay. We are just do keep changing gloves— I don't care we just use it for five minutes, we touch the patient once, next glove."

They could respond in that way or they may use substitutes with even higher margins so we may have a cheap old drug shall we describe it and a margin is quite low. If you don't make me allow— you want, you push it all the way down so the margin is low. Let me just find the latest new drug which has a higher margin which you may don't even need. But it's a higher margin for me, so I substitute it with something else.

Or they may decide to unbundle one item into multiple small items. I brought a hospital bill with me and when I looked at it, there will have topics which include let say nursing care as a service. We say lets say nursing care we are going to say maximum X price, how will the hospital respond? They will just unbundle and the next time you see it wouldn't be nursing care, it will be tracking vital signs, moving the patient out of the bed, taking the patient to have a bath in the toilet and doing your wound dressing. In the past, all these used to be counted under one. So, we'll end up with this kind of situation where it is not going to really work as effectively as we think so due to complexity of the healthcare industry.

Progress is also being made in health technologies and practice of medicine every day. If these services are not immediately reflected in our new price schedule,

it may affect the quality of patient care. We may not be able to get the newest technologies in. So, that's why we started by emphasizing 'primum non nocere' (first, do no harm) that cure cannot be worse than the disease.

Fortunately, moving to the right-hand side we actually have global practices to learn from. Rather than micromanaging the doctors and hospitals, we are working towards as the words in the blue say, "Satu transformasi kepada pendekatan pembendungan harga yang menyeluruh, bukan pengawal harga seunit sahaja. Ia untuk membuang insentif yang tidak wajar atau herotan pasaran."

So, if you look on the right-hand side of the screen, there is this mechanism for paying hospitals which you may heard of many times is called diagnosis related groups (DRGs) and this very simply groups together similar clinical and resource comparable episodes of care and it pays based on a single tariff for the whole episode of controlling for the severity and a complexity of case. The DRGs incentivises efficiency in contrast to the existing FFS payment mechanism which is pro inflationary.

I want you to see very clearly in this diagram, it is not only controlling the unit cost of each and every of these small items, but even the quantities and unbundling and what is actually included in this service. So, we are really encouraging as let's not move into knee-jerk reactions, to just control the price of one item here, one item there, where it can cause unintended consequences. Let's go towards a more holistic solution learning from best practices in other countries. So, that's really what we trying to urge. I don't know if we want to pause for clarifications, questions on this slide or just to finish up— there's only two other content slides.

Tuan Sim Tze Tzin [Ahli PAC]: Ya. Pengerusi. Terima kasih Dato' Seri Menteri dan juga Dato' Sri KSU dan Dr. Yap kerana berada di sini. *I am very happy that you guys are taking a very open-minded approach and work together because this is a healthcare issues that every concerned citizens are cares about. So, this is a— I salute the Minister for being very open and we have a very long discussion on this issue and I salute his dedication and his— he has the passion* lah*, he has the heart to do something and I really appreciate that.*

That's why on this point on this DRG, Malaysia— I think the KKM is trying to move towards DRG but DRG is not the be all— not the single solution for this because I think for operation, yes. But for complicated, cancer or internal— what do you call? They call internal medicine and all this, it may not work. That's issue number one. Issue number two is that there are possibility of private hospital, after they use up the— let say the budget lah*, RM20,000 for this operation and then they cannot solve*

it. So, they push it to the government hospital after they finished the insurance budget. So, that's also problem.

Learning from other country, I had a discussion with one of the countries that— the expert who came to Penang, so I had a private session with their one of the DRG expert. So, they said they actually use about 12 years to develop DRG and all the SOPs and et cetera and its actually a— because they have National Health Scheme (NHS). So, they have the power to push it. Tetapi di Malaysia ini, kita ini *a more market-friendly environment* di mana hospital swasta tidak semestinya bersetuju untuk bersama dan mereka tidak— mungkin mereka tidak rela untuk kongsikan data-data. *Then, they are also along the way, there will be a lot of— sorry to say, maybe sabotage.*

Maybe also a possible of other specialist yang tidak setuju dengan *certain— because every country has different environment and different ecosystem.* Jadi, adakah— saya hendak tanyalah sebab KKM *expert* lah, kita bukan, kita *layman*. Jadi, kita minta bahawa ada— *have you prepared because our windows of reform is very short. We only have three years moratorium and whether we can roll out DRG in time to address the issue.* Terima kasih.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Very pertinent,* sangat tepat ya, sangat mendalam ya. *It's very insightful comment* daripada Yang Berhormat Bayan Baru ya, YB Sim. *I think we will— surely will address that.* Kami pasti akan menggarap soalan itu. *It's coming in the next few slides. Don't worry. [Ketawa] Okay.* Ada lagi? Kalau tidak kita teruskan Dr. Wei Aun.

■1510

Dr. Yap Wei Aun [KKM]: *It's actually in the next slide. Thank you very much. Maybe I just— so, this is how you see all the parts fit together, right. Maybe I just answer very briefly those two initial questions. So, for DRG best practice is not to allow balance billing. So, they should not be able to just say, "Oh, if you stop this amount and then we want to charge more if you cannot pay, we will send you out". That is not what I would understand a DRG to be.*

Usually, the contracts would actually require the doctor— the hospital, sorry, to take on that commitment to see the patient for the agreed price and to deal with— in some occasion, the patient may actually be a very low, very simple case and they may fail to treat the patient. Even few resources cost them RM20,000 sometimes they pay more. But the ask is really to just deal with the case without balance billing. That's quite critical and that's why DRG is not what we would describe in the private sector here when they say that they are doing a package for caesarian.

That is not a DRG. That's actually implied risk transfer in a DRG. But that may be going too much into the detail. My minister would start saying— forking me and saying don't confuse them. I also want to confirm that DRG coverd not just surgical inpatients but also medical inpatients. This is normal practice globally. Now, maybe I just run through all these interventions that we are working on.

So, beberapa agensi kementerian terlibat dalam pembangunan strategi seluruh negara ini *and maybe it is just a caveat*. Kebanyakan daripada— *some of them, are still being finalised by the relevant ministries and agencies. So, some maybe subject to change. So, maybe they just add this caveat.* Ada beberapa kategori atau tonggak strategi seluruh negara untuk membendung inflasi perubatan ini. Yang tonggak atau kategori pertama di atas dalam warna hijau, adalah berkenaan dengan menambahkan informasi propersaingan.

Firstly, ini bermula dengan pemaparan harga ubat di klinik dan hospital swasta yang membolehkan keputusan termaklum dan menggalakkan persaingan. Yang kedua *is* kita juga sedang menyelaraskan metodologi penentuan kadar inflasi supaya perbezaan antara beberapa metodologi yang sedia ada dapat diselaraskan untuk menjadi satu metodologi. Yang ketiga *is* suatu inisiatif yang sedang dirancang *and this is related to DRG implementation.*

Ini tertakluk *autonomy caveat*, ini tertakluk kepada libat urus dan semakan undang-undang untuk menggunakan kuasa Akta 586 iaitu kuasa Ketua Pengarah Kesihatan untuk mendapat data dan maklumat harga dan minimum data set yang mengandungi maklumat klinikal untuk membolehkan perbandingan setara dan pembangunan DRG *relative weights*. Data ini seterusnya juga boleh digunakan untuk penelusan dan perbandingan harga perkhidmatan perniagaan penjagaan kesihatan lazim secara setara.

I think this is quite important. Tonggak kedua dalam warna biru adalah mengenai kelompok berkaitan diagnosis. Pembangunan sistem DRG ini melibatkan pembangunan subsistem dan kapasiti dan semakan perundangan dan semua ini adalah dalam sedang diuruskan, diusahakan. Tetapi suatu input yang agak penting adalah maklumat harga yang akan didapati melalui inisiatif daripada tonggak pertama. *That's why you can see the arrows and the interconnections.*

Ini akan diikuti dengan pengenalan DRG untuk pembayaran secara berfasa. Harus ditekankan untuk sistem ini mencapai kematangan, ia akan mengambil beberapa tahun. Menurut pengalaman global seperti mana yang dimaklumkan oleh Ahli Parlimen. *I think you all are aware of this. We can start, but for it to reach full maturity DRG, it will take many years, 10 years plus ya*. *So, this is not a new information, it is same thing. But nevertheless, we need to start. It doesn't mean that*

there is no impact at the start, because kita boleh mulakan dengan *condition* yang paling lazim dan sebagainya.

Yang ketiga adalah dalam warna kuning. Ini adalah transformasi sistem insurans dekat negara kita. Khasnya insurans dan takaful swasta. Bank Negara Malaysia dengan Kementerian Kesihatan bersama agensi berkenaan sedang mengusahakan pembangunan suatu produk, insurans takaful kesihatan asas yang lebih mampan mengandungi liputan sepanjang hayat dan *involves a change to* penjagaan kesihatan berasaskan nilai atau *value-based healthcare*.

Value-based healthcare is when we want to priorities to health outcomes or the health spending. So, its very terkait dengan isu inflasi. Produk asas ini akan digalakkan sebagai pilihan utama bagi golongan rakyat yang hendak liputan swasta dan ini akan juga di-*link* kepada satu strategi untuk meluaskan liputan swasta ini yang sedang diperhalusi dengan KWSP. Strategi pembendungan harga termasuk penggunaan DRG adalah antara ciri-ciri teras produk ini.

So, this is one of the ways why we want to use it as a mechanism to introduce DRGs and one of the interactions is between how the private insurance can then pre-hospital using DRG, once we develop this based-product together with Bank Negara *and relevant agencies*. Yang opsyen kelompok— kategori inisiatif yang keempat dalam warna merah jambu adalah dari segi pembekalan. *It's on the supply side*. Kita sedang mengembangkan pembekalan perkhidmatan hospital yang lebih mampu milik. *So, that we fill in this gap between the highly expensive, very grand hospitals and the public hospitals, we need something in between and affordable premium economy fill in.*

Jadi kita ada satu inisiatif yang dipanggil Rakan KKM yang kita sedang memperkembangkan sebagai pilihan ekonomi premium mampu milik yang juga ada boleh memainkan peranan sebagai penanda aras harga untuk mendorong hospital swasta, untuk menyemak semula harga mereka, bila mereka membuat perbandingan dengan perkhidmatan Rakan KKM ini. Kami juga menggalakkan perkembangan hospital tidak berasakan keuntungan supaya *this will be like the* Lam Wah Ee, 70 Seventh-day Adventist, Tung Shin Hospital yang mereka— *model business* mereka tidak untuk mendapat keuntungan tetapi *to provide service.*

Jadi, mereka *work on the volume* lebih daripada *the margin. I think that's quite inspiring* bila kita melawat Hospital Lam Wah Ee sebagai satu kumpulan tahun lepas. *There are also other initiatives*. Sebagai contoh, suatu inisiatif adalah DRG Health untuk mengurangkan duplikasi ujian diagnostik dengan memperbolehkan interoperasi antara sistem rekod perubatan. *So, a simple example is let's say you go*

to private Hospital A *and you get a CT scan there and now you want to go to private* Hospital B.

Rather than having you to get a CT scan done again, why don't we just create an interoperable system, so that this information can be shared across the private hospitals and maybe even the public hospital with patients having control of their data, so, that will reduce duplication of test. So, that's one of the aspirations with the digital agenda of our minister. All these do require some investments in peruntukan khusus untuk reformasi sektor kesihatan negara.

But, may I just go to the last slide before we have further questions. Dari segi intipati yang kritikal yang Kementerian Kesihatan ingin menekankan adalah yang pertama sekali, inflasi adalah suatu isu yang kompleks. Ia adalah suatu isu yang kompleks. Dia bukan— *so easy that we just book,* tukar satu *schedule and the problem is solved and we treat it like eggs or chicken*. Dia adalah kompleks kerana ada punca yang munasabah, ada juga munasabah yang tidak munasabah. Jadi, yang penting adalah untuk mengelakkan *the temptation* untuk penyelesaian yang membawa kesan yang tidak diingini ataupun *unintended consequences*. *Primum non nocere*, utamakan tidak memudaratkan.

I know that everyone is facing a lot of pressure. But, I just want to reassure you that the ministry is really working our hearts in collaboration with other ministries and agencies to address this issue. Kedua *is* transformasi kepada pendekatan pembendungan harga yang menyeluruh. Bukan pengawalan harga seunit sahaja untuk membuang insentif yang tidak wajar dan herotan pasaran. *But, this requires transformation of the structure of the* sistem pembiayaan.

This is not just interior design, change the colour of the paint of the wall, of your toilet. It's actually a structural change. Jadi, seperti yang Ahli Parlimen sudah memaklumkan kepada kami *it's something which is multiple years. This is something we should do in phases. But we are actually doing* transformasi struktur sistem pembiayaan daripada FFS *(Fee for Service)* kepada sistem DRG.

Yang ketiga adalah garis masa transformasi struktur sistem pembiayaan swasta secara fasa ini, ada juga beberapa inisiatif jangka masa pendek. Di mana impaknya boleh dirasa oleh rakyat dengan lebih awal. Tetapi juga ada pendekatan menyeluruh di mana jangka masa sederhana dan panjang diperlukan dan ekspektasi dari segi garis masa mestilah realistik. *We can start early* tetapi kematangan sistem in seperti DRG dan *pricing transparency* dan sebagainya akan mengambil beberapa tahun.

So, I think that's just the honest truth. I know we all want a quick fix. But a quick fix may result in unintended consequences. But their initial interventions which

we are going on with particularly price transparency and if bank to complement the initiative by Bank Negara *in a form that interior measures. So, that the structural change can carry on. So, that's the key message* daripada pihak Kementerian Kesihatan. Terima kasih.

■1520

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, soalan?

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau saya boleh tanya tentang isu *cases* yang *double charges* ya, *three time charges.* Contohnya, apa yang berlaku kepada denggi dan juga pneumonia di mana ada multi— saya difahamkan ada *five tiers of charging* oleh *private* hospital. *The first tier is of course the medical tourism. Medical tourist come to Malaysia, they have a charged* katakan RM10,000. *On top of it, they have agent fees of about 25 to 30 percent. Whoever refer to them, they get another extra 30 percent. So, it goes up RM13,000,* contohnya. *Okay, some kickback* dan sebagainya. Itu *tier* pertama. *Tier* kedua adalah *guarantee letter. Guarantee letter of course,* dia akan menjadi mahal. *Tier* ketiga adalah contohnya kita yang *pay and claim. Okay. Tier* keempat adalah yang tidak– *pay* sendiri, yang bayar sendiri tanpa— bukan *pay and claim* tetapi yang bayar sendirilah macam YB Kubang Pasu. Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] [Ketawa]*

Tuan Sim Tze Tzin [Ahli PAC]: Dan *last* sekali ada yang tidak dapat bayar, mereka bagilah *charity* dan sebagainya. Contohnya, yang tak mampu langsung, okey*. They give some you know maybe they heavily subsidised. So, that's five tiers.* Jadi, benda ini berlaku, apakah kerajaan ada apa-apa— sebab *to me some of the*— saya rasa amat tidak berpatutanlah dengan *guarantee letter versus the pay and claim.* Dia contohnya denggi empat kali ganda, *then* untuk pneumonia tiga kali ganda. Itu belum kira lagi yang Dato' Kubang Pasu punya kes lah, mungkin lagi rendah ya, dia punya perbezaan lagi besar. *What are we going to do about this? Because it's clearly— Sorry to say, it's abusing the insurance and causing the insurance price to go up.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Soalan macam itulah diramal soalan ini. Kita punya jawapan seperti yang tertera dalam slaid. Sila Dr. Aun.

Dr. Yap Wei Aun [KKM]: Kami sedar dan telah melihat pelbagai analisis oleh pihak industri, ITO dan hospital swasta yang menunjukkan perbezaan harga dalam bil hospital bagi episod kes yang serupa. Analisis ini menggunakan pelbagai metodologi dan tidak berasaskan maklumat yang mencukupi dan lengkap untuk membolehkan perbandingan setara yang sah bagi episod rawatan klinikal itu.

Perbezaan tersebut mungkin dan boleh mencerminkan perbezaan dalam tahap keparahan penyakit, perbezaan dalam kerumitan prosedur yang diperlukan untuk merawat penyakit, faktor pesakit seperti *comorbidities,* umur dan jantina dan sebagainya.

Bagi menambah baik analisis ini, Kementerian Kesihatan memerlukan data yang lebih lengkap dan sistematik untuk merangkumi keseluruhan sistem hospital swasta khususnya diperlukan lebih banyak maklumat mengenai diagnosis primer dan sekunder, prosedur yang dilakukan, hasil rawatan semasa discaj, berat lahir, umur, jantina dan sebagainya. Data yang diperoleh akan digunakan untuk mengkategorikan episod klinikal ini kepada kumpulan yang setara, *apples to apples comparison,* dari segi klinikal dan penggunaan sumber.

Kumpulan sedemikian juga merupakan asas kepada sistem pembayaran DRG. *So, it's related to DRG in that way.* KKM, Bank Negara dan rakan industri sedang bekerjasama untuk membangunkan pangkalan data discaj hospital swasta termasuk data minimum yang diperlukan untuk menyokong pengkategorian ini dan maklumat pengebilan yang berkaitan. Ini akan membolehkan ketelusan harga*. So that you will be aware of the prices and can make an informed consumer choice* dan perbandingan harga yang lebih setara antara hospital. *So, you are allow apples to apples comparison. So, we don't know whether the GL or the* tunai *really reflects a comparable episode of care or is it just because the population are systematically different, the severity different et cetera.*

Kuasa di bawah Akta 586 dalam bentuk sedia ada ataupun dengan pindaan yang diperlukan dijangka diperlukan untuk inisiatif ini. *Then,* berdasarkan perbincangan awal dengan pihak berkepentingan hospital swasta, telah wujud persetujuan awal mengenai perkara ini. *So, just to let you know that at least from the* Bank Negara, ITO, *private hospital, some of the major changes, they are more or less on board with the understanding that really rather than just argue, "Oh, methodologies and you say mine is three times, four times and the other person say it's actually seven percent cheaper". Let us focus on the future and the future is let's sort out our data, let's get enough data to allow an apples to apples comparison between conditions. So, that's just not industry-driven analysis and we fitting whatever narratives that they might be comfortable with. But, it's just something we just based on real comparable clinical episodes including the severity and comorbidities, patient factors, the complexity of the procedures and that's really much in the card for what we are working on together as a* seluruh negara...

Tuan Sim Tze Tzin [Ahli PAC]: *I think the KKM should go into— actually, you are trying to get the data. One of the data points that you can go into, to look into is the TPA, they call it auditor or the third-party agent* ya.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Third party administrator*.

Tuan Sim Tze Tzin [Ahli PAC]: *Administrator, yes. Third party administrator.* Mereka ini terlibat dengan *claim* dan sebagainya. *So, they have all the data. Actually, the information given to us is actually TPA who came forward to tell us that there are five tiers of charging.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: *And then, we have a whole way of regulating it and some of it is exorbitant. So, I think KKM should go into that*-lah. Terima kasih.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya. Terima kasih. Kalau boleh saya tambah sikit lagi. Sebab itu pada awal-awal kami telah menyebutkan bahawa meskipun DRG akan merupakan satu penyelesaian yang sangat baik ya, satu yang sepatutnya kita telah laksanakan sekian lamanya tapi *DRG is not a silver bullet* dalam bahasa kami. Dia bukannya senjata yang boleh menyelesaikan semula. Nah, sekarang ini baru kita perasan bahawa *important thing to do— actually, be able to* supaya kita dapat melaksanakan DRG ini, keperluan kepada data dan *this is where the National EMR. Another* satu *reform* yang saya cita-cita untuk bangunkan adalah *National Lifetime Health Record* ataupun *Electronic Medical Record* (EMR) yang akan mengizinkan *that every citizen would have— one citizen one record. They have a master patient index* yang meletakkan semua. *Insya-Allah, a few years down the road, all our health facilities* sama ada klinik, vertikal ataupun *horizontal integration, clinics to clinics and then vertical clinic to hospital, public to private.*

So, with that, dengan hanya kita dapat— *so, this is very important. It almost like a prerequisite,* sebagai prasyarat ya perasanan DRG ini adalah wujudnya data yang mengizinkan kita membuat keputusan-keputusan *that is truly data-driven.* Jadi, dengan itu saya sebutkan sekali lagi *the whole ecosystem is so very important. DRG is not the big all and all* seperti mana yang YB Bayan Baru sebutkan tadi dan dia perlu kepada *the entire ecosystem* termasuklah *besides the National EMR* itu adalah *the transparency* dan yang lainnya. Itu tambahan daripada saya.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sila. *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Hajah Halimah Ali [Ahli PAC]: Boleh tak kami PAC tahu *the category of health tourism hospitals and the non-tourism hospital? Do you have that kind of category in place or is it just by the* mungkin *by the* iklan *so,* orang Indonesia datang,

orang daripada luar datang *for surgery and all that. Do you have that? Is it in your radar?*

Dr. Yap Wei Aun [KKM]: Dari segi *regulatory, maybe I ask my regulatory colleagues to respond. But* yang saya faham *whether you are a foreigner or Malaysian* yang pergi ke hospital swasta, *the same fee schedules apply if I am not mistaken.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Dr., sila.

Dr. Harshinderjeet Singh [Kementerian Kesihatan Malaysia (KKM)]: Salam sejahtera. *[Bercakap tanpa menggunakan pembesar suara]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Guna *mic* dan bagi nama juga.

Dr. Harshinderjeet Singh [KKM]: Okey, selamat sejahtera YB Puan Teresa Kok sebagai Pengerusi Jawatankuasa Kira-kira Wang Negara dan Ahli-ahli Yang Berhormat yang lain. *Okay, the fee schedule.* Bagi saya bahas dalam bahasa Inggeris ya. *For foreigners, the fee schedule is applied to 13 fee schedules but for foreigners, there is a surcharge or additional charge of 25 percent of the maximum charger field of the maximum for the foreigners.*

■1530

For our rakyat *is the maximum chargearble which is currently in the fee schedule. But again, I repeat, in our— for foreigners coming in, we have to charge 25 percent.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Are you talking about public hospital or private hospital?*

Dr. Harshinderjeet Singh [KKM]: *It's private hospital.*

Tuan Sim Tze Tzin [Ahli PAC]: *Public... [Bercakap tanpa menggunakan pembesar suara]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Private— public right?*

Dr. Harshinderjeet Singh [KKM]: *No, private.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Private...*

Dr. Harshinderjeet Singh [KKM]: *Private hospital. For private hospital for foreigners, there is an additional charge for 25 percent of the maximum chargable fee.*

Dr. Hajah Halimah Ali [Ahli PAC]: *And, is it in the KKM's— MOH registry or something that you know, when you heard this, we heard— we heard Friday, when we had this public hearing because some of the hospitals, they said, okay. You go, hospitalisation, doctors' fees, medicine and all that, but the exorbitant fees, he was*

suprised that hospital got aquarium three— tiga tingkat? Tiga tingkat, *big aquarium,* apa lagi?

Tuan Sim Tze Tzin [Ahli PAC]: Piano. *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Hajah Halimah Ali [Ahli PAC]: *Piano. You know, in front of the lobby and all that. This kinds of six, seven star hospitals. So, is the cost of operation [Ketawa], you know, being or were shared to the patients? That means, the patient has got to pay that kind of, you know, luxury. That kind of six-star hotels and things like that.*

So, we were wondering the insurance thing, you know. Whether they are paying for what they want to have be treated with or is it the luxurious, ambience, atmosphere and all that? Is that— are you considering that? Are you aware of that? Because, we had that in the public hearing.

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: Dr. Harshinderjeet.

Dr. Harshinderjeet Singh [KKM]: *Okay. This one, because as what* Kementerian Kesihatan *or MOH, they regulates only the professional fees. That means, the consultation and also, the procedure. So, this be regulated in the [Tidak jelas] schedule of the Private Healthcare Facilities and Services Act.*

However, as what Dr. Wei Aun has mentioned just now, the other charges as, you know, lab charges, medication, your operational, your bed, your lounge, whatever, it's not being regulated. So, that may differ from one hospital to another hospital and some hospital categorised it.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry. When you say stop being regulated...*

Dr. Harshinderjeet Singh [KKM]: *No, we are— we don't develop...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Not regulated?*

Dr. Harshinderjeet Singh [KKM]: *Not regulated. So, we only regulate the consultation and also, procedure fee.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: YB...

Dr. Hajah Halimah Ali [Ahli PAC]: Okey. *I just want to add to that and I said to the BNM this morning. For* Menteri Kesihatan punya inilah *attention. If you see in this slide*— berapa ya? *You got the price regulation for* Akta— berapa? Sekejap.

Seorang Ahli: 786. *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Hajah Halimah Ali [Ahli PAC]: *Professional doctors' fees* itu, okey? Okey. *At 586. So, they are telling us that the doctors, the public hearing we had many specialists including oncologist who came which we were quite surprised that they would come, you know, to this hearing.*

They are saying that their fees have not been raised at all for the last many years. So, you can't blame the doctors, the specialist fees. The doctors are being blamed now. If anything happens to them going to hospital— itu doktor nak cari makan, nak cari duit. *Whereas, what I can see from your— from what you said all this while, all these thing, what is not regulated is the rest of it. It's not the doctors' fees.*

So, the doctors get blamed. I'm a doctor. So, I feel it, you know. [Ketawa] From what my friends are suffering. So, what's your response to that?

Dr. Yap Wei Aun [KKM]: *Yes. I'm a medical doctor as well and I do feel like, why is it like— just speaking personally, why is it it seems like only the doctors have their fees regulated? So, that's why I wanted to emphasise two things in this diagram.*

The first one is the need for something, which is much more holistic and if you look on the right-hand side. We are no longer trying to do unit by unit or we just do this particular procedure, this particular part of the hospital bill. Then, that's not enough. That's why, we highlighted to you, right?

The unintended consequences. You just control one part of it but not look at the keseluruhan *kind of approach. Then, it's not going to be a good solution. The next thing, you'll say but now, the other group will— the pharmacists may say, we want to introduce new drugs or something like that. So, we are in constant battle, if you just wanted to manage on the individual item by individual item basis.*

That's why, the whole crux of it was to highlight that this gap in the middle, the white portion is not omission of the ministry because we just did not want to extend the legislation-wise. It's because a better solution, which actually deals with the kind of three issues I told you about, the provider responses, about them increasing quality, substituting maybe something with higher margin, unbundling— all these things allow gaming. That's why, it's important let's move forward. Let's move forward into the solution on the right, which is something which is more of a wholistic solution, not just dealing with things in terms of individual cost components of it and just the overall solution.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Kubang Pasu. Selepas itu, Sandakan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: YB Pengerusi.

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: Kalau boleh, saya celah sebelum— poin ini adalah sangat sukar untuk— ramai untuk memahami dan inilah dia kuncinya antara lain. *Rather than—* di sebalik kita suka menyebutkan tentang kos yang disebutkan oleh beberapa Ahli Yang Berhormat sebentar tadi, sebenar-benarnya pada akhirnya, memperkenalkan satu sistem yang dikatakan *remuneration*

ataupun satu sistem pembayaran, yang akan dapat menggarap kumpulan dan bukannya *itemised billings.*

Kadangkala, kita menuntut sesuatu yang pada akhirnya akan menyusahkan kita dan akan berakibat— mengakibatkan peningkatan dalam kos. Yang ini yang dikatakan *unintended consequences.* Apa yang kami lakukan— maaf, kalau saya boleh— apa yang kami lakukan dalam *outsourcing* atau *our hospital* yang dikatakan HSOP tadi, *Hospital Services Outsourcing Programme*, di mana kita mengenakan *charges* kami berdasarkan *bundle payment.*

Kita telah pun memulakan ini. Walaupun DRG itu belum lagi satu amalan atau sistem, tetapi bagaimana kita mengenakan *charges* kepada hospital-hospital? *How many of them now? 94 hospitals are giving services to us* berdasarkan empat *services. Cardiothoracic, cardiology, nephrology* dan juga *radiology in imaging. Right? This four.*

Bagaimana kita mengenakan *charges* kepada mereka? Kita *bundle*-kan *payment* itu. Dengan kata lain, kita tidak izinkan mereka mengenakan setiap satu item, *itemised billings but* sebaliknya, kita mengenakan kaedah *bundle payment. Bundle payment* itu adalah sebenar-benarnya ke arah yang dikatakan *diagnostic-related groups (DRG)*.

Jadi, kita sebenarnya sudah mula mengambil langkah-langkah permulaan di situ, ya. *So,* itu yang saya perlu sebutkan dan dalam Akta 586, *The Private Healthcare Facilities and Services Act of 586,* di situlah kita berpeluang sebenarnya. *We will come to it.* Kita akan pastinya datang untuk membuat *amendments* tetapi bukan dalam waktu yang terdekat.

Kita perlu meneliti kesemua ini supaya kita hendakkan akhirnya nanti, kita dapat, dalam bahasa kami sekarang ini, *we want to nudge.* Kita nak asak *private health facilites* supaya memahami bahawa *charges* mereka itu seharusnya adalah lebih munasabah. Lebih munasabah, kata Dato' Sri KSU saya. Dengan itu, *this escalating medical inflation* akan dapat kita tangani. Kita memperkenalkan DRG.

Untuk sehingga kini, *private health operators and hospital* tidak ada langsung apa juga sistem dalam penentuan harga. *Except,* apa yang disebutkan oleh Dr. Harshinderjeet sebentar tadi, Akta *586* mengenakan *charges*— bukan. Mengenakan— menentukan *fees* untuk konsultasi ataupun rundingan, *consultation medical* dan juga beberapa *procedures.* Itu sahaja.

So, we are moving towards a bundle, kind of apa yang dikatakan sebagai DRG. Hari ini, DRG ini bukan *rocket science* dah. Orang dah lama tinggalkan kita. *They are now moving towards CRG, the clinical-related groups.* Tetapi, tak apa. Kita

akan mengambil langkah-langkah awal ini dan kita akan sampai ke— ke destinasi itu dengan kita meletakkan dan menekankan tentang *value-based.*

Kita kerap mengingatkan pada hospital swasta supaya jangan *pay* ataupun jangan *charge for services or procedures because the more you do services, the more you do procedures, you charge them.*

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Tetapi yang kita mahukan adalah *pay for outcome. That is the value based.* Terima kasih Pengerusi.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: YB Pengerusi?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, sila.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk Seri Menteri dan Dato' Sri KSU. Datuk Seri Menteri, *I think you are the right man for the job,* Menteri Kesihatan *[Tepuk]*. *I have been following, I am very fair. It doesn't matter which party you come from but I think you are done a good job. You are the right man for the job.*

Tadi Datuk Seri Menteri sebut fasal Dato Sri KSU sebut munasabah. *That is precise word.* Saya sebut tadi *reasonable, it's* munasabah. *That's what rakyat is asking for.* Saya nak *extend* apa yang disebutkan tadi *holistic approach* ini. Adakah— okey kita ada kawal selia, *regulatory for professional doctor fees,* Akta 586. Tapi kita tak ada kawal selia untuk *private hospital* dan juga insurans. *I don't know, this is my understanding and what have been told by doctors as well. [Dicelah] But not so tight* lah kawal selia. Kalau tidak tak jadi macam inilah. Kalau BNM buat yang itu.

So adakah kerajaan khususnya Kementerian Kesihatan berhasrat untuk melihat perkara ini, kawal selia untuk *private hospital. I think high time, you must look into it. I know it's going to be very detail. It's not easy. Professional fee is very simple but* saya *agree* dengan apa yang diperkatakan oleh Kapar tadi, *professional fee* untuk *specialist doctors* ini *is not been revised for many-many years and* saya bagi contoh Datuk Seri, *total charges for one hospital told by doctor,* RM100,000 tetapi *specialist doctor* ini hanya dapat RM10,000 *je* Datuk Seri. *In fact,* dia ini main peranan *life and death for the patient. So, I think this* kalau *you talk about this holistic approach, I think* tolong masukkan sama *to revise the professional fees for doctor.*

The next one Datuk Seri maybe this is my last question. Tak mahu kacau Datuk Seri dah. Adakah kerajaan bercadang untuk memperkenalkan *National Health Insurance? Thank you.* Terima kasih banyak Datuk Seri.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Soalan sangat kami nanti-nantikan untuk penjelasan *[Ketawa].* Cumanya kalau saya boleh singgung sikit sebelum saya minta sahabat saya Dr. Wei Aun. Dalam penggal pertama saya

mengemudi KKM lagi saya telah mengangkat isu *revision of* Jadual Ketiga Belas 586, bayaran ataupun *renumeration* kepada *MOs*. Dalam fasiliti, itu satu. Mungkin beza sedikit, yang ini *consultation.* Pokoknya *consultation. The Thirteenth Schedule is meant for those doctors in private hospital.* Jadual Tujuh, Dr. Harshinder— adalah kepada klinik-klinik swasta. Klinik swasta, Jadual Tujuh ini lagi berdekad lamanya tidak pernah dinaikkan, *revised.* Mereka mengasak saya hari ini untuk tidak— silap-silap nanti dia orang nak demonstrasi depan Parlimen ini. Tetapi yang *Schedule* Tiga Belas ini adalah *schedule* yang konsultasi itu. Jadi kalau dapat sikit— kami memang sudah bersedia untuk membuat *revision* ini. Kami sudah mengangkat perkara ini bukan sekali dua dan kita menunggu waktu yang sesuai atas NACCOL punya pandangan supaya dapat kami laksanakan. *Dr. Harshinderjeet, would you have to say something.*

Dr. Harshinderjeet Singh [KKM]: *Okay thank you YB. For Seventh Fee Schedule— again, may I speak in English. It's for the GPs who were practicing in the GP clinic outside. So in the— since the fees has not been increased since 2006, okay that is RM10 to RM25. So lately, in the December last year, we have engagement with Malaysian Medical Association and GP group that to increase the GP fees.*

So recently on 7th of February, we actually held a discussion with DOSM, Department of Statistic Prime Minister Office to run a simulation to see what is the appropriate fee to increase for the GPs. So, we are waiting for their reply. So that we can go on with the exercise to actually see what are the appropriate fees to increase for the GPs. That's for the Seventh Fee Schedule.

For the Thirteenth Fee Schedule, we have completed 1,300 new procedures to be added into the new fee schedule. Not the mean the new, in the amendment of Thirteenth Fee Schedule. The draft of the new procedures, approximately 1,300 is including robotic or the latest technology will be added in. So, at that draft now is with our legal advisor for the revision or to untuk disemakkan sebelum diangkat pada *AG Chamber. Thanks.*

Dr. Yap Wei Aun [KKM]: *Should I…*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Just now, National Health Insurance?*

Dr. Yap Wei Aun [KKM]: *Should I response on the…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Yes, insurance Datuk Seri.* Boleh?

Dr. Yap Wei Aun [KKM]: *I think there are two questions for me to respond to.* Pertama sekali jikalau kita memerlukan lagi badan pengawal, *so let me just mention as a caveat,* memang *we having informal discussion across various*

ministries and agencies. Tetapi inilah bukan polisi yang sudah di-*agreed upon or* dimuktamadkan. *So* apa yang akan saya kata ini adalah *just* pandangan daripada *experiences global* dan sebagainya *as just opinion,* bukan polisi kerajaan lah.

So let me just remind you all that actually that's more than one million in-patients' admissions to private hospitals in Malaysia a year. So kalau kita membuat satu— *if* kalau kita hendak menyemak nota kes walaupun untuk sebilangan kes-kes ini bagi memastikan pematuhan kepada CPG dan tatacara klinikal dan sebagainya, *what we are looking at is really huge administrative burden. We just review one percent of cases. You are looking through case note for 10,000 patients. Then this will have* meningkatkan kos pentadbiran secara ketara dan tambahan pula, dia akan *it's very hard.* Dia agak susah untuk mencabar keputusan seorang pengamal perubatan melalui nota kes sahaja pada masa— *you know when it's after the fact. When the patient is no longer in front us. It's only in really the most the* kes-kes yang sangat melampaui dan menyalahi tatacara klinikal di mana kita boleh *prove that you did unnecessary test, you order this unnecessary procedure and then you can review it in that way.*

So jadi kita fikir *the effectiveness of such regulatory body to just manage appropriate rational,* munasabah *used of care, it's going to be very costly exercise and may not have the effect that we want. On the contrary, we think that* memandangkan keperluan mendesak untuk menangani isu inflasi harga perubatan, Kementerian Kesihatan lebih cenderung untuk menggunakan institusi dan kuasa sedia ada di bawah akta yang sedia ada terutamanya Akta 586 untuk memberikan pengawasan yang lebih menyeluruh termasuk dalam isu-isu berkaitan dan dengan penetapan harga.

So basically to cut it short, we use this menyeluruh *strategies for DRGs, to change incentive structure for doctors and nurses so that there's no incentive for them, no financial incentive for them to over provide care beyond is what is in CPG and the clinical pathways. So that there's no need for them to— there's no incentive for them to be doing irrational use of care. That is much cheaper and effective way of dealing this rather than have another body to look through everybody's case note to complain about whether the bill is accurate or not and whether this test really needed or not. So that's the experiences from countries across. Of course, this is still in discussion and what I'm this describing here is not a government policy. It's just the status of discussion.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *It's Sandakan been waiting for half an hour.*

Puan Vivian Wong Shir Yee [Ahli PAC]: *Half an hour already. Thank you so much all doctors. I'm not a doctor. I'm just a patient. So, I just want to ask. Just now I think someone shared about the hospital is very posh,* ada akuarium, ada piano. *But all these I think is up to patient to choose whether they want a five-star hospital or three-star or one-star if they can afford. It's like a business of economy. Some of them really wanted to like very posh one.*

But my question is very related to doctor's explanation just now where how do as a patient can report if they feel like they are not fairly charged, like they did operation that is not needed. There is— I did some procedure that it's not needed because based on my experiences, I had— I went to a private hospital and I wanted to get my stomach checked. And they immediately say okay, let's do scoping and the bill came at RM6,000.

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Before I actually admitted, they had already started to claim my insurance. First thing they will ask you is not like your age or what. What insurance company are you having? [Ketawa] So, that is a— I want to ask if there… [Dicelah] Yes, the first question going to be that. So, soalan saya adalah *because we say that we don't want to have another body to regulate this but at least we have a place to accumulate all this data where the public can actually lodge a report where they feel like it is not rightly charged or rightfully charged. If there is any, can we get the answer from* kementerian *MOH. Thank you so much.*

Dr. Yap Wei Aun [KKM]: *I think— thank you for the suggestion*. *I think certainly* kami akan memperhalusi cadangan yang dikemukakan. *But also, just to let you know that overarching when we transition to a* sistem pembayaran yang tidak menggunakan *fee for service*, *we are actually removing the perverse incentives to overprovide the unnecessary care*. *So, hopefully, that would address a lot of that. Therefore, we just let the doctors act on their pure clinical judgment based on CPGs et cetera.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *CPG is a clinical procedure guideline*.

Dr. Yap Wei Aun [KKM]: *Clinical practice guideline.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Practice guideline.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Actually, this morning, regarding to the complaint things*, *Bank Negara said there is an ombudsman. Ombudsman for people to bring their complaints. I mean this is something that we do not know. We do not know. This morning, Bank Negara said so. There is an ombudsman,* kan? *So, I mean if there is…*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara] For insurance.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *That is for insurance? But maybe this kind of thing maybe KKM can work with Bank Negara or whatever to formulate something like— you see like* Kementerian Perumahan, *there is a* tribunal perumahan. But *they put set a cap of RM50,000. So, anything below RM50,000, you don't need to go to court, you can go to* tribunal perumahan. *Maybe things like that, ministry can suggest.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ringkasnya, kami pasti mahu mempertimbangkan perkara ini untuk kita wujudkan sepertimana yang lain untuk kita dapat membuat satu ombudsman. *Dr. Harshinder, would you want to conclude on that?*

Dr. Harshinderjeet Singh [KKM]: *Maybe I can just enlighten a little bit on that. If there is an issue on overcharging, if we find that the doctor is not ethically practicing, he is whatever he is doing, he is not following his ethics then he goes to the Malaysian Medical Council. Malaysian Medical Council, they will look into the ethics part of the doctor.*

If comes to the hospital and all the charging, overcharging or looking that, we will see as a whole the procedures, what the doctors charge, the hospital charges which we don't regulate. Has a whole bill. It can come to the Cawangan Kawalan Amalan Perubatan Swasta (CKAPS). *We can refer to that and we will look at the part of the consultation fees or the procedure performed appropriately. So, doctors go to MMC, the facility goes to CKAPS.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Still national health insurance…*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *It is that it is implemented. It is just not that it exists but that there's effective implementation and that* benda itu *is functional.*

Dr. Harshinderjeet Singh [KKM]: *Yes. As you revealed, appropriately we will base if there is any issue with the doctor overcharging and we will actually issue* teguran kepada hospital *based on the* Akta 586, *whatever provision annexes.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Any response on national health insurance system?* Kubang Pasu tanya.

Dr. Yap Wei Aun [KKM]: *Thank you. As you can see, actually, we* sudah ramalkan *three. There's only one question* yang kita ramalkan yang belum dijawab, ditanya... *[Ketawa] Okay, so anyway, jokes aside*.

Basically, we have been working very hard with Bank Negara and relevant agencies on thinking on how we can transform the whole insurance sector, private health insurance sector in Malaysia. So, one of the proposals that we have been working on together is really to come out with a based private health/takaful insurance option.

When we said based, this one will be proposed by— it will be the one which we will encourage Malaysian who really want private healthcare to select as their default option moving forward. So, if you are somebody who thinks I kind of one private healthcare, let me at least take tick box for getting this base product.

We want this product to be mampu milik *and sustainable*. *So, we want to add up all the best practices for health insurance products to be developed. We want it to be also, therefore to contribute to reducing the inflation rates. Just be aware, the price level is different from the insurance rate* ya*. Insurance rates just put things how its changes year by year. We want to do this by introducing value-based healthcare. We want to make sure that this product is also something which is very useful for people. So, it has life course coverage.*

We encourage people when they are young working people in their 30s and 40s before they develop, all the co-existing illnesses, to start signing up for this product. Then, to have a very fair rule so that as the progress in their career despite even breaks in their career and the progress even before— after retirement, that this coverage can stay with them across employers and across different life seasons.

Hong Kong for example, has a system VHIS where they don't allow insurance to deny renewals for the insurance up to the age of 100. So, that is quite good. If you start young. And also, we want— from the KKM perspective, we want it also to slightly shift the usage away from public hospitals to allow people the option of just choosing to shift toward private hospitals.

So, when you see the diagram here, the populations coverage that we are thinking of is really people who are working in private companies, in a SMEs and also in GLCs and perhaps even an option for their families as well as people who have high net disposable income or very high net worth, et cetera or fairly very high net worth.

And we want to use existing, we want to fine-tune existing incentives such as tax incentives for personal and corporate income tax as well as the potential to use Akaun Sejahtera *from EPF which is already at discussion with them to unlock that amount of money to be used for these base products. Then, to allow the existing private takaful and insurance in the country who which already have got a capacity to do so to offer this as a very standard structure product.*

So, it's highly regulated. You tell them what the rules are in terms of the benefit package, in terms of the providers, the network and how you going to pay for it, et cetera. We make use of a shared strategic purchaser in the form of PH Corp. Through contracting mechanisms, we can use DRG, et cetera to introduce into this market and make use not only of the six-star hospital/ hotel. I intentionally said hotel when you described the three stories of aquarium and also the grand piano which place itself in the lobby.

We also want to make use of non-profit hospitals as well as Rakan KKM *as well as shift care away from hospitals even potentially to clinics. So, this is an ongoing process that we are working on together as a whole of government initiatives. Just to let you all know, some of the details, many of the deals have not been finalised. So, some of these can change. But just to give— so, don't just look at this slide and think this is going to be it. It's not fixed in note. It's not a finalised policy but it's an aspiration which is being discussed with at working level.*

What about— how is this different from national health insurance? National health insurance, just let's be very clear. It is going to be mandatory insurance. That means we are going to the rakyat *and say, "Everybody who's in a formal work force, you've got your EPF, your LHDN, your SOCSO. Now you are going to have pay an additional amount, mandatory for healthcare coverage".*

People in the informal sector which is very substantial in Malaysia, will need substantial government incentives to do so. As you all are politicians, you will just tell me whether you feel that you can go to your constituents and tell them that tomorrow we are going to make you pay, paksa. *It's compulsory. A certain proportion of your* pendapatan *is going to go to a required national health insurance.*

The next question they will ask you is, "What will I get?". In Malaysia, I know that there's a perception that government services are under attack and not sustainable, et cetera. But the reality and we can show you data is we are continuing to increase our service probation despite being underfunded. So, I think your constituents will ask, "If you are going to force us to get this coverage, what will we get in return?".

The only thing better than Ministry of Health hospitals is private hospitals. The question is whether it's going to be very sustainable for most of our former labour force and most of our country to be able to move it into that coverage. That's a political decision. But what we want to do is at least in the short term, make sure that they are Madani-like options where we are not going to Ministry of Finance and ask them for yet more money and we are not going to go to politicians and say, "We want you to ask your constituents. We want you to go to Parliament and put some akta *saying*

their take home pay is going to be reduced because they must get national compulsory health insurance".

Isn't it better to think of a more Madani way to encourage people voluntarily to take up a product which is a life cost coverage is linked to DRGs and cost continuing measures, allows life called coverage, a mechanism to bring in preexisting conditions in an actually sound manner?

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I know we want to adhere to its committee rating at some point but this is not her. This is a— we are talking about a lifetime. I mean— it's a multiyear initiative right to get this really done. So, this is one of the options that we want to allow the government to be able to offer which does not affect the take home pay of our rakyat, *it does not shake down our measures of finance for additional budget but actually unlocks let's see existing tax incentives and account Sejahtera 2 and gives them an option which many would choose to have if they know what is going to be.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Shah Alam.

Tuan Haji Azli bin Yusof [Ahli PAC]: Okey, terima kasih Timbalan Pengerusi. *Saya* ada tiga soalan. Pertama tentang DRG. *When you set a single tariff, right— propose a single tariff, the DRG is basically— I mean comparing to other industries— it is similar to activity-based costing I believe where you trace from the beginning of the process until the end and then you set a price for it, right. Then— but across the different ratings of the private sectors then you have a range of services. Then, how do you then set a single tariff or would that be a range or like* julat *for that tariff? That's one.*

Number two has KKM or anybody done a comparison between the services provided by the public sector as compared to the private sector for say— for one particular operation or procedures or whatever right? I mean kita selalu kata *private sector* mahal, mahal, mahal. *While actually the public sector is not cheap but because they are getting free. So— subsidies or whatever. So, when you compare, where do public sector fairs with the private sectors— I mean maybe the middle range or something like that. That's number two.*

Number three I know Datuk Seri Minister has been very passionate about the EMR since the first time you assumed the post of minister. Now, you are second time. How long do you think this will take? Do we have to take until— do we have to wait until you become the third time Minister of Health? [Ketawa] Sorry. Thank you.

Dr. Yap Wei Aun [KKM]: Terima kasih atas soalan tentang kelompok berkaitan diagnos ya. Pada permulaan, saya minta *you understand info discussing something yang* agak teknikal *but then* sebaliknya anda tanya saya soalan *yang even*

more technical daripada itu. *So, maybe I just give more of a principle because these are the things which* memang perlu diperincikan di beberapa jawatankuasa teknikal *and may you understand further. But,* secara am*, the best is to see that especially in the context of this based insurance product, the DRG payment is to cover the whole clinical care package.*

Tetapi ada yang sesetengah yang akan meminta— *actually I prefer instead of eight bed share, I want one bed share. So, how do you add on to allow that pro— that consumer choice to have a little bit more of the non-clinical care component and then pay for that? So, these are some of the discussions that we had. So, it's possible in experiences done globally. It is possible to link DRGs to additional payments for non-clinical care. But I think it's an ethical choice that we should try to decide on that clinical care is something that it should be equitable. We should not allow that to be the basis by which we discriminate between Malaysians.*

So, saya rasa *yes, we can allow that some people go to the hospital which maybe they see the three-story fish tank and the grand piano. But we do want that whatever hospital they go to, if they are sick they have the best chance to get the best clinical, the most appropriate clinical care*-lah*.* Itu *I think I would suggest that as a policy that would be a good ethical principle that we should apply.* Soalan kedua *is* tentang…

Tuan Haji Azli bin Yusof [Ahli PAC]: *Comparison.*

Dr. Yap Wei Aun [KKM]: *Ha, comparison. Yes. I was actually involved in what's called the MHSR study (Malaysia Health System Research) study and* ini melibatkan beberapa kumpulan *care work packages. One of the ones was actually looking at the comparison between public costs with private prices. So, I think this study we are trying to push for this to be published then maybe they will put it on our* transformasi *website at some point then it can be reviewed in general. Thank you.*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya. Terima kasih Timbalan Pengerusi.

Tuan Haji Azli bin Yusof [Ahli PAC]: *The third one is… [Bercakap tanpa menggunakan pembesar suara] [Ketawa]*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Baik, terima kasih Yang Berhormat Shah Alam ya. Mengikut perancangan kami, kita akan *roll out* apa yang hari ini— semalam sebenarnya kami membuat peluncuran enam klinik kesihatan dan tujuh klinik desa di seluruh Pulau Langkawi dengan kita meluncurkan apa yang hari ini— apa yang sebenarnya adalah dipanggil dengan *Cloud-based Clinic Management System* (CCMS). Klinik atau CCMS ini akan merupakan EMR. *EMR is the strategic heartbeat* ataupun *the centerpiece* ataupun *the heartbeat of digital*

health landscape. That is almost like the spine, the backbone of all. Kalau kita tidak ada itu, kita boleh cakaplah tentang AI dan sebagainya. *It's not going to be meaningful*.

Jadi, kita punya 3,117 klinik kesihatan dan kita punya 150 hospital termasuklah hospital *centre of excellence* seumpama IKN, IPR dan IJN sebagainya. Kita punya hospital, hospital berpakar major, berpakar minor, dan *of course, there are others district hospital* yang tidak punya— tidak berpakar tetapi yang mustahaknya dengan pertamanya kita akan *roll out* untuk tahun ini dan tahun hadapan*. We wants to finish off clinics for CCMS. Yesterday, we saw what CCMS could do* dan *into operability of all clinics*— itu tidak termasuk lagi *the EMR* dalam hospital sebab kita belum dapat lagi meletakkan *our hospital information system in our* Hospital Sultanah Maliha di Langkawi.

But if you could have that then you see all of it the horizontal integration and vertical integration between clinics and hospitals were all be done. They are now all going live. Itulah antara lainnya kita dapat menurunkan *waiting time* di beberapa klinik juga yang telah kita lakukan, yang kita telah pasang, kita telah bangunkan CCMS di *Klang Valley* dan sebagainya. Kita dapat menurunkan *wait time* daripada tiga jam kepada 30 minit *and we want to do this throughout the country*. Jadi, itu CCMS di klinik-klinik dan kita akan— tahun ini kita hanya mampu untuk lakukan 16 hospital *for HIS, for our EMR.*

Now, given the adequate funding kita boleh *roll out is— we are limited by* dana sebab kita tahu kita punya berdepan dengan masalah *fiscal space of capital expenditure* tetapi kita akan cuba usahakan sekadar dalam— kalau boleh dalam Parlimen Kelima Belas ini, *insya-Allah. So, hopefully we don't need to go to roll over 16th Parliament but insya-Allah,* doakan kami dapat lakukan semua ini. Terima kasih Yang Berhormat Shah Alam atas *your concern*.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Sik ya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya, terima kasih Yang Berhormat Timbalan Pengerusi. Saya yakinlah semangat bersama kita hari ini dalam maksud kita hendak lihat paradigma khidmat kesihatan itu yang berasakan nilai. Itu yang kemuncak kita ya. Kita pun tidak mahu sampailah ada slogan seperti mana di Indonesia ya, *"Kalau kamu miskin, kamu jangan sakit."* Jadi, itu kita sangat-sangat risau kerana kita kena akui ada pihak segelintir saja yang haloba. Itu pasti ada ya.

Cuma, dalam pembangunan sistem DRG ini nampak kita ada satu hala tuju yang bagus ya. Tadi pun BNM pun menyebut hal ini dengan lebih terperinci. Jadi, saya ingin bertanya bagaimana dari segi persiapan kementerian sendiri dari segi kewujudan *task force* dan sebagainya? Sebab sistem ini nampak dia ada juga

kekangannya termasuk ketidakseragaman data yang kita katakan ada halangan bila dia orang tidak dapat buat *data sharing* dengan hospital kerajaan ini, hospital awam ini.

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Juga saya pasti ada hospital swasta ini akan dia membuat pelbagai alasanlah ya, kerana dia nampak akan ada kekurangan daripada *profit* dia sendiri ya. Dia pastilah akan ada mungkin sedikit kekangan di situ.

Begitu juga dari segi penetapan kadar caj itu. Jadi, maknanya *standardised* untuk caj itu mungkin juga pihak kementerian melihat model-model yang telah pun dilaksanakan di beberapa negara lainlah termasuk di Germany dan di Korea dan sebagainya. Apa yang juga kita— yalah kerisauan kita juga mesti kita dah tetapkan itu akan ada risiko pengurangan kualiti servis itu ya.

Kerana, yalah, seperti saya kata tadi, kekangan daripada pihak hospital sendiri. Jadi antara perkara-perkara yang baik itu dan risiko-risiko itu perlu dinilai lebih awal supaya *task force* yang akan diwujud untuk kita nak laksanakan sepenuhnya DRG ini dapat dilaksanakan dengan sebaiknyalah. Itu pandangan saya. Terima kasih.

[Ahli-ahli berbincang sesama sendiri tanpa menggunakan pembesar suara]

Dr. Yap Wei Aun [KKM]: *I think, I mean*, memang kita terima cadangan dan *all your suggestions.* Pembangunan DRG adalah sesuatu yang melibatkan beberapa agensi*. I think it's clearly a national priority as well. So,* memang kita perlu *figure out very carefully how we are going to move this as fast as possible*.

Sudah pun kita ada *at least the technical level, all the steps that are required, and reviewed all the* perundangan yang diperlukan, data *requirements*, *we've been organising town halls to engage with the*— untuk buat libat urus dengan semua *stakeholders*.

I *think even just two weeks ago, I think as minister mentioned in his social media posting,* kita juga ada melibatkan satu *technical capacity building workshop* yang melibatkan Bank Dunia, Bank Negara dan kesemua *all the stake*— pemegang taruh, *private hospitals, private ITO, LIAM* dan sebagainya. *So I think, we're already— even, ya— we're already working as fast as we can on this issue*-lah. Itulah. Pagi ini pun ada satu mesyuarat *technical advisory committee for national* DRG.

So all this are just happening— maybe, tak sempat pun nak *post* semua dalam *social* media, kan?

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *just about this* DRG. You ada *benchmarking to any*— apa, dia mula New Jersey, kan? *So, what's the best practice now of this DRG? Or is it just* lebih kurang sahaja? *Benchmark*.

Dr. Yap Wei Aun [KKM]: *Usually*, untuk pembangunan satu DRG, *we start with a— the principle of an existing grouping system. Then*, kita kena menukar dan *adapt* dia kepada situasi dekat negara kita khasnya dari segi *epidemiology* dan cara tata kelola klinikal.

So, for example, the classic one would be, if you just take something from Australia, then what about dengue? Which is one of our main admissions here. So, kita kena memastikan sistem ini adalah sesuai dengan negara kitalah.

Bukan sahaja dari segi jenis penyakit, tetapi cara perawatan yang digunakan dekat sinilah. *So, this is not like we just going to copy some other place. But we necessarily to based the principles on best practice from around the world*.

Puan Teresa Kok Suh Sim [Naib Pengerusi]: Saratok ya. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Ali anak Biju [Ahli PAC]: Terima kasih Timbalan Pengerusi. *[Merujuk pada pembentangan slaid]* Saya nampak di *page* nombor empat itu, yang warna merah itu, Akta 723, *Retail Price Transparency 2011*. Jadi, maknanya akta ini dah lama dah dibuat.

Jadi apakah implementasi Akta 723 ini terhadap *price transparency* dekat hospital swasta sekarang ini? Sebab saya rasa undang-undang ini dah lama tapi mungkin tak di-*impose* ataupun dijalankan. Apakah sebabnya tidak di-*imposed* dan— itu soalan nombor satu.

Soalan nombor dua, saya ingin tahu tadi hospital yang tidak berasaskan keuntungan. Bunyinya pelik jugalah. Mana hospital tak nak untung? Tapi kalau dia ada baguslah. Sebab ramai rakyat tidak sedar yang hospital ini wujud. Saya baru tahu tadi.

Jadi, apakah langkah-langkah kementerian menggalakkan hospital ini sekarang ini. Adakah hospital lain yang sedang meminta, memohon ataupun kementerian memberi kemudahan insentif kepada mereka dan apakah *sustainable*, mampan? Bagaimana *business* model dia? Keuntungan. Macam mana *charges* dia sekarang ini *compared to* hospital swasta yang lain? Adakah lebih murah atau lebih mahal.

Jadi ada dua soalan tadilah.

Dr. Yap Wei Aun [KKM]: Mengenai Akta 723, yang saya faham ini adalah di bawah kalau tidak salah saya, kementerian yang berlainan. *But, if you have anything to add Dr. Harshinderjeet, feel free. If not maybe it's best to let the* kementerian yang berkenaan untuk *answer*.

Datuk Seri Dr. Dzulkefly bin Ahmad [KKM]: KPDN.

Puan Fatkhiah binti Haji Khalil [Kementerian Kesihatan Malaysia (KKM)]: *Assalamualaikum warahmatullahi wabarakatuh and* selamat petang. Saya Fatkhiah daripada Program Perkhidmatan Farmasi. Akta 723 iaitu Akta Kawalan Harga dan Anti Pencatutan memang di bawah kawal selia Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup.

Untuk yang *price display, retail price*, perlu diwujudkan satu perintah baharu di bawah Akta 723 supaya semua fasiliti kesihatan mengkongsikan maklumat harga kepada pengguna. *So,* baru dibentuklah *then* akan berkuat kuasa tahun ini.

Berkaitan dengan akta lama, tapi tidak terangkum untuk ubat-ubatan dan caj-caj yang lain sebab bawah KPDN yang ini memang perlu dijawab oleh KPDN sendiri tapi berkaitan dengan ubat-ubatan, perlu buat perintah baru. Itu sahaja yang dimaklumkan oleh KPDN.

Datuk Ali anak Biju [Ahli PAC]: Itu perintah baru itu apa makna dia? Undang-undang baru ataupun?

Puan Fatkhiah binti Haji Khalil [KKM]: Bawah akta yang sama tapi bawah kuasa Menteri KPDN boleh membuat satu perintah bagi kawalan harga ataupun sebarang arahan untuk *price display*, pemaparan harga ubat.

Datuk Ali anak Biju [Ahli PAC]: Siapakah yang menentukan mereka membuat perubahan tersebut daripada pihak MOH? Atau hospital ataupun daripada Parlimen?

Puan Fatkhiah binti Haji Khalil [KKM]: Untuk perintah baru yang bagi pemaparan harga ubat, memang telah mendapat keputusan Jemaah Menteri pada 8 Januari 2025 yang mana perintah ini memang— untuk membentuk perintah ini, kerjasama strategik antara KKM dan KPDN bagi mewujudkan satu perintah baru ini dan dapat keputusan sekarang dalam proses untuk pewartaan dalam masa terdekat.

Datuk Ali anak Biju [Ahli PAC]: Okey. *Thank you. Good answer*.

Puan Fatkhiah binti Haji Khalil [KKM]: Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Timbalan...

Datuk Ali anak Biju [Ahli PAC]: Satu lagi. Fasal hospital yang tak nak untung itu.

Dr. Yap Wei Aun [KKM]: Dia bukan hospital yang tak nak untung, tetapi dia adalah hospital yang ada prinsip, bila mereka ditubuhkan di mana *the usual story* adalah ada *philanthropies* yang mahu menyediakan tanah dan bangunan *and then* mereka minta daripada komuniti untuk *share and then they actually build a hospital*. Ada yang tiga yang ketahui. Tung Shin Hospital dekat KL, ada juga Lam Wah Ee dekat Penang yang menurut nota saya, kita lawat pada 30 April, tahun lepas.

We were very impressed when we visited this hospital. It's a high-volume hospital, memang *very popular, charges are below. They have third-class wards which cross-subsidised by executive-class-ward patients and their third-class wards are aircond and quite cheap*.

So, I will just encourage you all to just have a look and visit all these hospitals like we did. Also when bila saya pergi ke sana, saya pun rasa, *if only we have more of hospitals like this. Because, it is lower fees, it's in demand, and it's a survival model.*

But what they were struggling with perhaps is the capital investments to buy the latest PET scanner dan sebagainya. *But the service to the public is there. The value I think, what I hear from you also is the importance— sure, we don't want to* melupuskan *six-star hotel because— hospital, sorry. Because, that's consumers' choice. But,* mungkin *as a government*, kita boleh menggalakkan *the mid-tier and indeed that's what we are planning to do.*

But maybe not just as the government, not just a Federal Government. Maybe when a state government. Maybe as the holder of zakat, dengan wakaf, dengan baitulmal. *Maybe as CSR from companies, we can do something along those lines. I think* Kementerian Ekonomi, *I can't quote them, so, I think also have— they kind of share the same desire as well.*

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So, ya, *I mean it will be great. It doesn't need to be only the government does everything.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Just to* apa Dr. Yap, *what about their* pekerja? *Are they paid as well?*

Dr. Yap Wei Aun [KKM]: *They are regulated as a private hospital under 586. So...*

Dr. Hajah Halimah Ali [Ahli PAC]: *But is it comparable or is it lower or what?*

Dr. Yap Wei Aun [KKM]: *When we asked them, one harsh— I mean one reality is like this. For nurses and what they told us is that they have to pay their nurses competitively, it's not lower. For the specialist and doctors, some of them ultimately come because they are passionate and they want to make a difference. Maybe they see a wider spectrum of cases, they feel they can practise as how they would want to practise without any distortion or perverse incentive and just trying to make people's live better.*

Dr. Hajah Halimah Ali [Ahli PAC]: *The full time or part time?*

Dr. Yap Wei Aun [KKM]: Ya, *some are full time.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Full time. [Bercakap tanpa menggunakan pembesar suara]*

Dr. Yap Wei Aun [KKM]: Ya, *it's a viable model. Yes. I will encourage you all to visit, I mean there's three of them of Seventh-day Adventist, Lam Wah Ee, Tung Shin. Have a quick visit.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Actually, what I know that Tung Shin Hospital because I've been there for acupuncture. They are foreign doctors' specialist, very good. Actually, the salaries are very high one you know. So, they are not like what you think volunteer service, like I pay RM70, as I know it's half of them— half of my money go to them you know. So, can you imagine if a doctor got 100 patients, how much he earn you know, one month you know. So, anyway sorry.* Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih. Okey, *I have one comment, several* soalan. *First comment is* tentang *this the basic care. I feel that it's a fantastic idea. I want to coined this as a Dzulkefly–Obama Care. That one is a* penghormatan kepada Dr. Dzul yang *I mean* mencetus idea tersebut. Okey, *that is the first comment.*

Okey, untuk isu tentang *this*— daripada *public hearing* yang kita hadiri, majoriti *people complaints is this overcharging. Gloves, face mask, face mask* RM12*, pampers RM50 you know and all sort of exorbitant charges. This is already engrained in the public's mind that this private hospital is overcharging them. They feel that they are being unfairly treated because of all these exorbitant charges. Even Bank Negara also feels that there has to be some regulation on that.*

But in here it feels that KKM is a bit resistance from doing this. I'm afraid this position, your position will be seen, will be questioned by the public. Okey. Saya rasa rakyat akan tanya kenapa tidak buat sesuatu tentang isu ini *when you are trying to bring in* DRG, okey, *when you are trying to do other reforms. But these reforms takes time, 12 years from now. By then, the gloves could be RM100 per pair, alright? Or the gloves, the face mask could be RM50 already per face mask. It's too late already.*

Jadi, saya rasa ada keperluan kementerian *look into this because rakyat feels that it's already exorbitant. I mean I'm sure your* pegawai *is there, you listen to them. 50 percent is about these exorbitant charges. I think we cannot stop it anymore. It has to be reign in, it has to be reign in, hold the bulls...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Hold the bull by the horns.*

Tuan Sim Tze Tzin [Ahli PAC]: *Hold the bull by the horns now or else we were all be ramped.* Okey. Saya rasa perlu *a serious look into regulating the hospital supply and services* (HSS). Okey, *that's my second comment.*

Ketiga adalah isu tentang kita *to bring in the medical cost,* okey. *I think one of the issues is how do we bring in the medical cost, bring down the medical cost. One issue I think we have 1,000 single product registration holders for pharmaceutical with* KKM, okey. *These are essentially monopolies,* okey. *They are there to supply to the government hospital and they actually create that kind of monopolies that I think we need to look into this.* Kalau tidak, harga ubat, farmaseutikal akan tetap tinggi. *There has to be a transparent open tender. This is what the Prime Minister is talking about, cartels. In the* Dewan*, Prime Minister say they want to brick the cartels.* Okey. *So, I think there has to be serious to look into cartels, how do you address—* Itu sebab saya nak tanya, *what the Prime Minister announced that he will break all the cartels, so what are KKM's doing? Because I look at the presentation,* tak ada. *How do you this? Address this issue?*

Okey, *related to this problem is medical equipment. There's a large industry of medical equipment in Malaysia that export their medical equipment overseas to Europe, to US, etcetera but they can't even access KKM, they can't even sell to KKM. In Penang, 30 companies medical supplies* yang *very top notch, they were used to be suppliers to B. Braun, they were used to be machine makers for B. Braun. They master the skill, they do all kinds of medical equipment. Now, they export overseas* tapi *they have no access to KKM* punya kontrak. *Alright.*

And then, I pernah usaha untuk bawa mereka ke KKM, *former DG then* dan juga TKSU, satu sesi *they present to them.* Tapi, selepas ini masih tak ada lagi. *I asked them, "Eh, have you have any progress?", "Tak ada", you know, they still have this roadblock. They can't access to* KKM punya kontrak. *Because let say if we can't— even local manufacturer* yang boleh *drive down the cost of about 30 percent because they are Malaysian— made in Malaysia. We are all talking about localisation, we are talking about bringing out the cost but our local manufacturers can't even access government contracts. What does it mean? Why we must buy from B. Braun? B. Braun for sure 30 percent more expensive, because of the brand name* sahaja, tak ada apa pun. *Alright. So, I think something has to be look into this. If we want to talk about reducing medical inflation, this is the fundamental supplies, equipment, medical manufacturer, this supplies* lah.

Isu keempat adalah *health commission.* Kita tadi kata banyak isu rakyat yang mereka— *they have no where to complaint already.* Contohnya, kena *gloves* RM20, kena *itemized bill of nine pages of 90 itemized bill, 90 items.* Mereka rasa mereka ditindas, mereka rasa ini adalah *something that is unfair.* Apabila mereka masuk, mereka pengsan masuk hospital, keluar dia tengok bil lagi, pengsan sekali lagi.

[Ketawa]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *But when they have a problem they cannot complaint, there's no avenue, there's no avenue.* Tak ada— *I know KKM very busy, you are firefighting everyday, pity the Minister, pity KSU, everyday firefighting.* Jadi, itu sebab ada cadangan *health commission* dalam *white paper* di mana Bank Negara, KKM, MoF, dia ada satu platform *or something to address this kind of issues that people are unhappy and very-very angry about.* Ya, saya nak minta komen.

Last sekali, dalam *public hearing* juga. Ramai yang kata dia ada kementerian, *they have no choice, they have to go for private hospitals because* di kawasan contohnya di PJ di mana *easily one million population in PJ has no access to government hospital.* PJ ya. *It's a highly dense.* Itu sebab...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *University hospital? [Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *University hospital* okey lah tapi GH tak ada lah.

Seorang Ahli: GH tak ada. *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: GH tak ada. Contohnya, di Bayan Baru juga. Daerah Barat Daya *very densely populated* tapi semua— *the whole island* hanya di GH sahaja.

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Satu lagi, di Balik Pulau, *which is not an option. You* kena panjat bukit, turun bukit *and it's a very small government hospital.* Jadi, *it's unfair for a densely-populated area to have no government hospital.* Okey, minta komen. Terima kasih.

Dr. Hajah Halimah Ali [Ahli PAC]: Sebelum itu, nak tambahlah...

Tuan Sim Tze Tzin [Ahli PAC]: *[Berucap tanpa menggunakan pembesar suara] No, no.* Bagi dia respons.

Dr. Hajah Halimah Ali [Ahli PAC]: *No, no. It's the same with your* apa— *I have been to the* kilang yang Bayan Baru sebut itu. Memang *I testify,* betul, dia buat *these appliances and all that,* termasuklah *catheters, and all that. So,* dia memang *that* kilang— apa itu— memang katakan.

They export it because the Government of Malaysia doesn't want to use it, kan? *So, I think that's one thing you need to look at. All everybody mentioned about the glove, RM20. The biggest glove producer in the world is in Kapar, you know. So, Minister* selalu lalu nak pergi Kuala Selangor. *So, I don't know why it's RM20. So expensive.* Banyak di sana, *world producer.* Tolong Menteri tengoklah.

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: Hartalega. Dato' Sri KSU jawab *and then also, Puan Fatkhiah from our PRA, ya. Please, you can start off.*

Dato' Sri Suriani binti Dato' Ahmad [Ketua Setiausaha, Kementerian Kesihatan Malaysia (KKM)]: *Thank you,* Datuk Seri. YB, ada lima soalan ini. *I'll try to answer some or if not,* kita boleh PM tepi sekejap lagi. *[Ketawa]*

YB, *I think* yang tadi itu, *on overcharging, unfairly and exorbitant charges, you are saying that the KKM is being resistant about that. I think,* tadi dah kita jawab. MMC *could be the platform where you can actually place your complaint about the price that is being very exorbitant. But, at the same time,* tak apa. Kita boleh *try and address it together. We'll see* macam mana kita boleh *need somewhere, whereby we can actually address this issue.*

Panjang nak cerita dengan YB. *But I would like to also address* yang kartel tadi, *the monopoly of the* ubat-ubatan itu, ya. *For your information,* memang PM sebut banyak kali *and every time* jumpa PM, *I cannot hide away from him. The first thing he will ask is when you are going to break the cartel? When are you going to break the monopoly?*

For your information, kita akan buat *what we called* penyumberan *[Dicelah]* Penyumberluaran. Maknanya, *we are going— we are outsourcing.* Maknanya, kita tak akan terlalu *dependent on* apa yang syarikat-syarikat farmaseutikal beritahu dekat kita orang. Okey, ini sahaja yang *you* boleh beli. *You can only buy from us.*

Kita akan melangkah lebih jauh lagi. *We are going to do this on our own.* Kita akan keluar untuk cari sumber ubat-ubatan ini, yang mana akan memberi harga yang lebih kompetitif, berbanding dengan harga-harga yang ditawarkan oleh syarikat-syarikat yang *so-called* kartel dan monopoli ini.

Maknanya, kita akan ada lebih banyak *choices of* sumber ubat-ubatan ini dari luar negara. *We are looking at India, China, Turkiye, Egypt. China, did I mention it? China* dan negara-negara yang mana ubat-ubatan mereka adalah lebih banyak *choices.* Oh, Thailand dan juga Indonesia.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry,* Dato'. *When you said 'we'* itu, 'kita' itu, *that's for the public consumption and the private consumption.* Betul?

Seorang Ahli: *[Berucap tanpa menggunakan pembesar suara]*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *It's for public. For public...*

Dr. Hajah Halimah Ali [Ahli PAC]: *Public* sahaja. *What about the private because I think, we can reduce the cost,* yang kita sibuk-sibuk ini cakapkan? *I think, we can reduce because it's now monopolised by a branded company. So, the private* ini yang kita sebut semua sebut ini kan? Pembendungan harga perubatan swasta ini,

I think we can go for the swasta *too*, *open to the* swasta *too*, *I think you can help there.*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: Okey. Kita akan tengok mekanisme dia, bagaimana kita boleh...

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: Kalau boleh saya celah, *if you want to— if you are talking about strategic purchasing and procurement,* kita mengadakan *strategic purchasing* di kalangan KKM, MOHE dan juga ATM. Itu kita lakukan. *We will have the economy of scale, we get the price down* tetapi belum lagi dapat kita lakukan bersama dengan sektor swasta.

But I think that is the way to go. You know, kalau betul-betul sektor swasta boleh bersama dan *this will be the way forward*-lah. *Of course, it is easier said because these are sometimes, they see it as more like a competitor than* kita *have a synergy with them* ya. Tetapi, dalam perolehan dalaman kita, *government,* ya. Kita lakukan. KKM, MOHE dan juga ATM.

Cadangan untuk kita dengan swasta ini memang lama dah. Saya cuba uar-uarkan tetapi *there is a bit of resistance.* Tetapi, *we will still continue to push for this strategic purchasing in the future, insya-Allah. Dato' Sri, please continue.*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *That is why* kita *come out with the* perintah— pemaparan harga supaya rakyat boleh tengok, boleh buat *comparison* harga-harga itu di hospital-hospital swasta itu. Ini *is imposed* untuk hospital swasta. *So, they have a choice* di mana nak pergi. Hospital mana yang memberikan harga ubatan yang kompetitif kepada mereka? *So, they have a choice.*

This is the reason why we giving this to them, kepada rakyat supaya kita mengutamakan rakyat ini dahulu. Kita utamakan rakyat yang akan menerima ubat-ubatan tersebut. *So,* itu kita akan— *we will do that soon. Once we* wartakan ubat-ubatan tersebut.

Tadi, YB juga sebut mengenai *no access to KKM on devices, medical devices. Actually, we are open YB.* Kita *open* kepada mana-mana syarikat sahaja yang berkeupayaan, yang memenuhi *spec,* yang mempunyai keupayaan kewangan yang bagus, kita buat *open tender, YB.*

Datang kalau dapat markah yang tinggi, dia akan dapat. *Best man wins from there.* Tetapi, *we are very open.* Kalau datang jumpa kami dan *we know that your company is very good, very competitive, you will get the highest mark, you will get the tender.* Itu kita sekarang dalam proses membuka tender. *All our medical devices* memang buka tender, YB.

So, masuk tender, kita akan menilaikan dengan sebaik-baik yang mungkin. *So,* kalau memenuhi *spec,* penilaian teknikalnya cemerlang, *they will get the contract.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry. On this point, I think it is much more complicated than a policy*-lah. Polisi atas memang— tetapi, *when it goes down, they don't translate into the*— takkan *the whole industry is facing these problems? My question* sebab dia bukan syarikat individu. *I asked several. Did you, after our* sesi dengan KKM, adakah *you* dapat akses *to the KKM?* Tak ada, tak ada.

Dato' Sri Suriani binti Dato' Ahmad [KKM]: *Sorry*, YB. *What do you mean by* tak ada akses?

Tuan Sim Tze Tzin [Ahli PAC]: *No.* Maksudnya, dia tak ada— *still cannot sell to KKM. That's the thing. I mean, I asked general*-lah. *Did you manage to, you know, supply or sell or get a contract from KKM? They said, no.*

Dato' Sri Suriani binti Dato' Ahmad [KKM]: Itulah, YB. Kontrak itu *comes through the tender process that we open* itu. *So,* bila *once they win the contract, then we will buy from the company*-lah yang *gets the best offer,* yang *gives us the best offer. So,* dari situ, dia akan dapat akses tersebut.

Datuk Seri Haji Dr. Dzulkefly bin Ahmad [KKM]: Ada dua faktor di sini. Satu adalah farmaseutikal. Yang kedua adalah *medical device,* peranti perubatan dan peranti perubatan menjadi satu fokus sekarang ini dalam NIMP, *the New Industrial Master Plan* sebab *new area of growth sector* peranti perubatan menyumbang kurang lebih dalam RM18 bilion *to our economy.*

Kita mutakhir ini, *especially our the last, our signature event called International Medical Device Conference* (IMDEC). Yang hadir *into the hundreds and of exhibitors* dan *medical device players, international and local.* Ya, kita memberikan fokus dan saya punya antara perkara yang mungkin tak dapat *much of your attention,* ketika *our people looking healthcare services.*

But, medical device is our new area of growth dan *we have in our Medical Device Authority* (MDA), *our CEO, Dr. Murali, they are doing well. This is where we want to ensure that Malaysia becomes the hub and already we are gaining the attraction. Our IMDEC, international conference to testify for itself.*

In fact, we are really looking with the particularly, khasnya dengan *players* tempatan, ya. Kita memang memberikan segala insentif dan *lower pharmaseutical,* contohnya *pharmaseutical industry, we also provide an offtake* sebagai satu galakan untuk pelaburan mereka buat, *not in just generic but as well* untuk kita buat R&D, *biosimilars and by way of our clinical driven research, Malaysia had just taken over*— mengambil tempat nombor satu *in this region, in ASEAN, winning over Singapore.*

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Because we are giving the emphasis on clinical driven ataupun dia panggil *clinical sponsored researches* dan *we are— In this regard,* kita juga telah memulakan

first in human research into rheumatology, oncology dan sebagainya. *So,* memang kita berikan tumpuan dan memang kita berikan segala galakan *among others to give off take agreement.* Maknanya kita akan— kita jamin kita akan membeli *from them because* kita nak galakkan mereka buat *investment* dalam negara dan bukan di luar. Apa yang menjadi masalah antara lainnya kalau saya boleh minta PRA, Puan Fatkhiah untuk komen *later. But we have this problem of as you said Yang Berhormat Bayan Baru, YB Sim, that is this almost like RM1,000 single product registration. That's where you do not have the competition. That's where the problem is.* Sebab itu Dato' Sri KSU sebutkan tadi *we are going out, we are going out to meet— because* dulunya kita *rely only on one or two. Now we are going out to get— others also to come in to invest here, together with our local players. So, that we grow the pharmaceutical industry.* Mungkin saya minta untuk Puan Fatkhiah untuk sikit komen lagi, satu.

Puan Fatkhiah binti Haji Khalil [KKM]: Tambahan untuk yang Dato' Sri KSU dan Datuk Seri YBMK telah maklumkan tadi, yang mana terdapat 1,500 ubat-ubatan yang tiada alternatif, yang mana ada *single product* sahaja didaftarkan negara yang menyebabkan inilah monopoli yang memberikan harga ubat itu lebih mahal dan perancangan apa yang telah dimaklumkan oleh Dato' Sri KSU bahawa kita akan— Dato' Sri akan keluar untuk mencari alternatif kepada ubat-ubat yang tak ada alternatif di dalam negara. Itu salah satu.

Bagi akses syarikat tempatan kepada kontrak kerajaan, apa yang berlaku dalam perolehan tender ubat-ubatan, produk lokal biasanya menawarkan harga yang lebih tinggi daripada produk import. Jadi bila dalam penilaian kewangan dan perbandingan harga, ini menyebabkan markah dia rendah. Ini yang dimaksudkan oleh Dato' Sri KSU tadi bila penilaian markah dia tinggi, dia boleh masuk dalam tender kerajaan. Itu yang...

Tuan Sim Tze Tzin [Ahli PAC]: Untuk *medical devices,* sebenarnya mereka lebih rendah *device?*

Puan Fatkhiah binti Haji Khalil [KKM]: *Medical device* saya tak pasti tapi untuk ubat-ubatan...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Saya tahu, *this is where*— secara peribadi, saya mengambil perhatian perkara ini. *We have local* yang akan— mungkin saya tak boleh sebut nama-nama itu *for matters of*— takut prejudis pula ya. *But we have our local champions— and we have our local champions who are producing for example*— saya mungkin boleh sebutlah ya, *on the peritoneal dialysis machine which is state of art and they have their footprint all over the world. They maybe complaining that they are not getting good buy in* daripada kerajaan kita. Ini

saya *personally want to look into because* dia *compete with MNCs here.* Itu saya berani sebut dan ya, kita harus— PMX selalu menyebutkan kepada kami Menteri-menteri supaya memberikan *all that we could*. Supaya kita memberikan keutamaan dan sokongan dan dokongan kepada *our local manufactures, our local champions* ataupun *even our startup,* kita mesti berikan galakan.

So yes, Yang Berhormat YB Sim, *I'm very conscious of that. We need to do more.* Saya tidak berpuas hati dengan prestasi kita. *There's a lot that we can do, with the lot that we can break the cartel.* Saya *comeback this way, I want to make sure that especially the pharmaceutical industry* ini*. There are four or five companies that take about almost 80 percent of* ini. *They will get into RM2 billion, RM3 billion while others do not get it* ataupun *suffer, again and again, failures in their tender. How others would also be able to achieve success, it's for us to also educate and make them more sustainable by way of technical expertise, finance* dan sebagainya.

Saya mengakui, *we need to do a lot more medical device sectors* dan juga farmaseutikal dan juga termasuklah *by way of other research* termasuk *our vaccine development* dan sebagainya. *I take your point* Yang Berhormat. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey Wangsa Maju, ya.

Dr. Davis Johnraj [Timbalan Pengarah Kanan I (Bahagian Perancangan), Kementerian Kesihatan Malaysia]: *Datuk Seri can I just… [Dicelah]* Ya. *One of the reasons also why the private sector medicine fee is very high is a tendency for all drugs to be innovator even though the generic version is available. That is one.*
The second is there is a tendency when compared per cabin pattern of government specialists. The private specialist turns always go for a higher version of the same drug rather than— So, we have seen the private insurance companies told us, one of the most commonly prescribed antibiotics is a really strong antibiotic which in the KKM, we're only prescribed in eye for ICU patient. It's very expensive. One dose is like something like RM300. So, all this drives up the cost. Because I think the tendency for the private sector to feel or we want to give the best to the patients because they pay a lot.

So, I think this is something that is driving up the cost but I was told today morning that some of the insurance companies actually telling the private hospital that we will only be paying generic. So, I think that is a good way ahead because the effectiveness is almost the same. If the patient chooses innovator, they can probably choose to pay themselves or buy from the pharmacy. But I think it shouldn't be imposed on the patients and increase, drive the healthcare inflation.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Thank you Dr. Davis ya. So,* kita pun— KKM pun menggunakan *a generic first policy because you know very well*

doctors and others, I'm a former oncologist. So, we know to get the generic status, you have got to do both pharmacokinetics and pharmacodynamics by equivalent. So that dari segi *efficacy*, dia adalah sama. Cumanya *in the generic drugs, they do not do the clinical trial.* Maknanya *they escape all the billions of dollars in terms of investment during the clinical drug development. So that is the reason why they are cheaper. But by away safety and efficacy, they are equal.* Itu sebab dia *called by equivalent studies.* Begitu juga halnya tentang *not just generic but also biosimilar drug we called it.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Boleh saya minta yang pegawai yang berucap tadi, boleh bagi nama dan jawatan? Ini untuk *Hansard recording. Just now you spoke about…*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Dr. Davis, Dr. Davis. Your both…*

Puan Fatkhiah binti Haji Khalil [KKM]: *You give your name.*

Dr. Davis Johnraj [KKM]: *Okey, the one private, I mean…*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *No, no, no. Your name, your name.*

Puan Fatkhiah binti Haji Khalil [KKM]: Nama *you. Your name. Davis Johnraj.*

Dr. Davis Johnraj [KKM]: *My name, is it? Or the name of…*

Puan Fatkhiah binti Haji Khalil [KKM]: *Yeah, yeah. Your name, your name, your name.*

Dr. Davis Johnraj [KKM]: *Davis. D-A-V-I-S.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Sorry?*

Seorang Ahli: *Louder, louder*

Dr. Davis Johnraj [KKM]: *Davis. D-A-V-I-S. S for Singapore.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Jawatan *is a?*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Timbalan Pengarah…

Dr. Davis Johnraj [KKM]: *Oh, I'm a* Timbalan Pengarah Kanan *in the* Bahagian Perancangan.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Bahagian Perancangan.

Dr. Davis Johnraj [KKM]: Bahagian Perancangan.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Thank you.*

Puan Fatkhiah binti Haji Khalil [KKM]: Saya Fatkhiah binti Haji Khalil, Timbalan Pengarah Program Perkhidmatan Farmasi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, thank you.* Ya Wangsa Maju.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: Okey, ini *on the underground. Frustrations, building up*-lah. *People come to* pusat khidmat *for example, complain about doctors, complain about hospitals et cetera, et cetera. Bundle of it.*

Now today we have been informed that okay for doctors, this is a channel for us to complain. For hospital services, this is a channel for us to complain. Now we only know. I just like to emphasize the fact that we need— let's have a one-stop centre of aduan *which I think is not rocket science for you to have that.*

Seorang Ahli: *Correct. [Bercakap tanpa menggunakan pembesar suara]*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *You have that then you channel it because for us to understand, for* rakyat *to understand, I think is a little bit asking too much. That's for the first comment.*

The second comment is the situation on the ground. My daughter is also in the hospital, a pharmacist there. She got hurt and being an employee of the public hospital, she got an accident. Subsequently, she goes to the private hospital. Why did she go to a public hospital? Because long way et cetera, et cetera, et cetera. So, she knows the situation. So, she decided to go to a private hospital.

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Another situation is that, if I may conclude, that bed. Now, can you all share as well, that means how many total beds do public hospital has right now? Total number of beds versus how many total numbers of bed of private hospital. Then, we know, have a feel of what is the available services that public hospital providing and the private hospital providing. Now, that is third one.

The fourth one is just like to confirm the fact that even in public hospital, you have certain discussion for you to decide. If my blood is a B40 blood, you give a generic prescription. If my blood is blue, different prescription. If my blood is without mention that the specific color, different types of prescriptions. Can you confirm that in this proceeding? That means you have in your store of a medicine or whatever in the hospital, you have categories of antibiotics, for example. For this class of people, this kind of prescriptions, et cetera, et cetera. Can you just confirm to me on that?

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *I kind outrightly say that is nonsense. We don't practice that way at all. Prescriptions must be commensurate, indicated by diagnosis. Prescription is given when you have gone through differential diagnosis of all the attending physician.* Ubat-ubat itu diberikan, dipreskripsikan tergantung kepada *indication of the disease. The five, right? The right medications, the right patient, the right dose, the right time*. Apa lagi? *What have I missed? One more right.*

So, these are the practice of our doctors in our hospital. Tak ada. Kalau apa-apa, kalau kita ada dengar-dengar, semua itu tak betul kerana *we don't prescribe that way*. Saya harap dapat *misinformation* macam ini dihentikan segera sebab *I know for a fact that our doctors are very responsible. You know very well how finally*, kan?

Kalau orang pergi ke *private practice* pun, *finally, if they are really stuck, they come back to our specialists. They come back to our consultant physician and other clinicians because* apa pun orang kata tentang *our public health facilities, we still have the best healthcare professionals managing. As I said* tadi, *managing 150 of our hospital* yang kita kalau kita nak tanya, *we have 45,964 beds*.

We have 28 major hospital berpakar, *we have 26* pakar minor, *14 state hospitals. We have centre of excellence,* 11 institusi khas *and we have so many*. *Because we are essentially a facility-based ministry* dan kita punya— *we are the most complex ministry. We have 83 schemes of services, 83. We have 3,114 KKs here* dan *all that I could see besides got the small clinic called* klinik kesa dan klinik komuniti.

So, let me just say it again that apa yang disebutkan oleh Yang Berhormat tadi pastinya tidak betul. *No, there is no such differential treatment whether you are* B40 kah, M40 kah, T20 kah. *You are prescribed the drugs as indicated through the differential diagnosis of our attending physicians.*

Whether they are MOs, whether they are our consultants, senior consultants. Jadi, harap perkara itu dapat kita perjelaskan *because* kalau ada isu-isu tentang *innovator's drug being used in the IJN*, contohnya. Memang ada sedikit waktu dahulu. Ada pertikaian tentang IJN *using the innovator's drug, public hospital using generic*. Itu memang ada sedikit sebanyak tetapi telah pun kita relaikan perselisihan faham itu ya.

They are only giving when it is not available. Some of these— the innovator drugs itu *during their waiting period* memang tak ada *generic but some* kalau lepas *waiting period pun* dia masih guna lagi *because they are indicated by the attending— by their clinicians and physicians*. Itu yang kita boleh berikan *the best benefit of the doubt.*

Apa lagi soalan tadi? Saya...

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *On private hospital. How many beds do they have?*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Private hospital. Private hospital, they are total private hospital* kita di Malaysia ini 212. Mereka punya *official*

bed mereka adalah 18,779. Sementara kita, kita punya 149 hospital dengan 45,964 katil, *beds* ya. *That is the latest of 2023.*

Puan Teresa Kok Suh Sim [Ahli PAC]: *Only 212 hospital beds in private hospital*?

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Hospital, 212.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: 212 hospital dengan 18,779 katil ya.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Thank you.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Thank you*. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Tuan Pengerusi, tadi ada...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Saya ingin tekankan sekali lagi. Kita punya *health ecosystem is a* dwi-*construct of a public health facilities* dengan *private. Public health facilities are run and funded by general taxation. General taxation. That's how we have been funding. That's why it is RM1. That's why it is to see* a *doctor, RM5 to see a specialist in our outpatient clinics.*

Apakah munasabah? Memanglah tak munasabah. RM1 dan RM5 *because we are general taxation. Meaning*, rakyat telah dicukai dan dengan cukai wang yang disatukan itu, *we run. For example, this year, we got RM54.27 billion allocation to run our health facilities. Public health facilities.*

Now, the dwi-*construct is while we maintain what generally B40s and the government officers are all going to public hospital, we have also equally vibrant private health facilities and operators generally funded by of course* apa yang dibangkitkan sebagai *private health insurances and more importantly*, satu yang kami mahu *handle*, mahu *tackle* adalah *what is known as out-of-pocket expenditures.*

This is very inflationary. Out-of-pocket spending ini*.* Ini yang sebab itu kami dalam KKM memulakan satu usaha. *Even for the private health facilities* ini, kita nak mengarusperdanakan penggunaan *private health insurances* (PHI).

Kita tidak mengambil pendekatan NHI ataupun SHI, *National Health Insurances* dan *Social Health Insurances* kerana kedua-dua itu adalah secara mandatori. Ini dari segi pandangan kami.

It is just not politically right but it as well dari segi ideologinya *when you are already a general taxation-based financing system*, *you* tak boleh paksa lagi. *Already you have taxed your* rakyat. *Then, you* guna wang yang disatukan itu membiayai *public hospitals* dan tiba-tiba *you implement* NHI atau SHI. *It would be a double war.*

To them, they will not accept it but going forward, our trajectory forward we want to— kita nak mengarusperdanakan dan mengembangkan lagi. *That's why we*

are trying to nudge ITOs, *the insurance and takaful organisations to make them understand that if they— and also private hospital operators, if they reduce* atau lebih— bukan *reduce.* Dia lebih munasabah mengenakan *charges, they will finally get the volume.*

But if they increase it, then people render their policies, they will all be making bee line to our public hospital. That will jammed us. It will be a race to the bottom. Nobody wins in that situation. Sebab itu kita nak— sebab itu *we cannot kill the private health facilities* juga.

Bukan bermaksud saya tidak *kill* tetapi *we must make them equally vibrant. Because as an upper middle-income economy, contribution to health sector should be around five to six percent GDP.*

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We are only struggling at 4.5. So, this underfunding has cost this country health facility under staff, under resource, overwork, overburden, because we have not been spending what should be as an upper middle-income economy should be spending five to six percent to GDP. We are only spending public spending 2.3 and private spending 2.1. Total we are only spending 4.5 percent GDP. But, as I said to the Prime Minister if you cannot allow me to have more resources, allow me to be resourceful, that's the reason why we are coming with diversifying sources of funding among other thing to come out with the Rakan KKM, an improvement of the private wing, full-paying patients. Terima kasih. *I just thought I must make a mention of all this.* Terima kasih semua.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Very good.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya, Timbalan Pengerusi.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Bayan Baru mahu tanya lagi.

Tuan Sim Tze Tzin [Ahli PAC]: Okey. *So, I think Minister has come to a very important part which is* tentang *impact on the public health* lah*, public hospital* dan sebagainya. Sebab kita nampak bahawa apa yang berlaku adalah apabila insurans *goes up, they surrender their policy and then they decided to go to public hospital especially on the retirees. That caused a lot of problem I think to the government hospital.* Jadi Menteri, *do you find that actually the increase of people surrendering their policy and goes to public hospital? Do you have statistic or* kajian tentang isu ini?

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Need to be very careful* ya*. I need to be very data-driven.* Kalau ada yang boleh menjawab soalan itu? *I don't think*

we have, right? For the time being. Do we have Dr. Wei Aun? Or do we have a— ya*. Oh,* ya*. Of course, I've seen this slide before. Please Dr. Wei Aun, try to explain this.* Tidak apa*, it's okay. I think this can give some insight to what's happening* ya*.*

Dr. Yap Wei Aun [KKM]: Terima kasih Yang Berhormat. *So, now we get to use four out of four* soalan ramalan slaid. *[Ketawa] So, I think that important trend to see here which also explains why everybody is feeling a bit under pressure is that after the pandemic, we can see that there's a deep in the number of admissions to private hospitals in orange and in public hospitals in dark blue. That was a dip in the pandemic followed by a massive increase in utilisation both in the public and the private side.*

This is a global phenomena, it's not a Malaysia specific issue. But you can see how this is linked in the private side, the increase in demand to inflation and the pressures and you can also see on the public side how the increase is also resulting in our staff saying that their overburdened and overworked. This is just— it's just a global phenomena. It's just is what it is that in the recent years post-pandemic, there has been massive correction. If you look at the numbers like let say looking at private one and you look at 2021 which is approximately 800,000, it is now 1.4 million it's not doubled but it's very, very much higher. It's very, very much higher.

So, this the broader context underpinning the inflation issue that maybe we need to communicate to our public a bit better— that the demand for private services and public services has really increase, very, very dramatically in just a very short space of time. There's no other point in time where this steeper kind of curve than this that we see. So, just maybe this gives a broad sense of the thing. So, at this point you see the last number we have is 2023. So, of course this doesn't really answer the question that you are asking. 2024 numbers are being finalised. We checked internally. So, we don't have the final numbers to be able to present to you all.

But nevertheless, I think what we are finding is that there's no particular indicator showing us that there's a huge drop in the people with private coverage heading to the public sector. The main trend— looking at the data is actually what we are talking about, punca *yang* munasabah *that due to aging, due to increase in NCDs and the post-pandemic relate factors of catch up. There has been really just a massive increase in utilisation in both the public and the private sectors. So, I know maybe we can all communicate to our stakeholders that this is just not— is not like a problem which we have been careless about. It's just that the reality all over the world. This is the post-pandemic trend and it is causing the public sectors a pressure, private sector increases in inflation as they have to expand to that.*

But, it's not like just like one is going to another or is an imbalance issue, it is just this the reality of the punca munasabah *increase significantly in the demand for healthcare services, public and private resulting in a variety of challenges* lah*. So, do be understanding when we are faced with all these issues.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau boleh saya minta kalau boleh KKM bagi kami data tentang— *another data that we need is that how many people in Malaysia actually bought healthcare insurance? Medical insurance? How many didn't have? Another thing is how many people goes to— okay* lah*, this is— how many people go to public hospital and private hospital? So, this data is good.*

Okey. Tadi ada juga dua soalan lagi yang belum dijawab iaitu tentang tak ada hospital di Petaling Jaya dan juga Bayan Baru dan satu lagi adalah tentang *healthcare commission, health commission.* Saya hendak tambah satu soalan tambahan adalah adakah perancangan untuk KKM untuk menggubal Akta 586 atau 723 untuk mengawal selia *private* hospital? Terima kasih.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya, kita dengar daripada Encik Syazli dulu daripada Pejabat YB MK. Pegawai pembangunan. Sila.

Encik Mohd Syazli bin Yahya [KKM]: *Assalamualaikum* dan salam sejahtera YB Timbalan Pengerusi, YB Menteri. Saya Mohd Syazli bin Yahya daripada Pejabat Menteri Kesihatan. Untuk persoalan berkaitan dengan hospital di PJ, kita sedia maklum bahawa sejak PPUM diswastakan memang ada *demand* yang agak tinggilah di PJ. Kementerian dah pun bekerjasama dengan kerajaan negeri, isu utama di PJ adalah disebabkan oleh masalah tapak. Sukar untuk kita dapatkan tapak yang mencukupi untuk dibina sebuah hospital.

Sebelum ini kalau kata hospital biasa, biasa kita perlukan 30 hingga 40 ekar tetapi dengan Kerajaan Negeri Selangor sekarang kita mohon 10 ekar sahaja sebab kita akan *go for vertical development*. Respons terbaru daripada Kerajaan Negeri Selangor di kawasan PJ banyak akan ada kawasan yang akan tamat tempoh pajakan (*leasehold*) antaranya di kawasan Sungai Way yang kawasan perindustrian itu akan mungkin akan dipindah keluar apa semua dan kemungkinan besar Kerajaan Negeri Selangor akan *allocate* sebahagian kawasan tersebut untuk pembinaan hospital di PJ. Di pihak Kementerian Kesihatan, kita akan meletakkan Hospital PJ antara keutamaan yang tertinggi lah untuk kita *bid budget*.

Untuk di hospital di Pulau Pinang tidak silap saya di Daerah Barat Daya, ya lah, kawasan-kawasan Yang Berhormat, setakat ini kita tidak pernah mendengar sebarang perancangan untuk membina hospital yang baharu di dalam pulau. Bermaksud Hospital Pulau Pinang sentiasa kita *upgrade* setiap tahun, projeknya memang *at least* ada RM200 juta, RM300 juta setahun. Setakat *planning* di peringkat

kerajaan negeri dan juga Jabatan Kesihatan Negeri Pulau Pinang, tiada sebarang perancangan untuk membina hospital baru dalam Pulau Pinang. Yang banyak adalah di kawasan Seberang Perai iaitu di Hospital Sungai Bakap dan juga untuk *upgrade* di Hospital Kepala Batas.

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Untuk konteks ya, di Pulau Pinang ia ada dua bahagian. Satu bahagian pulau, satu di bahagian *mainland*. Di *mainland* ia ada Hospital Kepala Batas, Hospital Seberang Jaya dan Hospital Sungai Bakap. Tiga, *it serves three whereas* sebenarnya di bahagian pulau *population* lagi tinggi. *It's about 800,000 to 900,000 population,* seberang hanya *about* 700,000 *to* 800,000. *So, you can see that a smaller population served by three* hospital tetapi di pulau hanya satu hospital sahaja. *So, there's a disparity*. Itu sebab saya *highlight* kepada Menteri, KSU dan juga bahagian perancangan tentang isu ini yang perlu di-*address* lah. Kalau *you* katakan PJ itu keperluan, sebenarnya *the population is almost equivalent to PJ already* di bahagian Barat Daya. Terima kasih.

Okey. Satu lagi adalah *the perception about* PJ atau Bayan Baru *is very rich. No, there are sizable B40 and actually a lot of* untuk *Bayan Baru's context,* sebenarnya dulu orang yang susah dipindahkan ke Bayan Baru. *When they start building PDC low-cost housing which is about in the 70s or the urban poor are been moved to* Daerah Barat Daya. Jadi, *the population* di sana sebenarnya *is quite* memerlukan *general hospital* lah. *Sorry, issue healthcare commission.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Okey. *Commission* ini. Ya, sila Dato' Sri KSU.

■1710

Dato' Sri Suriani binti Dato' Ahmad [KKM]: Okey, *commission* ini *is a very a big thing to do* lah, YB. *Maybe for the beginning* sebab kita faham sekarang YB baru tahu cerita siapa yang ini, siapa yang *handle*, yang ini siapa yang *handle*. *So, perhaps* untuk memulakan dulu inisiatif ini mungkin KKM akan buat, akan *establish* dulu *with your consent,* Datuk Seri *for a one-stop centre*. *Whereby* semua orang yang ada pemasalahan itu, *will come to us and then* daripada situ kita akan kumpulkan soalan-soalan, permasalahan *then we know, we find out* dekat mana kita boleh *channel*-kan *this* permasalahan ini.

Tapi kita akan jadi koordinatorlah, *the one-stop centre. Instead of having a commission, commission* ini besar, YB. *It's going to take time for us to establish it. But why don't we have a one-stop centre*, lagi mudah, YB.

Tuan Sim Tze Tzin [Ahli PAC]: *It's in your white paper. Health White Paper. That's why I was like "Eh?".* Ya.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Saya tahu dan saya sangat sedar tentang keperluan ini. *You want to say it first,* Dr.*? Who want to? You want to* jawab dulu*?* Ini *commission*. Ini adalah Suruhanjaya Perkhidmatan Kesihatan bukan, Yang Berhormat? Bukan ya*? It was about one-stop centre is it? Which is it now?*

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Sebenarnya, *I think your white paper has a very grand plan*. *Whether you can reach there or not, I don't know*. Tapi sekarang kita memang *on the ground* dia ada isu yang *complain* tentang *high exorbitant charges*, isu-isu *mishandling*, *doctor* punya— *you know, overcharging* dan sebagainya. Itu memang ada isu seperti tersebutlah yang perlu di— yang kami, kami *layman*-lah. *We don't know what is the* perancangan *for KKM to address issues like this.*

Okey, contohnya sekarang, isunya dia *inter-ministry in this private healthcare problem is inter-ministry.* Bank Negara pun terlibat, MoF pun terlibat, KKM pun terlibat. Jadi, dia tak dia tak ada *one agent, one place where you address until the issues came out and we are very glad also and very thankful that you finally come out with nine* perancangan, *nine plan. I think which is good. But if let's say,* benda ini sudah selesai, *and then you know, we go back to* masing-masinglah *and wait for another disaster to come back and we come back again*.

So, maksudnya, saya nampak bahawa *we are ad hoc when response, we are reactive. There's no forward planning in addressing a long-term planning for healthcare, both public healthcare and also private healthcare. That's my point. Whether we have a commission, if we have a commission that sits regularly to plan forward on various problems in our healthcare. Then it's better where all— many-many industries are involved.*

Dr. Yap Wei Aun [KKM]: *May I respond? I think it's very important to correct the narrative on this. I think that's why very clearly which we mentioned that on the 2nd April 2024, it's recorded in the proceeding of Parliament, YB already informed PSSC for health that there was an issue with medical price inflation. Then in 27th August, issues presented to the same* Jawantakuasa Pilihan Khas Kesihatan *on solutions to do with inflation issues and even from that time we already indicated that we are working together with* Bank Negara.

Actually you may not be aware because we are not actively posting in social media. For the last few months, even prior to the inflation issue, we've been working on these solutions including the transformation of private health insurance together with KWSP. These are issues which way predated the public blowup of the inflation issue. We have been using normal government mechanisms to be working together as multiple agencies.

So, it's really important to correct your perception that is not that because of the inflation issue that only now we realised there is an inflation and only now we are working together. We have been doing this months, we really have been doing so. When I first started this appointment in March last year, by April of that same year, I have already requested DG Chair. I think this corporation has been going on for almost a year. We have been working with the Ministry of Finance, so on things like Rakan KKM, *all these are happening behind the scenes.*

So, I think really there are a lot of pre-existing government structures to do if inter-ministry of coordination like Kementerian Ekonomi *which we also have been working on together RMK-13 process, M10 process. This is not just because there is this issue that suddenly decided we need to talk to each other. It's totally a wrong perception. Yes. Even for* Rakan KKM, *we set up an appropriate governance structure with two ministries for intervention-based issue. But that is on the policy setting. But you are also asking a question on the consumer side, who do they go to, when it's a issue with multiple agencies?*

So, I think, just to reaffirm what my Sec-Gen was mentioning, that basically one of the— because it's urgent. The fastest thing we can do, let's create a one-stop centre. So that people know where to redirect their issues. Given that there's already a pre-existing prevent mechanisms which exist.

Puan Teresa Kok Suh Sim [Ahli PAC]: *Good*. Itu *last* lagi.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Boleh sikit lagi? *Sorry. Sorry.*

Tuan Sim Tze Tzin [Ahli PAC]: Akta, *are you going to do something about* Akta 586 and Akta 723? Any perancangan?

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya. *I think we have answered that earlier.* Dalam satu jangka jauh ataupun o*n a middle to— term. I mean it's not like a quick fix.* Kita tahu bahawa kita punya peruntukan dalam Akta 586 untuk akhirnya kalaulah kita memerlukan untuk mengawal selia dan menentukan *prices particularly* inflasi seperti ini, kalau kita perlu tangani. Sebenarnya Yang Amat Berhormat PMX telah pun mengisyaratkan perkara itu *that we may invoke 586 to handle medical inflation.*

Ini diberi jawapan tahun lalu, *December I think* atau tahun ini. *So, already we are—* kita sangat sedar bahawa *we may eventually need to invoke amendments to* Akta 586. Kalaulah itu satu cara pendekatan yang berkesan untuk mengawal inflasi— *medical inflation. We don't rule that out, we may have to take that option on legislation* ya. Tapi saya juga diperingatkan untuk sentiasa kita berwaspada seperti mana tadi,

we do not want the unintended consequences. So, we fall for something that we don't to use the sledgehammer whatever.

Tapi kita sedar bahawa kita punya beberapa *options and our multi-prompt approach would be best* disamping saya sebutkan tadi. Mungkin Dr. Harshinder *would you say something Dr.?*

Dr. Harshinderjeet Singh [KKM]: YB— *yes*, YB Datuk Seri. *Because in the* bawah *the* Akta 586, *there are already section or* peruntukan untuk melaksanakan *if DRG to be introduced, there are other subsections to amend. Section 106 for* Jadual *Fees, so we can amend that to cater in the DRG. So*, ada peruntukan di bawah Akta 586.

Puan Teresa Kok Suh Sim [Ahli PAC]: *I think as I heard— that day after the 500 people came to complain under this hearing, actually at the end of it, some of them come to us,* "Bila?". *Because finally they have a chance to talk to the* wakil rakyat, *talk about their problems and all that, "When is government going to you know stop or the halt", you know increase the premium, bla-bla-bla and all that. So, maybe for some communication thing, maybe* KKM *or* Bank Negara *or whatever agencies need to have some sort of timeline to assure the public.*

You know why, this issue comes out front page in Sin Chew, front page in many media. So, if the government does not respond then it will end up you face a lot of criticism.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Terima kasih Timbalan Pengerusi PAC. Saya sangat sedari— menyedari perkara itu. *Especially in the Mandarin media*. Liputan sangat luas tentang perkara ini. *So, we were struggling* sebenarnya *to come out with*. Ya, betul, *to have encounter narrative on this dan especially* kalau kawan-kawan kitalah dalam sosial media*, I don't have to mention their names. Their attacks sometimes can be very damaging* seolah-olah macam *the ship of* KKM ini *is about to sink*, nak karam dah ya.

Tapi, tak apalah. *They can say whatever*, tapi kita tahu bahawa *as what Dr. my good HTOCEO said that we are working almost like around the clock non-stop you know. To get this reform* dan pelbagai pendekatan *multi-prompt but as usual this people are not very good communicator, maybe*. Dia tak pandai masuk bakul angkat sendiri. *So, I think we need to have strategic communications on what reforms that we are doing, what achievements we have done and what are in the pipeline, what are coming. You know— what we are—* jadi, kesemuanya di dalam pengendalian kami.

■1720

So, sometime the impression dalam *social media* seolah-olah Menteri Kesihatan ini dia bole buat semua. Dia boleh— *you know, those things like on* perjawatan dan *the numeration*, *on calling*. Semuanya *I'm a Superman that can solve all these problems and they keep hammering at me.*

Tapi, saya tahu bahawa *it takes the whole— whole-of-government approach to understand because* pada akhirnya, kemaslahatan dan kebajikan rakyat dari sudut kesihatan adalah sangat penting. Saya selalu menyebutkan bahawa *health is the macro, macro critical imperative— Social, moral and political imperative* yang kalau kerajaan tidak tangani, *any* kerajaan *for the matter— for that matter, the government of the day will be shown the exit door in the next general election.*

Saya kerap ingatkan rakan-rakan dalam Kabinet dan juga termasuk PMX*. We have to really address this and address this* dengan segala kebertanggungjawaban dan keamanahannya. Terima kasih Timbalan Pengerusi PAC *for this opportunity...*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Sedikit ya. *Last* ya, *last. Sorry.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ada lagi *last?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Last* ya? *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Last. Sorry.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya, juga. Saya, saya...

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Last* ya? *Real last* ya? Okey.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Last. Sorry. [Ketawa]* Menteri, *sorry...*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Boleh, boleh. Cumanya saya ingin mengumumkan ya, kita juga lazim melakukan ini. Hari bertemu pelanggan kami Kementerian Kesihatan akan berlangsung sekali lagi di— Pada 27 Februari ya dan kita telah juga menguar-uarkan perkara ini di dewan serba guna kami di KKM iaitu A7— Blok A7. Dari pagi sampai petang.

But these are the ways we need to have the touchpoint untuk kita— *Of course, we need a lot more. But we also do a lot others engagement* dan libat urus dengan rakyat. Terima kasih Timbalan Pengerusi...

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Sorry* Menteri...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya, sila, sila.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Mungkin tadi dilihat— saya nak tanya berkaitan penyampaian bagaimana pihak KKM melihat infra-infra asas hospital-hospital dan klinik di luar bandar termasuk di desa semua. Saya cerita soal

sedikit di daerah sayalah, di Sik itu ya. Ada beberapa surat saya telah hantar kepada Yang Berhormat Menteri. Jadi, mohon dapat perhatian...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Saya ambil, saya ambil perhatian...

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Lah ya.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: *Insya-Allah*, *insya-Allah.* Hal yang—Satu. Itu...

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Di klinik —Ya. Di Klinik Kesihatan Jeniang itu agak— sangat daif. Bumbungnya bocor...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Jeniang ya?

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Dan di Hospital Sik itu..

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Encik Mohd Syazli tolong ambil perhatian. *[Ketawa]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya. Yang paling agak kritikalnya ialah pusat hemodialisis dia dah sekarang sangat-sangat *crowded* dan...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Okey.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Kapasiti dia tak boleh tampung dah. Kami di situ hanya ada satu saja pusat hemodialisis swasta. Jadi...

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Betul.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ada terpaksa pergi jauh sampai ke Kuala Nerang dan itu sangat-sangat diperlukan perhatianlah oleh kementerian.

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Ya. Baik. Terima kasih Yang Berhormat.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Sorry.*

Datuk Seri Dr. Haji Dzulkefly Ahmad [KKM]: Saya ambil perhatian perkara itu. Saya baru balik daripada Langkawi sebentar tadi. Juga, begitu ya permintaannya adalah kalaulah 30 unit-unit dialisis yang telah sarat diguna dengan 19 *in the waiting list, in the pipeline.* Mereka mahukan satu yang swasta *driven* yang mungkin juga kami akan memberikan ruang untuk *such*— untuk *dialysis centre* swasta itu dibangunkan juga.

Saya yakin banyak lagi tempat-tempat yang memerlukan fasiliti-fasiliti sedemikian *because* inilah masalahnya kalau kita sentiasa terus-terusan dengan *sick care* dan bukan *healthcare*. *[Ketawa] We have got to go preventive, we got to go really getting our* rakyat untuk *be on healthy living lifestyle* supaya kita dapat elakkan *end stage renal failure* ini apabila kita tak jaga diabetik kita *in our— all our—* Minta maaf saya macam— macam *proselytising* pula ya.

Because this is true kalau kita tak kawal *the NCDs,* ya *one in three, one in three* adalah hipertensi, *one in three* tinggi kolesterol, *one in five diabetic, one in two overweight and obese, I tell you, we will always be in crisis. No amount of* hospital pakar, pakar *major* kah, pakar *minor* kah, *centre of excellence* kah *can take* untuk kita bangunkan negara yang Madani punya rakyat, rakyat Madani yang sihat kalau kita terus-terusan tidak menjaga dan tidak mengambil pendekatan preventif dan *probative* dan *predictive* ya.

Apa pun, kita juga perlu membangunkan fasiliti-fasiliti ini seterusnya. Sebab itu saya tekankan tentang kepentingan *transform primary healthcare. That is truly not all hospital but clinic.* Orang Indonesia dia pandai. Dia kata kalau hospital saja, dia kata rumah sakit. Tapi kita juga lebih pandai. Kita kata kalau klinik, kita kata klinik kesihatan. *So, that's where healthcare is.* Di hospital itu, *sick care* Timbalan Pengerusi PAC.

Terima kasih semua ya sekali lagi atas sokongan dan dukungan ya. Satu yang sangat baik dan kami sangat menyanjungi. *[Tepuk]* Segala keprihatinan dan segala sokongan PAC khususnya kepada hal-hal cabaran di Kementerian Kesihatan ini. Terima kasih sekali lagi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Terima kasih Yang Berhormat Menteri dan juga KSU; dan juga rombongan pegawai dari KKM dan jabatan-jabatan lain. *So*, prosiding kita hari ini akan berhenti akan berhenti pada pukul 5.25 petang. Sekian terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Esok sambung pukul 11.00 pagi.

Encik Ahmad Johan bin Mohd Affandi [Sekretariat PAC]: *[Bercakap tanpa menggunakan pembesar suara]* 11.30.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: 11.30 pagi.

[Mesyuarat ditangguhkan pada pukul 5.25 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Selasa, 25 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

Rakyat/NGO

(i) Dr. Lim Chee Han
Senior Researcher, Third World Network

(ii) Encik Ng Kian Nam
Penasihat Undang-undang, Kempen Mempertahankan Hak Pemegang Polisi Insurans Di Malaysia (CPRICM)

(iii) Dr. Chan Chee Khoon
Chi Co-Ordinator, Citizens' Health Initiative

(iv) Dato' Indrani Thuraisingham
Naib Presiden FOMCA, Gabungan Persatuan-Persatuan Pengguna Malaysia (FOMCA)

(v) Prof. John Chan Ninyii
Presiden, Persatuan Penasihat Kewangan Malaysia

(vi) Cik Nur Zawanah binti Zamri
Executive, FOMCA

(vii) Encik Ethan Teh Eng Teck
Bendahari, Persatuan Penasihat Kewangan Malaysia

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

SELASA, 25 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] *- Naib Pengerusi*
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato' Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Datuk Ali anak Biju [Saratok]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]

Tidak Hadir *[Dengan Maaf]*
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] *- Pengerusi*
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Dr. Hajah Halimah Ali [Kapar]

URUS SETIA
Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Mohamad Tarmizi bin Ahmad [Penasihat Undang-undang I, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Puan Zulfa Amirah binti Jubri @ Mohd Zufri [Pegawai Tadbir, Seksyen Sinergi dan Kolaborasi Strategik, Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Encik Aznirul Fariz bin Alwi [Ketua Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)
Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan]
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Suzana Binti Alias [Ketua Cawangan]

(samb/-)

Kementerian Ekonomi (KE)

Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) (Bahagian Perkhidmatan Sosial)]
Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah Makro]

Jabatan Akauntan Negara
Encik Mohd Nizrulizham bin Jamaludin [Akauntan]

HADIR BERSAMA

SAKSI

Rakyat/NGO
Dr. Lim Chee Han [Senior Researcher, Third World Network]
Encik Ng Kian Nam [Penasihat Undang-undang, Kempen Mempertahankan Hak Pemegang Polisi Insurans Di Malaysia (CPRICM)]
Dr. Chan Chee Khoon [Chi Co-Ordinator, Citizens' Health Initiative]
Dato' Indrani Thuraisingham [Naib Presiden FOMCA, Gabungan Persatuan-persatuan Pengguna Malaysia (FOMCA)]
Prof. John Chan Ninyii [President, Association Of Financial Advisers Malaysia (Persatuan Penasihat Kewangan Malaysia)]
Cik Nur Zawanah binti Zamri [Executive, FOMCA]
Encik Ethan Teh Eng Teck [Bendahari, Persatuan Penasihat Kewangan Malaysia]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

SELASA, 25 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 11.40 pagi

[Yang Berhormat Puan Teresa Kok Suh Sim
mempengerusikan Mesyuarat]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Salam sejahtera, selamat pagi dan selamat datang saya ucapkan kepada Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas, Ahli-ahli ex-officio PAC yang terdiri dari Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, Suruhanjaya Pencegahan Rasuah Malaysia, Kementerian Ekonomi, Jabatan Akauntan Negara dan Penasihat Undang-undang Parlimen selaku wakil Jabatan Peguam Negara.

Yang Berhormat Ahli-ahli Mesyuarat sekalian, hari ini PAC Parlimen akan mendengar keterangan dan penjelasan berhubung isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan Bank Negara Malaysia.

Prosiding ini adalah merupakan yang ketiga diadakan bagi tujuan mendapat penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan caj hospital swasta. Ini termasuk kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan faktor luar seperti pandemik.

PAC berpendapat bahawa terdapat keperluan untuk mendengar penjelasan daripada semua pihak yang terlibat berhubung isu ini seperti pihak NGO yang mewakili suara rakyat yang memastikan dapatan dan cadangan yang dikemukakan oleh Jawatankuasa ini kelak akan bersifat lebih menyeluruh.

Yang Berhormat Ahli-ahli Mesyuarat sekalian, hadir memberi penjelasan di hadapan PAC dalam prosiding pada hari ini adalah Yang Berbahagia Dato' Indrani Thuraisingham, Naib Presiden Gabungan Persatuan-persatuan Pengguna Malaysia (FOMCA); Yang Berusaha Dr. Lim Chee Han, Penyelidik Kanan Third World Network; Yang Berusaha Tuan Ng Kian Nam mewakili *Campaign To Protect Rights of Insurance Consumers in Malaysia;* Yang Berusaha Tuan Chan Chee Khoon mewakili

Citizens' Health Initiative; dan Yang Berbahagia Profesor John Chan Ninyii, *President of Association Of Financial Advisers Malaysia* iaitu Persatuan Penasihat Kewangan Malaysia.

Terima kasih saya dan PAC ucapkan kepada semua kerana sudi hadir di hadapan PAC bagi memberikan penjelasan pada hari ini. Sebelum saya menjemput saksi untuk memulakan pembentangan dan memberikan penjelasan, ingin saya maklumkan bahawa semua Ahli-ahli Mesyuarat sekalian bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 [*Akta 88*] dan Peraturan Mesyuarat 85, Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat sehingga prosiding selesai dan laporan dibentangkan di Dewan Rakyat.

Jadi tanpa membuang masa saya ingin terlebih dahulu menjemput Dr. Lim Chee Han, penyelidik kanan Third World Network untuk memberi pembentangan. Dipersilakan.

Dr. Lim Chee Han [Third World Network]: *Hello,* selamat pagi kepada semua. Terima kasih kerana jemputan PAC. Saya ucapkan tahniah kerana mengadakan *meeting* sebegini untuk mendalami isu yang berkepentingan rakyat.

I will continue my presentation in English. So, I'll introduce myself, I'm Chee Han from Third World Network. Today, as the title of my presentation would suggest, I would like everyone to focus on the transparency and market competition issues. I think this are the fundamental issues that give rise to the phenomenon today of the rising or medical inflation and the insurance premium increase.

So, I do have a biomedical background. I graduated from Imperial College in Biotech and Immunology. I also have a PhD in Infection Biology. I'm the current senior researcher at the Third World Network. We actually do policy advocacy and research.

I'm in the health team, working on the access to medicine campaign. My speciality is in health financing, public health and heath reform. I'm also the co-convener of the People's Health Forum coalition and current Assistant Secretary of Together Against Cancer, which is a patient advocacy group for the cancer patient and survivors.

I'm also the policy coordinator for the health chapter of the Manifesto Rakyat *two years ago. Affiliated with the Consumers Association of Penang and was also a senior analyst at the Penang Institute for the state government think tank at the economic section.*

So, I think the core issue today what we are looking at— yes, people are unhappy. Why? Because they think they pay a lot more for healthcare. Probably too much. They feel unfair. They feel very frustrated. That's why you had the many public hearings, hurt people very disgruntled voices.

The crux of it is that they think that the private healthcare facilities for example the hospital and clinics, they charge patients too much on medical bill. So, for your information if you're talking about the private sources of the health expenditure, actually more people are paying out of pocket is about 76 percent according to the statistics for 2023 by the Ministry of Health. Only 17 percent paid by private insurance.

But for the healthcare, you also includes purchasing the drugs from the community pharmacies and so on and visit the private clinics which do not take too much and private insurance primarily pay for the inpatient medical bills in the private hospital.

But we need to have a breakdown of the medical bills to see what are the problems. I put it into four major categories. The doctors' fee and services which is heavily regulated in our Medical Act and Private Healthcare Facilities and Services Act and so on.

So, these fees and charges actually remained unchanged for certain years already. We also have test and investigation. So, all these use of equipment and testing and diagnostic all come under this one. Then, we also have things like the ward. Like first class or second class or what are the food like and other kind of charges.

Lastly, was also very importantly for certain categories of patient. Drugs and medication. This is also very fundamental issue. About the private insurance problem, we mainly be talking about the premium increases and also the issues of co-payment and non-coverage of certain kind of condition.

Why the problem right is now because of the number of amounts of medical claims surges for the past few years and it's backed by— data also provided by Bank Negara Malaysia and the origin is still go back to the charges. Why the medical bills are so expensive?

One explanation, too many people in general, things are getting more expensive. You can look at the core or headline inflation figures. It's just 1.8 percent last year. But to account for like over 10 percent or maybe 12 percent of general medical inflation rate. It has been something.

Even if you look at the global average at 5.6. It's still— Malaysia is two times more than the global average and many times more than the general inflation. What makes healthcare expenditure so particular, so interesting and so much expensive? This is what we need to dive in today.

I would argue that we need to look at the unregulated market and anti-competitive behaviour of certain sector. I will bring up the issues of the non-

transparent pricing. Some among the sector some are already uncooperative in providing key information to the government and the regulators. It's a very big issue.

Secondly, I want to bring to your attention about the abuse of dominant position or legal monopoly in terms of drugs and medicine in the form of patent.

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So, this are the area I want to shine light on today on the market behavior of certain sector is— want share with you my insights and I work primarily looking at the medicine. So, I will highlight from the point of view of medicine because I understand from the press conference last Friday, PAC want to look at the monopolistic nature of the market in terms of medicine, this is what I would like to share today to all of you, our insights and finally looking at the private insurance.

So, the first issue is we want to have the access to affordable medicine. Their two ways to do about it is to encourage more competition, that means you need to have more generics coming into market. So, focus on the first one first and second is about markup regulations. We know that expenditure on jobs and medication can vary in private hospital bills, some would say 10 percent to 20 percent, it depends on the conditions, the medical conditions. Some patient pays more disproportionately for example cancer patient because cancer drugs are very expansive. According to a study about 10 years ago, many— 72 percent of those treated in private hospital who are cancer patients, they're faced financial catastrophe within one year. That means they spend more than two-thirds of their money for the treatment. So, these terrible things to have if there is only original medicine, they can use of course the cost are higher. So, the statistic from the government already shows, government actually did a fantastic job at monitoring the medicine prices.

In 2022, the originator prices— at the procurement price are we're talking about to the generics in private sector is actually about four times. That is only the median, so it can go up to six times and more. So, that means if you have a choice to buy a generic is four time less expensive, so this a very important for you to take a note and if talking about purchasing price, even for the government and the private sector also has a difference. The difference is about 55 percent, not 0.55. So, that means from the start private sector already purchase the medicine at a more expansive price, 55 percent more expensive than public sector, government price is because government has this full procurement, so they purchase in large quantity, so they can joy probably better rate. But this is also a factor to go in because when you start at the higher price already, when you also have a markup then the price will just double.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi. *Can I ask Dr, about this bulk purchasing, actually a lot private hospitals are big groups, IHH, KPJ, they can do a bulk purchase as well, why can't they get a good price?*

Dr. Lim Chee Han [Third World .Network]: *Surely MOH also pool for MOHE because there are a few university hospital run by our Minister of Higher Education also Ministry of Defense. So, the volume will be large and they also have open tender, so they invite bids in an open manner, so I think all this can drive to savings because they are competition. I don't know how the private sector did their procurement but I would say that a government has been effective in controlling the procurement price through their procurement processes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Can I just interject here?*

Dr. Lim Chee Han [Third World Network]: *Sure.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *What you are saying here is if the government procure Panadol, is cheaper than the private hospital procures Panadol? Is that what you mean?*

Dr. Lim Chee Han [Third World Network]: *I didn't go to specific…*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *I mean what you are saying is roughly that...*

Dr. Lim Chee Han [Third World Network]: Ya, *for original products, Panadol is original product because we have other paracetamol.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Alright.*

Dr. Lim Chee Han [Third World Network]: *Also— I think government has policy for to procure generics. They don't care about brand, they want for specific medicine, they just open tender for them.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *I understand, I just like to understand what you mention. If I heard correctly which means if the government procure Panadol, it's cheaper than private hospital procures Panadol? That is what you are saying?*

Dr. Lim Chee Han [Third World Network]: *Yes, according to the survey.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Can we— can you share where you get the survey from?*

Dr. Lim Chee Han [Third World Network]: *Ya, this is medication prices monitoring in Malaysia 2022, survey is done by the pharmaceutical program under MOH.*

Tuan Sim Tze Tzin [Ahli PAC]: *[Berucap tanpa menggunakan pembesar suara]*

Dr. Lim Chee Han [Third World Network]: *55 percent.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Okay, I don't know about health but usually on other sectors, government procurement is more expansive than— this is first time I hear when government procurement is cheaper than private.*

Dr. Lim Chee Han [Third World Network]: *We need to give applause to MOH colleague to fight hard on the public interest, I think because of the volume. Other procurement, I don't know probably in what department or the ministry, they work differently because is a one project of many people open for biding but this is we're talking about volume, so with the volume you can actually have a competition, you can drive the price down.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *If the government…*

Dr. Lim Chee Han [Third World Network]: *Just from my perspective.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Just for your information, government procure photostat machine paper, they procure a lot but still expensive than private sector. So this is— I think, I am quite catch by this fact.*

Dr. Lim Chee Han [Third World Network]: *So, out of my studies to answer you— out of my depth to answer you that question. [Ketawa] I just can talk about the medicine procurement perspective.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Ya, I think is interesting point to be highlighted, thank you.*

Dr. Lim Chee Han [Third World Network]: *Ya, that is median price I'm talking about. The interquartile range is from 25 to 17 percentile is 16 percent to about one time cheaper if you— for the public sector to purchase. Now I am talking about…*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Doctor, wait.* Kubang Pasu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ya, *thank you Mrs. Chairman. Mr. Lim?*

Dr. Lim Chee Han [Third World Network]: *Yup.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Right, I called you right name* ah.

Dr. Lim Chee Han [Third World Network]: *Ya, my surname is Lim, yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You did subject something else, you study in something else but now you doing something else. You are biotechnologist from Imperial College?*

Dr. Lim Chee Han [Third World Network]: *Yes, yes, I am, I am.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, I just want to ask you certain things on page two and before that I would like to ask you, you*

said in case of medical charges in Malaysia higher in more other country is, right? What is your main reason Mr. Lim? That's number one.

Number two, I see their median procurement price ratio, page two at the bottom. You used IQR .

Dr. Lim Chee Han [Third World Network]: *Ya.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *…And then that is for private sector and for public sector, how do you— please explain on that.*

Dr. Lim Chee Han [Third World Network]: *Okay, that means …*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Private sector higher.*

Dr. Lim Chee Han [Third World Network]: *Yup, okay.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Ya, please.*

Dr. Lim Chee Han [Third World Network]: *Okay, for the second questions is the private sector to public sector ratio on the selective numbers of product on the originators. So, they find out that for the range of product they have, private sector pay on the median price the 50 percentile is 55 percent more than the public sector's procurement price and range then go from 16 percent to 97 percent from the 25 percentile to 75 percentile*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You used a figure 1.16 and 1.17?*

Dr. Lim Chee Han [Third World Network]: *Yes, that what how we can interpret.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What does— we are laymen, what does IQR mean? What is...*

Dr. Lim Chee Han [Third World Network]: *It's inter quartile range, that means for 25 quartile to 75.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, quartile.*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Q.U.A.R.T.I.L.E.*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Right, thank you.*

Dr. Lim Chee Han [Third World Network]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The first question. Why* kita punya *increase* di Malaysia *higher than other countries? What is main reason?*

Dr. Lim Chee Han [Third World Network]: *You mean the reason for the healthcare…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Ya.*

Dr. Lim Chee Han [Third World Network]: *The healthcare cost?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You did mention just now.*

Dr. Lim Chee Han [Third World Network]: *Ya, the medical inflations. Okay, just now on the slide previously, we talk about what constitutes into the medical bills? I mean the most of the money we spend on the curative care and also private hospital even in the healthcare expenditure from the private sources quite a lot, quite substantial about half, I think we spend in the private hospital.*

So, whatever the prices change in the private hospital sector, we have an impact on the overall expenditure.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That's why.*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, our charges are higher for private sector.*

Dr. Lim Chee Han [Third World Network]: *That doesn't mean that the other only problem, I think you can also look at private clinic prices and also pharmacies, all this will constitute into the total healthcare expenditure.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay.*

Dr. Lim Chee Han [Third World Network]: *But for the hospital side only, we take up about 50 already.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Alright, thank you.*

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Tuan Sim Tze Tzin [Ahli PAC]: Okey YB, satu soalan. *Original drug versus generic usually is how many, how much, what you said is about RM3.91. Let's say RM1 generic, RM4 original price. Am I right?*

Dr. Lim Chee Han [Third World Network]: *YB, this is ratio. I'm not talking about prices but if you just want, just convert to easy explaining this— okay, you can say that for RM1 generic you can procure there's another selection of the originator at RM3.9. So…*

Tuan Sim Tze Tzin [Ahli PAC]: *Originator is the original one* lah? *Okay.*

Dr. Lim Chee Han [Third World Network]: *The more expensive one. This is provided there are generics availability.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay.*

Dr. Lim Chee Han [Third World Network]: *Imagine there are many drugs actually do not have generics. So, you cannot make comparison. The ratio can be much higher.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *In terms of effectiveness, generic is as good as original?*

Dr. Lim Chee Han [Third World Network]: *Yes. Because we do have NPRA and we do have a very high standard of requiring the medicine to have the same effectiveness and safety and there are three criteria to look at so they need to pass all the tests and do the bioequivalence studies to show that they are actually similar in the effectiveness from medical point of view.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, we better use generics* lah?

Dr. Lim Chee Han [Third World Network]: *Yes, there's a MOH policy for all to keep the healthcare cost low.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tapi, *I don't want generics when the pharmacist asked me, "You want generics or not?". I want original. Now, I can go back and say I want generics.*

Dr. Lim Chee Han [Third World Network]: *Yes, please, please do so. Alright, okay.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Sorry, sorry can we go back one slide before this?*

Dr. Lim Chee Han [Third World Network]: *Sure.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *To the chart yes. You mentioned that in the purple bubble there…*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *You mention that's unregulated market / anti-competitive behaviour. Now then on your rectangular light brown…*

Dr. Lim Chee Han [Third World Network]: *Okay.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *You mentioned four areas.*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Now, when you mention unregulated, are you saying all these four are unregulated or any one of the four is regulated?*

Dr. Lim Chee Han [Third World Network]: *Ya, the doctor's fee is regulated heavily and drug prices and whatever hospital can charge you on the ward, food and even test, investigation and all unregulated.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *So, what are you saying only doctor's fees and services are regulated?*

Dr. Lim Chee Han [Third World Network]: *Correct, correct. Yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *The other three not regulated?*

Dr. Lim Chee Han [Third World Network]: *Yup, yup.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Alright. Thank you. Okay.*

Dr. Lim Chee Han [Third World Network]: *Alright, let me continue. Just now is about the purchase price. Now, I want to talk about the markups which can cost eventually very high prices because you can see that on the left side is private hospital in-patient drug selling prices from innovator and generic. You can see that they actually these markups. Mark-ups mean if you see 100 percent, means it's double, they are two times more expensive than what they pay for the procurement, okay.*

So, what I found is that for originator, private hospitals can charge 2.2 times the purchase price and about 3.7 times the generic price. Bear in mind, the innovator is usually a lot more expensive so 2.2 times is really something a really very high markups. So, it's about 120 percent.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *About the term again, what do you mean by innovator there?*

Dr. Lim Chee Han [Third World Network]: *Ya, innovator I just use government phrase but I prefer to use originator that means the first company that brought this medicine to the market.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Originator* lah.

Dr. Lim Chee Han [Third World Network]: *Originator.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Clear originator.*

Dr. Lim Chee Han [Third World Network]: *Ya because this, this…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] [Tidak jelas]*

Dr. Lim Chee Han [Third World Network]: *That one should report they use innovator and in the graph also it says, innovator. So, I don't want to confuse you. So, I just use the language.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay. [Ketawa]*

Dr. Lim Chee Han [Third World Network]: *Although I prefer to use originator. Ya so you can see actually it's funny because if you look at the outpatient setting, you see the markups, the medium markups will drop or half. That means those inpatients if admitted to the private hospitals you pay a lot more of markups.*

This is something that we need to do more careful study why there's kind of difference ya.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Which is generally claimable on insurance? Generally?*

Dr. Lim Chee Han [Third World Network]: *Ya, some says outpatient treatments, sometimes you cannot get the coverage. I think this private insurance issue there will be covered later. But if you look at these statistics from the government, it shows that there is a difference between inpatient medicine prices the medium markups compared to the outpatient. And outpatient is actually more closely resembles to the one, to the right side that is the private clinics prices for innovator and generic.*

It's more or less similar range because I think there is some kind of competition if patients do not want to get the drugs from the outpatient department, they can go to clinics or go to pharmacies. So, I would argue that maybe the competition drives them not to have higher markups but because you are admitted to hospital in the bed already…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *No choice.*

Dr. Lim Chee Han [Third World Network]: *You cannot make a choice. So, I speculate this is one reason that they have a higher markup on the inpatient setting.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Mr. Lim, somebody mentioned to me that the if you are hospitalized— you hospitalised…*

Dr. Lim Chee Han [Third World Network]: *Yup.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The drugs and medicine, they charge higher let's say* RM2 jadi RM10 *and I say, I asked why. They said because the insurance, they already fix certain charges for other things. So, they say in order to cover for the cost of cleaners, cover for the cost of security guards, all that, they put* dalam *medicine* dalam *drugs. I don't know true or not.*

Dr. Lim Chee Han [Third World Network]: *That's one way definitely there has many other…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Ya because they have to avoid from this problem with this insurance, so they markup on the drugs. Sometime even 10 times. So, I do not know maybe you know better than me. Thank you, Mr. Lim.*

Dr. Lim Chee Han [Third World Network]: *If you— for the outpatient, I mean for out-of-pocket patients, when you need to make a payment, they need to give you an itemised bill. I don't know maybe someone has to re-study if there is any in discrepancy between the insured patient or the uninsured patient. This statistic*

doesn't tell you that but you tell you about the selling price. In the real case, the inpatients setting and the outpatients.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Dr. Lim, if I may ask about— this comparison is only on the markups, right?*

Dr. Lim Chee Han [Third World Network]: *Ya in markups only.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *It doesn't, it doesn't compare the real price between the innovator and the generic, right? Now, if you compare say, side by side and you put in a bar chart on the real price of the innovator and the real price of the generic, have you done that? That's number one.*

Number two, I believe the difference is still so great and that makes the generic price gets higher. I mean even if there is an increase so much that it still below the innovator price. And in this case, I think the generic one is really making the— is profiteering from that. I mean what do you— what is your comment?

Dr. Lim Chee Han [Third World Network]: Yang Berhormat, *we can't know about the real prices because some the companies that produce or manufacture the medicine there can give different prices to different people according to volumes, according to the market situation.*

I mean it's— this one you see a variation in the prices. So, there is no fixed price for whatever they want to sell to whoever. So, that's why I say it's a very unregulated market markup, they can simply markup whatever numbers they want. This is just median. I'm not talking about the full range of the markups; it is just median.

I think in 2017 we can see about markups of 900 percent, nine times for the generics because generic is the cost is already very low, so for example one piece is RM3, if you markup to like nine times more, 27 for a very complicated medical condition you don't see 27 is very expensive drug, for example.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Sorry Dr. Lim, just I want to understand a little bit. I mean what is your base for coming up with that markup?*

Dr. Lim Chee Han [Third World Network]: *Ya the point that I mentioned about markup is this will actually determine your medical bill in the end, how much you will pay for medicine. If the markup is a lot more times higher, you pay a lot more because there are some medicines are very expensive and this can contribute to the higher cost of healthcare and just a topic we are talking about the medical inflation.*

If you have the inflation of don't know how many percentages of the markups, it definitely contributes to the medical inflation. So, I want to look it this way for the— it's not very distance past about this survey done— it's 2022's numbers.

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So, for the original drug, if they can averagely charge 2.2 times more than the purchase price what is the cost past to the patient? So, I think, I want you to look at it this way. In general, for any inpatient medical bills, 10 to 20 percent actually usually go to drugs and medicine. So, it is a component of the healthcare expenditure I must mention here.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Boleh kita— hari ini kita ada— pagi ini ada empat pembentang. *So, now is already 12.10. So, can we pull back* itu *question* bagi dia teruskan, habiskan dulu lepas itu bagi dia tanya.

Dr. Lim Chee Han [TWN]: *Thank you, thank you* ya. *Thank you* Yang Berhormat Pengerusi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, ya. *20 minutes per person and try* lah ya.

Dr. Lim Chee Han [TWN]: *Okay. So, secondly, I want to mention about the mark-up is so higher in private clinics and hospitals compared to community pharmacies which are they are in a real competitive market. Private clinics, some they don't— sometimes don't give you a prescription, so a lot of time patient just have to purchase from their clinic. So, there is one reason that the— for example on the generic drugs their pricing, the markup can be higher.*

Second issue we want to talk about is the dominant— a bit of dominant position and anticompetitive behaviour. Those with the— from who host the original drug patent holder they want to do as much as possible to delay and block the generic availably in Malaysia then they can drive up the cost and set the high price. So, how does it work?

If you have only one supplier there's no competition. So, you have the dominant position to set any price you think that the patient can pay, afford to pay or they can pay. They must pay because if you want to recover, you have to pay the price because there is no other medicine other than theirs, okay?

So, if you have multiple producers or importers that means they are— its condition for competition then is possible that patients will have the choices. Then you can access to the low-cost generic medicine. So, available generics are very important in driving down medical inflation and healthcare costs. So, this is the ideal situation I highlight here. Our policy should move towards to encourage more producers and more competition so that they drive the cost down.

So, their common practices for the pharmaceutical industry for those who are the patent holders of original drugs. So, if you can— I think this deserves another public hearing or investigation to see the situation also in Malaysia. This is a common practice worldwide but also in Malaysia. What they do is they have pattern

evergreening that means they— I just fall many, many secondary patterns that improve the drug's side and find another pattern. If they got successful, got approved, they got 20 years of protection. So, you can imagine a job probably out of favour probably 20 years ago because of multiple pattern protection.

So, they prolonged their market monopoly ya, for the whole 20 years because of subsequent so-called innovation which is just modified slightly they got another 20 years. So, it can prolong more than two times of the original, the first pattern. Ya, this is very important because market monopoly determines the price, whatever pricing they can set, okay because there is no competition of generics.

Secondly, they also can take legal action against local generic manufacturers and importers. If they try to bring in the generics after they register with the authority, they will try to sue them, scare them and delay them into the market. Because once they in the market, the price will [Tidak jelas]. I guarantee you this happens, this is called pattern cliff, okay?

So, the third tactic is to— because these generic manufacturers or importers, they need to register the drugs first with our Malaysian authority MPRA, so in order for a registration to be successful, they need to do the bio-equivalents studies to show that they are actually in the same efficacy compare to originator. But the originator company just refuse to sell or to provide them with the quantity of drugs for them to test. Some you can easily get from the pharmacy is no problem.

But if you need a quantity, a very large quantity of very expensive drugs, where can you get from? Only from them right? Because you need to have the drugs sell in this country to make the comparison because the original drugs in other countries may have different kinds of modifications. So, in order for them to register the drugs they hand it to get the originator products but they refuse to sell. So, this anticompetitive behaviour is quite common also in Malaysia. You can talk to our local generic manufacturer industry about this.

Okay. Once the generic market is in the market, they also have other strategies. For example, they can sponsor or incentivise doctor specialists to prescribe originators over generics and they can spread misinformation creative and narrative that to cut down on generics saying originator is superior, you are more familiar with that already, why change your course, things like that. I mean doctors also play an important role in helping this kind of narrative.

But you must know that generics are many times cheaper and with the entry of generic, the original price will also almost immediately half, almost immediately half, okay. Lastly, they also can use the media to inverse the public opinion. If there's

any regulation that comes to regulate the pharmaceutical industry, they have their media. They probably own the operate the media also to counter. So...

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Dr. Lim can complete, can finish in five, 10 minutes because we have another three more people.*

Dr. Lim Chee Han [TWN]: *Can, okay 10 minutes*-lah, *10 minutes. I go without interruption, I can go faster.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, ya.

Dr. Lim Chee Han [TWN]: *Okay, second issue I give you a case study, still about the anti-competitive behaviour. So, about this drug called Trastuzumab is to treat breast cancer. So, in 2018 December, we have a generic version, is because this drug is biologic, we call it a biosimilar version we don't call it generic ya but is similar. So, it comes to— is approved in the— was approved in Malaysia and the price for our local manufacturer, they price a 50 percent of the original price.*

But, because of our MOH call for an open tender and then this the original brand company Roche immediately jot their price to 52 percent in order to win the open tender. So, this is a tactic for them to win to— how to say, to sideline the generic because these producers already spend a lot of investment money to produce this biosimilar but they don't get the lucrative contract from the MOH because of the volume.

So, this is also a tactic to kill off your opponent by this predatory pricing because in one night the price can jot that 52 percent. So, is really something— is also happening in the private sector once the generic comes in, they were job to match the price of the generic. So, generic entry is very important, availability is very important to keep our medicine price down.

So, I want to show you also— we have this market review report back in 2017. [Menunjukkan senaskhah buku] I have a market renowned for the pharmaceutical sector which I am also part of the researcher. We also found that— actually the profit you can say that the local pharmaceutical industry says that their profit margin is very low, we are not earning that much of profit compared to insurance and private insurance guy— private hospital sector.

But one thing you need to know is that they don't operate the research office here. Most of the operation is only for to sell ya. So— but they buy the product from the parent company from outside Malaysia. So, of course, you can see the profit margin is very low for the Malaysian subsidiary companies. But if you look at the global, those companies in Geneva, in New York all this, they got 20 percent something of the profit. These phenomena are called transfer pricing.

So, that means what we pay in Malaysia is actually the profit that goes to Geneva, to Germany, to New York. So, we need to scrutinize this, is it something that we should pay for those does not stay here in Malaysia? If you look at the top ten of market shares of the pharmaceutical companies, the top nine are already foreign-owned. So, it's an issue I would say is a medicine security issue also because pricing is determined by this parent company. Okay, there's come our government policy in medicine price mechanism. The objective is to provide availability of the qualities of safe and effective medicine at affordable cost and it also aims to increase the transparency of medicine price information. The government did that since 2018, try to implement that.

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The government in 2019 actually approved some kind of price regulation. Six years ago, but where are we getting at? I will tell you later. But this is the plan because they have so much information about all these pricing issues already.

So, they set the control of the markups. So, the price regulation is not really about setting a had *price. It is to set— it's to negotiate with the originator or the producer about the wholesale price. They set the maximum, they gazette that under the Price Control and Anti-Profiteering Act and then, they also set a markup for at the retail level from 10 to 35 percent. So that all this can really control the kind of markups that we see is very extreme for certain drugs.*

But sad news is that until today, we still don't have any regulation on medicine price because the private sector says no, collectively said no. They pushed back the policy despite our government has spent rounds of engagement with them, doesn't work anyway.

They also have diluted the proposal from setting the wholesale drugs price to controlling markup at both ends to only display retail drugs price also the private sector— I want to tell the committee here, they still want to block it. Just display. We don't say that if you want to display a higher price, we want to control you. No, it's not, just display. They also refused.

So, there are some GPs strongly objected to this policy and our APHM President also denies there's overcharging in private hospitals and say that they want to have more regulations. It's in the news. I didn't say anything not in the news. We know their position in the news.

They say to regulate a private hospital rate will hurt their industry. The MMA representing many majority of the private clinics GPs, they also don't want. They even want to call for Black Monday Campaign to oppose to the medicine price display policy. Just display price, it's not to regulate your price.

So, they also have been way uncooperative in providing price information. When the government wants to implement this medicine price mechanism in 2021 onwards, government did a study. But they only managed to get about nine percent of the drugs required for the study out of 1,300 single drugs for drugs for the control. They only get nine percent.

So then, they label this study as a failure and it's unfair. Instead, this private sector, they sponsored another study under MITI. Then, they say, they claimed to cover more products. They say, they claimed can cover 5,000 products. You have this information. I don't know you have this information, didn't provide.

They disregard— crucially disregard the conflict of interest by the co-chairing a Technical Committee. So, this is the public studies but sponsored by the pharma. You can see the highlighted there. How can they in the Technical Committee to determine the terms of the study?

Of course, this study is very much in their favour to block the medicine price policy. So, all this I want to show is that their concerted efforts from the private sector to block price regulation and transparency in Malaysia.

If you want to get down to why the medical inflation is so high, you need to have all this price information data. But, it's very difficult to get it from a private sector even for a government.

You can tell a government about this and as a researcher, health policy researcher, I also face a same issue. It's very difficult to get price data from the private sector. It's a fact.

So, I want to highlight this of my former comrades from the Together Against Cancer, the late Mr. Ng, to show you the fourth issue, the private insurance coverage is insufficient for people with certain conditions. I think the cancer one is big area to look at.

You see, the treatments that she got for the medicine on the leftmost column, her two treatments are actually the Trastuzumab. You can see before 2018— just now I showed you the case study, right? Before 2018, she used to pay about RM92,000 just for the drugs.

This doesn't include other kinds of out of pockets, other hospital charges. Thus, for those in the industry, private insurance industry, they will know usually in the policy will have annual limit. So, she just uses up to RM100,000 limit. It's not too much if you look at the medicine, already RM92,000. So, there is no helping at all.

So, she has to fork out her own money. But you know, for cancer patient is not just one time you can cure. A lot of times you can get the relapse and see from

the subsequence years she also has to spend money and also have to fork out money for herself.

If you look at the whole journey until the end, when she needs to use even more stronger medicine, the only expenditure on drugs alone cost RM437,000 already. So, if you talk about the healthcare expenditure in terms of medicine is significant for cancer patients. Let's not belittle that and the insurance is never enough if you look at RM100,000 limit. A lot of time just drugs alone can just hit or be go beyond. There is no guaranty that it's sufficient at all.

There are other kinds of a conditions that are excluded from a private insurance. For example, the preexisting conditions. The cancer survivors have these challenges, have these challenges because they are heavily discriminated. They survived, more than five years they are clinical clear from a cancer, still they are excluded form an insurance coverage.

So, this very unfair. In other countries, there is other policy to forget those conditions, five years as a time limit. So, there's this one patient said that patient with benign breast condition cannot get new insurance cover. Whether past history with surgery or biopsy and even an ultrasounds screening or mammogram detected also they rule them out. This I think is very cruel for the cancer survivors. There are many of them.

Some medicines or treatments are excluded because an insurance company says they are preventive, not treatment. So, they refused to pay. There is one patient also told us that insurance has recently stopped carrying hormone therapy such as Tamoxifen and Letrozole as they considering these drugs as preventive instead of treatment. 80 percent of more cancer patient needs— required to take these drugs daily for five to ten years.

This is a maintenance medicine and it's not that cheap, okay. That's not that cheap. It's from hundreds to thousands, okay? So, these are excluded. Many outpatient treatments if you are not admitted, not detected with certain— have certain diagnosis, you are not covered also. Importantly about the prophylactic procedure is to prevent you to getting certain disease, but this are also not considered in the private insurance.

So, now comes to our recommendation from Third World Network. We say we need to implement the medicine price display policy as soon as possible. There is no excuse. It's very lame for them for not able to do that and for the government to consider implement the full medicine price mechanism in the near future to control the unreasonable markup.

I showed you the markup can be two times, up to six times more and for the extreme cases, they will nine times also. Extreme cases. So, we need to get everything in the most transparent manner to see the price get controlled and have to increase the stringency of patentability to stop patent evergreening, to stop granting undeserving secondary patents for those trivial changes to a drug. Because once they got the patent, they can get a monopoly for 20 years, okay.

Private sectors must be mandated to cooperate in providing key information for the purpose of market transparency and regulation in particular pricing information. It's very important. This is the area that we need to go at.

Insurance companies must justify their repricing to their policyholders by providing more information on the risk of their policies and their fund pool. So, that they are well informed— so, you can justify, yes because of our funding shrinking, we cannot have capital. So, they are on the risks of liquid. So, the risks of the policy cannot carry forward. Okay.

Health insurance should also move towards community rating rather than personal risk rating. We need more risk pooling needed because we heard from so many people saying that when they get ageing, they must pay even more because they have higher risks. So, this very unfair to those people. I think we need to have more risks pooling, so that it will be fair for those who needed the most at the time they need to have the coverage get the insurance.

■1230

To develop the DRG for the hospitals billing so everyone knows what will be the charges like. There's no surprises okay. If there is anything hospitals have to do more, they have to find their ways to help it to make sure the patient gets treated until recovered okay. To introduce the cost containment measure also in the health insurance.

Lastly, importantly I think its time for us to do a market review on the private healthcare providers, what do you think. I think we have done on the pharmaceutical sector just at the last level of retail pricing and all these we actually don't know how they do the markups, why they do it this way and that way. So, MyCC— the Malaysian Competition Commission have to ensure that the healthy and fair market competition for the healthcare sector. With that I thank you for your attention.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Ya, thanks to Dr. Lim Chee Han. So, now we go straight* to Yang Berbahagia Dato' Indrani Thuraisingham, Naib Presiden Gabungan Persatuan-persatuan Pengguna Malaysia. *Before that any question?* Mahu lagi? *You know we have spent one hour here you know. Now we have another* empat.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Chairman, one question please.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Ya.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Dr. Lim, I would like to refer to number six, implementation of DRG. In your point of view do you think that this implementation of DRG definitely will give a positive impact to the reduction of the prices charged by the private hospital? Do you think it will be positive impact?*

Dr. Lim Chee Han [Third World Network]: *Yes, definitely* Yang Berhormat*. Because currently is totally unregulated. So, with the DRG at least they set some kind of boundaries or some kind of packages for the treatment for certain diagnosis. So, also they have to— government also have to negotiate with the private sector about the kind of payment range. It's not a range, it is kind of pricing they have to confirm. So that for short term then everyone will be very clear about that kind of expenses and diagnosis involved.*

It's not a guarantee for reducing the medical inflation but it's one way to do it because DRG also practiced in USA and we know that medical inflation in USA is crazy. So, but it gives some kind of framework of control. I think it's good for the consumer, patient and also government to regulate so that the hospitals cannot charge unreasonable billing charges.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *You're meaning to say that it will be more transparent, is it? In terms of…*

Dr. Lim Chee Han [Third World Network]: *I think it is fairer* ya*.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Transparent?*

Dr. Lim Chee Han [Third World Network]: *Ya.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *It will be more transparent compared to you know, traditional way of doing things.*

Dr. Lim Chee Han [Third World Network]: *Yup, so hospitals don't have to bother to give itemise billing for glove and like a small syringe or things like that. There is no need to markup for everything. Just everything in the package, just go. I think it will be very healthy that way.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Okay, thank you Dr.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Mr. Lim, I just like to ask you on page four and five, this is about the anti-competitive behavior to block delay or generic availability. I think this is something very serious because generic drug can really help us to reduce the cost of the healthcare. What's your opinion? How do we resolve this issue? Number one.*

Number two, private hospitals through APHM of course they don't like government to regulate them for medicine price and all that. So, in my opinion we

should not bother about whether they agree or they don't agree, we should proceed. What do you think?

Dr. Lim Chee Han [Third World Network]: *On the anti-competitive behavior of private sector, I think it deserve a strong looking into the issues especially tightening our regulations and laws to regulate— for example also strengthening our Malaysian Competition Commission to regulate such behavior and activities because it's clearly to undermine the consumers and patients to pay more unfairly. I think also deserve some kind of review for the private sector especially private healthcare sectors and behavior to the market review.*

Secondly, I think ya *of course government you are the policy makers. You have the public interest in your heart. You have to do what is right for the public interest. Industry needs economic growth is one thing but you have to be fair to our own people because this is the rakyat that you are serving.*

So, to me I have also know conflict of interest are always top on the public interest. I think this is the right thing to do so that people too would have the right to healthcare at the affordable pricing.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey ya*. So, we end this session here. So, I would like to invite* Yang Berbahagia Dato' Indrani Thuraisingham. *Can you finish it in 20 minutes? [Ketawa]*

Dato' Indrani Thuraisingham [Gabungan Persatuan-persatuan Pengguna Malaysia (FOMCA)]: *Very good afternoon, Puan Pengerusi, YB Pengerusi and to all the* Yang Berhormat*. On behalf of FOMCA which is the Federation of Malaysian Consumers Association. I'm pleased to be here to represent the voice of consumers I would say all of us the 32 million or 33 million consumers are in Malaysia.*

So, our perspective of course we do agree with what Dr. Lim has presented because we can see evidence you know high prices of drugs. But for us we are looking at the overall impact on the consumers. People do not have now the ability to go to a private hospital especially when it comes to certain emergencies because they are giving up their medical insurance. Number two, charges are so exorbitant. I think last Friday session clearly indicated that where you know the insurance industry just keeps on denying or delaying in giving out claims. Then the medical insurance— I mean the private hospitals then continue to operate with minimal oversight. So, for us it's like you know getting hit from both sides for the consumers

So, for us of course as mentioned healthcare is definitely a fundamental basic right. For us, what we would like to urge the government is to actually for Bank Negara especially when it comes to medical insurance, for them to take a more proactive

role, The excuses that they gave that they were not aware that the insurance industry was increasing their fees was very flimsy. They as the regulator they should be monitoring, they should be getting information from the insurance industry.

So, for us actually in the long-term which I will reiterate again is that we feel that the Madani Government needs to consider implementing the National Health Insurance System. Basically, this can be implemented gradually on the phase-by-phase basis and use current mechanism like for example PERKESO where PERKESO is already giving opportunities for those who are subscribers to actually go for what you call this for the kidney dialysis. You can actually already use that.

So, I think there are many you know those who are employed who are already contributing to PERKESO to perhaps to use that as a mechanism to start and then maybe later improve on that because the situation now is very dire and if you look at the situation of our nation I think everyone of us knows someone who is either dying or passing away you know just like that, sometimes due to not going to the hospitals because it is so expensive or sometimes delay even in healthcare.

So, our first main concern is actually looking at the lack of transparency and accountability in the insurance industry. For us we still do not understand how did they come up with that statement that they we going to increase 40 to 70 percent of the medical insurance. Then because there were such a hue and cry from the public that Bank Negara had to you know intervene and say okay then we are now capping it at 10 percent for the next three years.

But even then, how did Bank Negara come up with that 10 percent? What was the data that was used for them to agree to that even that 10 percent because from the consumers perspective we do not agree because until today we have not seen the necessary data that the insurance industry should be providing for them to be able to claim that they are actually going at a loss.

Because if you see usually there has to be certain I would say key metrics in measuring what is medical inflation. I think Dr. Lim already mentioned what results in medical inflation other than the service chargers of the professionals, the medical professionals, everything else is not controlled. Right from medical devices— you talked about equipment, medicine, he highlighted a lot on the medicine.

■1240

But from what I understand, unfortunately, my brother is also a doctor. My cousins are all doctors. They're all in the MMA as well. So, I've been having a lot of debate even talks with a lot of these individuals. Then, of course, I wanted to hear also the two sides of the story because sometimes they always say consumer

associations, we are very emotional. So, I also wanted to hear you know, what do the doctors have to say from the other side?

And I've been told many things, of course, this has to be verified, that means, the government needs to ask for this kind of data. But I've been told even, for example, when you talk about medical devices. When you talk about devices that you put for your knee replacement or whatever other small devices. Now, all these need to be registered under the Medical Device Authority. It has to be not only— the company has to be registered but each product has to be registered.

Apparently, these are all very exorbitant, very exorbitant rates. A lot of the SMEs or suppliers who are actually getting these products, now have to close shop, especially post-COVID. Now, you see more of the bigger and huge and more expensive products being brought in. And these products not necessarily the best quality, that sometimes for a certain product, you need to actually import just one product from overseas. That also then raises the cost of any surgery that is being done. So, it's not just the medicine but it's also the medical devices, the equipment because again because of the bureaucracy and also then of course, they also have the other issue as well.

So, when we talk about information that is lacking from the industry. We do not get the information like the loss ratio. If you were to look typically at what would be the health insurance loss ratio, it would be about 80 to 85 percent. And this, we can also see in Germany, which actually has a loss ratio about 90 percent. America has got about a loss ratio about 80 percent. This means whatever amount of premium that you collect from the consumer, that amount is paid out as a claim.

So, if you're paying out is like 80 percent, 90 percent which means for every RM100 consumer is getting back RM80 or RM90, then, that's fine. But if you only get— if the consumer is getting back RM50 or RM40, where is the other RM60 going to? Most of the time it's going for profits. Most of the time it's going to administration. That's where the money is going. You can see this on a lot of data that is available from other countries.

But unfortunately, in Malaysia, we do not have mandated or standardised medical loss ratio…

Tuan Sim Tze Tzin [Ahli PAC]: *I think it's not loss ratio, it's called claim ratio. Meaning how many percent is being claimed.*

Dato' Indrani Thuraisingham [FOMCA]: *Being claimed. Yes. Correct. The claims paid over the premium collected, yes. So, Malaysia does not have a standardised claims ratio and what we see if you look at the statistic that was given*

on the website of Statista, it shows that in 2023, 65.9 percent was actually paid out. So, which means for every RM100, RM66 was paid out to the consumer.

But I had an engagement even with the insurance industry but they claimed that you know for every RM100 they paid out, RM111. That's why they have this loss. But when you ask them for data, they're not able to share that kind of data.

So, I think you know, this is the kind of information that is needed by Bank Negara because at the moment now the practice of collecting this data, especially on medical insurance statistics is not there. You have it for property, you have it for motor and all the other insurance aspects but for medical part it's still not available.

So, in publishing this data, I think that's how Bank Negara will be able to justify any increase because at the moment now it's at at their whim and fancy. If the insurance says it's RM111, who are we to say, "Oh, yeah if every RM100 you're paying out RM11". So, unjustified. But where is the basis?

So, for us, I think this one of the things that we are really very concern with, that the insurance companies must prove their losses. And they must provide strong evidence of this and so that we know that it is aimed at— looking at medical inflation and not maintaining high-profit. We have seen statistics of how much of profit and I think Dr. Lim also shared about that. Every year they made profits and the bonuses and the commission that the agent gets but it's always the consumer who are at the losing end.

So, for us this what we ask Bank Negara to basically look at. The other area is actually looking at the unethical business model that the insurance company has. And I think this was also raised by Dr. Lim about how insurance uses the personal risk rating compared to the community rating where you have a bigger pool and sometimes and what we see now especially when Bank Negara announced about co-payments. They've now allowed under their guidelines to insurance companies— for this kind of new policies on co-payments you can actually stop an existing policy and offer this new policy with co-payment.

So, not necessarily with co-payment that your premium is going much lower. We've got cases of where it is just nearly RM10 or RM15 difference in terms of paying lesser premium. But now you have to fork out your own pocket money for the balance co-payment.

What we're also realise is that many of these insurance industries or the companies are actually segregating that using this opportunity now to offer those who don't claim a separate category. So that, all those who are claim go into another category and that's where then you know you see this smaller pool of people who are

constantly claiming and that's why they say the medical insurance has gone up. But this is again how they're doing internally, this kind of practices.

The third area that I wanted to highlight is actually on the private medical charges. I think Dr. Lim also adequately talks about that. But the current model of fee-for-service payment that the private hospital uses, where the hospital charges per procedure. So, for them, they can actually when you go to for a headache, they can actually do whatever that they want say that you know, "Oh, your headache is related to some spinal checkup and we need to do some MRI". So, every procedure, then you know consumer is billed.

Also then, again the procedure of itemised billing. Again, where this— they are seem to be looking to being transparent but then you're charged for every individual service or product, right. I think last Friday we heard that even the plastic cup for medicine is also charged, sanitising the whole room is also charged. So, it's like everything is charged. They want to be extra transparent and you're get 50 pages, 60 pages of billing that consumers will have to go through.

This is why we are in favour of the diagnosis-related group, the DRG payment scheme because here at least the costs are fixed based on the diagnosis and this ensure some sort of a uniform pricing and also give the consumers a lit bit of opportunity to actually compare prices from one hospital to another hospital. At least you will get some sort of engaging in terms of the DRG payment system.

So, that is something that we are in favour of compared to the current mechanism. And also, then the case-mix system where patients with the same type of illness, of course either with the complication or without pay some sort of a standardised amount.

So, this will actually give some sort of information to the consumers. I think at this moment in time when we fall ill, it is like free for all. We go to the hospital; we don't know how much we're going to be charged. We really have got no idea. It may be just a wound on your leg but maybe because of you're a diabetic patient, you may think it's a wound on your leg, I may do it within the day and I don't have to stay the night.

■1250

But when you end up going to the private hospital, they give you a three-night stay and they say, "Oh because of the wound and because you are a diabetic patient, so will have to bring the necessary physician". And you end up being looked at by three or four specialists with a different kind of treatment and so on and end up having I think a huge amount and I think we have heard all those nightmare stories last Friday.

So, for us actually having the DRG and the case mix system as well as perhaps Bank Negara or the Ministry of Health publicly displaying prices for specific procedures. This again will have— will enable consumers to have an idea if Prince Court is charging for cataract operations, you know for RM50,000 and Subang Jaya is charging RM30,000 and Sunway is charging RM40,000, it is up to the consumers to decide. It may be because I do not necessarily want to go for the cheapest, I may know that you know certain hospitals give better services but, at least they give me an idea that I know how much the cost of that particular treatment will be.

So, this mechanism actually will mandate full disclosure of treatment costs and that is important for the consumers, making informed decisions. I think for us that is the perspective that we want to highlight and it eliminates potential hidden charges that may burden especially vulnerable consumers. We are talking about those who are OKU, those who are elderly, many of us are aware that OKU are not able to access medical insurance and for the elderly we have heard so many stories about how the insurance policies are only covered until about 70 or 75 and then after that, they are not covered. So, these are really the areas of concern for us.

The fourth area is actually to urge that the government actually increase the public healthcare spending, I hope that as Members of Parliament here, that you actually push for that because at the moment now, if we look just purely at healthcare, I think is about 2.47 it is only for the healthcare, it's still too low and we feel that, we need to reach the five percent as recommended by the WHO and also then to strengthen the government hospital and clinic. I mean they also heard a lot of stories about how— You know, when I getting enough housemen and medical officers, in terms of human resources, they hold politics that result in people leading the hospital on the government side. So again, not only to look at the financial aspect but also look into the mental aspect as well because I think a lot of them need support in terms of mental health also in terms of this bullying and all that. I put effort as I said, I've spoken to a lot of people, a lot of housemen who tell me about how their colleague just ended up leaving or quitting the hospital because of certain conditions.

So, they need to strengthen the government hospital, the government clinic and the community clinic. I think they are the ones who are nearest to the consumer, especially in suburban areas and rural areas and to ensure that affordable healthcare services are there for all. Finally, we hope that, you know the problem is always when we ask certain ministries like for example Ministry of Domestic Trade whom we are usually aligned with, you know you have the Price Control and Anti-Profiteering Act coming under the Ministry of Domestic Trade, but then you see issues like medicine you know are not— you know within the purview and you ask them why, oh because

healthcare is not under the Consumer Protection Act. So this is not under our jurisdiction.

So, we still see government agencies working in silos and that is why, we are also calling for an independent joint action council under the Prime Minister's Office, they can bring all these agencies together and actually look into all these three aspects of the medical insurance and also the healthcare of the consumers as well.

The additional issues, I think the first point that we wanted to say is again about the pharmaceutical pricing that Dr, Lim had mentioned earlier. About looking at agent commission, you know if you— I mean many consumers actually end up buying insurance policies because it's a relative or a friend who comes to and says, "Hey can you buy insurance from me?" So many times, we actually say okay. You know you tell me what and I will cover and they tell you everything you want to hear that you have critical illness, 33 critical illness, you have RM2 million coverage. You know, don't worry that when anything happens, RM2 million, RM3 million is covered. But when you want to claim just RM50,000 for the particular procedure, that is where they tell you, oh you did not disclose this, you did not do this, no you are got a rider and things like that.

So, a lot of information is not given by the agents themselves and even when you talk about— you know now— even in the banking sector. If you go to the bank, you see you've 10 teller machines but you only see two or three of them working because most of them are out there trying to sell insurance for that particular bank. So, that they can get additional commission. So, that another area that— you know that are lot related areas that we need to be looking at.

The price disparity between public and private healthcare, I think that was also mentioned by Dr. Lim just now and as I mentioned the quality of medical devices. At the moment now, it is much more expensive because both private hospitals as well as government hospitals have to use the one that has been registered under the medical devices authority but because is exorbitant in terms of bureaucratic prices that— we are not getting the right product in the healthcare system.

Did oversight of drug prescription and pricing? That was also mentioned by Dr. Lim and also then expanded price control to a broader range of services and of course— for the insurance companies themselves, not to lump everybody as trying to fraud, defraud the insurance industry because if you ask, every time they will say, "Oh the buffet syndrome that is pushed by the consumer". It's not every consumer that asks us for the buffet syndrome. Sometimes it comes from the private hospital, not in many— in many of times when the consumer is in hospital, they usually rely on the private doctors who tell them that you have to undergo this, this, this kind of

treatment. It's only those who sometimes know how to use your ChatGPT and Google— they put their symptoms and they say, "Oh you know I could possibly be having this, this, this". And then they demand from the hospital, I want to do this test and that test. So, there has to be a balance or there must be certain protocols that the insurance industry must put in place to ensure that they eliminate ways of abuse and fraud and actually then don't delay genuine claims from the policyholders.

I think this point also brought up the critical role of social determinants of health in last Friday, public hearing as well. This is definitely related because you have aging, you have issues on nutrition, you have issues of housing, mental health. All this actually correlates to the medical inflations issues because if we do not— if our obesity rate and malnutrition rate keep ongoing sky high, this means more and more people actually end up being in the hospital which means again, we are going to end up being a sick nation if this is not look at.

In terms of ageing, there were many cases last Friday that was heard, perhaps we need to consider looking at Japan as a best practice where they introduced in the year 2000 the long-term pay insurance for those who are 65 and above. As you know, their rates for birth a very, very low. It sometimes even goes in the negative and they have actually put in place long-term care for Japan that and even for those between the age 40 to 64 that if you develop age-related diseases like dementia or stroke, they are also covered for this and you can actually cover home-based care, nursing home, daycare and rehabilitations. So, perhaps we need to study some of these options, especially for the elderly.

Of course, then the point on a public awareness campaign. Insurance industry always claims that they are doing a lot of awareness but their awareness is basically to get more policies but not really getting— making sure that the consumers actually understand what they are signing when they are actually signing up for the insurance policy. Because at the moment now, everything is on a tab because digitalization is there, everything is on a tab or they show you the last page and ask you to sign.

■1300

All they tell you, you swipe, swipe, swipe and then you sign at the end you know and consumers are not aware. And if you look at the policies, they are usually framed by legal advisors, by lawyers. So how do consumers understand? So, again here they have to be aware for consumers to understand what they are signing up for. So public awareness can [Tidak jelas] to be there, so that they have adequate information. And finally, of course the point about the long-term solution.

For us we still feel there's a need for national health insurance system that can be implemented as I mentioned earlier on a gradual phase by phase to reduce

the reliance on private insurance and of course to not overwhelm the public healthcare system at the moment now. So, to look at the funding that could be shared between the employers, employees and government subsidies and this would be definitely reduce the financial burdens of the middle and lower-income consumers.

So finally, I think that's what I would like to highlight from the consumers' perspective. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Thank you very much Dato' Indrani. So, we have another three right? We have* Yang Berusaha Tuan Ng Kian Nam?

Encik Ng Kian Nam [Kempen Mempertahankan Hak Pemegang Polisi Insurans Di Malaysia (CPRICM)]: Ya. *[Bercakap tanpa menggunakan pembesar suara]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *And also, I just want to make sure you are here.* Tuan Dr. Chan Chee Khoon, Chan Chee Khoon *here.*

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *[Mengangkat tangan]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *And Prof. John Chan Ninyii, here. Okay since Professor John are here maybe you sitting there maybe you start first.*

Prof. John Chan Ninyii [Association Of Financial Advisers Malaysia (Persatuan Penasihat Kewangan Malaysia)]: Ya, *can.* Salam sejahtera, salam Malaysia Madani kepada tuan-tuan dan puan-puan, Dato', Datuk, Datin-datin, YB dan Yang Berusaha.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Can do it in 20 minutes?*

Prof. John Chan Ninyii [Persatuan Penasihat Kewangan Malaysia]: *Can you— yes. Yes, so I'm Professor John Chan, President of* Persatuan Penasihat Kewangan Malaysia *(Association of Financial Advisor Malaysia) representing the industry player for financial advisor and financial planner licensed by Bank Negara and Securities Commission. I'm sharing from the perspective of industry player of e-medical insurance.*

Now our issue here is medical insurance repricing, let's focus on this thing only. Other thing is it will drag us very far. From the perspective from medical insurance repricing, I would like to pay attention to three things.

One misuse or overuse of insurance. Second thing, about the actuarial problem. Third thing about the pricing issue. Less come. So, we need to know about certain things about some background first, background story sorry, disclaimer. This is for the right thing-lah *in case you want to use.*

Some additional scenario from public perspective, right? Other than other people who shared last week, just now. So, from the actuarial perspective, there is freeze portfolio of sick and old policyholders, insuring each other in a leftover pool. While a healthy policyholders are invited to upgrade to a new policy medical insurance rider.

So, now we understand that from the perspective of actuarial, if I'm not mistaken this has to be referred to Bank Negara policy where we understand that a few years ago Bank Negara did introduced some framework on their accounting and actuarial standard. Where to stay the insurance rider or product to be profitable for the solvency of the insurance company also.

This might be one of the structural things that could lead into the pricing of the policy. How to say like that? So where insurance pool should be pooling everyone together right but now it could be pooling under product pool. This product, then they launch another new product then that's another risk pool, different risk pool. So, when this young policy or those people who still can upgrade those are still healthy they can either upgrade— they are invited to upgrade to a new policy, new riders or maybe some other insurance companies' agent come and offer to go to their insurance company.

So left those people who are not healthy, so here what I write here this three types of of people with pre-existing conditions, with medical history, and old people, they cannot upgrade so they left to self-insured within the single pool. So that is the scenario today that actually the problem is not the future new insurance. The problem here is the existing policyholders that are making noise. Because they are self-insuring so this are for me it is also one of the contributions is the actuarial problem.

So let's say— look let's look at— okay. Okay, the following group are the policyholders who are significantly affected by the existing challenges, elderly policyholders, policyholders with pre-existing, and policyholders with claim history. For the benefit of the doubt, new riders' plan will still be offered at the affordable rate. Aiyoo this is Apple always bila saya cakap dia hendak cakap juga Apple. *[Ketawa] Okay. For benefit of doubt, insurance premiums for newly launched policy are still at the affordable rate, yes?*

What is the problem here is that the existing plan that is being repriced almost every year they sent you letters to increase 20 percent, 50 percent, 100 percent, 200 percent. The all block. But the new block is still affordable.

You see why the new block are affordable? Because they are using a different actuarial calculations, right? So, for the benefit of the doubt, as I write here, new

medical riders may still be offered at the affordable rate compared to the old plan which is experiencing frequent repricing exercise.

So here in an insurance company, there is a new pool and also an old pool. The problem that imposes public healthcare concerns are the old pool because the old pool has no way to go. You see? If this condition left unattended, public healthcare may collapse, I use the words collapse if the leftover policyholders have no choice to experience frequent drastic hike in medical insurance premium and worst still if certain people strive not to renew the insurance, they left the policy, the number of pools become smaller and smaller.

Kalau dulu ada 1,000 orang dalam pool itu kan, 500 sudah pergi yang baru, 500 yang sakit apa-apa *leftover then* ada yang *left* tak mahu tinggal 200. *Can you imagine if 200 people, self-insuring in an old pool I think no IC, [Ketawa] no IC. So, the task of medical insurance pricing mechanism should be equally important for both the new block and old block of business, right?*

Concerns and party. So the first thing if you want to solve this problem there are four parties involved. So, we put away personal agenda, we put national agenda first, okay? So that is important right?

*The first party, insurance company because if they launch a new policy, new pool they got new business to do, right? They got KPI of new business, KPI on profitability for insurance intermediaries. If you got new pool, means new business-*lah *for conversion. Old customers you are still healthy, you convert. There is new business, right? They needs new business as KPI so these are certain agendas.*

For hospital is profitability. For policyholders, policyholders also got some problems. You know what? Certain of the healthy clients, they say, "Why you want to imposed deductible? I'm healthy. I got the right, this one, this one, this one," but the uncles and aunties— repricing until hendak menangis.

So, the healthy ones also got agenda. They want full claim, "I don't want deductible, I want full claim, I don't want to co-share with the insurance company. Why cannot I have full claim insurance?" Full claim insurance is the problem today. Let's continue, why it's the problem today.

So, there are four things that we can do. First, four additional pillars of improvement other than what the doctor says and FOMCA says just now. Four additional things. First, segregating risk into are single risk pool. [Merujuk pada pembentangan slaid] So 1.1, aggregating all— aggregating risk into a single risk pool. What I mean here, there are two ways of doing it. 1.1 aggregating all medical plans both new and old into a single actuarial pool. Which means the sick and old, the leftover and the new policies when you design new policies, new riders, those risks

should be aggregated together with the entire insurance company's old pool. So, one insurance company, one risk pool. But now, one insurance company they segregate by product pool.

So that is actuarial problem, you could refer to Bank Negara on these things. So when the whole company, old and new segregate into a new single, one pool it means the healthy, the young, the new comer, the new policyholders, those healthy ones will complement the sick ones. That is the purpose of insurance, right?

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Insurance is not about sick insuring the sick but the healthy complimentary the weak one, right. So, task aggregating both the new and 1.2, aggregating all medical risk together with other insurance benefit. Why we say like that? So, ladies and gentleman, when we buy one medical insurance, sometimes we buy it through a package bundle, right. You buy life insurance, critical illness, PA and also medical into one plan especially investment-linked plan. We have all riders into one policy.

So, when the actuaries design the product or looking at the profitability of the insurance, it could be looking at those benefit complementing each other. Now, the life insurance company earn huge money on life and critical illness by the way, right. But they lose money or breakeven at the medical plan. So, but when they sell it in the bundle, it maybe coming from the perspective that we regulate it using a complimentary total risk pool. I don't know whether you understand what I mean you know. [Ketawa]

With all the life CI medical— under the risk calculation on actuarial point on aggregating all the insurance benefit including medical insurance, life and critical illness into a same risk pool. So, that insurance company will not say, "Oh, I breakeven on my medical but I earn a lot of money on my critical illness or my life, or my saving plan or whatsoever…". But when you aggregate what everything together it complements each other. That could control the price down from actuarial point of view.

Right, so this 1.2. 1.1 is about aggregating all the new and all medical insurance risk together. 1.2, is bundle, also according to bundle. I hope you understand lah ya, right. 2.0, implementing blanket. Just now talking about aggregating risk pool from actuarial perspective. 2.0 we talking about blanketing deductible for old and new medical plans.

Ladies and gentleman, we know that now Bank Negara come out with the policy that all new policies must have deductible RM500. But that is to new policies but what about the old policies? Ladies and gentleman, the problem here that can threaten our public healthcare is the old policy not the new policies. Again, I say, the

leftover the sick, the poor, the sick not insurable cannot upgrade. The old customers are the problem to our public healthcare not to that healthy one, right.

So, if you are implementing a deductible on the new plan what about the old plan? We should blanket it. When we blanket it, the old policy, the new policy the all the existing policy when they go to the hospital, they have to come out with minimum RM500 for example, let say a deductible. Then the hospital will understood, "Oh from now onwards all the plan whether is old one, new one all they have to pay RM500 yourself…". So, the doctor will not be misused the— because it will not confuse already. Everyone needs to do that RM500 minimum right. So, the doctor will not say, "*Eh, you tak apalah pergi masuk hospital, full claim punya, full claim punya…". So, especially the children. Children's policy ya, is one of the highest claims, short, short go hospital one.* Sedikit, sedikit *go hospital one so because full claim ya.*

So, if they have a mandatory RM500 I think the misused or over used of hospitalisation will drop tremendously, you know. So, by blanketing deductible insurance, deductible RM500 you need to amend the act. It is not about Bank Negara guideline. Why, because insurance companies are bound by their insurance contract. All policy document are contract, insurance contract. You cannot say, "Oh, today you get full claims, or your medical card is full claim one you can do full claim…". Suddenly ya. "Oh, no, no, no you have to pay RM500…". They will complaint to FOMCA lah you know.

"I got human right one, you breach the insurance contract you should pay in full, right…". But by amending FSA, for example. FSA insurance Financial Services Act 2013 we add another clause all medical insurance needs to have deductible of RM500. So, when it falls under the act all the old insurance policy, they had to follow it is a regulatory requirement to follow the act. So, everyone has to follow RM500 minimum than this problem will solve. You know so that is one thing that our proposal is to blanket the deductible for old and new policy.

So, 2.1 ensuring consistent. For by blanketing the old and new one it will ensure consistent and reducing confusion among the stakeholders. Because a standardised blanketing deductible structure across all medical plan old and new would create a uniform understanding among stakeholders including insurance policy holder and hospital. Because hospital may not know your plan got deductible or not. They thought that you are full claim then go warded lah*. A lot of customers they do not know their policy got deductible or not, that is why they are confused. If we blanket it then everyone knows if I want to go to the hospital, I have to pay RM500 first then I need to think is it necessary I need to hospitalise or not because I have to pay RM500, right. So, hospital and policyholder may not aware whether the policy have.*

So, 2.2 managing healthcare risk and ensuring sustainability. Policyholder who pose a higher risk to public healthcare system often belongs to leftover policyholder group therefore implementing a mandatory deductible for all block business is crucial to ensure sustainability.

A blanket deductible for old policy would improve claim ratio directly by discouraging unnecessary medical utilisation and mitigating potential misuse of medical insurance and deductible mandatory deductible. By the way to clarify right, there might be people do not know what is call deductible. [Ketawa] Define deductible first. Deductible means when you go hospital, let say deductible RM500 means you have to pay yourself RM500 others only can claim by insurance company. So that call deductible by the way ladies and gentleman.

So, we hope that we amend the act to make a RM500 deductible across all— old and new right. So, that is a suggestion. The deductible RM500 will help stabilise or even reduce assisting premium and benefit policyholder and insurer alike. So, ladies and gentleman, RM500 deductible at this current inflation inflated medical pricing it could actually drop the insurance premium by 10 to 15 percent already if RM500 deductible.

With deductible of RM2,500 ya deductible ya. If let say RM2,500 the insurance premium will drop 50 percent, discount 50 percent you know by deductible RM2,500 only by our current medical pricing whatever you say just now lah. But if the customer willing to pay in front RM2,500, the insurance premium drop 50 percent. That is significant. That is really significant.

So, now maybe RM2,500 a lot of people didn't have lah right. By RM500 first lah but it is good if we can also amend the act to make every policy have a choice of deductible also. Mandatory RM500 but every policy old or new must come with the option RM1,000 deductible, RM2,000 deductible, RM5,000 deductible or RM10,000 deductible, let the old people choose, let the sick people choose instead of paying RM10,000 premium or RM7,000 for a medical insurance.

If let say deductible RM10,000, that premium only RM2,000 other than— if no deductible is RM8,000 premium right. With deductible RM10,000 the premium could fall to RM2,000 he can afford it because he might have a saving RM10,000 inside the bank. He can afford RM2,000 premium but he cannot RM8,000 premium, that's the story. So, we can actually amend the act by make a RM500 deductible mandatory blanketing everything and by the act we need to have a choice. Every policy old or new have a choice of deductible.

You know let say, RM1,000, RM2,000, RM10,000 let the client choose you know. Amend the act FSA 2013. Why, implementing a mandatory deductible for all block

need to amend the act because every policy are subjected to contract. So, 3.0 regulating the H&S itemised bill. Like what just now FOMCA said about itemise, I think Dr., also about itemised bill. So, this regulatory body to regulate the itemised billing should be from two parties from the government, MOH and also the Ministry of Domestic and Trade and Cost of Living, Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup *that representing the rakyat interest. The MOH representing the hospital and professional interest. So, I think a regulatory body should be formed for this purpose.*

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For itemised billing right— wait ah. For itemised billing— for itemize billing — lao hua already, cannot see. I have to see so far, right. Especially—itemised billing— this today the pricing of a medical claim right, the issue here is sometimes falls other than the medicine or whatsoever. It falls under the non-doctors you know and non-medical charges. Why? Like what you said you know, all those, all those, all those you know, like HDU you know, they blanket the nursing care you know, separately, separately like we buy a chicken last time during MCO. Chicken right, potong *chicken also they charged you RM3 because they control the chicken price ma. So, the service charge* potong, potong, potong ayam pun RM3*, kind of* lah*.*

Maybe after my presentation maybe Mr. Ethan will add something. Let me finish my point number four. Okay, point number four, mandatory option for pay and claim medical plan. This one is— okay, some of the general insurance companies, they offer pay and claim and cashless. Two options. Same medical plan, they have cashless, they have pay and claim premium table, different. With the current medical pricing, the premium is having a different— is really different, much cheaper, right. So, with that, I think that whether it's an old plan or a new plan, the insurance company should come out with the table, the pricing table, cashless option which is you go the hospital and you no need to take out your own— you pay the deductible and others are settled by the hospital with the insurance company using the panel hospital, you know. That is called cashless option or the pay and claim option. Meaning, you pay your whole bill and you file your claim to the insurance company. So, these are two options, the prices are much different although the same benefits.

For the reference of tuan-tuan dan puan-puan*, from our client's experience told us, for cashless, usually insurance company will pay in full in the claim. But, when our client goes and do a pay and claim, let's say the claim is RM40,000. When come to pay and claim, certain insurance companies will reject. Oh, this one I pay only RM7,000. This one I pay only RM3,000. This one— so you know, when you come to pay and claim, the RM40,000 bill becomes RM30,000 you know. But, if you go for*

cashless, right, the RM40,000, they full claim one. That is the you know, that's something that it makes a difference. So, if kalau boleh *right, we make a mandatory to have these two options to our old and new policies.*

Ladies and gentlemen, certain of the old people right, they got money in the bank, but they just don't want to pay the premium because they think the premium is too high. So, but they can still actually pay and claim, if the premium is affordable. But they have no choice now because insurance companies have only one option, cashless. No deductible some more. So, they have got to pay, whether you pay or you leave it. So, they are left with choice, now they are no choice. End up, if they leave it, then it's a public healthcare issue, right?

So, maybe Mr.— so, the pay and claim option could lower the claim ratio; encourage responsible medical spending; reduce in overall claim amounts; prevent misuse; meditate the overprice of medical bill because the customer needs to pay; the client will oversight the doctors you know, because they have to come out with their own wallet right and it will make the premium more affordable. I think Mr. Ethan over there would probably explain more on the itemised billing part on the you know, that issue be regulated. Mr. Ethan.

Encik Ethan Teh Eng Teck [Persatuan Penasihat Kewangan Malaysia (AFA)]: *Sorry, am I allowed?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya. *Now, we come to another presenter or…*

Encik Ethan Teh Eng Teck [AFA]: *No. He's from AFA also.*

Prof. John Chan Ninyii [AFA]: *No. He talks— he will add in on the itemised billing part. Small part only.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya. *Can you complete in three to five minutes? Can?*

Encik Ethan Teh Eng Teck [AFA]: *Can, less than that. Okay, first of all, I think I see some confused faces as to why we are asking for a deductible and it is contradicted by most of the consumers. Because of our experience, we have different views. When there is a deductible— I mean from a consumer's perspective, I don't want to pay anything. It's better, but we do see that we don't want some— just a few of them who misused the card make the whole industry, I mean the price increased. That's the rationale that's why we think the deductible is good.*

On the itemised billing is because on a personal experience, whereby it can be like HDU. You thought you paid for the whole package and then when it became an itemised bill right, nursing is paid separately. Then, the devices to monitor are paid separately, then why should I pay more for HDU? There is no reason. The room is

actually a shared room compared to a single room. So, this is something that from personal experience. But of course, this happened again because we paid on our own.

There is another point that perhaps even though using insurance, the bill should be signed off by the patient before the insurance company payout, you see. Nowadays, people don't care, okay. They don't see and how would a person sitting in the insurance company that approves the claim knows like what happened in the hospital, okay. So, there is no check and balance. So, most of the time the patients will just leave only because it takes too long to process the bill. So, most of the time the patient will just leave, but then it leaves back to the hospital and the insurance to deal. Insurance who are processing there, they just assume what is necessary, but no one is knows what happened.

Also, the other thing is to claim for— to use your insurance, you must be hospitalised. Sometimes, it is not necessary to be hospitalised. This is another issue, okay. Perhaps, when it's a procedure, then it is ought to be able to claim. Why you want to how to say— okay, instead because just because I cannot claim if I do it daycare or I do it within one or two hours, so doctor write for me to be warded and that is extra cost. This is totally unnecessary. So, these are the things that I think we should consider. I think that's all. I won't to take up more time. Thank you.

Prof. John Chan Ninyii [AFA]: Ya. *Nothing from AFA.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay. Thank you very much Professor John Chan. Now, we come to* Tuan Ng Kian Nam. Tuan Ng Kian Nam, dia mewakili *Campaign to Protect the Right of Insurance Consumers of Malaysia*

Encik Ng Kian Nam [Kempen Mempertahankan Hak Pemegang Polisi Insurans di Malaysia (CPRICM)]: *Thank you YB Teresa and all the YB PAC.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: 15 minit bolehkah?

Encik Ng Kian Nam [CPRICM]: Ya. *So, we have prepared the memorandum* lah *for today's hearing* untuk PAC. Sebenarnya, memorandum ini *we have given to Bank Negara since 2021, but leaving unattended any of our proposals until today. We have about 15 points to propose how to control the insurance premium in our current situation now. I only wish to highlight a few.*

Before that, let me introduce myself. I am a practising lawyer as well since 2021, after a specialist doctor friend referred a cancer patient, critical illness case to me. After that, I have started to attend this kind of life insurance litigation cases. Throughout these five years, we have attended about 100 of the cases against almost all the 16 companies in Malaysia including medical life insurance.

So, I'd just like to highlight few important points in our memorandum. First is paragraph four, cross four lah*. I think that our insurance company play hide and seek game with us and not transparent. Because the whole main issue,* isu utama dalam kes ini *is not about whether how much is our medical inflation, the so-called 12 percent, 15 percent. That's not our business. Our main issue today is how much actually their own premium, insurance premium inflation in Malaysia? Can they disclose his figures to us first before your finger pointing to the medical inflation? You have to disclose. Every one of us know, you have to self-disclose your own interest first.*

So, the main issue here because throughout so many complaints that we have received, some of the policyholders, they show us the notification. One of them was extreme one, within two years increased 200 percent and another one, within 12 years increased 1,000 percent or 10 times. That means RM800 from the first day until RM8,000 after 12 years.

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So, we want the total figures disclosed by our insurance company first. Secondly, you have to compare in the past 10 years how much the increment of this medical premium, what about your other countries because you are a multinational country— these companies. You have other businesses in Singapore, in Hong Kong in various countries. What about that premium inflation? Is it similar to Malaysia? We want that data, okay.

Secondly, I would like to refer to paragraph eight. We're off the wheel that one of our medical inflation or dual prizing are cost by the unhealthy intransparent hospital panel ship system implemented by our insurance company including to allow their panel hospital to markup the hospitalisation bills to 300 percent higher. Okay, this one I have to highlight. Bear in mind, insurance and banking they are very smart in investment. They introduced so many investment-linked insurance plans and forced our consumers to accept. But today, they as the main bulk purchase customer of the private hospitals, they allowed them and they have full knowledge all the while. Oh, the same procedure this my panel hospital will charge me higher 200 to 300 percent compared to the cash payment patients. Why do they still allow?

I ever seen some of the hospital panels they showed me the healthcare service agreement entered and drafted by the insurance company, they signed with their panel hospital. The insurance company, they has full discretion to approve all the claims submitted by their panel hospitals, okay. So, we think that this is something breach of trust. You are managing the pool risk fund for our policyholders. You use their money to allow this to happen.

Actually, as an insurance company, you should bargain. You have more bargaining power you should get lower medical fees, lower hospitalisation fees for our policyholders and not in the contrary. In this situation, can you imagine how the claim ratio were not increase? But whether this claim ratio is, in fact, a quality claim ratio because every procedure already marks up to 200 to 300 percent or even more. So, eventually, our policyholders is not benefited.

Okay, and then— So, in this so-called very— we can say we urge our PAC to investigate and to question, to find out whether any integrity problem, whether any exchange of hidden interest involved between the insurance company and their certain panel hospitals that sacrificed our consumer interest. They should open up cashless facilities to all the hospitals so long they're licensed by MOH and set a limit of hospitalisation fees like our doctor's skill fees. At least for each insurance company in their healthcare service agreement.

Also, further, we refer to paragraph five, clause five. We think that the insurance company have violated our anti-competition law because 16 of our insurance companies via Liam has controlled the premium increment and forced all our consumers to accept with no alternative or cheaper choice. MyCC should investigate. We have consulted many insurance agents. This is a medical policy. Whenever you want to buy or switch to a new policy, you will not become more healthy. Everyone will become ageing and have more health problems.

Secondly, once you have more health problems to disclose and you go to buy a new policy, we have the agents commission scheme. So, eventually, our consumer has to buy a new product with definitely higher premium. It will not lower. So, we suspect this is a monopoly and anti-competition of our liberal market.

Then we refer to paragraph one. We observed that over the years our Bank Negara totally failed as a so regulator under the Financial Services Act and they seem like become the customer service of our insurance company. They allow our insurance company to have so much one-sided unfair terms or practices in their policy. Because we know that every policy of the policy book or the terms must be approved by Bank Negara. For example, those unfair or one-sided terms including to allow our insurance company to have unlimited full discretion and unilaterally to increase the insurance premium under the policy. Okay, one-sided.

After they ask you to sign up with this premium rate, afterwards they can anytime unilaterally one-sided without any limit increase to any premium, okay. So, how are we going to ensure? Even the Prof just now mentioned about the old— the new policy is more affordable. But with this full discretion to increase the premium,

can you ensure this new policy eventually will not follow the steps of the old policy whereby the insurance company, they can also increase anytime afterwards, okay.

Then also a very high declined claim rates with very subjective or unfounded reasons okay. We even handled one case in Penang personally, a true experience, a wife, a spouse lost a husband. The husband was initially covered by medical insurance. The annual limit is RM2 million and the whole life is unlimited, okay. After that, first year the husband was diagnosed with cancer, okay Admitted to the hospital and then gone through certain procedures and gradually recovered, okay. Then the insurance company paid RM1 million to Sunway Hospital for the first stage of the treatment.

But the following years, okay, when suddenly there was some uncontrol situation whereby the husband was admitted to the ICU again in the same Sunway Hospital, the second year. Suddenly the insurance company said, "Sorry, I have to withdraw my GL because I suddenly discovered you didn't disclose your minor stroke 20 years ago." So, eventually this husband, his full of fighting spirit to receive the treatment of cancer, after listening to this shock news, he gave up. He decided to give up because they already accumulated RM400,000 treatment fees. Then, he told his wife, "I decided to— you keep the money, save the money for our kids. They still need to further study. I will not continue." Then he starts to kick the doctor, kick the nurse and eventually pass away. Okay, this is the true story of how our insurance company manipulated the medical plan, okay.

Then, another controversial product is the whole life unlimited. I believe all of you, you are the insurance consumer, you will know whole life unlimited. This is a new trend of product.

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That means for example if your annual limit is RM2 million, you are offered whole life unlimited. After we consult so many insurance agents and brainstorming gone through, we made a conclusion, whole life unlimited plan is totally cannot be realised, needs representation and misleading.

Ladies and gentlemen, bear in mind, everyone of us have no unlimited age. The maximum we can live is about 110 or 120, if we are very fortunate. So, you're try to calculate and imagine. If the insurance company offer you one year RM2 million limit and you can live 110 years. Eventually, your limit is still capped under your age. Is it possible you can get whole life unlimited coverage? It's totally misleading. You cannot realise this product.

Puan Teresa Kok Suh Sim [Naib Pengerus PAC]: *How many more minute?*

Encik Ng Kian Nam [CPRICM]: *Yes, okay one more thing I just want to highlight another controversial plan we received the complaint recently. Our insurance company I don't since when, they offer the fetus insurance plan. That means when your baby is still in your stomach, in your wife's stomach, they already started to offer the insurance plan. We suspect and this controversial product is high-risk and uncertain because we cannot even to fulfil the basic criteria of Contracts Act.*

Under the Contracts Act the insured person must be named. But in this policy, you're unable to name the insured person. The only insured the mother. After give birth the baby, only issue a notification to you change insured person. So, we received various complaints about there're some loopholes in this plan. Okay, that's all. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerus PAC]: *Okay, that's it. Yes, thank you very much Encik Ng. Now, we come to the last presenter is Mr. Chan Chee Khoon, right.*

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *Yes.*

Puan Teresa Kok Suh Sim [Naib Pengerus PAC]: *Citizens' Healthcare Initiative.*

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *Citizens' Heatlh Initiative.*

Puan Teresa Kok Suh Sim [Naib Pengerus PAC]: *Citizens' Health Initative*, okey.

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *I'm a retired professor. My background is in public heath, I'm a public health specialist with the experience in epidemiology, health policy, health system and healthcare financing.*

So, I think the other speakers have touched quite a bit on the sound of things that I was going to address, okay. So, I can be more brief on that okay. [Merujuk pada pembentangan slaid] Now in my first slide okay— my first slide is the titled contextualising insurance premium increases. I like very much the phrase that the PAC chair Datuk Mas Ermieyati. Is she here anyway today?

Puan Teresa Kok Suh Sim [Naib Pengerus PAC]: *No, she's absent.*

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *Okay, anyway in news report, I think it was in Malay Mail. She use the phrase 'healthcare ecosystem' to talk about a range of issues that she intended PAC to address, arising from this the recent uproar over the very dramatic rise in health insurance premium.*

So, I put the first slide together with first the very first phrase 'healthcare ecosystem'. Then, I was thinking about it yesterday I thought maybe I should begin at an even earlier point. Now, I think it's good to bear in mind that people resort to the

private healthcare sector for number of reasons. There are many reasons right, why people choose to patronise private healthcare facility or hospitals.

But one of the reasons is because of a very congested public sector healthcare. We are all aware MPs in particular, that the Malaysia for several decades now has experience quite chronic underfunding of the public healthcare sector.

Before the COVID-19 pandemic it was typically in a range of two percent GDP. Sometimes, a bit lower, many years 2.1, 2.2, two plus percent, okay. Of course, during the COVID-19 pandemic it was bumped up quite substantially up 2.5 and more but it settled down to about two and a half percent.

Now, for our level of economic development is upper middle-income country in Malaysia. This is actually very modest. I would even say miserly. For most countries at our level of economic development, you would be spending six, seven percent as an upper middle-income country. Six, seven percent and whereas our public sector spending only two and a half percent. You add the private sector comes up to about four and a half percent thereabouts.

So, because we have been underfunding the public sector healthcare, things are congested. So, people feel that they want to avail themselves of private sector, when the need arises. So, patient who resort to the private sector, they find that they get themselves entangled in the tug of war between profit-driven health providers and profit-driven health insurance.

We're heard of rise fee-for-service against private health sector where, the is billing is itemised. So, there's a built-in incentive there to do more whether it's the hospital or the medical professional because it's itemised. The more you do, the more revenue, we are cruise to the provider.

So, the other hand there's that. One the other hand, the profit-driven health insurance. They have the opposite incentive because profit margin of private insurers you do your premium collections and profit margin depends on how little you payout as reimbursement.

So, the profit-driven providers try to do as much as possible and the profit-driven health insurers tries to reduce tendency towards undertreatment, encourage providers to undertreat, underdiagnose, maybe undermedicate.

So, in so far as the tendencies of the providers for unrestrained deployment of a prepaid healthcare, prepaid health intervention. In so far, these tendencies are not reined in or not successfully reined in to the satisfaction of the health providers.

It would come back to impact upon the policyholders because insurance companies are not going to sustain the loses indefinitely. So, eventually it comes back to the policyholders and the healthcare consumers in a form of a high premiums.

Now, so that has been an underlying trend. This pre-existed even before the COVID-19. This has been a circular trend going back many years. But over and above this background situation overlying this, it is something which is more— some additional consideration that is during the COVID-19 pandemic, the peak year in Malaysia was 2020 to 2021.

As we all recall, during that year there were COVID-19 restriction and people tend to avoid hospital because there's pandemic going on you don't want to go hospital if you don't have an urgent medical issue. So, you have an elective procedure. You said, "Okay, if I can delay this, postpone this, I will."

So, during 2020 and 2021, with less private patients going to the hospital, the claims obviously go down. So, if you're using 2020 to 2021, the pandemic years as a baseline for calculating how much increase. That was percentage is increase, that was. After the pandemic that is 2022 to 2023, you see dramatic rise because that's a rebound, that's a rebound effect. Those people who decided to postpone the elective procedures, now going to the procedure.

■1350

So, the claim is shoot up again, right? So, the use of 2020, 2021 is baseline for the calculating for exaggerated the increase of claim, 2022 and 2023 and in fact, in my latest slide, I actually I have a link to a Bank Negara report which actually indicated the Bank Negara was quite aware on this— in 2021, the possibility of this is rebound effect okay. So, I would urge the Bank Negara people to revisit these issues whether this dramatic recent rise, 40 percent, 100 percent in insurance premium is partly because of this artifactual effect of using 2020, 2021 as a baseline for looking at for accessing that dramatic rise for 2022, 2023. Because that was the rational given, because claims went up so much those two years versus the other two years and that was the rational given, we have to increase. Reprice again, very dramatically.

Actually, was should have been done was you should take it over four years to see whether it was substantially below or above trend rather than take the first two years as a baseline and look at the latter two years to assess.

Alright, so now this is the front-page of The Star, many years ago— January 18th 2008. I think is a good illustration of what has been refer to earlier as restricting in some of the problem of restricting very serious ethical and moral problem. This was scheme that was offered by LIAM in 2000. In consultation with the EPF which allow— this scheme allows the EPF members to use the account three to pay for— to purchase insurance policy from consortium of LIAM members. In this case, the risk proxy case age, right— now the deal is like this. You have number of, a couple of

options. The first option is you want coverage for 13 critical illnesses or major procedures and depending on how much payout you want, upon diagnosis of any of those 13 conditions, then the premium is calibrated accordingly. It also depends on age group.

Now, where you see the red arrow – the red arrow circling green refers to the annual premium you have to pay okay. If somebody was age 65 to 70 years old— in other words, very high age risk group, if you wanted RM100,000 payout upon diagnosis of not 13 but 36 you want to expand of coverage of 36 major illnesses or procedures required. So if you want RM100,000 payout upon the diagnosis of any of those 36 conditions and if you are aged 65 to 70, you annual premium is RM20,034 and this is in year to 2000, I am not sure Prof. John, what's the premium now for somebody who wants a coverage for 36 illnesses if their age 60…

Prof. John Chan Ninyii [Association of Financial Advisers Malaysia]: *[Berucap tanpa menggunakan pembesar suara]*

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *Almost a same, remarkable, okay. But beyond is 70, I think insurance company won't even cover you. You are lost prospect, they're no interested covering you. So, this is an example of risk-rated insurance coverage. Now, you may— all of us are familiar with drivers' insurance, right? If you buying drivers insurance, if you are somebody, you are a driver whose accident-prone or with history of reckless driving, drunken driving, you are more likely to make claim on insurance company. So the company insurance say, "Well, with this kind history where they charge you higher premium." That sounds very reasonable, it's a very reasonable business proposition. Higher risk you pay more okay. Okay, you pay more premium.*

But if you translate, that kind of logic in to health insurance, you will end up with these very disturbing situations. What it would mean is that, the people who are most likely to fall ill and required treatment would be the people who are least likely to get treatment because the premium would be so high that they can't afford it. RM20,025 every year. At the end of the year, you don't fall ill, I don't know whether you are lucky or not but that's it. Another year, another RM20,024. So that the…

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Can try to finish it?*

Dr. Chan Chee Khoon [Citizens' Health Initiative]: *Okay, I just have about four or five slides more okay. So, risk-rated health insurance reprised— that's basically what I say. So few days ago, I was at a stakeholder consultation at Bank Negara, this is also one suggestion I made to Bank Negara since they are the regulator for health insurance. Whether Bank Negara should consider banning risk-rating, health insurance in favor of uniform community rating. And this is not new idea,*

it was a incorporated into Obamacare, US health insurance towards the end of President Obama's tenure. A lot people are not satisfied with the many aspects of it but this one is a better feature of Obamacare. Australia also okay, another country that implements community rating and it bans risk-rating.

So the question is, is non-profit health insurance example social health insurance (SHI) is this an option to consider? Well, in the last year and more, I think some of you have probably heard some debate in the media, in the public arena about social health insurance (SHI). It's actually One Care, reincarnation of One Care. You recall the One Care experience and it's basically an attempt to deal simultaneously with two distinct problems, how to raise more money for national health expenditures because we have been chronically under funding KKM and they propose us to do is through a proportional payroll tax that is de-facto supplementary regressive income tax with matching employee contribution.

Secondly it hopes to integrate an over burden public healthcare sector with an underutilised private sector through a unified provider payment system which can rationalise utilisations of services across both sectors and the DRG is the integral part of that and it's intended as a cost control mechanism for this unified provided payment system.

Now, citizen health initiative we are very wary of SHI because we think that our existing system in Malaysia, tax-funded system, the KKM for instance which is a variant of UK NHS. We think that there are many things to be improved about our existing tax-funded healthcare system but there's no need to throw the baby out of bathwater in favor of social health insurance. One of reason we— one we think we have been bringing attention to is considerable body of evidence from researches in international and government agencies among academicians, which demonstrate quite comprehensively that when you compare social health insurance with a tax-financed healthcare system— the tax-financed actually outperforms SHI. For instance, this study that was done in 2009 by Adam Wagstaff, one of the most respected health economist at the time at the World Bank and he use cumulative data from OECD countries.

The abstract— the next slide summarises in a more succinctly what the findings of this World Bank study. So, comparing social health insurance with tax funded healthcare such as we have in Malaysia. He finds that the per capita healthcare spending increased by three to four percent, compared to tax funded without corresponding improvement in health outcomes. Secondly, there's worse amenable mortality raise for the diseases that require strong population based public health program such as breast cancer.

■1400

And thirdly okay, now I mean this is of course, a different modality and financing healthcare ya while HHI or tax funding okay. But it also has an impact on labour situation okay. So, when you introduce HHI, okay HHI basically involving a payroll deduction from the employees, we will match employer contributions with federal top-up, okay. And then this fund, this tabung *is used to pay for healthcare whether through comply government hospitals or private hospitals, non-profit hospitals through a standard uniform fee schedule DRG-based, DRG-based fee schedule.*

So, when you impose that kind of matching employer contributions, so sort of like EPF but EPF is actually individual savings accounts it's not a pool fund. So, when you impose that kind of matching employer contribution on are employers as part of HHI there is a tendency for employers to try to resolve informal employment arrangement. So, because of this requirement doesn't often times doesn't apply to informal employees.

So, you in the OECD countries that Adam Wagstaff's study look that again, he found that formal sector employment drops by between eight to 10 percent in also casualisation of labour, eight to 10 percent. And total employment dropped by as much as six percent. So, this of concerned and not just to Ministry of Health, or Bank Negara or but also the Ministry of Human Resource. These are the employment impacts of introducing HHI if you want to replace our tax-funded healthcare system.

And the— now at Adam Wagstaff's studies of based on OECD countries and another one is upper middle income and affluent countries. This is a study— this article was published in Health Affairs which one of the most prestigious health policies journal in the world. And this study was conducted among low and low-middle-income countries okay. The authors that you see that listed are among the most, the most— among the top health economists in the world whether in academia or in international department agencies World Bank, in the American Development Bank, WHO.

So, this was published in 2020. Now, the interesting thing is that the two of the authors listed in this publication, while members of the Harvard consultancy team that was retained by KKM okay Ministry of Health to advise on reforms healthcare financing. So, in this article, you have it's a bit too long to read out the complete abstract. I'll be happy to— or you have the slides with you so you can read for yourself but basically the consensus opinion among these eight or 10 co-authors as I said some of the most respected health economists and profession.

Okay, they came to a consensus opinion okay that the evidence overwhelmingly demonstrated that tax-funded healthcare systems are outperformed social health insurance. So, the question that I keep putting I don't know whether there is anybody from KKM. At Bank Negara there was a deputy director and assistant director of the planning division of KKM. I had the opportunity to ask him, you know. Why was KKM still considering HHI when the evidence is very clear again favour of tax-funded healthcare system such as we have.

Okay, so, basically we put the question what might be better solutions. We could consider to address those two problems raising more funds and how we going to use our funds through some provided payment system So, what the season health initiative? Favours is a dedicated ring-fanced Tabung Kesihatan Negara which is funded by a supplementary progressive health tax in other words, add on to income tax. Now, how progressive it is, is a matter they can be debated. There are some people will think that well maybe M40 and B40 should be exempted from this supplementary income tax again shall apply to T20. That's one possible scenario.

So, more progressive supplementary health tax, corporate taxes, property and capital gains taxes, Tobin tight taxes I'll say a bit more in the last slide. Sin taxes; tobacco, alcohol et cetera. Other public revenues perhaps as zakat. *And so, and this fund like this Tabung Kesihatan Negara would be subjected, should be subjected to robust governance provisions and stakeholders representation, accountability and transparency. This national this* tabung *would be used to reinvigorate public provision of healthcare, expanded delivery capacity recruit and contract for more staff, strengthen public comprehensive primary care with continue the new care et. cetera, et. cetera. .*

Establish the health services commission to address some of those primary grouses which is the driving the concern outflow of senior experiences staff from the public sector, rationalised and re-organised use of resources, build and equipped more health facilities when it needed to ease congestion and bottlenecks. Where shortfalls in delivery capacity exist in the public sector, spillover patients from public hospitals can be channelled to panel private hospitals in accordance with DRG-based fee schedule or case-mix-based institutional grants.

So, KKM could be a bulk purchaser of supplementary of top-up services from the private sector at negotiated these counters prices required of licensed private providers, licensed hospitals in other words. Much like how housing developers are being required to fulfill a certain quota of low-cost housing. Alright, the last slide okay gives some figures on how realistic some of these additional alternative sources of

funding are which can be— which can be— which can contribute towards Tabung Kesihatan Negara.

Tobin taxes it is Tobin taxes are named after well-known economist in the James Tobin. He basically suggested initially his initial idea was a— he was concerned about excessive speculation and volatility in a foreign currency market so he thought of this idea of applying 0.5 percent tax on foreign currency trades. So as to dampen down the volatility. He has stabilised foreign currency markets.

But eventually, the idea was extended to also look at Tobin tax as possible ways of raising funds for public finances. So again, at the meeting a few days ago at the Bank Negara this was my second suggestion with them to Bank Negara whether the Bank Negara— well actually not quite the Bank Negara as far as Bursa Malaysia because Bursa is under Security Commissions. We separate Bank Negara handles insurance but also foreign currencies trades.

So, but as far as Bursa Malaysia. If you share you find that the average daily trading value recently in a first half of 2024 differences. If you look at that trading volume and you apply a 0.5 percent Tobin tight tax on all share transactions conducted on Bursa Malaysia. You can raise 4.26 billion annually. Tobin eventually increased tax recommendation to one percent.

So, if you raised that to one percent, one percent tax on all share transactions on Bursa Malaysia will raise about 20 percent of the current allocation, 2025 for Kementerian Kesihatan. This 2025 allocation was 45.3 billion. You can increase up by 20 percent if you apply a one percent tax on share transactions on Bursa Malaysia.

Now, more relevant to Bank Negara is a foreign exchange. So, again looking at the first half of 2024 again in the daily average foreign exchange trading volume. If you apply a 0.05 percent tax right, 0.05 percent not 1.5, 0.05 percent Tobin tax can raise in a year.

USD4.69 billion which is equivalent to RM20.73 billion. So, a 0.05 tax on foreign currency trades you know between Malaysia and foreign currency can raise about 50 percent of the allocation for KKM for 2025. Okay, thank you very much.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Thank you very much Dr. Chan. So, I think no question because we are supposed to have another session starts at 2.30 but anyway,* Majlis kita tangguh mesyuarat pada pukul 2.10 minit dan mesyuarat akan sambung semula pada pukul 2.45 petang. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 2.10 petang

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Selasa, 25 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Galen Centre For Health and Social Policy
Encik Azrul Mohd Khalib
Ketua Pegawai Eksekutif

(ii) Department of Social and Preventive Medicine
Prof. Dr. Tharani Loganathan
Associate Prof.

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

SELASA, 25 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] *- Naib Pengerusi*
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato' Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]

Tidak Hadir *[Dengan Maaf]*
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] *- Pengerusi*
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Mohamad Tarmizi bin Ahmad [Penasihat Undang-undang I, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Puan Zulfa Amirah binti Jubri @ Mohd Zufri [Pegawai Tadbir, Seksyen Sinergi dan Kolaborasi Strategik, Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Encik Aznirul Fariz bin Alwi [Ketua Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)
Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan]
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Suzana Binti Alias [Ketua Cawangan]

Kementerian Ekonomi (KE)
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) (Bahagian Perkhidmatan Sosial)]
Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah Makro]

Jabatan Akauntan Negara (JANM)
Encik Mohd Nizrulizham bin Jamaludin [Akauntan]

HADIR BERSAMA

SAKSI

Galen Centre For Health and Social Policy
Encik Azrul Mohd Khalib [Ketua Pegawai Eksekutif]

Department of Social and Preventive Medicine
Prof. Dr. Tharani Loganathan [Associate Prof.]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

SELASA, 25 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 2.54 petang

[Yang Berhormat Puan Teresa Kok Suh Sim
mempengerusikan Mesyuarat]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Salam sejahtera. Selamat petang dan selamat datang saya ucapkan kepada Yang Berhormat ahli-ahli PAC Kelima belas, ahli-ahli Ex-officio PAC yang terdiri daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, Suruhanjaya Pencegahan Rasuah Malaysia, Kementerian Ekonomi, Jabatan Akauntan Negara dan Penasihat Undang-undang Parlimen selaku wakil Jabatan Peguam Negara.

Yang Berhormat ahli-ahli mesyuarat sekalian, petang ini PAC Parlimen akan mendengar keterangan dan penjelasan berhubung isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan Bank Negara Malaysia. Prosiding ini adalah merupakan yang keempat diadakan bagi tujuan mendapatkan penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan caj hospital swasta. Ini termasuk kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan faktor luar seperti pandemik.

Yang Berhormat ahli-ahli mesyuarat sekalian, hadir bagi memberi penjelasan di hadapan PAC dalam prosiding pada petang ini ialah Yang Berusaha Profesor Madya Dr. Tharani Loganathan Universiti Malaya, *Associate Professor of Global Health* dan Yang Berusaha Tuan Azrul Mohd Khalib *Galen Centre for Health and Social Policy, CodeBlue*

Terima kasih saya dan PAC ucapkan kepada semua kerana sudi hadir di hadapan PAC bagi memberi penjelasan pada hari ini. Jadi tanpa membuang masa, saya menjemput Profesor Madya Dr. Tharani Loganathan untuk memulakan pembentangan. Dipersilakan.

Prof. Dr. Tharani Loganathan [Fakulti Perubatan, Universiti Malaya]: Selamat petang. Sebelum saya mula, saya minta izin berucap dalam bahasa Inggeris.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. *No problem*.

Prof. Dr. Tharani Loganathan [Universiti Malaya]: Ya. *Thank you. Good afternoon*. *I am Dr. Tharani, I am from University of Malaya. Today, we are talking about rising healthcare cost and private healthcare insurance. But I would like to say that we might be looking at it at a narrow perspective. We should look at it from a health system perspective.*

What I talk about is UHC, the Malaysian Healthcare System. What it means to have rising healthcare cost and the implications on the healthcare system and I would like to suggest some policy solutions. So, what is universal health coverage. Universal health coverage is what we would say a goal for most national health system. It's an aspirational concept. It's also WHO's goal. You look at universal health coverage, you look at all people having access to needed help services and this is a spectrum of services from preventive care to promotive care, curative care, rehabilitative care and palliative care.

It also needs to be of sufficient quality to be effective and to ensure that the use of this healthcare does not put users at financial hardship. So, what does that mean? So, we have this universal health coverage. We usually look at this cube. What services are covered, can we improve that, who is a population that's covered, are we missing out somebody or some population and what are the proportions of direct cost that's covered. So, direct cost we are talking about is out of pocket cost, it's cost that you pay at the point of contact at healthcare.

So, this is considered the most regressive form of healthcare expenses because patients usually have to pay at the point of service that means they make their decision based on ability to pay. So, if they can't afford to pay, they may not get their healthcare. It's regressive because the poor are impacted more that the rich. The poor might have to sell asset if they don't have money, they used up their savings, they have to go for loan and so on. So, it is a health system goal that we prevent users from having financial hardship when accessing healthcare.

So, in the Malaysian Healthcare System we have a mixed public-private healthcare system, we have a public system, which we think that we have universal health coverage through the public health system because it is largely subsidised, financed by government revenue and the services are comprehensive and all over the country from independence time is rural-focused. Okey.

■1500

But despite having the public healthcare system, we also have a private healthcare system which is actually 50 percent of our financing. The private healthcare system as you know is mostly curative care only and it's located mainly in towns and cities. Private healthcare in Malaysia as you know is for profit. Mostly for profit and it is actually largely financed by out-of-pocket payments.

So, if you look at our financing in Malaysia, about 50 percent is financed by the public healthcare system. You can move up. The other 50 percent is by private healthcare. But private healthcare is largely financed by out-of-pocket. So, it's 75 percent is about out-of-pocket payment. That means patients are paying for it directly. About only is under 20 percent that is financed by private insurance.

So, the risk here is private households out-of-pocket is actually for the poor and middle class because you can never save enough for healthcare. Healthcare is something that is unexpected. You might have you can incur catastrophic payment. Just say if you have a cancer diagnosis and so on, you might actually have to sell assets, you might go into debt or incur poverty..

So, if you look at that, this is our financing for the entire country. So, MOH is about half and nationally our private household out-of-pocket payments are 31 percent. So, you look at that. How does Malaysia rank compare to our neighbouring countries? Compared to our neighbouring countries, we are closer to Vietnam and Indonesia in terms out-of-pocket payments rather than Thailand which has universal coverage through social health insurance and Singapore. So, Thailand has out-of-pocket payments of 10 percent and Singapore has 19 percent.

So, private health insurance we would think protects people from catastrophic payments and high out-of-pocket payments but some research that has been done on national data has actually found that actually having private health insurance in Malaysia put people at risk of increased out-of-pocket payments, okay. So, this is the paper you could look at later.

So, I mean we know the issues with private healthcare and the rising cost and so on, insurance premiums rising, people having to cancel their coverage and so on. Then the interim measures set up by BNM. One of the reasons that is stated is because of medical inflation. So, worldwide global average medical insurance inflation for 2025 is 10 percent. But Malaysia's inflation rate is about 15 percent. Again, we are higher than our neighbour than average.

So, I don't think you can see the figures down there is kind of small. I also can't read anymore but we are actually higher than neighbouring countries. 15 percent is more than the global average. So yes, we can say that aging society, there is rising the medical technology has changed as all this new medication is expensive

and so on. But why are we different from neighbouring countries? They are all facing the same medical inflations.

So, one and two. We are talking about medical inflation rising cost of advanced technology against same as the other countries in the world. Aging populations we are facing it like other countries and the increase chronic burden of diseases, yes. We know about this but what else could cause the inflation to be so high?

One is presumably the profit-driven model of private healthcare and the way that they priced product and also the insurance-driven pricing in private healthcare. The other thing is private insurance and the limited competition among private insurance to actually improve their services. So, what are the implications for the healthcare system? I know you guys I mean this committee has heard a lot. So, this, I'll just repeat this. For patients of course, access to healthcare that would be access in equality.

So, in equality and this worsen our divide between the health system public and private is worsening. So, we are moving towards the rich— private healthcare for the rich only and public healthcare for the poor only. This would mean even more crowding and, a long waiting times and issues in the public healthcare system. The increase in out-of-pocket payment is actually what is concerning us a lot because I mean everyone knows that healthcare is not an aspiration, it's a need.

If you have an illness, you just want to seek the best treatment so on. So, it puts people at risk. So, for the public healthcare of course, services I mean we know one of the big challenges in public healthcare right now is actually the workforce challenge. So, our workforce is similarly defeated and basically this would add more pressure to them to actually leave the public healthcare sector not good.

For private sector as well, this has implications because there is a risk of exclusion. When you have this high insurance premium and all the sort of things, your client pool would reduce. So, it is sort of like a vicious cycle, the cost will increase more when you have less clients. So, not good as well. Okay, this is my old slide but I can talk you through.

Let's look at this in broader way. If you look at private healthcare fees. Healthcare fees actually this the solution for private healthcare fees actually is not easy. It is not one size solution. It is actually a package of solutions. We need to look at how providers are paid for. Right now, providers as in they're paid for fee for services. It's itemised and every single thing is paid for.

So, that is better ways to pay for providers. That does not give incentives for overspending or overcharging, or overprescriptions.. So, pay for performance and so

on. The drugs, the technology that they prescribe and so on that should be some evidence-based for those prescriptions. Strategic purchasing, value-based care. We are talking about like how technology assessment, cost-effectiveness analysis to make sure that the medications, the drugs the technology that we are getting are value for money.

One of the things that Ministry of Health is considering is DRG. So, that might actually it might work in terms of payment mechanism. So, instead of paying for each single thing, there is cap or there is a standard for each procedure that you are paying for a surgery and so on. So, instead of paying for multiple items inside that one thing. You are paying this is the average and this is the payment. So, a lot of that needs to be looked at. For private health insurance. There are a lot of things that they can actually do but my concern is it puts the owners on the consumers.

So, like things like co-payment, co-share deductibles. That concern is the same mechanism is given to everybody or consumers. Irrespective of them being rich and poor and so on. So, we really have to be careful about it especially things like co-share which— or co-insurance that means a percentage of the bill the patient has to pay.

So, that can actually drive up out-of-pocket cost quite a lot. But a co-payment, a co-payment is like a fixed amount that agreed upon like for instance maybe an insurance policy says that for each admission, the consumer has to pay like RM100.

■1510

I think that kind of thing is still fair. A deductible is maybe a certain amount that you have to pay in access per year. But there must be a cap to this and this need— This kind of thing mechanism needs to be regulated to ensure that the consumer is protected.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau boleh saya tanya. *Professor, I want to ask you about this co-pay, co-share. What is the difference between co-pay and co-share?*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *So, co-pair is more like fix quantum. So just say you go to— we don't cover clinics. So, I would say inpatient admission. So, a certain amount is fixed by the insurance companies agreed upon that for each admission, the patient has to pay RM100. Something like that or RM25 a day or something of that amount, so they— This is to actually prevent overutilisation and also to give them a skin and the tips. They are paying the bill. A co-share or co-insurance is a percentage of the bill. So that means it might be five percent, it might be 10 percent of the bill. But imagine some of the hospital bills are really high and if you are paying 10 percent of RM10,000, you are paying RM1,000.*

So, this kind of mechanism, the thing is it will be implemented on everybody, irrespective of their financial status and condition whether they can afford it or not. So, it would put a lot of people at harm because…

Tuan Sim Tze Tzin [Ahli PAC]: *Bank Negara co-pay is in percentage or in cap? Because Bank Negara has allowed a co-pay.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *I only know what is published in the newspaper and Code Blue and so on. So, it sounds like a percentage which is worrying to me.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih.

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Okay. So regulatory oversight. I would say private healthcare and insurance, both need regulatory oversight. So, in private healthcare right now, the only thing that is regulated is doctor fees. Doctor fees are regulated. So, they cannot— it's a fixed amount that you are paying the doctor— of the bill that's going to the doctor but everything else is not regulated. This we should look at as well. So, to make sure that there's no cost inflation here. Private insurance also needs— like an ombudsman body oversight regulatory body to look at them.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry Pengerusi. If let's say you talked about this regulatory or the hospital services and supply (HSS), how would the industry— you know, we don't want to strangulate them, but if you regulate them, what are the things that you think that is appropriate to regulate?*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *I think it would be the billings.*

Tuan Azrul Mohd Khalib [Galen Centre]: *YB, I can help with answering that question during my presentation later on but there is a very important question in terms of the factuality of regulating this, 70 percent. Thanks.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Next slide. No, sorry the slide before. I really think that we should look at this issue as a bigger problem in our health system and the bigger problem in our health system is lack of financing in the public healthcare system and universal health coverage. So, a solution that is long-term is actually a health transformation and social health insurance. Social health insurance would cover everybody and would allow— could be designed to allow patients to go to public and private healthcare. So, this is something that MOH have discussed and have worked together with their Health White Paper.*

So, next slide. It's actually my final slide. So, we really that the healthcare system needs to serve everybody, not just the privileged few and we really need to remember this. Okay, thank you.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Thank you very much.* Ya*,* ada lagi?

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya.

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *I'm done.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Last* soalan.

Dr. Hajah Halimah Ali [Ahli PAC]: *Okay. Policy solution, your slide before that. About promoting preventive health.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Yes.*

Dr. Hajah Halimah Ali [Ahli PAC]: *And incentivised wellbeing initiative. So, what exactly do you mean by that?*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Okay. Actually, right now if you look at the private healthcare system, it is managing curative care only. That means it's treating illness. So, they don't have the same service agenda as the Ministry of Health. Ministry of Health we are looking— I mean I'm saying we because I worked there a long time but basically is looking at the entire spectrum of services from promotive, preventive, curative, rehabilitative, palliative. Promotion and preventive is actually to prevent a disease coming about and also the prevent severe complications.*

So, a lot of this is done at private healthcare, in GPs, in public healthcare klinik kesihatan *and so on. It also education patients on health behaviour and so on. Health insurance could actually play a role in this incentivising good behaviour, lifestyle changes, clinic visits, preventive care maybe services like monitoring BPs, monitoring sugar, having regular blood screenings, cancer screenings. Those kinds of things will actually drive down costs because the population get healthier. So, they come to healthcare, not in a very bad stage.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Are you talking about just the private sector or should the Ministry of Health as the authority for health overall, maybe put more emphasis on their expenditure and all that? So that big portion is been done on the preventing part, prevention is better than cure.*

So right now, their spending a lot on as you said if their secondary and tertiary treatments instead of the primary and the public learn about how to look after themselves from the salesman of produk-produk kesihatan *you know.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Influencer like that.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Yes. Influencers, TikTok and all that instead of being getting all the right information,* macam *why do you* makan, *what they* makan, bila *you* nak makan, you know. *The kind right proportion and all that,*

instead of you listening to the salesperson. Do you think that should be not just the private sectors but also the ministry in making the policies?

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *I agree with you. Actually, the problem right now is actually is only the Ministry of Health who's doing it. They are the holder of that responsibility. And of course, as you pointed out the most of their budget is not going there. It's going to curative care. But what I'm suggesting right now is private sector also take a part into this because the patients that they are coming in the entire model for their business model is curative. It's illness, not wellness.*

So, the wellness we are talking about is not like getting beautiful and faith and stuff like that. It's actually prevention. So, I would say a shared responsibility. So, there are a lot of things like private health insurance could do to incentivize the public to take better care of their health.

Dr. Hajah Halimah Ali [Ahli PAC]: *Because only that M40 and above. Now* M40 pun nak kena pergi *public hospital and clinics* kan.

Prof. Dr. Tharani Loganathan [Wakil Akademik]: Ya.

Dr. Hajah Halimah Ali [Ahli PAC]: *Is that T20, the upper M40* yang mungkin *get the health insurances.* Yang B40, *they don't know about insurance. They just go to the private. So that's why I was thinking that the policymakers should also emphasize on this.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *So definitely MOH is playing the major role on this and they— I feel that in this concept of discussion…*

Dr. Hajah Halimah Ali [Ahli PAC]: *That's enough.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *…It's – Yes, I know, it's not enough. That's why I brought it out.*

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It needs to be in greater emphasis. But in terms of today's question of healthcare cost and so on, preventive care is a major player and that gap is there in the public health system. Okay, because a lot of preventive care, it is available but even the B40 cannot get. Like for instance, cancer screening. How easy is it to get a mammogram?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, I think we must ask now or I wait for second speaker?*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Quick one, quick, quick, quick one. Sorry, I came in late but if my question is already answered earlier just say that it has been answered already. If it's not, I just like to ask UM.*

Recently, end of last year you increased your fees. That's one issue. At the same time, what is the rationale for having the public wing and the private wing and what was the consideration then or until now? Because we are talking about giving care to everybody et cetera but UM is now started with private— public wing and you increased your fees last year.

Prof. Dr. Tharani Loganathan [UM]: *Yes, I think...*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *So, what was the consideration? What's the rationale? Thank you.*

Prof. Dr. Tharani Loganathan [UM]: *I actually am not in the position to answer because I am UM. That's UMMC. But maybe I can just briefly— UMMC is actually not a MOH hospital. So, it's funded through the Ministry of Higher Education.*

The budget is not the same as Ministry of Health's hospitals. Okay. UMMC basically it was a COVID-19 hospital, it did not get extra COVID-19 budget from MOH because it's not MOH hospitals. So, it needs to sustain itself. But that being said, you all as MPs should know, it's the only public hospital in Petaling Jaya which is a big city.

So, I mean a lot of people who— I mean average people go there. So, it should not be a private hospital or semiprivate hospital, we need a public hospital in Petaling Jaya.

Okay, the fact that we have a private wings so-called. This is actually to retain our professors and consultants in the hospital to— because if not they cannot survive with government salary. Yes it's a simple as that. It is actually to retain staff and to make sure that they are happy.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *So,* terima kasih kepada Profesor Madya Dr. Tharani Loganathan. *Now, I would like to invite* Yang Berusaha Tuan Azrul Mohd Khalib dari CodeBlue.

Encik Azrul Mohd Khalib [Galen Centre For Health and Social Policy]: Terima kasih Puan Pengerusi. Saya Azrul Mohd Khalib daripada Galen Centre For Health and Social Policy. *Just* sedikit latar belakang, kami merupakan badan pemikir atau badan penyelidikan yang menjalankan penyelidikan mengenai dasar yang berkait dengan kesihatan dan juga mengenai yang berkait dengan *social determinants of health.* Salah satu daripada projek yang kami jalankan bagi meningkatkan kualiti dan keberkesanan komunikasi kesihatan adalah CodeBlue iaitu *health news portal* yang kami telah wujudkan sejak 2018, 2019.

So, mungkin di kalangan YB-YB lebih *familiar*-lah dengan CodeBlue daripada Galen Centre. Tapi, kita oranglah yang *behind the project. So,* untuk pengetahuan Puan Pengerusi, kami juga telah terlibat dalam sesi libat urus dan *consultation*

bersama dengan Bank Negara minggu lepas juga mengenai isu yang sama dengan memberikan pandangan dan juga input di atas apa yang telah berlaku dalam masa beberapa bulan ini.

Saya berterima kasih kepada pihak PAC kerana melibatkan pihak kami juga untuk sesi ini kerana ini merupakan salah satu daripada isu yang sangat bukan sahaja relevan tapi juga terlibat secara langsung dan berkait dengan sistem kesihatan Malaysia secara amnya dari segi kebergantungan kepada sistem kesihatan awam.

Dalam pembentangan saya ini, saya akan merujuk kepada beberapa helai dokumen yang saya harap telah diberikan kepada YB-YB dan saya akan *refer*-lah sekejap nanti kepada dokumen tersebut.

Juga minta izinlah kepada Puan Pengerusi untuk menggunakan bahasa Melayu dan bahasa Inggeris untuk pembentangan ini tapi slaid memang dalam bahasa Inggeris. *So,* kita akan melihat pertama sekali *overview* kemudiannya kepada isu insurans dan takaful, *private health hospital charges* itu sendiri dan juga memberikan saranan dan *recommendation.*

Kalau kita tengok secara *slight shot,* kita melihat kepada 2023 dan beberapa fakta telah pun dikemukakan oleh Prof tadi tapi ini adalah data yang terkini daripada Kementerian Kesihatan. Kalau mahu melihat dari segi *how much we have spent* untuk kesihatan ini pada waktu adalah lebih kurang RM84 bilion pada 2023 dan dianggarkan untuk 2024 angka ini semestinya akan meningkat. Kalau kita melihat dari mana dan bagaimana kita membelanjakan wang ini, kita tengok memang pada waktu ini awam masih lagi 53 peratus daripada bahagian itu di mana MOH adalah 43 peratus dan bagi swasta pula kita tengok adalah 47.3 peratus.

Kalau kita melihat dari segi bagaimana ia telah dibelanjakan, kita pastinya melihat kita dah pun menjangkau atau menyentuh lima peratus GDP kalau kita melihat secara keseluruhannya dan per kapita RM2,521.

Ini *just slight— I'm sure some of you curious to know who spending more for health.* Okey, kita tengok dari segi negeri pastinya Selangor, Kuala Lumpur, Johor. *So,* boleh tengoklah.

[Ahli mesyuarat berbincang sesama sendiri]

Encik Azrul Mohd Khalib [Galen Centre]: Ya, *so...*

Tuan Sim Tze Tzin [Ahli PAC]: *Which means per capita then it reflects the number right?*

Encik Azrul Mohd Khalib [Galen Centre]: *Of course, we have the per capita also but this one we just want to show because it's an interenting way of presenting*

the data from the Kementerian Kesihatan. Next slide. So, there's growing development that is ocurring right now. Kalau kita melihat isu *private...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But the figures* itu *in million?*

Encik Azrul Mohd Khalib [Galen Centre]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That means Selangor RM16.6 billion?*

Encik Azrul Mohd Khalib [Galen Centre]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *All right.*

Encik Azrul Mohd Khalib [Galen Centre]: Kalau kita melihat dari segi peratusan, peratusan semakin meningkat dari segi *out-of-pocket payment* di mana kita merujuk kepada keadaan di mana keluarga individu terpaksa gadai rumah, keluar duit simpanan, duit KWSP dan sebagainya untuk membelanjakan mengenai isu kesihatan.

Kita melihat kedua-dua *private insurance* dengan *private household* bersama, bukan berasingan tapi bersama. Kita melihat 40 peratus sekarang ini— kalau tahun lepas dia baru nak sentuh 40 peratus, kami dah 44 peratus. *So,* peningkatan itu sangat mendadak. Dia bukan satu persen, dua persen. Dia meningkat lima, enam peratus daripada tahun-tahun sebelumnya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Yang *private household* itu yang bayar sendirilah *from their own pocket?*

Encik Azrul Mohd Khalib [Galen Centre]: Ya. *So,* dia— duit simpanan, dia gadai tanah, dia pinjam duit daripada orang dan sebagainya, KWSP, itu semua daripada itulah. Tapi, kita memang kalau kita lihat— kita melihat dua-dua *private insurance* dengan *private household* itu sendiri.

Yang merisaukan kalau you tengok graf di sebelah kanan itu, angka ini meningkat ini dan ia adalah berdasarkan peratusan di mana lebih banyak wang yang dikeluarkan untuk pembiayaan *out-of-pocket payment.*

Tuan Sim Tze Tzin [Ahli PAC]: Sekejap. Pengerusi, *private insurance* hanya lapan peratus?

Encik Azrul Mohd Khalib [Galen Centre]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: Maksudnya, hanya lapan peratus yang dibiayai oleh insurans?

Encik Azrul Mohd Khalib [Galen Centre]: Insurans. Ya.

Tuan Sim Tze Tzin [Ahli PAC]: Tapi, *according to some of the statistics, Malaysian actually almost half of the population bought insurance already.*

Encik Azrul Mohd Khalib [Galen Centre]: Ya, *this is the expenditure. I'll go into that* sekejap nanti.

Tuan Sim Tze Tzin [Ahli PAC]: Okey.

Encik Azrul Mohd Khalib [Galen Centre]: *So, when you look at the actual expenditure, you* belanja dalam satu tahun itu, berapa banyak adalah insurans. *So,* kita tengok *that is the eight percent*-lah. Nanti *I'll go into the* peratusan untuk insurans, YB.

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya itu pula. Yang *5.1 percent. Other federal agencies. What exactly do you mean by other federal agencies? Agencies government?*

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Encik Azrul Mohd Khalib [Galen Centre]: Kementerian Pertahanan contohnya, dia ada dia punya *own facility. So,* ada perbelanjaan juga dekat situ.

[Ahli-ahli berbincang sesama sendiri]

Encik Azrul Mohd Khalib [Galen Centre]: Kesemua hospital universiti adalah di bawah Kementerian Pendidikan Tinggi, *Higher Education (MOHE). So,* kalau kita tengok perbelanjaan untuk *private* sahaja, *just* kita ambil *that 40 percent* daripada angka tadi, kita pecahkan, kita lihat dari segi peratusannya untuk *private household* itu 76 peratus dan *private insurance* adalah 17 peratus.

Kalau kita melihat bagaimana perbelanjaan itu dikeluarkan, ke mana wang itu keluar, ia boleh tengok dekat situ 46.4 peratus ke *private hospital* dan selebihnya kepada *GP clinic,* dia ada *community clinic, TCM* pun ada dan sebagainya. Kebanyakannya adalah *out-patient services.* Kalau tak mengenai wang yang dibelanjakan untuk ubat-ubatan ini, hanya 17 peratus.

So, ini memberikan gambaran yang jelas bahawa pada waktu ini, ketika kita melihat keadaan di mana semakin ramai rakyat Malaysia yang semakin sakit, dia disebabkan NCD, penyakit tidak berjangkit seperti diabetes, *hypertension, cardiovascular disease, chronic kidney disease* dan sebagainya. Walaupun dia mungkin bergantung kepada sistem kesihatan awam, tetapi dia juga mengeluarkan wang untuk *access private hospital.*

So, kita boleh lihat dekat situ, *46.4 percent* itu adalah kepada *private hospital* dan sekarang ini, kalau kita melihat pecahan penduduk yang menggunakan awam dan swasta, awam 70 peratus daripada *population,* 30 peratus guna swasta. *So,* 30 peratus ini dia menggunakan insurans dan dia guna duit sendiri *out of pocket household. Okay?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Satu lagi, *Chairman. So, what it means, Encik Azrul*— nanti, saya nak tengok balik ya. *From the household* punya *financing* ini, yang *73 percent* itu, *46.4 percent is spent in private hospital?*

Encik Azrul Mohd Khalib [Galen Centre]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Selalunya, *not hospitalised* lah? *Just daily* punya ini *kut. Not entirely, most* lah. *Most.*

Encik Azrul Mohd Khalib [Galen Centre]: Dia pergi untuk diagnosis, rawatan. Sebab, ada yang mampu juga, dia tak ada insurans tetapi dia keluar sebab dia mahu servis yang cepat dan mungkin dia boleh lah keluar duit untuk dialisis.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm one of them.*

Encik Azrul Mohd Khalib [Galen Centre]: *Oh, yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm one of them. I just spend money.*

Seorang Ahli: *[Berucap tanpa menggunakan pembesar suara]*

Encik Azrul Mohd Khalib [Galen Centre]: *So— yes.* Dia tak semestinya T20.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tetapi tak gadai apa lah. *[Ketawa] Satgi, depa* ingat saya gadai apa pula.

Encik Azrul Mohd Khalib [Galen Centre]: Kalau kita tengok *actually even the lower middle income* pun memang dia akan buat, di mana dia kalau ada wang itu, dia fikir *I can just manage,* dia akan keluar duit sendiri.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That mean,* orang kita dia mampulah, banyak duit boleh pergi ini, bayar sendiri hospital swasta?

Encik Azrul Mohd Khalib [Galen Centre]: Dia *sustainability issue.* Contohnya, kalau *you* pergi untuk buat hemodialisis, hemodialisis satu *round* dah berapa ringgit? Kalau sebulan, mungkin dah...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Banyak *private clinic* lah, *private clinic.*

Encik Azrul Mohd Khalib [Galen Centre]: *So,* mungkin had dah mencecah RM2,000 contohnya dalam sebulan dan sebagainya. *So,* dia akan termasuk dalam angka tersebut tetapi...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Private hospital* ini termasuk *private clinic also,* ya?

Encik Azrul Mohd Khalib [Galen Centre]: *Private hospital* sahaja.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak masuk klinik?

Encik Azrul Mohd Khalib [Galen Centre]: *Private clinic* dia ada angka dia sendiri. *Private medical.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Hemodialisis banyak *private clinic.*

Encik Azrul Mohd Khalib [Galen Centre]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey.

Tuan Sim Tze Tzin [Ahli PAC]: Tuan Pengerusi, ini bermaksud bahawa hanya *8 percent of the population is insured, based on your...*

Encik Azrul Mohd Khalib [Galen Centre]: *No.*

Encik Azrul Mohd Khalib [Galen Centre]: *Eight percent is spending.*

Tuan Sim Tze Tzin [Ahli PAC]: *In spending?*

Encik Azrul Mohd Khalib [Galen Centre]: *But, if you look at this slide, this current slide...*

Tuan Sim Tze Tzin [Ahli PAC]: *17 percent, private insurance? This is spending also?*

Encik Azrul Mohd Khalib [Galen Centre]: *If you look at the slide right now...*

Tuan Sim Tze Tzin [Ahli PAC]: Oh, okey.

Encik Azrul Mohd Khalib [Galen Centre]: *You will see at the bottom there that according to NHMS, 22 percent of the population has insurance and LIAM says, it's around 45 percent.*

Dewan Rakyat. Hajah Halimah Ali [Ahli PAC]: LIAM? *What is that? [Berucap tanpa menggunakan pembesar suara]*

Encik Azrul Mohd Khalib [Galen Centre]: *The Life Insurance Association of Malaysia.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *23 percent? [Berucap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *Why does it discrepancy, between 45 and 22?*

Encik Azrul Mohd Khalib [Galen Centre]: *We are not entirely sure about that but we do know is that* ramai yang ada insurans tetapi dia tak tahu insurans apa yang dia ada. Kalau *you* pergi hospital untuk kesihatan, insurans kesihatan, dia akan cakap, *you* tengok *you* punya polisi, dia cakap, *"Eh encik, ini bukan polisi insurans kesihatan. Ini insurans nyawa."*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Accident. [Berucap tanpa menggunakan pembesar suara]*

Encik Azrul Mohd Khalib [Galen Centre]: Atau *accident* ataupun *critical illness.* Sebab, masalahnya kadang-kadang, keluarga dia nak bantu anak saudara

dan sebagainya, dia akan bantulah ambil insurans kan, dan mungkin dia dah bayar itu selama 20 tahun, 15 tahun tetapi dia tak tahu insurans apa dia ada.

Tup-tup, dia pergi masuk hospital. Dia ingat, okey *cover* lah. Dah lama ada insurans ini, okey lah. Tengok-tengok, itu bukan insurans kesihatan. *So,* masalahnya ialah walaupun adanya *portion* yang mempunyai insurans, kita tak tahu insurans apa dia ada *and that's the fac* -lah. Itu yang jadi masalah.

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *This is the literacy problem.* Ada *literacy problem. A lot of people who have insurance also, they don't know what's in the policy. They don't know what is covered, what is the limits and so on. A lot of them, we speculate they under insured.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I think, what has happened is this, I think* lah. *Insurance company* ataupun ejen, dia nak jual insurans *to anybody or a family, okay.* Dia kata, *health insurance RM60.*

Tuan Sim Tze Tzin [Ahli PAC]: Ya, ya. *[Berucap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tetapi, dia *link* lagi. Kena *link* dengan *life insurance* juga, RM100. *Then, add insurance education. So,* dia orang ini ingat, *all you can go anywhere* lah. *But, actually,* kalau pergi-pergi hospital, RM60 sahaja *per month.* Betul kan?

Encik Azrul Mohd Khalib [Galen Centre]: Betul. *So...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, this is what the trick they are doing* untuk itu.

Encik Azrul Mohd Khalib [Galen Centre]: *So,* masalahnya sekarang ini, ada yang dia kata insurans itu...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Apa *link* itu, YB *you* kata tadi? Apa *link?*

Tuan Sim Tze Tzin [Ahli PAC]: *Investment-linked. [Berucap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Investment-linked. They use investment-linked. All these altogether. So, they had to pay a lot. But, actually* kesihatan *only* RM60 *per month.*

Encik Azrul Mohd Khalib [Galen Centre]: *So,* kalau kita tengok insurans, *you will find that* untuk individu, kadang-kadang dia punya insurans itu *employer provided. So,* maksudnya, dia bawah *employer* lah. *Employer* akan bayar, mungkin RM85, RM45, RM65 setiap bulan untuk *cover insurance* tetapi dia punya *coverage* itu sangat minimum.

You tahulah, kalau *you* bayar RM45 untuk insurans itu, apa *you* dapat, kan? Dia punya *limit* itu *is very-very limited as well.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Covered? [Berucap tanpa menggunakan pembesar suara]*

Encik Azrul Mohd Khalib [Galen Centre]: *So,* itu pun *covered* juga dalam angka yang dilaporkan ini juga. *So, right now,* kalau kita melihat insurans, *the questions is what insurance? So,* seperti mana YB telah katakan tadi, ada juga *investment links. So,* dokumen ini daripada Allianz, kalau *you* boleh tengok.

Saya tak nak guna orang lainlah. Saya guna saya punya *insurance policy* sendiri, *so you* boleh tengok.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I see your name. Your name* di sini.

Encik Azrul Mohd Khalib [Galen Centre]: *My name is here. This is my insurance policy,* telah diberikan notis penyemak semula. *So, you* boleh tengok. Saya ambil *investment-linked insurance. So,* setiap bulan itu, saya bayar – pada mulanya hari itu, RM860 lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Sekarang, RM1,200.

Encik Azrul Mohd Khalib [Galen Centre]: Selepas itu, dia buat *revision.* Sekarang ini, saya kena bayar RM1,198.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: RM500 lah, dia naik.

Encik Azrul Mohd Khalib [Galen Centre]: Peningkatan hampir 40 peratus.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, my God.*

Encik Azrul Mohd Khalib [Galen Centre]: Tetapi, itu *I* bukan nak *show* yang itulah. *I mean,* cekik-cekik jugalah. Tetapi, *you know.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ini dalam masa setahun ya, Encik Azrul?

Encik Azrul Mohd Khalib [Galen Centre]: Ini dalam setiap bulan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Oh, okey-okey.

Encik Azrul Mohd Khalib [Galen Centre]: Setiap bulan, saya kena bayar ini.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Without an...*

Encik Azrul Mohd Khalib [Galen Centre]: *The period is it?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tetapi, dia punya *increase* itu *over one year* kah?

Encik Azrul Mohd Khalib [Galen Centre]: *Two years. This one is a two-year period.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Two years?*

Encik Azrul Mohd Khalib [Galen Centre]: *Because, this one policy I took it two years ago* lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dua tahun sahaja? Naik 40 peratus.

Encik Azrul Mohd Khalib [Galen Centre]: Cuba YB tengok bahagian bawah ini, dekat *box* punya *section* ini ada *highlight* kan? Dia ada mengatakan dekat sini, purata kadar inflasi perubatan adalah sebanyak 19.1 peratus.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *19.1 percent* kan?

Encik Azrul Mohd Khalib [Galen Centre]: *19.1 percent.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Betullah *you* cakap, *40 percent in two years. So, about 20 percent per year.*

Encik Azrul Mohd Khalib [Galen Centre]: Ya. *So,* kalau *you* tengok apa yang telah dikatakan oleh Bank Negara dan juga *the analysis* mengatakan, kononnya hari itu 12.6 peratus dan tahun ini, 2025 patutnya 15 peratus.

■1540

Tetapi, *communication* yang diberikan kepada pemegang polisi, dia kata 19 peratus. *So, got problem of misinformation.* Malangnya, Malaysia mengalami antara yang paling tinggi untuk *medical inflation* di kalangan negara-negara kawasan Asia. Indonesia dan Filipina lagi tinggi daripada kita, *I think it's around 16 to 19 percent* dan memang kawasan ini mengalami peningkatan *double digit medical inflation* sebenarnya. Tetapi untuk kita ini memang *top three* lah, kita nombor tiga. *So,* walaupun dianggarkan tahun ini naik 15 peratus, sebenarnya ada anggaran lain pula kata mungkin naik lebih tinggi hingga 17 peratus. *So, just wanting to share that* lah. *So,* Februari tahun lepas, telah dikemukakan oleh Bank Negara dan mungkin kalangan YB *familiar* dengan slaid ini sebab Bank Negara tahun lepas bulan Disember telah memberi taklimat kepada *Backbenchers Club* dengan Jawatankuasa Khas Kesihatan mengenai isu ini dan menggunakan slaid ini. Dia menunjukkan bahawa *claim* untuk setiap— *claim* telah naik dan angka purata pun naik. *So,* kalau dulu hanya 6.8 daripada 100 permohonan polisi sekarang 8.6 dan angka atau kos itu meningkat juga kepada 10.7 peratus.

So, tahun lepas Bank Negara telah mengatakan perlu ada *co-pay* dan *deductible*. *So, cashless* di mana kita pergi saja ke hospital hanya tunjukkan kad, keluar GL, *you* tidak payah fikir hendak bayar apa, *that is all going to go away.* Bank

Negara telah menetapkan polisi di mana bermula tahun ini, *cashless product* akan dikeluarkan atau *eliminated. Meaning,* walaupun— kalau *you* dah ada polisi itu, boleh teruskan tetapi kalau untuk produk baru tidak ada. Semua produk baru yang dilancarkan pada 2025 semuanya *co-pay* dengan *deductible*.

Seperti mana yang telah diterangkan oleh Prof. tadi, *co-payment* adalah peratusan atau angka yang tertentu yang *you* kena bayar lepas rawatan. *Deductible, you* kena bayar sebelum rawatan. *So,* kita melihat daripada Bank Negara dia kata *must be minimum five percent co-payment*. Tetapi, masalahnya yang telah kami bangkitkan ialah dia tidak ada *cap*. *Meaning* dia boleh bukan sahaja lebih daripada 30 peratus dan sebagainya tetapi ia adalah untuk setiap kali insurans digunakan. Kalau *you* masuk hospital tiga kali dalam setahun atau beberapa kali, angka itu bukannya *cap,* ia lima peratus atau 10 peratus setiap kali *you* masuk.

Kalau di Singapura, dia *cap* kepada SGD5,000 setiap tahun. Dia ada *limit,* dia ada *cap.* Kita tidak ada *cap.* Saya telah *point this out* dekat Bank Negara bahawa ia boleh menyebabkan kesusahan kepada pemegang polisi. Juga, untuk *deductible,* diberitahu bahawa *deductible* ini RM50, RM80 kira boleh jugalah. Kalau *you* masuk *you* kena bayar dulu RM50 atau RM80. Tetapi, sebenarnya angka yang telah dikemukakan oleh pihak insurans kepada pemegang polisi adalah angka yang beribu-ribu.

Saya punya, *deductible*-nya yang di-*offer*— saya tidak terimalah, saya teruskan saya punya *cashless*— RM10,000. Maksudnya, sebelum dia hendak mulakan rawatan kepada saya kalau saya masuk ke hospital, saya kena bayar RM10,000 dulu. *That is the deductible. So,* kita kasi *warning* lah tahun lepas bahawa kalau *you* buat macam ini ia akan menyebabkan *possibility of medical catastrophe* iaitu *medical bankruptcy. So,* kalau *you* tengok sekarang ini *all of the new products from insurance* semuanya dah tidak ada *cashless* bermula tahun ini. Kalau *you* dah ada, dia akan teruskan.

November, Disember tahun lepas, Utusan telah melaporkan bahawa peningkatan yang berlaku di kalangan pemegang polisi adalah antara 40 hingga 70 peratus. Saya boleh katakan dekat sini ia adalah tidak tepat ya. Kami telah mendapat dokumentasi bahawa ada sehingga 250 peratus. *In fact,* slaid yang dibentangkan oleh Bank Negara bulan lepas dalam taklimatnya kepada Ahli Parlimen, kalau *you* tengok dia punya slaid kan, *this is the slide here,* tunjuk dekat situ kemungkinan bahawa ia kebanyakan adalah kurang daripada 20 peratus dan kalau melebihi 60 peratus itu ada yang empat persen sahaja.

Saya *point out* dalam *meeting* saya minggu lepas dengan Bank Negara bahawa ini adalah *misrepresentation* sebab ia menunjukkan macam dia berhenti

pada tahap 60 peratus sahaja. Tetapi *actually we have 100, 120 percent, 150 percent* yang dia punya polisi itu memang dalam sebulan itu memang tidak boleh hendak bayanglah kalau *you* hendak bayar.

Then, masalahnya di sini ialah ia seperti membabitkan hanya mereka yang berumur 50 tahun ke atas yang dapat peningkatan begitu mendadak ini. *So,* ia merisaukan dan kami telah bangkitkan tahun lepas mengenai isu ini dan apa yang kami *predict* akan berlaku pun sedang dan telah berlaku, di mana mereka yang ada polisi ini diberitahu yang dia orang kena bayar lebih ini, dia orang tengah *terminate the policies, they ending their policies.*

Tuan Sim Tze Tzin [Ahli PAC]: *On this point,* sebenarnya apa yang mereka *complain* kepada saya— *the highest lah that I got complain is 186 percent.* Itu sebab saya hantar kepada Bank Negara dan mereka kata mereka sudah *solve* untuk semalam kan, mereka *testify that they are already solved the problem for me, for the guy* lah, *that guy. It's true, it's true*. Saya umur— semalam kan saya kata saya umur *between bracket 40 to 49, I got 50 percent increase* tetapi di sini *41 to 60 percent* hanya *five percent. This is not true because majority our age group* semua kena. *I don't know about* Betong. Betong, *you* dapat berapa?

Dato' Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Saya pun menyangkal data ini juga. Saya sendiri dalam *bracket 60 to 70*. Saya ingat realitinya memang hampir 200 peratus juga ya.

Encik Azrul Mohd Khalib [Galen Centre]: Ya, *exactly*.

Dr. Hajah Halimah Ali [Ahli PAC]: Lagi tinggi lah...

Encik Azrul Mohd Khalib [Galen Centre]: *So,* memang saya *point* out kepada Bank Negara minggu lepas bahawa *this is a misleading slide.* Kita perlu melihat *the issue* dengan lebih terperinci kerana ia tidak menggambarkan keadaan sebenar. *You know yourself,* kan? *How it is,* kan? *So, they are people terminating their policies and* masalahnya di sini ialah *there are even family's* yang membuat keputusan— bagaimana ya? Satu *family* ada insurans, anak dua orang, ibu bapa. Ibu bapa mengambil keputusan untuk menamatkan polisi dia orang semata-mata untuk memastikan anak *covered*. Dia orang akan kata kalau apa-apa kita akan pergi ke sistem kesihatan awam.

So, sekarang ini isu insurans ini pemikirannya sudah pun berubah juga. Kalau dulu kita memikirkan insurans ini *is like an investment right? Not anymore. Insurance is only* untuk *protect* kita pada waktu itu saja. *So,* sekarang ini kita ada kes-kes yang mengatakan saya dah bayar insurans 20 tahun, tidakkan saya tidak *covered?*

Tetapi *actually* kalau *you* punya *cover* 20 tahun yang lalu itu bukan boleh terima pakai hari ini sebab dia punya *cover* itu terlalu sikit. Tetapi insurans *doesn't*

care yang *you* bayar 20 tahun. Dia hanya kisah *you* bayar bulan itu dan itu yang menjadi masalah ini kerana pemikiran untuk insurans ini kita kena ubah.

Seorang Ahli: Dia dah jadi liabiliti.

Encik Azrul Mohd Khalib [Galen Centre]: *So,* dia dah jadi liabiliti, *exacly*. Dia dah jadi liabiliti. *So,* dia kata tidak mampu untuk bayar insurans padahal insurans ini patut untuk *protect* kita daripada *financial catastrophe*. *What is happening now* seperti mana dalam slaid itu ialah ia meningkatkan *financial catastrophe* dan bukan menurunkan. Saya merujuk kepada surat di sini daripada AIA.

■1550

Surat ini adalah surat dari AIA kepada hospital. Kalau boleh tengok, yang *highlighted* ini, *Pharma Management.* Kami meningkat— kami membawa perhatian bahawa disebabkan oleh pendekatan yang diambil oleh Bank Negara dan insurans ia menyebabkan berlakunya kemungkinan campur tangan dalam rawatan di mana insurans boleh menentukan kaedah rawatan yang anda alami. *I have to say this to you very clearly, a lot of people take insurance* supaya dia boleh mampu untuk membiayai rawatan yang mungkin tak ada dalam sistem kesihatan awam.

Bukan semua ada *generic*, bukan semua ada *biosimilar*. Banyak— bukan isu *brand. It is* isu, adakah tidak ubat itu dalam *formulary* sistem kesihatan awam? Kebanyakan untuk mereka yang ada kanser contohnya *stage* tiga dan empat, kemungkinan tidak ada ubat itu dalam *formulary* tapi ada dalam sistem kesihatan swasta. *So,* dia ambil insurans ini supaya dia boleh akses ubat tersebut.

Sekiranya langkah ini dilakukan di mana mereka mengehadkan atau mencampur tangan dalam kaedah rawatan ia membimbangkan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Encik Azrul. *Chairman, I heard this is happening already. Insurance detecting private hospital, you know, what to do what not to do and ask for a discount and all that*-lah. *It's happening already.*

Tuan Azrul Mohd Khalib [Wakil Akademik]: *I agree*, masalahnya ia seperti di Amerika Syarikat di mana memang perkara ini memang sering berlaku dan menjadi *normalisation*-lah. Kita, *alhamdullilah,* belum *wide spread* lagilah *that* langkah itu. Tetapi memang ia sedang *and* akan berlaku. *Next, slide.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Before that* Encik Azrul. *Because the reality is* kalau *patient* itu dapat *paracetamol in* KK, hospital, klinik kerajaan *and* dia pergi dekat *this specialist medical centre* apa-apa, *they get the same* rupa, *the same brand, exactly* apa yang dia dapat daripada pusat kesihatan *this and that. So*, dia kata, *why should I go to this specialist medical centre just to get this* ubat parasetamol yang sama ini. *That is* dia punya apa itu— *they pay, they willing to pay.*

Satu, *because of the service* mungkin *is better* inilah. Dia cepat sikit, lebih senyum *and all that and also they look at the brand even though the thing is paracetamol. But it looks better*, dia lagi *absorbable*, senang nak telan *and all that. So, if it is* balik *to* pada— *I have got no problem with their* guna *generic*. Tapi *if it is for every single thing*, maknanya *defeats the purpose of having this* hospital swasta.

Tuan Azrul Mohd Khalib [Galen Centre]: *Exactly, Dr…*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *No. Wait. Wait. I think I need to comment on that.*

Tuan Azrul Mohd Khalib [Galen Centre]: Ya. *Hold on, but Dr., one thing we have to remember, not every drug has a generic or biosimilar equivalent.* Yang ada *we should get.* Polisi Kementerian Kesihatan adalah mencapai 80 hingga 90 peratus *generic* untuk *formulary*. Tapi, *not everything* yang ada *especially* yang masih lagi *innovator drugs* kan. *So, we want to make sure*, kita ada *access* pada *the drugs even innovator. So, one way to do it is through insurance.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *So, I also want to say that there's nothing wrong with generics. Generics should be exactly the same as the innovator drug. It's just – it's out of the….*

Tuan Azrul Mohd Khalib [Galen Centre]: *Pattern*.

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *Ya. The pattern. So, it should be exactly the same. There's nothing wrong in terms of quality and so on. But the fact that what* Azrul *is talking about is very, very true. So, innovator drugs for cancer, for diabetic treatment and so on. MOH does not have a lot of them in the formulary. Because it cost a lot…*

Tuan Azrul Mohd Khalib [Galen Centre]: *A lot of money.*

Prof. Dr. Tharani Loganathan [Wakil Akademik]: *A lot of money. So, this would save people's lives. Then, of course like diabetic care now, I mean the medication is so advanced. You know, it would really save your life.*

Tuan Azrul Mohd Khalib [Galen Centre]: *So, we come to the question about the VNM* punya *interim measures, are they working? It still early. I have to admit right now*-lah. Kalau kita nak tengok patutnya dia *announce* hari itu *in late December*. Patutnya bermula 15 Januari, tapi kita tengok macam mana. *So*, tengok, ada tiga *measure* yang kita lihat. Pertamanya adalah *the 10 percent cap* untuk semua *premium increases* untuk tiga tahun. Dikatakan oleh Bank Negara ialah 80 peratus pemegang premium akan menikmatilah *this cap.*

Actually, it's not true. We have a serious problem because kalau kita tengok *the fine print of the policy* ini, *it turns out* kalau *you* dah *sign-in to the revise policy rate* sebelum *announcement, you are excluded. So, only those* yang akan *renew* dia

punya polisi lepas 15 hari bulan, *included. So far, as we have asked different people* dan sebagainya, belum lagi ada yang melaporkan *cap* itu telah pun dilaksanakan. *Nobody. No insurance provider yet has indicated that 10 percent to their*— dia buat. Mungkin *too early, I don't know.*

But look at the second measure, which is when they announced hari itu, 60 tahun ke atas dia tak akan *affected by the repricing policy*. Saya pun *thanked them also*-lah waktu saya jumpa dia orang minggu lepas. *Turns out*, ini pun satu hal. *Because*, kalau you ada *product* atau *pricing package* yang lebih tinggi, *you are not included.* Dia hanya *is the* paling minima *60 years above,* dia punya *basic package then you are included. So, even that one* pun dia selektif juga. *So, again, not inclusive of what was actually informed to us.*

The third one is still too early, tapi *I am hoping that we can have that happening* sebab terlalu ramai yang telah *terminate policy* dia orang. Dia orang dah angkat tangan, tak boleh dah, tak mampu *already and the idea is to bring them back. To give back their policy* belum lagi ada. *I am sure you heard Friday* minggu lepas, cerita yang telah diluahkan oleh mereka yang datang untuk *townhall* minggu lepas. *You know how it is.* Apa yang saya katakan di sini bukan benda yang asing. *You have the testimony of a few people from Friday.*

Masalahnya sekarang ini, *what happen after three years?* Memang Bank Negara pun garu kepala *because* memang *we are just postponing the inevitable*. *It will* lonjak naik. *So, what happens after three years is the question. I will just go to the next slide. So*, kita cerita fasal *private hospital charges* ini— *is very hard to talk about private hospital charges, without knowing what exactly what's going on. So, I thought I give you, actual bills so that you* boleh nampak sendiri.

So, this is Liam punya CEO. Dia *share* dengan *Code Blue* dia punya cerita dapat hernia *operations*. *So, if she knows the operation is minor*, tapi dia kena bayar banyak juga. *You can see the breakdown of* dia punya *hospital charges. The first thing I have to emphasize to you,* kenaikan insurans premium ini tidak berlaku dalam vakum. Ada sebab dia naik. Sebabkan *private hospital* ini pun tengah meningkatkan caj yang dikenakan kepada pesakit. *First question they will ask you* apabila *you* masuk *admitting* ini, *you* ada insurans tak. *So, the implication is* dia macam ada dua *pricing system*.

Kalau *you* ada insurans, *price* dia macam ini. Kalau *you* tak ada insurans, *out of pocket, pricing* dia macam ini. Tapi, industri insurans katakan kepada kami mustahil— *sorry*, industri *private hospital* mengatakan kepada kita orang yang mustahil ada dua sistem. *We just give a discount. So, they term it as discount fall and*

out of pocket patient. So, *how are they being charged? So, I thought I give you, some demo*-lah.

This is a surgical glove [Sambil mempamerkan sarung tangan getah]. Surgical glove ini*, we familiar*-lah *because of COVID-19* kan. *So, each of this is maybe a few cents, a piece.* Tapi, kalau *you* tengok dalam bil itu, dia caj RM20 setiap kali dia guna, dia caj RM20. *This is* RM14.90 beli dekat AA Pharmacy.

Seorang Ahli: *Less than RM20 [Bercakap tanpa menggunakan pembesar suara]*

■1600

Tuan Azrul Mohd Khalib [Galen Centre]: Kalau *you* tengok *and the bill* berapa kali ada berapa kotak dia guna *these latex clothes. Patient even* ada yang dia *dispute* dia punya *bill*. Dia cakap dia nak kotak dia minta, "*I paid for five kotak. I want the kotak."* Kasi *the five* kotaklah. *But so it's like this for example, mark up* dia macam ini. *This one....*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *As one person on hospital, I said why you charge this much USD20 per pair and yet RM14, RM20 for one* kotak? Dia kata *nurse* ini, *nurse* kah doktor kah dia pakai banyak kali. Dia pakai buang, pakai buang. Keluar masuk, keluar masuk jadi mahallah. Itu pasal dia caj satu kotak.

Tuan Sim Tze Tzin [Ahli PAC]: Setiap kali dia caj. Dia *prepare* caj RM20. *[Bercakap tanpa menggunakan pembesar suara]*

Encik Azrul Mohd Khalib [Galen Centre]: Tetapi juga dari segi *contamination. Infection control*. Setiap kali *you* buka satu kotak, *the whole* kotak *is exposed to possible contamination. So, this is their argument.*

Prof. Dr. Tharani Loganathan [UM]: *This is the argument.*

Encik Azrul Mohd Khalib [Galen Centre]: *This is the argument. This is the argument. So, this is how they argue it. So, they have to open up a new box every time, this is their argument.*

Prof. Dr. Tharani Loganathan [UM]: *So, they follow the standard care, levels of care MOH does...[Bercakap tanpa menggunakan pembesar suara]*

Encik Azrul Mohd Khalib [Galen Centre]: *So now this. This is a syringe. Item* dia sebelah kanan itu. Kalau *you* beli dekat AA Farmasi, ini tujuh kupang.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tujuh kupang.

Encik Azrul Mohd Khalib [Galen Centre]: RM0.70. Tujuh kupang. RM0.70. *This is the same item yang you* akan tengok dekat situ RM24? RM23. RM7 satu dia caj.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Berapa? RM23?

Encik Azrul Mohd Khalib [Galen Centre]: Ya. Lebih kurang RM7 lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: RM7 satu.

Encik Azrul Mohd Khalib [Galen Centre]: Cuba bayangkan. *So* ini adalah *gauze. This is gauze for example. This gauze is* RM10.10 beli dekat AA Farmasi. Mungkin dia akan caj RM30 tetapi gauze ini dia punya *practice is* dia sekali dia buka satu ini, habis. *You cannot* pakai untuk *patient* lain. *One patient one box. One package*. Dia tak boleh sebab dia punya *argument is infection control*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Betulkah *argument* daripada ini?

Encik Azrul Mohd Khalib [Galen Centre]: Ini *argument* yang dia kasilah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tetapi *is it right? Is it a correct argument?*

Encik Azrul Mohd Khalib [Galen Centre]: *Is it not correct. [Ketawa] So, here is thing and I almost finished with my presentation*. Maaf kalau terlalu lama juga. *Issue of consultation. Now, next slide*. Perlu ditekankan di sini bahawa untuk c*onsultation fee* telah pun ada *regulation* ya di bawah PHFSA memang ada *limit floor* dan siling untuk GP untuk konsultan di hopsital dan sebagainya.

In fact, Kementerian Kesihatan telah mengatakan dalam perbincangan hari itu. Dia kata untuk *specialists* yang melawat pesakit di wad, hanya dua kali sehari sahaja dia boleh caj. Cuba tengok *this slide which is an actual bill*. Berapa kali *specialists visit this patient in a day*?

So, you can see there pun dia tidak mengikut Kementerian Kesihatan punya *regulations. So* kita perlu tanyakan bagaimanakah *consultation fee* itu walaupun ada *regulations* sedang dikenakan kepada pesakit di hospital. *Next slide please.*

We go back to the slide earlier. *This slide by* Bank Negara. *This is the most important thing that you need to take away* daripada perbincangan pada hari ini ialah 10 peratus daripada *hospital bill is regulated*. Hanya 10 peratus.

20 *percent* daripada bil itu mungkin ubat-ubatan, farmaseutikal dan sebagainya. *Not regulated* tetapi dia *market fresher*-lah. *You* tak boleh just 1000 peratus kenaikan ke dan sebagainya. Dia ada limit juga. Tetapi yang tidak ada *regulations* langsung adalah *the 70 percent. The HSS* yang YB Sim ada katakan tadi. *The health supplies and services. Up to 70 percent of a bill is currently unregulated.*

So masalahnya sekarang ini *is the recommendation. So, I just put that your colleague*-lah. Kluang MP kan. Tahun lepas dia garu kepala jugalah. Tanya isu ini sebab dia *fast. Back and forth*-kan. Bank Negara kata KKM, KKM kata Bank Negara dan sebagainya. Seperti mana yang kita lihat *it looks like* dari segi isu *private*

healthcare ini tidak ada *ownership of this issue.* Sebab tidak ada *mandate* atau punca kuasa sebenarnya untuk *even* KKM untuk uruskan atau pun Bank Negara.

Ini adalah satu *loophole* yang cukup besarlah sebab ia nya sekarang ini *giving problems* dari segi the kawal selia isu *private hospital* ini sebab nak minta KKM buat pun *not fair. I told you* tengok Dr. Zul dekat Dewan tadi pun kesian juga. Nak jawab soalan *just now because at the end of the day on this issue* tidak ada *regulations* atau *legislations* untuk *regulate 70 percent of that bill. So, we need a consumer protection policy approach for healthcare. So, my final slide is the recommendations*.

We need a private healthcare commission to regulate charges in the private healthcare sector. I don't like to set up new bodies or agencies yet another commission dan sebagainya. Tetapi dalam isu ini, disebabkan ia mempunyai impak yang cukup tinggi kepada masyarakat dan juga kepada mereka yang menggunakan *private healthcare* ini perlu ada *regulator*.

Sekarang ini fungsi itu tidak ada pada Kementerian Kesihatan atau pun Bank Negara. Dalam perbincangan saya dengan Bank Negara minggu lepas, telah ditekankan bahawa walaupun Bank Negara ada fungsi untuk *take care of insurance industry but it's more like we will take care of the standard. Make sure there is nothing illegal* dan sebagainya. Tetapi *when* merujuk pada peningkatan *the premium* itu tidak ada punca kuasa.

So, right now we need a consumer protection agency sebab ia tidak wujud untuk isu ini pada waktu ini dan komisyen ini boleh dimandatkan untuk *review dan regulate private healthcare charges and fees* termasuklah *insurance premium* yang kenaikan yang kita katakan tadi. *I think it's the only way forward* sebenarnya untuk isu ini dan kita *raise one recommendation* sahaja.

There is no quick fix ya. Masalah sekarang ini, walaupun you boleh cerita fasal DRG. *You* boleh cerita fasal *this* Bank Negara punya polisi dan sebagainya. Ini semua sementara ia *not a silver bullet. You cannot fix it. Because right now we don't have the tools to fix it*. Kita perlu wujudkan *this commission to get it done. So,* dengan itu saya mengakhiri *and then* kalau ada soalan-soalan. Sekian, terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Beri soalan lima minit sahaja. Kita semua perlu turun untuk undian perbahasan. *Okay, five minutes, go.*

Tuan Syahredzan bin Johan [Ahli PAC]: Okey, *very fast.* Saya nak merujuk kepada slaid berkenaan dengan langkah-langkah yang telah diumumkan oleh Bank Negara. Jadi, saya— yalah, kita pun dah dengar *presentation* daripada Bank Negara. *It sounds good on paper.* Tetapi kalau ikut apa yang dipersembahkan ini indah khabar dari rupalah.

Jadi, saya nak tahu kenapa— okey, bila nak mereka laksanakan ini, siapa yang sebenarnya tak laksanakan ini mengikut apa yang diumumkan oleh Bank Negara? Adakah syarikat insurans sendiri yang cuba cari jalan untuk tidak laksanakan atau pun BNM sendiri yang memberi gambaran yang tak tepat tentang apa yang mereka nak lakukan?

Encik Azrul Mohd Khalib [Galen Centre]: *To be honest YB, I had several very frank discussions with both the CEO and chair of insurance companies as well as Bank Negara.* Dia *punya leadership over the past couple of months.*

Untuk menjawab soalan itu sebenarnya, kita kena lihat *what kind of powers exist in the regulator. In the case of Bank Negara, I always thought that before* ada polisi yang akan dinaikkan dia perlu ada kelulusan daripada Bank Negara *before* dia buat*. It turns out what they do is, they do first, report to Bank Negara later. So, Bank Negara could be catching up after the fact.*

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So that's the problem. The other thing is that dari segi *the* insurans punya *companies, they were very frank with me. In their conversations with me, their priority is shareholder. Their shareholder and the same thing were for Bank Negara as well. Bank Negara said to me, their priority is the financial sustainability and stability of the health insurances ecosystem. Because* masalahnya sekarang ini dengan adanya apa yang berlaku sekarang ini, dia macam *reverse of musical chairs,* tahu? *The musical chair* itu *is* siapa tak ada *chair* ini apabila muzik dimainkan, dia *loser* lah. *Then the last person who has the chair is the winner.*

Actually, untuk insurans, *it's the other way around. The last person who is sitting on that chair is the loser.* Sebab bilangan orang yang ada insurans itu akan berkurangan dengan peningkatan premium setiap kali dia punya *repricing* berlaku. *So* lebih kurang orang dalam sistem, lebih kurang *resources* untuk membiayai kos perubatan tersebut. *So* premium itu akan meningkat dengan mendadak. *So, if you stay into the system, you loser* lah. *The problem here is that, they are not looking on behalf of the consumer. They're not looking on your best interest,* tahu? *And they were very frank to me and said that. It's not our function. Both Bank Negara and the insurances companies said the same thing. Because we do not have a stakeholder for that.*

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *Bank Negara said that the insurances companies are too big to fail. Because they are afraid that they will close shop, not good business in Malaysia and then they will move out and then, that's it. So that's what they want to prevent.*

Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Kalau senario *policy holder insurances* yang ada ini, *they* mogok, *they* cabut dan sabotaj *all these things.* Ada kemungkinan ITO ini akan lingkup kah?

Tuan Azrul Mohd Khalib [Galen Centre]: Dia mengatakan yang *every year* peningkatan itu sehingga sekarang ini dia 54 peratus dia punya peningkatan. Dia kata dia tak ada dah. *Enough resources* untuk bayar *the claims.* Sebab c*laims* itu terlalu tinggi tapi *every year there is dividend that is paid to shareholders. So, there is a reality of business here* yang kita kena ambil tahu lah. *But...*

Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Ini kalau kita lihat *this ITO* yang besar-besar ini, tengok bangunan *giant building,* canggih-canggih, besar-besar ini, mana dia dapat duit untuk bina semua itu.

Tuan Azrul Mohd Khalib [Galen Centre]: *One final thing actually if I may say, it has been highlighted to me that if the situations do not improve, the insurance companies will leave health insurances and focus only on critical illness* dengan *life insurances. They will not do health insurances. That's the warning* lah yang dikatakan daripada *the insurances companies.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Azrul Mohd Khalib [Galen Centre]: *I think health insurances is a big business. So, if wanting to get out the business, it's a little bit strange. I think— it's not an empty threat but definitely it's a threat* lah.

Tuan Sim Tze Tzin [Ahli PAC]: *Because I think the issue is Malaysia is a young country, growing economically and also I think rising income. So, what is the— I don't think this company will leave Malaysia. This kind of country. So, I think is empty threat.*

Tuan Azrul Mohd Khalib [Galen Centre]: Ya. *I believe it myself. Upper middle-income country coming up to high-income country, and we have a lot of unfortunately those living with non-communicable disease, chronic illnesses is good for business at the end of the day. But they are saying that if the claims are too high, then they don't have enough money. But the fact for the matter is that* kita punya *medical tourism in Malaysia is doing very well and people come from other country also to do their treatments in Malaysia and they also using insurances. The fact is unfortunately when you look compare to other countries, Malaysia in one of the lowest in terms of cost of healthcare* berbandingkan dengan *other countries in these regions for private healthcare.*

Tuan Haji Azli bin Yusof [Ahli PAC]: YB Pengerusi*, I just want to ask Encik Azrul. Chicken and egg. Which one is chicken, which one is egg? I think APHM also mentioned. They claimed the private hospital contribute about 40 percent of the*

healthcare system here. I mean yesterday Ministry of Health presented and according to their data, private beds is about 30 percent, say 30 percent, 40 percent is a matter.

Now, most of the private hospital also operate in the same way as this insurance because for profit and for their shareholders. So which one is egg, which one is chicken?

Tuan Azrul Mohd Khalib [Galen Centre]: *I can tell you YB, our conversations with private hospital is that they tell us,* dia orang tak risau. Dia orang punya *beds are full, emergency* penuh orang, tak boleh nak *give enough service. So, for them business is great and if you look at who owns these private hospitals also,* setengah daripada dia orang GLC. Ada *EPF shareholders there as well, LTAT. So, there's a lot of problems here when we want to* kawal selia *the cost of healthcare. It means reducing their profit, meaning you will have impact on things like EPF, LTAT* dan sebagainya. *So, it is a very complex system with no simplistic solutions. That's why we need this commission to be responsible and to take care of that. If possible, take away some of the responsibilities from Bank Negara as well.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I think* semalam kita ada perjumpaan dengan Kementerian Kesihatan yang Menteri sendiri datang, yang idea tentang kita perlu ada satu aduan. Sekarang ialah yang pesakit itu, mereka terima bil yang sangat tinggi tapi mereka tak tahu pergi mana buat aduan. *So, I think Bank Negara after that— Bank Negara said, they have something that ombudsmen system but nobody knows. So, there are lot of communication problem that Bank Negara and KKM need to address.*

Tuan Azrul Mohd Khalib [Galen Centre]: Betul YB tapi Bank Negara pun dia kata *very clearly, it should be not reactive but proactive. Meaning you have to prevent those cases from coming first rather than responding after because the numbers that they dealing with is in hundreds or even thousands and this is from the bureau in Bank Negara themselves. So* dia macam kalau *you have a problem with your case, you have go direct to Bank Negara. Not everybody knows how to get to that bureau of complaints in Bank Negara.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ada apa isu lagi? *Anyway,* Dewan sudah habis bersidang.

Tuan Sim Tze Tzin [Ahli PAC]: Dato' Ku, tak payah pergilah. Dato' Ku, Dato' Ku, Dewan habis Dato' Ku.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Habis sudah. Dewan dah habis.

Tuan Sim Tze Tzin [Ahli PAC]: Kubang Pasu, Kubang Pasu, Dewan dah habis. Dewan dah habis.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak ada perbahasan lagi kah? *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: Tak ada. Habis.

Dr. Hajah Halimah Ali [Ahli PAC]: Kalau macam itu, boleh tanya lagilah ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tak ada, tak ada. Baru habis.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dia gempak kita. *[Ketawa].*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Balik, balik, balik. *Okay can we end by 4.30pm or not*? *4.30pm.*

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya kita punya *CodeBlue* punya orang. *So from your point, from your perspective* sebagai orang luar, *so what happen?* Kenapa ini *suddenly happening? May all of this while, okay, okay, okay.* Tak ada apa *and suddenly* ini naik *200 percent*— itu berapa naik tadi, *100 percent and all that. Why suddenly? What's the cause?*

Tuan Azrul Mohd Khalib [Galen Centre]: *Well doctor, actually it's not* tiba-tiba. *This issue* kalau *you have conversation with the insurances* pun *and also people with their own policies, actually* benda ini *before COVID* dah memang *was starting to happen but the* angka itu *is not as* mendadak lah. *During the COVID crisis* pada tahun 2020, sepatutnya ada kenaikan polisi premium dan apa yang berlaku adalah Bank Negara dia minta *the insurances companies to hold because we have that COVID crisis, cannot do this,* menyusahkan rakyat dan sebagainya. *So* selama tiga tahun itu dia *hold* tapi *the inflation* itu *continue. So* sekarang ini *it's* macam *is catching up after us* lah. Kita *just delayed* lah apa yang sepatutnya berlaku, dia berlaku. Masalahnya ialah disebabkan Malaysia ini memang mengalami *double digit medical inflation from at least 10 years ago, this was already going to happen.*

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Memang masalahnya tidak ada penyelesaian. *There was no like what do we do about it* kan? *Like how do we prevent that from happening? In fact, some of the conversation* yang *we having today* fasal *medical inflation ini, if we had it like 10 years ago and we put into place some of the things we needed to maybe* dia punya impak itu kuranglah sikit. Tapi, *now because COVID* punya impak *is still an issue, Malaysians are increasingly more sick. The impact is just* memang mendadaklah. *It's a financial punya progression. So, it is quite worrying because* peningkatan mana pernah dengar 200 peratus kenaikan premium. *How is that acceptable? Nobody can*

afford it, you know. So, I'm actually quite worried, Dr. because we are seeing a lot of people yang *thinking* yang insurans ini *will help them to avoid using savings or EPF money and that option is no longer available sebab dia orang tak mampu nak bayar the premium.*

It's not even the medical bill, it's the premium. Tak mampu bayar premium.

Dr. Hajah Halimah Ali [Ahli PAC]: *From the academician's point of view, Prof? What's happening and what can we do about it?*

Prof. Dr. Tharani Loganathan [Universiti Malaysa]: Ya, *I mean, I agree with Azrul. I mean this is not a problem that happened overnight. It's just— I mean, it's something that we could've done something about long ago. The solutions are not simple. There's no one no one-shot-fits-all. It's like reimagining how private healthcare works, reimagining how the private health insurance works. There are actually a lot of things about private health insurance that actually don't cover people the way that we would think of social health insurance. The concept of insurance is actually very good. The idea is you prepay when you are well, to cover when you are sick. Right? So, you prepay in advance and then this will cover you once you are sick. Then, there's a concept of cross-subsidy and so on.*

So, the younger people who are paying premium subsidise the older people, the richer people who are paying premiums subsidise the poor people. So, in that sense, there's a pool, there's a pool of population and that cross-subsidy happens. But in private health insurance, it doesn't happen that way because of the way that the insurance packages are designed. So, you see it seems like it's according to the age group. So, if you are suddenly 50 years old or 60 years old, your pool is that 60 year old group or 70 year old group and this is the group that has the highest risk, you know. So, they would incur the most medical care you know compare to a 20 year old group and so on.

So, of course, the cost will go up, their premiums will go up, their healthcare needs will go up so there's no cross-subsidy. So, it really defeats the purpose of this insurance. So, ya*, there are a lot of things about the Malaysian— private health insurance that doesn't make sense actually internationally as well.*

Okay, when we look at different countries and how they do it, they regulate things by exclusion. Right now there's something call like restricting and exclusion. So, right now, if I go in and I want to buy insurance, they will do restricting for me. So, I am what age? Okay. What are my medical conditions? Then, from there they will exclude diseases. So, "Oh, you have diabetes. So, this insurance will offer you this premium but diabetes is not covered". Okay. All they might say, "Oh, you got all these

diseases. Actually, we will not cover you at all". They won't offer you. So, excluded because you had cancer before. So, now, suddenly, cancer cannot be covered.

Okay, this is a footballer who had an injury, ini replacement therapy. Okay, surgery. Go in, no surgery of knee, no treatment of knee is covered. Okay. If you are a footballer and you had a knee injury, later in your old age, you'll have osteoarthritis, all sort of things. It is going to happen. But this sort of thing, what we call in medicine, it is like it's almost unethical. Right? So, ya. Because we don't have a law. It's is difficult.

Encik Azrul Mohd Khalib [Galen Centre]: *I just wanted to mention...*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Can I comment?*

Encik Azrul Mohd Khalib [Galen Centre]: Okey, sila.

Tuan Haji Azli bin Yusof [Ahli PAC]: *I can understand, I mean people who purchased insurance at a later age where they are being accessed first. That one I can understand. But I mean, people like me who purchased insurance 25 years ago, I would expect that you know that saving or my contribution would cover for my medical expenses at the later age. You are right, I mean then the younger people would contribute and you know pay for my expenses. I mean that's circular and you know, cross-subsidised. I mean at that age...*

Encik Azrul Mohd Khalib [Galen Centre]: *I mean the pool approach is definitely the way that it should work. The problem here is what happens when the depletion of the pool is too rapid which is what the insurance is saying* lah. *So,* sekarang ini masalahnya *your 25 years of paying insurance is irrelevant because the person whose paying for you today is the current policy holders who are 20-25 years old. But you know what, they are also seeing an increase in their premiums like 30 percent, 25 percent, these are people who just started work you know, they are early in their careers and the* peningkatan *of the premium* itu *is actually costing them to decide, "I don't want. I cannot afford the premium".*

So, when they stop their premium, they do not have the money to support you, you know and that is what's happening in the current system now.

Prof. Dr. Tharani Loganathan [Universiti Malaya]: Ya. *But I understand, I mean I don't know the details of the private health insurance and so on but what I understand from the conversation with Bank Negara, it sounds like the pool is aged. They are not like an entire pool where 20 year old is subsidising the 50 year old. No. They have a different criteria. I am not sure how would they work on it, it's packaged and so on. That's another thing to consider. Like if you bought insurance at 20 year old, I presume YB you bought it when you started working or something, right? The thing is when you buy that insurance premium, you have to think 30 years, 40 years,*

50 years in the future and what is the medical needs in 40 years. Because now you buying what you think you can afford or what is the best in the market, right? Depending on your comfort and all that.

But it may not be enough at 30 years or 40 years because the cost have gone up inflation, all that...

Tuan Haji Azli bin Yusof [Ahli PAC]: *I was looking at the coverage. So, I think that coverage is enough for me. [Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Tharani Loganathan [UM]: *At that time.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *At that time.* Ya. *[Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Tharani Loganathan [UM]: *But in 40 years time, it's not. So, you think about it maybe like 10-20 years ago insurance premium in Malaysia they didn't cover, they only went up to 70 years old, you know. Now the new premiums go up to 100. Okay and that's actually should happen— anyway I think in Singapore, most countries' insurance goes up to 100. Why would you stop coverage at 70? That's when you need it the most right? 70 years old has the highest healtcare needs.*

Encik Azrul Mohd Khalib [Galen Centre]: Tapi, *therein lies the problem. If at the age of 60s, 70s suddently your premium is so expensive, can you afford? The answer is probably no because you stop working already. Maybe you retired* dan sebagainya. *So, your* duit pencen itu *goes to paying your insurance you know and this is where we also— the aging economy you know the aged population* yang *we always talk about. The cost of an aged person for healthcare is four times more expensive than a person who is in their 20s and 30s.* Kita kena *budget that in. The problem is that we don't. So, right now, we are seeing a situation where like what Prof said just now the time when you need the most is when you don't have the insurance.*

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *I would really like you all to think— I appeal to you all to think about social health insurance and bring MOH to hear about this because I think the solution needs to be broader than just looking at private health insurance. Social health insurance could cover the issue about private healthcare.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Prof, you familiar with the Australian health insurance? Is that similar?*

Prof. Dr. Tharani Loganathan [Universiti Malaya]: *I am not totally familiar. Each of the countries has a different sort of system, okay. So, some* ya.

Encik Azrul Mohd Khalib [Galen Centre]: *The best way forward for us is really to adopt and I'm sure the previous speaker who you've heard this morning we*

all disagree is to adopt National Health Insurance. I would actually say that we need to adopt a national health and social insurance where part of the income goes to health and the other part goes to aged care.

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Because right now, we have nothing budgeting for aged care. So, when we look at national health and social insurance, we have preparing for needs today and needs for tomorrow. The problem here is it's not popular. It's politically problematic. It's another form of tax, maybe. But you need to enact the law. How do you go about it?

So, there's a lot of complications for that. From— it takes years to introduce national health insurance. I think UK took— I think six years for their NHS, the national health insurance that they have and it has taken many years in other countries.

But, when you pair national health insurance dengan DRG, *you put them together, you have a good system. If you only have one, like just TRG, it won't work. The DRG is not the magic bullet, you know. It's not going to solve— It's not a* minyak urut *that's going to solve everything. It just won't. [Dicelah] It's just a tool.*

Tuan Sim Tze Tzin [Ahli PAC]: Tuan Pengerusi, *I think what we are having here is one root cause. The root cause is capitalism, excessive capitalism. Capitalism is involved in two healthcare, which is insurance as well as hospital.*

Azrul Mohd Khalib [Galen Centre]: *Free market.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, when those— This entity private hospital is listed, the insurance also is listed. They are chasing quarterly profit and then, that's where they are thinking how to make that— you know, to make it attractive to shareholders. So, how do they squeeze it? They squeeze maximize profit from healthcare. I mean, from the hospital, they squeeze every bit out of the patient. For insurance, they squeeze every bit out of your premium. So, that is the problem. Okay?*

When we continue with this system, it's never-ending because they will continue to pursue more profit. They put profit above your sick care-lah, *your patients. So, I think as long as we go this route, we will have this kind of problem all the time.*

Prof. Dr. Tharani Loganathan [UM]: *We will end up like America. America has the highest healthcare cost and they are just dependent on private healthcare insurance. They don't have social health insurance.*

The only social health insurance they have is Medicare. Medicare and Medicaid for older people. So, the rest is private health insurance and it's capitalistic. Okay? So, it's got the highest healthcare cost everywhere.

For Malaysia, we need to develop a system of our own. We cannot adopt from like Australia, Singapore and so on. Ya, we need to get something that works for our

country and our health system and our people. It doesn't need to be everyone has to pay for healthcare. I mean, the government's subsidy will have to come in as well, for the poor, for the B40 and so on.

Azrul Mohd Khalib [Galen Centre]: Puan Pengerusi, *I had a chance to talk about this issue* dengan *some Taiwanese experts last week in Penang. They had three people come down from Taiwan to share their experience in DRG and the system over there. I can tell you, for them* kan, *they* cakap dekat sana *is that they only have one boss, which is the national health insurance.*

They have a private hospital juga. *They have a public hospital* juga. *Everybody gets paid by the same single payer. So, you are all receiving the reimbursement*-lah *from the national health insurance.*

In Malaysia, kita banyak bos. *You know, too many bosses. So, the problem here is there is no incentive to move away from this system* sebab *I'm a pro-business guy. You know, I like capitalism. But, the fact is it's that the system that we have right now,* kalau kita nak *change it, we actually have to really change, you know. It has to be overhauled.*

One of the ways to do it is really introducing national healthcare insurance where everybody contributes. You know, using a means-tested sliding skill and the ones who are most poor get subsidised 100 percent, while everybody else pays a bit.

Right now, when we look at tax revenue, this is sebab dekat Malaysia, *we are tax derived funding for healthcare. About 2.6 million people pay tax out of the population of 16 million workers, out of a population of 33— 34 million people.*

So, the vast yang bayar *tax* ini memang tidak mencukupi untuk membiayai kesemua keperluan. *So, we have to find new ways of money. I know, the Ministry of Health is working with EPF right now, to see about can we add on or extract from EPF money to go for healthcare. But, you know the crisis situation in EPF right now,* kan?

I mean, 90 percent of the money in the EPF belongs to the 10 percent of [Tidak jelas] including myself. 90 percent of EPFs have less than RM10,000 in their savings. So, we cannot use EPF also because the tank is not as full as it should be. So, there are problems here. There is no quick solution, unfortunately. Sorry to be a little bit pessimistic but it is what it is.

Prof. Dr. Tharani Loganathan [UM]: *[Bercakap tanpa menggunakan pembesar suara] I mean, like for instance, EPF idea is like Singapore. They have a MediSave account, right? It's a medical savings account. They don't like the idea of— Singapore doesn't like the idea of solidarity and subsidizing other people with your own money. So, you save for your own healthcare expenditure. But, now they have*

medical health insurance as well, which is part of their packages. Malaysia, we have to look at our own situation and tailor according to our health system.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Terima kasih kepada kedua-dua *panelist* kita. *Thank you for your— you know, sharing with us. We will try our best. We will come out with some recommendations for the government. So,* mesyuarat prosiding kita tangguh pada pukul 4.36 minit. Terima kasih kepada semua. Yang Ahli-ahli PAC, minta *stayback.* Kita ada *discussion*.

[Mesyuarat ditangguhkan pada pukul 4.36 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Rabu, 26 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

Ejen Insurans (NAMLIFA)

(i) En G Saseedaran Gengadharan
Mantan Presiden

(ii) Encik Krishnan Appanu
Presiden

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK MESYUARAT JAWATANKUASA 1, TINGKAT 2 BLOK UTAMA BANGUNAN PARLIMEN, PARLIMEN Malaysia

RABU, 26 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Datuk Ali anak Biju [Saratok]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Puan Vivian Wong Shir Yee [Sandakan]

Tidak Hadir *[Dengan Maaf]*

YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat Jawatankuasa Kira-kira Wang Negara, Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam (JPA)

Muhammad Fikri bin Karmajaman [Ketua Penolong Pengarah (Bahagian Perkhidmatan)]

Kementerian Kewangan Malaysia (MoF)

Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan (Kawalan Kewangan Strategik dan Korporat)]
Ng Yee Hang [Pegawai Komunikasi (Unit Komunikasi Korporat)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)

PKPj Suzana binti Alias [Ketua Cawangan (Bahagian Penyiasatan Tatakelola)]

PKPj Tuan Mohd Shahril Che Saad [Bahagian Siasatan]

Kementerian Ekonomi (KE)
Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah Makro (Bahagian Industri Perkhidmatan)]
Puan Noor Diana Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)

Jabatan Akauntan Negara
Encik Mohd Nizrulizham bin Jamaludin [Akauntan (Bahagian Perkhidmatan Operasi Pusat dan Agensi)]

SAKSI

Ejen Insurans (NAMLIFA)
En G Saseedaran Gengadharan [Mantan Presiden]
Encik Krishnan Appanu [Presiden]
Encik Chew Siew Lay [Naib Presiden I]
Encik Nelson Tan [Timbalan Presiden]
Encik Jegatheesen a/l Elanchelian [Setiausaha Agung]
Encik Karunakaran a/l Muthu Veeran [Penolong Ketua Setiausaha]
Encik Danny Lim [Ketua Bendahari]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

RABU, 26 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 11.31 pagi

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
***mempengerusikan Mesyuarat**]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh*. Salam sejahtera serta selamat datang Ahli-ahli Yang Berhormat Ahli PAC Parlimen Kelima Belas, ahli-ahli ex-officio dari Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, Suruhanjaya Pencegahan Rasuah Malaysia, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen selaku wakil daripada AGC.

Yang Berhormat Ahli Mesyuarat sekalian, hari ini PAC akan mendengar keterangan dan juga penjelasan berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan Malaysia dan juga Bank Negara Malaysia. Ini adalah merupakan prosiding yang kelima diadakan bagi tujuan mendapatkan penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan juga caj hospital swasta. Ini termasuk kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan juga faktor luar seperti pandemik.

Ahli-ahli Yang Berhormat Mesyuarat sekalian hari ini hadir di hadapan PAC adalah Yang Berusaha Tuan Krishnan Appanu, Presiden Persatuan Kebangsaan Insurans Hayat Malaysia dan juga Penasihat Takaful Keluarga (NAMLIFA). Keduanya, Yang Berusaha Tuan Nelson Tan, Timbalan Presiden NAMLIFA dan juga ketiga Yang Berusaha Tuan G Saseedaran Gengadharan, Mantan Presiden NAMLIFA. Terima kasih saya dan juga PAC ucapkan kepada semua kerana sudi hadir di hadapan PAC bagi memberikan sedikit penjelasan kepada PAC pada hari ini.

Sebelum saya menjemput saksi untuk memulakan pembentangan dan juga memberikan penjelasan, saya ingin maklumkan kepada semua ahli mesyuarat

sekalian bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 [Akta 88] dan juga Peraturan Mesyuarat 85 sehingga prosiding selesai dan juga dilaporkan di Dewan Rakyat. Tanpa membuang saya dengan ini menjemput Yang Berusaha Tuan Krishnan Appanu untuk memulakan pembentangan. Dipersilakan. Tuan ada slaid ya? Okey dipersilakan.

Encik Krishnan Appanu [Presiden, Persatuan Kebangsaan Insurans Hayat Malaysia dan juga Penasihat Takaful Keluarga (NAMLIFA)]: Selamat pagi puan. Saya nak terus kepada penjelasan saya. Kami dari NAMLIFA. Kami ditubuhkan pada tahun 1978. Kami bukan sahaja mewakili *insurance agent*, kami juga mewakili pemegang polisi. Kami di sini sebab untuk menjelaskan pada PAC cadangan kami dan juga maklum balas daripada pihak kami.

Salah satu interim yang diluluskan oleh Bank Negara yang katakan kita akan adakan 10 *percent* peningkatan premium dari tahun 2004, 2005, 2006. Dalam peningkatan itu, kami nak dapatkan penjelasan yang tepat daripada pihak Bank Negara iaitu peningkatan itu adakah ia standard atau akan menaik mengikut premium yang sudah dinaikkan. Contohnya macam kalau mengikut apa yang pandangan kami, contohnya kenaikan premium— contohnya premium dia RM1,000 sebulan kenaikan pada tahun 2004 10 *percent*, kenaikan akan sepatutnya RM100. Tahun yang kedua kenaikan dia 10 peratus, adakah kenaikan itu akan *compound* jadi RM1,210 dan yang tahun 2006 adakah ia juga akan *compound* juga RM1,331? Dalam masa tiga tahun peningkatan mungkin— kami tidak pasti. Kami hanya nak beritahu kepada pihak puan, mungkin kenaikan akan 33.1 peratus ataupun dia tetap. Contohnya tetap *means* setiap tahun hanya RM100 akan naik.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ini soalankah apa?

Encik Krishnan Appanu [NAMLIFA]: Bukan soalan puan. Saya nak...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ini *your statement? [Ketawa]*

Encik Krishnan Appanu [NAMLIFA]: *Statement. Our statement here* puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Oh, your statement. Okay.*

Encik Krishnan Appanu [NAMLIFA]: Ya, sebab kami nak betulkan benda itu sebab pemegang polisi akan dikenakan bayaran— kami tidak pasti. Sebelah kami pun tidak pasti. Bahagian pemegang polisi pun tidak pasti. *So*, kami nak PAC mengambil maklumat inilah puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan, sebelum tuan *go further*, boleh jelaskan pada PAC dah berapa lama tuan memegang sebagai presiden dan juga timbalan presiden.

Encik Krishnan Appanu [NAMLIFA]: Saya jadi presiden pada tahun 2024 pada 1 Julai puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Apa kelayakan untuk membolehkan seseorang itu dipilih menjadi seorang presiden?

Encik Krishnan Appanu [NAMLIFA]: Sebelum kami jadi presiden, kami dipilih sebagai wakil *council member* sebelum itu. Selepas itu kami akan jadi *exco member.* Semuanya dalam bukan sahaja dipilih, kami akan di-***elect****… [Dicelah]* Kita punya *Annual Delicate Conference* (ADC).

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Di bawah persatuan ini mewakili— ada berapa banyak? Dia macam...

Encik Krishnan Appanu [NAMLIFA]: Ahli. Kami ada 12 cawangan dari *north* hingga *south* dan juga pada Sabah dan Sarawak. Kita ada 12 cawangan. Dalam setiap cawangan, kita ada juga c*ommittee member* dia punya *chairman*. Di *national* kami ada 15 *council members* termasuk saya... *[Dicelah]* Kami mewakili 120 ejen dekat luar.

Seorang Ahli: 120,000.

Encik Krishnan Appanu [NAMLIFA]: 120,000 puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: 120 sikit sangat. 120,000 baru betul. Okey. *[Ketawa]*

Encik Krishnan Appanu [NAMLIFA]: Kami hanya satu wakil dari bahagian ejen dan juga mewakili pemegang polisi berurus dengan LIAM dan juga dengan Bank Negara.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Teruskan.

Encik Krishnan Appanu [NAMLIFA]: Kedua puan, kami tidak kepastian tentang kadar kenaikan caruman yang bakal dikenakan selepas tahun 2026. Kita tahu yang 10 *percent* ini pada tahun 2004, 2005, 2006. Apa akan berlaku selepas 2027? Kita belum dapat kepastian. Angka pesakit di hospital kerajaan akan meningkat sebab tidak kemampuan. Ramai pemegang polisi bila dia luputkan polisi dia, dia tak ada *choice,* dia akan pergi kepada hospital kerajaan. Dalam masa yang sama, kos penjagaan kesihatan awam dijangka naik. Keyakinan masyarakat terhadap pengurusan kesihatan secara umum adalah tidak memuaskan.

Bukan semua pemilik polisi yang berumur 60 tahun ke atas dapat menikmati moratorium satu tahun yang diberi. Setiap syarikat mengenakan syarat yang

berlainan mengikut ciri-ciri produk masing-masing. Puan, sebagai contoh apa yang kami dapat maklum balas daripada ejen dan juga daripada pemegang polisi, moratorium yang diberi untuk yang berumur 60 tahun ke atas hanya untuk pelan yang paling terendah.

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Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh jelaskan dengan lebih *details*, contoh?

Encik Krishnan Appanu [NAMLIFA]: Contohnya, puan. Contohnya, kita ada *plan* katakan 500,000, 1 juta. Contoh ya, puan. 1.5 juta. Hanya untuk 500,000 sahaja diberi kecualian. Untuk satu tahun. Lain semua akan dikenakan kenaikan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Moratorium itu tak terpakai kepada pelan yang bernilai tinggi?

Encik Krishnan Appanu [NAMLIFA]: Tinggi.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, tanya sikit fasal *basic plan* itu kan*. Basic plan* itu. *What actually does it cover*?

Encik G Saseedaran Gengadharan [NAMLIFA]: Dia punya, *sorry*. Boleh saya.

Dr. Hajah Halimah Ali [Ahli PAC]: Ya, ya.

Encik G Saseedaran Gengadharan [NAMLIFA]: Okey, *basic plan* untuk *medical* ini dia, ciri-ciri dia begini. Ada tiga jenis pelan perlindungan kesihatan. *First is* sebagai *plan* yang dia kata *standalone* yang mana dia *cover* untuk *admission* sahaja. Kemasukan ke dalam wad sahaja dan *post-hospitalisation* dan *pre-hospitalisation* punya tuntutan *reimbursement*. Itu sebagai *medical card* yang *standalone*.

Satu lagi ialah *medical rider* yang disertakan dalam polisi insurans ataupun takaful hayat. Polisi insurans hayat ataupun takaful keluarga di mana *rider* itu pun memberikan perlindungan yang serupa iaitu kemasukan ke dalam wad sahaja dan kalau dia kata *outpatient* itu hanya untuk kes-kes melibatkan kemalangan, kecemasan dan dia ada had dia. Ketiga ialah perlindungan *medical* yang dijual oleh syarikat insurans am ataupun takaful am. Bukannya hayat ataupun takaful keluarga. Di mana perlindungan dia pun serupa. Semua *medical coverage* iaitu dia kepada *admission* dalam hospital ini. Ini ciri-ciri asas dia. Dia *basic feature of* a polisi *medical*.

Dr. Hajah Halimah Ali [Ahli PAC]: Dia *depends on the complexity*-kan *of their medical condition and the cost is according to* dia punya inilah *medical condition*.

Encik G Saseedaran Gengadharan [NAMLIFA]: *Condition*...

Dr. Hajah Halimah Ali [Ahli PAC]: *That's what I mean by my basic plan*. Maknanya, selepas lebih dari had itu dia kena bayar. *It's not covered by the insurance*. *So, what is the basic?*

Encik G Saseedaran Gengadharan [NAMLIFA]: Okey, kita *we are talking about the* had lah. Had, *limits*-kan. Kalau sekarang ini, ada had iaitu had tahunan. Had tahunan. Contohnya, had tahunan 500,000 setahun iaitu bil sehingga RM500,000 itu akan di-*cover*, dilindungi oleh polisi insurans tersebut. Kalau untuk jangka hayat sepenuhnya, tidak ada had. Ini ciri-ciri yang lazim dijual di Malaysia sekarang ini. *So,* kalau dahulu kalau pelan-pelan perubatan yang lama yang banyak terkesan sekarang ini disebabkan *repricing* ini, dia ada had tahunan dan juga had jangka hayat dan had jangka hayat itu adalah tiga kali had tahunan.

Contohnya, kalau had tahunan kalau polisi-polisi lama terutama sekali masyarakat senior yang amat terkesan dengan ini mereka telah melanggan polisi ini mungkin 20 tahun yang lepas, di mana had tahunan dia mungkin RM100,000 setahun. Jadi, ataupun RM70,000 ataupun RM80,000. Masa itu, had tahunan itu amat rendahlah bila mungkin 20 tahun lepas dan had jangka hayat dia ialah tiga kali had tahunan.

Katalah dia sudah habis had tahunan dia hari ini. Contoh, kalau had tahunan dia RM70,000 sekarang, dia pergi untuk satu *bypass* dan bilnya sampai ke RM80,000. Sudah mencecah RM70,000. Maka tahun ini, dia sudah tidak dilindungi lagi. Dia kena tunggu sehingga tahun hadapan untuk mendapatkan RM70,000 lagi *coverage* dia dan jumlah yang telah dituntut itu, ditolak daripada jumlah keseluruhan iaitu jumlah keseluruhan iaitu had jangka hayat itu.

So, ramai yang terkesan disebabkan dia punya jumlah sudah kurang dan premiumnya semakin naik. Ini satu fenomena yang amat merunsingkan. Sebab itu, kita bermesyuarat di sini. *So, I hope Dr. you are clear with this*? Okey.

Dr. Hajah Halimah Ali [Ahli PAC]: *So, you all life insurance* kan? *And health and medical* kan? Ada orang lain itu dia *just health insurance* kan. *It's not life* kan? *So*...

Encik G Saseedaran Gengadharan [NAMLIFA]: Dia *from health* dia *as I mentioned* tadi, *health standalone medical insurance* ini dijual oleh *life insurance company* dan juga *general insurance company*. *So*, dua-dua pun dia ada. *And all of them are facing the same impact.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya nak tanya berkenaan dengan nombor dua. Ketidakpastian tentang kadar kenaikan caruman yang bakal dikenakan pasca 2026. Sebelum ini, macam *you all, I mean*

being an NGO NAMLIFA. Pernah kah ada *engagement* dengan pihak Bank Negara Malaysia ataupun pertemuan ataupun perbincangan ataupun taklimat? Ada tak yang dibuatkan oleh Bank Negara Malaysia?

Encik Krishnan Appanu [NAMLIFA]: Sebelum ini Puan, kami memang ada perbincangan dengan LIAM dan juga dengan Bank Negara mengenai *repricing*.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Boleh kongsikan dengan PAC, bagaimanakah *engagement* yang sebelum ini telah dibuat di antara pihak Bank Negara, LIAM dan juga NGO dan apakah perkara-perkara yang dibincangkan dan apakah *outcome* hasil daripada *engagement* yang dibuat?

Encik G Saseedaran Gengadharan [NAMLIFA]: Dalam kami punya pembentangan ini yang kami kongsi dengan semua. *[Sambil menunjukkan senaskhah dokumen]* Memang dia telah cerita perkara ini. Tetapi, biar saya *recap* balik di sini ya.

Cerita *repricing* ataupun kenaikan premium ini bukan baharu. Ia bermula pada tahun sepatutnya kenaikan asal dia pada 2020 dan disebabkan pandemik, Bank Negara memutuskan untuk menangguhkan kenaikan ini selama setahun iaitu dia hanya boleh tangguh selama setahun. Dia bermula pada 2021 dan sebelum itu, kami sudah pun ada banyak siri-siri *engagement* dengan Bank Negara dan juga Persatuan Insurans Hayat iaitu LIAM berkenaan dengan kenaikan ini dan sudah pun menyuarakan apa yang kami sedang suarakan di sini masa itu pun. Di mana, *sustainability* untuk premium insurans itu dia kena pastikan tidak akan berulang lagi lah dia punya kenaikan itu.

Tetapi selepas itu, Bank Negara mengeluarkan satu polisi dokumen. Polisi dokumen *for medical health insurance* dan takaful. *So*, di dalam polisi dokumen itu, banyak perkara yang telah dijelaskan dan juga Bank Negara sarankan bermula 1 September 2024, produk-produk *medical* yang baharu itu mesti ada ciri-ciri perkongsian ataupun *co-payment*. *Co-sharing* bermaksud syarikat insurans akan membayar satu jumlah dan baki yang ada satu had yang kurang lah, pelanggan kena bayar. Dia kena tanggung. *Co-sharing. So,* sudah melaksanakan langkah ini, syarikat-syarikat insurans takaful terus menaikkan premium sekali lagi pada tahun 2024 hari itu dan kenaikan ini bukan bermula pada 2024. Dia bermula sejak 2021. Dia 2021 dia naik sikit. 2022 dia naik sikit. Lepas itu, 2023 kenaikan dia mungkin dia tunggu sebentar. 2024 naik balik.

Jadi, bila kita kata tentang ketidakpastian ini, baik sekarang ini sudah ada langkah-langkah interim yang bagi orang kata *capping* sebanyak 10 peratus satu kenaikan setiap tahun sehingga 2026. Okey, jadi sekarang ini maklum balas yang

kita terima daripada kami punya pelanggan-pelanggan kami. Bayangkan 120,000 orang kalau seorang itu ada 10 pelanggan macam mana? *[Ketawa] So*, daripada pelbagai lapisan.

Ketidakpastian dia ialah baik, sekarang saya boleh tahan sehingga 2026, bagaimana pula 2027? Jadi, ketidakpastian ini sebenarnya oleh semua pihak dan syarikat-syarikat insurans juga tidak boleh memberikan sebarang unjuran apakah yang akan berlaku 2027 ke atas itu.

Jadi, ini satu *feedback* yang kita kena bagi tahu di sini akan *the uncertainty* ataupun ketidakpastian yang sedang dialami oleh rakyat di luar sana.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Teruskan dengan pembentangan.

Encik Krishnan Appanu [NAMLIFA]: Pihak insurans dan juga pengurusan tertinggi syarikat insurans harus dipertanggungjawabkan kerana menjual produk yang tidak mampu bertahan kepada masyarakat umum. Sebab, setiap produk yang diluluskan telah dipastikan yang produk ini akan menahan untuk takat yang lebih panjang.

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Tetapi buat masa sekarang, dalam masa yang singkat, peningkatan itu berlaku dengan begitu cepat.

Had tahunan perlindungan *medical* yang tidak terkawal menyebabkan perlumbaan yang tidak sihat di kalangan syarikat insurans yang menyumbangkan kepada kenaikan bil hospital. Sebagai contohnya puan, dulu kita ada had tahunan dia RM100,000. Lepas itu, jadi RM500,000 dan tiba-tiba had tahunan dia, *medical bill* menjadi RM1 juta. Sekarang, dah jadi RM3 juta dan yang *latest* dah jadi dekat RM8 juta.

Apa yang kami risau, bila syarikat tidak dapat menguruskan. Bila seseorang itu ada had yang paling rendah pun tidak boleh uruskan, macam mana pula mereka beri perlindungan yang lebih? Bagaimana mereka akan menguruskan benda itu? Dalam masa yang sama, kami juga nak hospital yang disenaraihitamkan. Contohnya, ada sebab-sebab dia tidak jadi panel kepada syarikat, mana-mana syarikat itu harus disenaraihitamkan oleh semua syarikat insurans.

Tuan Haji Azli bin Yusof [Ahli PAC]: Tuan Krishnan, boleh saya tanya? Sepanjang penglibatan tuan dalam menguruskan insurans dan melakukan *claim*, *reimbursement* dan sebagainya, ada tak tuntutan-tuntutan yang mencapai kepada tahap yang *exorbitant* itu? Maksudnya, yang *more than RM1 million, RM2 million* apa

semua itu ataupun *this is just* macam umpan sahaja tetapi sebenarnya tidak berlaku pun? Ada pandangan?

Encik G Saseedaran Gengadharan [NAMLIFA]: Itu yang kami— itulah kami kata, ia lebih kepada umpan. Saya rasa kalau kita tukar otak, tukar paru-paru kita, tukar jantung kita, tukar semua pun, tak sampai RM1 juta. Tetapi, had tahunan sampai RM10 juta sekarang. *It's* perlumbaan yang sebenarnya nak mengumpan. Apa yang tuan kata itu memang kami setuju. Umpan, untuk mendapatkan perniagaan. Itu sahaja.

Encik Krishnan Appanu [NAMLIFA]: Contohnya tuan, kita bagi RM500,000 limit dia dan lagi satu RM10 juta kepada hospital. Kita bagi *credit card* kepada dia untuk menguruskan apa dia nak buat. *So*, bila dia punya limit tinggi *and* hospital ada cara dia nak uruskan apa sahaja dia nak buat.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tapi kan *you all* punya persatuan ini adalah Persatuan Kebangsaan Insurans Hayat Malaysia. Maksudnya, *you all* kan macam terlibat juga dengan perlindungan semua. Betul?

Encik Krishnan Appanu [NAMLIFA]: Tidak, puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Dia *different*?

Encik Krishnan Appanu [NAMLIFA]: *Different.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh jelaskan tak? Boleh jelaskan tak *the differences* apa yang ada pada *you all* punya...

Encik G Saseedaran Gengadharan [NAMLIFA]: Boleh ulang balik soalan tak? Perlindungan? Apa beza?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. *You all* punya persatuan ini adalah Persatuan Kebangsaan Insurans Hayat Malaysia?

Encik G Saseedaran Gengadharan [NAMLIFA]: Insurans hayat dan takaful keluarga.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Takaful keluarga. *So*, maksudnya ia juga ada perlindungan *medical*?

Encik G Saseedaran Gengadharan [NAMLIFA]: Kami persatuan...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tahu.

Encik G Saseedaran Gengadharan [NAMLIFA]: ...Yang mewakili semua syarikat. *I mean*, saya satu syarikat. Semua daripada berlainan syarikat.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, faham.

Encik G Saseedaran Gengadharan [NAMLIFA]: Kami memang memasarkan produk-produk *medical* ini.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey...*[Dicelah]* Ejen. Tetapi, bila yang nombor lapan ini, bila nombor lapan ini berlaku, apa— daripada pihak *you all* apa intervensi yang dilakukan?

Encik G Saseedaran Gengadharan [NAMLIFA]: Kita telah memberikan *feedback*, bukan sekali atau dua kali kepada Bank Negara mengatakan benda ini perlu dibendung sebab tak praktikal. Hanya kerana dia bagi had tahunan yang begitu tinggi untuk mendapatkan perniagaan, tetapi ianya tidak praktikal. Kami telah beritahu Bank Negara dan Bank Negara mengatakan mereka tidak boleh mengawal sebab ini adalah keputusan-keputusan komersial yang di mana Bank Negara tidak boleh mencampuri urusan mereka. Itu satu.

Keduanya, saranan kami untuk membentuk banyak pilihan-pilihan produk. Itu Bank Negara telah terima di mana di dalam polisi dokumen yang telah dilaksanakan tahun lepas, dia telah disarankan supaya semua syarikat memiliki lebih daripada satu pilihan produk kesihatan di mana masyarakat boleh pilih mengikut kemampuan. Ini baru sedang bermula.

Tetapi, kalau kita sudah biasa melihat angka yang besar di mana kita selalu jual minimum had tahunan RM1 juta, kita tidak ada apa-apa yang sebelum itu. Kita tidak ada pilihan. Minimum RM1 juta kita jual. Sekarang tiba-tiba kita patah balik mengatakan minimum sekarang RM500,000 pun ada, kan?

Jadi, produk-produk yang sebegitu kami tidak pasti sama ada begitu laris ataupun tidak sebab masyarakat sudah biasa melihat angka RM1 juta itu. *[Ketawa]*

Encik Krishnan Appanu [NAMLIFA]: Caj-caj bukan profesional yang tidak dikawal harus diaudit, puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh *explain more on this*?

Encik G Saseedaran Gengadharan [NAMLIFA]: Yang kita faham, terdapat dua jenis caj. Satu ialah caj profesional iaitu caj-caj doktor yang dia memang *regulate*. Tetapi caj *non-professional fee* iaitu caj hospital dan perubatan, ubat, ia tak dapat di-*regulate*. *So... [Ketawa]* Jadi, kita faham masalahnya lebih cenderung kepada dari mana.

So, pihak hospital dia nak *justify* dia punya sebab kenapa kenaikan begitu tinggi sekali. Dia kata, kalau dibandingkan bil-bil ataupun caj hospital swasta di Malaysia dengan caj-caj hospital di serantau Asia di sini, kita antara yang masih bagus lagilah. Masih rendah, dia kata. Sebab itu kita punya *medical tourism* pun sedang naik. Jadi, itu justifikasi dia.

Satu lagi ialah iaitu *approach* yang dia kata *comprehensive treatment*. Bila seseorang itu pergi ke hospital untuk dapatkan rawatan, maka hospital dia kata dia nak *check* semua sebab kadang-kadang sekarang ini *very complicated* punya era di mana banyak jenis virus yang kita tak kenal pun masih sudah ada dan pihak hospital akan melakukan *comprehensive* punya diagnosis. *So*, di mana mungkin si pesakit itu pun mahukan yang sebegitu.

Jadi, disebabkan semua sebab ini, bilnya akan naik. Kadang-kadang dua hari sahaja sudah capai RM19,000. Jadi, kita lihat di sini kalaulah kos-kos yang dikatakan sekarang ini tidak diaudit, jadi saya rasa tidak ada kesudahan lah tentang kenaikan caj hospital yang melambung tinggi selalu. Itu maksud kami di sini. Caj-caj ini harus diaudit.

Encik Krishnan Appanu [NAMLIFA]: Kos ubat serta farmaseutikal haruslah diseragamkan dan fasiliti tanpa tunai harus ditawarkan kepada hospital awam seperti hospital swasta.

Tuan Sim Tze Tzin [Ahli PAC]: Tolong jelaskan apa maksud yang nombor 12.

Encik G Saseedaran Gengadharan [NAMLIFA]: Okey. Sekarang ini, apabila seorang pemegang kad perubatan dimasukkan ke hospital swasta, syarikat insurans akan mengeluarkan *guarantee letter* iaitu surat jaminan untuk menjamin bil itu. Tetapi, ramai tidak tahu *medical insurance* ini juga boleh digunakan di hospital kerajaan iaitu bayar dan tuntut.

Contohnya, saya bagi contoh. Dia tukar tempurung lutut. Dia sebenarnya boleh ke hospital kerajaan, dapatkan rawatan, dia bayar untuk yang tempurung lutut itu. Kemudiannya, bila dikeluarkan dari— bila dia *discharge* dari hospital itu dia akan datang ke syarikat insurans untuk membuat *reimbursement* ataupun tuntutan.

Apa yang kita dengar daripada masyarakat di luar sana, ini maklum balas ini. Dia kata, "*Alangkah baiknya kalau syarikat insurans dan juga pihak MoH boleh memberikan cashless ataupun guarantee letter itu untuk mereka dapatkan rawatan di hospital kerajaan".* Contoh macam tempurung tadi, dia pergi dapatkan *guarantee letter* dari syarikat insurans dan juga kos yang dicaj oleh hospital awam sudah tentu tak boleh dibandingkan dengan hospital swasta.

■1200

Jadi, dengan ini dia boleh membantu mengurangkan jumlah tuntutan yang total dia itu. Itulah kami punya *feedback*. Dari sini, kami juga akan berkongsi tentang saranan kami. Apa yang NAMLIFA sebagai persatuan kebangsaan yang mewakili

kepentingan warga agensi dan juga pelanggan-pelanggan kami, apakah saranan kami.

Baik, kalau tuan-tuan lihat di skrin, ini saranan daripada NAMLIFA selepas mengambil kira banyak *feedback* daripada masyarakat dan juga selepas kami berbincang, buat perundingan di sini, berunding di pelbagai tahap. Saranan kami ini lebih ditujukan kepada mengukuhkan *healthcare* penjagaan kesihatan awam.

Itu kami punya saranan. Lebih kepada— kalau *public healthcare* ini, dia boleh menampung. Jadi, saya rasa yang swasta ini tidaklah— apa orang kata dia punya perbandingan itu. Tuntutan daripada swasta ini boleh dibendung sedikit. Sebab bila kita pergi ke hospital kerajaan dan pada masa yang serupa, hospital kerajaan ini dia juga menggunakan pelindungan insurans.

Jadi, saranan kami ialah nombor satu, skim pelindungan perubatan untuk setiap rakyat Malaysia. Macam sosial insurans untuk rakyat Malaysia, contohnya. Di mana had pelindungan rawatan kemasukan tahunan harus mampu menampung kos jenis rawatan standard MOH. Ada rawatan standard yang contoh *appendicitis*, contohnya ataupun pembuangan *fibriod*, contohnya.

Jadi, dia had pelindungan rawatan itu. Apa yang dibagi, contohnya dalam *medical national healthcare, whatever name* kita boleh bagi, skim insurans sosial ini. Katalah tahap tahunan dia bagi RM50,000 atau RM100,000. Kalau sesiapa yang mahukan lebih daripada itu, mereka boleh melanggan ataupun memiliki insurans perubatan persendirian. Itu saranan kedua.

Ketiga, pelindungan ini sah digunakan di hospital awam dan juga di swasta. Kalau ada skim *national healthcare*, contohnya, *national health policy*, di mana dia boleh pergi ke hospital swasta dan juga ke kerajaan. Itu dua-dua tempat di boleh guna.

Nombor empat, mekanisme caruman premium ataupun sumbangan boleh ditentukan oleh pihak kerajaan sendiri. Itu memang dia ada perkiraan *actuarial* di mana kita bagi saranan secara am tapi mekanisme dia itu, *only the experts can determine*.

Lepas itu nombor lima, had umur maksimum kelayakan memasuki skim ini boleh ditentukan oleh pihak pengunderaitan yang dipertanggungjawabkan. Itu pun pihak kerajaan boleh *determine by yourself.*

Nombor enam, kelayakan memasuki skim ini adalah tanpa pengesahan kesihatan serta melindungi penyakit dan status kesihatan semasa ataupun *pre-existing illness.* Maksudnya, *pool* ini *it's very big pool* iaitu dia punya *exposure* ini besar. Di mana kalau kita ada satu tabungan yang sangat besar dan ia diurus

contohnya menerusi macam satu konsortium contohnya, ia boleh membantu mengurangkan ataupun mengagihkan risiko itu sama rata di mana dia punya kos itu boleh *sustain*. Itu maksudnya. Kita kata *we need a very big pool for this*. Kelayakan memasuki skim ini adalah tanpa pengesahan kesihatan serta melindungi penyakit dan status kesihatan semasa.

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya. *That means it's all ages?* Daripada *babies* sampai ke warga emas, *everybody*?

Encik G Saseedaran Gengadharan [NAMLIFA]: Kalau kita pergi ke nombor lima tadi, had umur maksimum kelayakan memasuki skim ini boleh ditentukan oleh pihak pengunderaitan yang dipertanggungjawabkan. *So,* yang itu sudah perkiraan *underwritting* di mana saya rasa kami tidak ada kelayakan nak cakap pasal benda itu *because* yang ini untuk *actuarial* punya *calculation.*

Kalau kita kata kita buka *medical coverage* ini, *special medical coverage* ini untuk orang yang berumur 80 tahun. Mungkin kosnya kita tidak tahu, kan? Tapi mereka yang tidak dapat dilindungi dalam skim ini sudah tentu status quo, apakah *treatment* yang mereka dapat daripada hospital kerajaan seperti sekarang ini dia sedia maklum, dia macam sekarang. Ini khas untuk insurans sahaja di mana pihak *actuarial* ataupun pihak *underwriters*, mereka boleh tentukan had umur maksimum. Had umur minimum tak perlu tentukan. Ia memang daripada *one-day-old baby.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Do you have— what reference do you have* yang dah ada? Yang dicadang ini, ada sistem *anywhere that you are referring to specifically?*

Encik G Saseedaran Gengadharan [NAMLIFA]: Ya. Sistem yang sedang dipraktikkan di Taiwan di mana kepadatan penduduk Taiwan itu lebih kurang macam Malaysia, *population* dia itu. Tetapi dia ada satu macam *national healthcare scheme,* ciri-ciri dia macam yang kami ceritakan tadi. Sebenarnya kami ambil contoh dari Taiwan. Tapi dia punya umur had maksimum maklumat itu tidak ada. Sebab ia terpulang kepada dia punya— macam kita punya jangka hayat kita. *Our life expectancy* dekat Malaysia ini, *it all depends.* Kita punya *risk exposure* dan statistik kita itu. *That* yang dia boleh *determine* oleh kita punya *actuarial* di mana *what is the maximum age capping* yang dia boleh gunakan untuk skim yang kita sarankan ini. *All these mechanisms* ini boleh di-*construct*, yang kita cerita sekarang ini konsep.

Satu lagi, semua hospital swasta wajib menyediakan jumlah katil mengikut kapasiti masing-masing untuk peserta skim ini dengan kos rawatan yang telah ditetapkan. *Something very near to DRG. So, di* mana kalau seseorang itu memiliki kad perubatan— katalah *national healthcare* kah, *national insurance* kah, *whatever*

name that it can be coined-lah kan*,* kalau dia pergi ke hospital swasta, *depends on the capacity* hospital itu, *certain percentage of the* katil itu, dia kena untuk mereka yang memegang kad ini dan dia punya *charges* itu *must be very controlled* ataupun dia memang sudah ada *scheme chargers* ini, anggaran dia.

So that, kalaulah pelindungan ini, had tahunan dia contoh, contoh RM50,000 saja tapi dia pergi hospital swasta, satu hari RM50,000 itu boleh sapu. Jadi, kalau dia pergi ke hospital swasta tapi untuk *charges* dia itu mesti *something that exactly* macam *government* punya *charges* itu.

Kami, *we are very sure*, kalau kita sudah ada satu konsep yang sebegini *and then* dia punya *costing*, cara dia, *mechanism* dia, dia punya *operational* dia semua itu, *it's a happy problem for everyone to do. So, this is our concept that we would like to share.* Konsep yang kami nak kongsi dengan pihak PAC hari ini.

Ini saranan kami. Kami juga ada *wishlist* untuk masyarakat kita iaitu hasrat kami, NAMLIFA punya hasrat *for the sake of our aging population* ini. Nombor satu, kami sedia maklum Kertas Putih yang dibentangkan di Parlimen tahun lepas kalau tak salah kami iaitu *on the public healthcare* punya kertas putih untuk *public healthcare.* Komitmen kerajaan untuk menjayakan kertas putih itu yang dibentang. Dalam kertas putih itu banyak disebut tentang memantapkan lagi mutu dan kapasiti hospital kerajaan. *So,* ini hasrat kami.

Nombor dua ini, meningkatkan kapasiti serta mutu perkhidmatan penjagaan kesihatan di setiap hospital awam. Daripada masalah ini, kita tahu penjagaan kesihatan hospital awam di Malaysia ini *it's still very much better* kalau nak bandingkan dengan banyak hospital di negara-negara maju pun, *we are still very good.* Nak banding dengan US kah, UK pun— siapa nak masuk nak jumpa doktor, boleh jumpa doktor. Bukan macam di negara-negara maju yang lain. Tapi kita antara yang bagus. Tapi masalahnya ialah kapasiti sekarang ini semakin berkurangan. Dari segi *professional capacity,* dari segi dia punya *housing offer,* dia punya *manpower*, banyak yang sedang kekurangan itu. Jadi, kita harap *at least* boleh menambah baik perkara ini.

Nombor tiga, membina hospital awam berkapasiti tinggi. Jadi, kita haraplah aktiviti ini boleh dipercepatkan di mana *priority* kepentingan awam itu lebih kepada penjagaan kesihatan yang lebih baik. Nombor empat, menaik taraf hospital yang sedia ada. Nombor lima, rakyat mendapat khidmat penjagaan kesihatan bermutu tinggi di hospital awam.

■1210

Nombor enam, khidmat penjagaan kesihatan awam yang mampan dengan gandingan khidmat penjagaan kesihatan swasta dengan kos yang munasabah untuk seluruh rakyat Malaysia.

Jadi ini kami punya *wishlist,* hasrat kami. Sekiranya ada sebarang soalan, mungkin pihak kami akan cuba sedaya upaya untuk memberikan jawapan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan, hari itu tuan datangkah masa pendengaran awam di Parlimen Malaysia?

Encik G Saseedaran Gengadharan [NAMLIFA]: Ya?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan hari itu hadir tak dekat pendengaran awam di Parlimen?

Encik G Saseedaran Gengadharan [NAMLIFA]: Tidak. Kami diberikan *appointment* hari ini.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ada hantar wakil? Ada hantar wakil untuk mendengar?

Encik G Saseedaran Gengadharan [NAMLIFA]: Ada ejen yang datang.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tapi, tuan dapat maklum balaslah daripada ejen tersebut tentang apa yang berlaku pada hari itu?

Encik G Saseedaran Gengadharan [NAMLIFA]: Ya.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ada.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Datuk Wira Pengerusi, saya ingin minta pandanganlah, *what is your views* fasal naratif hospital swasta ini yang dikatakan *overcharge* lah?

Seperti yang kita sedia maklum bahawa *this private hospital is business entity* lah. *Of course, their priority number one is to make money. Number two is to provide medical service. Am I correct or not? So,* oleh sebab itu, maka dia punya *top management* akan menyediakan satu *sales target. Maybe daily sales target or monthly or annually. Therefore, you must— today you must achieve this kind of sales target,* contohnya. *Therefore, all these medical providers* yang berkhidmat di sana akan memastikan supaya *that to achieve a certain target per day.*

Naratif di luar sana mengatakan bahawa mereka akan melakukan pelbagai *non-medical chargers* ataupun *some medical tests, procedures* dan sebagainya yang mungkin tidak perlu tetapi terpaksa dilakukan untuk mencapai *sales target* harian ataupun bulanan tersebut. Jadi oleh sebab itu, bila kita lihat dia punya *itemised bill* itu tadi memanglah kita tahu bahawa profesional ataupun *chargers by that specialist*

memang tak banyak *because that one is* dipantau tapi yang lain-lain itu memang tidak ada dihadkan.

So, that is where they charge even di *[Tidak jelas] syringes, they can charge up to RM20 whereby one box is almost RM20. You know gauze also, is talking about RM20 this kind of thing* tapi harga satu bungkus itu mungkin RM20. *Even gloves, they charged one pair is about RM20* tapi sekotak *glove* itu hanya RM14. *So, these kinds of chargers. What is your* pandangan dan *view you see? True or not this kind of thing happened?*

Encik G Saseedaran Gengadharan [NAMLIFA]: Pandangan kami memang konsisten iaitu caj-caj *non-professional fees* ini, *must be audited. Exact example* yang tuan berikan tadi ya. Macam kalaulah mereka itu adalah *paying patient* iaitu mereka yang membayar sendiri, mereka punya bil itu adalah rendah kalau dibandingkan dengan mereka yang menggunakan insurans perubatan. Ada juga perbezaan sehingga sampai 40 peratus beza dia.

So apabila mereka yang membayar itu secara terus, kami pernah ada *experience—*

pengalaman ini di mana mereka kena pergi *bargain* dengan pihak hospital untuk mengurangkan ataupun mengeluarkan caj untuk membatalkan caj itu macam—seperti yang tuan kata tadi, *gauze* lah. Sekarang ada *nursing chargers* pun yang akan berjalan setiap hari. *Nursing chargers.* Kita tahu sebab memang *manpower* pun dekat hospital, kepakaran *manpower* dari segi *nurses* punya kapasiti pun dah kurang jumlah dia. *So, we understand the problem* tetapi mesti ada imbanganlah iaitu *your socialist approach and the capitalism approach* lah kan.

So, pihak hospital itu macam tuan kata tadi dia ada bagi *sales target. It is very difficult to speak and accuse* kan. Tapi memang kita tahu kalau doktor itu, kalau boleh dia nak buat banyak *test.* Tapi pada masa ini, ada satu perkara yang baik juga sedang berlaku sekarang ini. Sebarang *test* yang dia nak buat, kalaulah untuk yang menggunakan kad *medical,* dia kena buktikan kepada syarikat insurans dengan maklumat yang secukupnya bahawa *test* itu perlu. Kalau tidak, insurans takkan *cover.* Perkara ini sedang berlaku.

Bukan itu sahaja, pada masa ini, syarikat-syarikat insurans selepas banyak yang kita bising-bising sekarang ini, syarikat insurans sudah mula melaksanakan satu lagi iaitu dia buat *estimated length of stay* iaitu dia jangkakan, dia profesional ataupun *specialist* itu harus memberitahu syarikat insurans, kalau untuk penyakit dan rawatan yang sebegini, lazimnya berapa hari *patient* itu harus duduk dalam wad. Kalau lebih daripada itu, dia kena dapatkan *permission* daripada syarikat insurans

dulu. Dia kena buktikan pada syarikat insurans yang *patient* itu harus duduk lama lagi. *So, controls* sebegini sudah mula sebenarnya. Tetapi *it should've been done long ago.*

Tapi yang kita nak *balance* itu ialah *consumer* itu *not*— dia tak dapat dia punya *benefit.* Hanya kerana syarikat insurans terlalu konservatif, konsumer tak dapat *benefit* dia. hanya kerana hospital mungkin keuntungan dia, dia lebih peka kepada keuntungan dia, *insurance is overcharge.* Jadi di sinilah kita lihat bagaimana peranan yang boleh dimainkan oleh MOH. Memang kita harap MOH boleh buat benda ini. *So,* tidak menafikan dan juga memberitahu apakah langkah-langkah yang mereka sedang lakukan sekarang untuk membendung perkara ini.

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya *something technical* kan. *So, you said the hospital, doctors have got to convince the insurance people that they need a list of procedures. How do they do it? What is the time limit that you giving them so that they can communicate effectively* sementara *patient* itu sakit? *Kut, kut* dia nak pecah— *appendicitis* itu nak pecah dah. Elok-elok *very simple* apendiks, dia jadi *already infected, perpetrated and all that because of all the complications.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *I will explain to you. Quite details [Ketawa].*

Okey, dia punya *flow,* apabila seseorang itu *admitted,* sepatutnya hospital itu terus— *they sent request for admission* itu di mana doktor itu akan *diagnose and propose treatment* dia dan apakah *whatever diagnosis related and treatment related* punya prosedur itu dia akan hantar. *The turnaround time of insurance company,* kalau tidak ada sebarang *question, no further*— kalau tidak ada sebarang *ambiguity* kan, *very straight forward, the turnaround time* biasanya maksimum *45 minutes.* Itulah *turnaround time, internal turn round time by insurance company* dan dia akan keluarkan...

Dr. Hajah Halimah Ali [Ahli PAC]: *24 hours. Because* kalau *emergency* pukul 3.00 pagi...

Encik G Saseedaran Gengadharan [NAMLIFA]: *45 minutes* itu *turnaround time.* Tetapi katalah bila syarikat insurans menerima laporan itu tak lengkap di mana dia mahukan maklumat tambahan dan dia hantar balik kepada hospital. Dia kata kita perlukan *further information* kan, mungkin masa itu doktor itu sudah balik rumah ataupun dia tengah buat *operation. Patient* ini— kalau sesetengah *patient they said, "Nevermind. Treat me whether insurance covers or not. I need the treatment". Emergency* kan. Sesetengah pula dia tunggu. *This is where we find that* sepatutnya dia dapat terima ini. Dia tak dapat *because waiting for clearance* dari *insurance*

company then insurance company, they turn around time itu *is not supposed to be very far.*

Ada juga GL yang dia *request,* dua hari selepas *patient* masuk hospital. Dia mulakan *treatment* dulu, bila nak *discharge*, baru minta GL sehingga itu syarikat insurans pun tidak tahu yang ada pelanggan dia sudah masuk hospital. Pernah juga macam itu.

So, there are situations yang mana *if*— tidak ada *ambiguity, turnaround time* dia *is very fast. Within half an hour, 45 minutes* dia bagi. *If* ada *further enquiries, the doctors must be convinced.* Contoh ya, contoh. Kalau ada satu prosedur yang mana sebenarnya *daycare* pun boleh buat. Kata contoh, dia ada satu *bleeding* dalam *nose* dia itu. *So,* dalam *daycare* pun dia boleh buat itu tapi dia kata dia nak *admit patient* itu sebab dia nak buat banyak prosedur. *So, the insurance company will ask you to qualify your statement* itu. Kalau tak boleh, dia kata *you pay and claim because you* tak boleh *convince*. Benda yang boleh dibuat *daycare* itu *you* nak masuk *admission* pula.

■1220

So, it all depends on apa dia punya *ailment* tu, *what is the diagnose and what are required for the insurance company to make an immediate decision tau.*

Tuan Sim Tze Tzin [Ahli PAC]: YB...

Dr. Hajah Halimah Ali [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] We are talking about after or office hours?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Yes. The third-party administrator works 24 hours.*

Dr. Hajah Halimah Ali [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] 24 hours?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Yup.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, terima kasih. Saya nak tanya tentang *very technical* lah ya. *Number one, what's the difference between guarantee letter and pay-and-claim?* Sebab tadi *from your case*, dia tidak dapat *guarantee letter* tetapi lepas itu, dia boleh *pay-and-claim*. Sama juga datang daripada syarikat insurans. *So, what is the difference?* Kenapa ada perbezaan sebab kita nampak Bank Negara pun katakan ada perbezaan. Contohnya, pneumonia. *Pay-and-claim*, bayar RM1,200. Tapi *guarantee letter* hospital swasta *charge* RM5,000. *That's a difference four times.* Kenapa?

Encik G Saseedaran Gengadharan [NAMLIFA]: Ya. *True. When insurance company provides guarantee letter, the charges as we are told* yang kita faham, dia

bagi *maximum charges that* hospital itu sudah pun *they gazetted maximum rate. So, patient don't pay, insurance company will pay later. So,* mungkin dia ambil kira tempoh masa yang dia menunggu untuk dapatkan duit dari syarikat insurans kah apa, sebab itu dia *charge* maksimum.

Tapi pada masa yang serupa, kalau *paying patient. Patient* itu bayar dari poket dia, sudah tentu kos dia lebih rendah daripada apa yang syarikat insurans yang akan bayar. *So,* RM1,200 sahaja. *Pay-and-claim*. *So,* ada situasi di mana syarikat insurans tidak memberikan *guarantee letter* tetapi kata *pay-and-claim* disebabkan kemungkinan ia nya adalah *pre-existing* iaitu penyakit yang sedia ada ataupun dia tidak memberikan maklumat yang jelas tentang penyakit dia apabila dia mengambil insurans masa itu.

Jadi, dia dilindungi tetapi dia diminta untuk bayar dahulu, kemudian *claim* dari syarikat insurans. *So,* ada bezanya. *As I mentioned just now*, dekat *40 percent* ada beza. Biasanyalah.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Pengerusi. Sekarang NAMLIFA ini adalah ejen kepada syarikat-syarikat insurans. Jadi, dia orang banyak *dealing* dengan syarikat insurans. Sekarang, isunya adalah syarikat insurans juga dia dilihat bahawa *excessive profiteering* lah. Maksudnya, dia ada banyak yang menyebabkan kenaikan kos harga— *this premium insurance.*

Jadi, daripada perspektif NAMLIFA, apakah yang *insurance company* perlu buat untuk mengurangkan kosnya supaya dia boleh *sustainable* dia punya *pool,* dia *sustainable* dan premium tidak akan naik mendadak.

Encik G Saseedaran Gengadharan [NAMLIFA]: Okey. Kalau kita lihat sekarang ini, banyak produk *medical* yang sudah tidak dijual lagi tapi masih boleh digunakan lagi. Dia *migrate* dari satu *plan* ke *plan*— contoh ya, saya bagi contoh. Katalah syarikat insurans ini ada pelan A. Pelan A yang mana had tahunan dia, contoh ya, *example* RM100,000 setahun. Sekarang dia punya *sustainability*, dia tak boleh tahan lagi produk ini. Syarikat insurans kata nak naikkan premium sebab ramai yang *claimed* daripada tabungan ini, *pool* ini.

Jadi, dia akan keluarkan pelan B. Apabila dia perkenalkan pelan B, dia memberikan peluang ataupun dia menjemput mereka-mereka yang dalam pelan A itu yang masih sihat ataupun belum buat sebarang tuntutan lagi untuk *migrate,* hijrah kepada pelan B. Apa yang berlaku ialah di pelan B ini, premiumnya serupa, *the premium is the same.* Tetapi, dari sini RM100,000, sini mungkin RM1 juta pula. Tabungan yang RM100,000 itu dia kata kena naikkan premium dan mereka yang

sihat dalam tabungan ini akan dijemput untuk mengambil pelan B yang mana *annual limit* dia, *limit* tahunan dia jauh lebih tinggi.

Jadi, mereka semua *migrate* ke pelan B. Siapa yang sekarang tertinggal dalam Pelan A? Semua yang sakit. Jadi, ini menjadi satu *pool, a pool which has very high claim ratio.* Sekarang ini, banyak *pool* macam ini dalam syarikat-syarikat insurans. Salah satu saranan kami ialah *all this we said,* katalah *unperforming pool* kah atau *high claim ratio pool* lah, satukan semua dalam sebarang bentuk *actuarial* yang dia boleh. Bila satukan semua, *the pool is spread bigger,* lebih besar. Jadi, kemungkinannya, kenaikan itu tidak macam apa yang kita *experience* sekarang.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Adakah cara ini sudah dilaksanakan?

Encik G Saseedaran Gengadharan [NAMLIFA]: Tidak.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tidak ada?

Encik G Saseedaran Gengadharan [NAMLIFA]: Belum lagi.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Sebab mustahil?

Encik G Saseedaran Gengadharan [NAMLIFA]: Tapi kami dapat maklumat daripada LIAM, mungkin itu pun mereka akan sarankan kepada syarikat-syarikat insurans lah. Itu kami tidak tahulah.

Tuan Sim Tze Tzin [Ahli PAC]: Adakah yang *high claim ratio pool* ini dia akan ditutupkan kalau satu hari dia tak *sustain* lagi lah, dia *bankrupt* lah kata *pool* itu. Akan dia ditutupkan *pool* itu ke? Boleh? Tak boleh?

Encik G Saseedaran Gengadharan [NAMLIFA]: Setakat ini belum, tidak ada lagi. Masa depan kita tidak tahu. Itulah kita kata tadi, ketidakpastian. *The uncertainties are very high because of all these factors.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kuala Pilah?

Dato' Adnan bin Abu Hassan [Ahli PAC]: Terima kasih, Yang Berhormat *Chairman.* Soalan saya adalah kepada persatuan. Apakah pendirian dan pandangan persatuan yang berkaitan dengan pengenalan DRG? Terima kasih.

Encik G Saseedaran Gengadharan [NAMLIFA]: Okey.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Diagnostic-related group.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *It's a very good way forward* sebenarnya. *In fact,* DRG ini sesuatu yang dekat dengan DRG telah pun disebut di dalam polisi dokumen MHIT oleh Bank Negara tahun lepas iaitu *shared information*. Maklumat itu dikongsi tentang bil ataupun caj-caj dan kos-kos pelbagai jenis rawatan dan *procedures* dan mereka boleh— syarikat-syarikat insurans itu dia

boleh memantau ataupun membuat perbandingan antara caj-caj ini di kalangan semua syarikat insurans. Sekiranya ada hospital yang caj lebih tinggi, mereka boleh gunakan maklumat ini untuk membuat— adakan *limit* lah ataupun mengehadkan caj yang dibuat oleh hospital itu. *So, DRG is a way forward* bagi kami.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau boleh saya tanya. Bank Negara telah keluarkan arahan pada Januari 15 dah. Maksudnya, apa *certain things* lah. *Number one, 10 percent* had. Kedua, adalah *the 60 and above moratorium* tetapi sekarang limit kepada *basic care,* dan ketiga ada beberapa lah ya dia punya ni.

So, from your experience daripada *you* punya pencarum-pencarum, *I mean your customers.* Adakah mereka *complain* atau memberi maklumat bahawa *certain-certain* syarikat tidak mengikuti arahan BNM?

Encik G Saseedaran Gengadharan [NAMLIFA]: Saya rasa mungkin bila kami buat pembentangan tadi, tuan tidak ada. Kami sudah pun *addressed* perkara ini tadi iaitu saya ulang balik ya, iaitu kami bagi maklum balas daripada pemegang-pemegang polisi di luar sana dan maklum balas ini bersabit dengan langkah interim oleh Bank Negara.

Langkah pertama ialah mengehadkan peratus kenaikan setiap kali ke 10 peratus, premium sedia ada ataupun caruman sedia ada. Katalah sekarang dia sedang mencarum RM1,000. Kalau dia naik, *10 percent* dia naik RM100. *So,* itu *understanding.* Apa yang kita faham tetapi apa yang kita tidak tahu ialah bila dia naik 10 peratus pada tahun 2025, kita tidak tahu ramai yang sudah pun membayar premium kenaikan ini pada tahun 2024 sebelum langkah interim ini diperkenalkan. 2024, mungkin dia sudah kena *22 percent* atau *25 percent* kenaikan dia.

So, mereka yang telah kena lebih ini, mungkin syarikat-syarikat insurans akan menghantar jadual untuk *adjust,* buat *adjustment.* Okey, kalau mereka yang tidak kena kenaikan pada tahun 2024 tapi hanya sekarang 2025 dia kena, kali pertama dia kena *10 percent.* Dan, premium, kalau contohnya RM1,000, dia naik *10 percent* maksudnya RM1,100. Kali kedua itu, adakah kenaikan itu dia kira atas RM1,100, *10 percent* atas RM1,100 ataupun 10 peratus atas premium yang sebelum naik itu, RM1,000 asas itu?

So, kalau kita dia kira *on compounding basis,* 10 peratus itu kalau tiga kali naik sudah jadi *33 point something percent*. *So,* ini *an uncertainty*. Ketidakpastian kita nak tahu satu perkara dan itu satu soalan yang kami punya *customers* tanya dan bagi soalan tuan tadi, apakah *feedback* kan? *The feedback is* ramai orang risau sekarang. Sekarang dia boleh membendung lah, dia bagi had sampai 2026 boleh bertahan. *What happens after 2026* ini? Apakah— *what will be offered by the*

insurance company masa itu? Katalah, *they are seniors citizens* contohnya *who are retiring. So, the current phenomena is— the simple phenomena* yang pelanggan-pelanggan insurans di luar sana diceritakan ialah *you don't have it when you need it most.*

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Kita perlukan— masa kita perlukan itu, kita tak mampu. *Because something is wrong* dengan *mechanism* ini. *Something is wrong* dengan *mechanism* di mana kita boleh *quote* satu dunia dia kata masalah ini bukan di Malaysia sahaja. Seluruh dunia. *Then, something is wrong. In this modern era,* kita kena ada— *we must have better actuarial creativity* kita kata. *So, what can we done in order to make sure* mereka yang semakin tua dan sudah pun menggunakan *medical card* ini masih boleh mampu membayar. *That is a challenge that the whole country face today. We want to see how we can help. Thank you*.

Tuan Sim Tze Tzin [Ahli PAC]: Kalau tak ada soalan— tak apa, sila.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Satu lagi mengenai insurans ini. Saya pun kurang arif juga hal insurans ini. Boleh jelaskan perbezaan antara apa yang dikatakan oleh premium dan juga caj insurans. Premium ini yang dibayar oleh *policy holder, right?* Apa bezanya dengan caj insurans itu sebab contohnya kalau orang berusia 60 ke atas. 60 tahun mungkin RM1,000 dia punya caj insurans. 61 tahun dia meningkat 10 *percent.* Sampai 65 tahun mungkin 20, 30 *percent. How do you explain*.

Encik G Saseedaran Gengadharan [NAMLIFA]: Dia panggil *cost of insurance*. Sebenarnya perkiraan ini adalah ciri-ciri *investment-linked product. Cost of insurance*. Kos perlindungan dia akan naik setiap tahun mengikut umur kita. Kos insurans adalah sebahagian daripada premium insurans yang dicaj. Dalam satu premium insurans itu ada pelbagai *elements*. Satu, *cost of insurance*. Satu lagi, dia punya *acquisition cost*. Satu lagi, dia punya *reserve*. Satu lagi, *investment cost*. Macam-macam dia campur semuanya dia jadikan premium ataupun sumbangan *in takaful.*

At the back cost of insurance (COI) *is determined by your age*. Tetapi adakah ini bermaksud premium akan naik tiap-tiap tahun? Tidak, sebab mekanisme untuk *investment-linked product* ialah walaupun di belakangnya *at the back end* kos insurans naik tetapi premium akan kekal kerana jumlah yang dilabur *(fund invested)* itu pulangan dia itu digunakan untuk membayar kos yang naik setiap tahun. Di situlah dia punya sampai satu tahap mungkin bila terlalu tinggi dan pulangan pelaburan

memang katalah iklim pelaburan agak mundur. *Very bad economic crisis* di mana *all the funds are not doing well* dalam produk sebegini.

Masa itu *cost of insurance* sudah tinggi dan premium yang pelanggan itu bayar, tak boleh menampung lagi. Masa itu syarikat insurans akan minta dia *top up* untuk *cover. Maybe it is an interim or temporary top up* ataupun *continuous*. Perkara ini berlaku hanya banyak kali apabila kita sertakan *rider medical* di dalam *investment-linked policy*. Kalau produk ini hanya *cover* untuk *live coverage* sahaja dan untuk dapatkan *force savings* lah, simpanan. Dia tak akan *burst*. Dia boleh *sustain very well*. Tapi bila sertakan *rider medical* ini *it is very heavy because of the costing. That's what we are seeing now*. *Cost of insurance is bursting. So,* tak boleh *sustain, reprice*. Kalau tuan nak tahu lebih, kami ada banyak kursus yang bertauliah.

[Ketawa]

Tuan Sim Tze Tzin [Ahli PAC]: Boleh terangkan dalam premium itu ada apa-apa elemen. Tadi *you* kata *cost of insurance then* apa lagi? *Can you tell us a little bit more?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Generally, cost of insurance it is from the mortality* punya *rates. Actual rates. Cost of insurance,* lepas itu dia punya *cost of acquisition, management fee. [Dicelah] Then, acquisition fee. Then,* dia punya *reserves.* Ada *a few more elements*, *underwriting elements* ini*. If you need to know in details we can send to you*. *Sometimes it changes for example takaful products* dia ada lain sikit. Dia ada akaun peserta, akaun risiko*. Different,* kan? *Details we can provide you later. It is just that a premium has got so many elements. There's the understanding.*

Puan Vivian Wong Shir Yee [Ahli PAC]: Datuk Wira Pengerusi. Saya tertarik dengan poin nombor sembilan. Hospital yang disenarai hitam oleh mana-mana syarikat insurans haruslah disenarai hitam oleh semua. *So, is there any hospitals that you have in mind that should be* senarai hitam. *I mean since you already have this suggestion* bermakna memang ada kes-kes yang tidak berpatutan sedang berlaku *then* ada hospital yang dalam *your mind has already with your data that should be* senaraikan hitam.

Encik Krishnan Appanu [NAMLIFA]: Contohnya puan. Contohnya syarikat A ada dia punya panel hospital. Tiba-tiba salah satu panel itu dia tak akan jadi panel lagi. Sebab apa dia tak jadi panel. Mesti ada *something is not right.* Apa kita nak, setiap syarikat *should not put them as in a panel after that. Why? One,* dia dah buat satu kesilapan atau satu yang tidak betul dengan dia punya bayaran atau dia punya pengurusan. Contohnya kalau satu syarikat sahaja senarai hitam dia, yang lain

semua masih berurus dengan dia, *there is no fear for the medical hospital. They can do whatever they want to do.*

Puan Vivian Wong Shir Yee [Ahli PAC]: *So, in your mind there is no hospital that should be in the* senarai hitam. *I mean for this I think it is supposed to work with the* Kementerian Kesihatan *because MoH where if you have hospital that supposed to* disenarai hitam*. Maybe most of it is the payment* kah ataupun *on the medical services* kah *or what. I mean for this on cases like this.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Well, I think what we gave just now* senarai hitam *is the worst case scenario where there is when you are beyond certain compliance that the insurance company don't want to associate with you. That's the worst case scenario. But* pernah satu-satu hospital dia kurangkan dia punya kapasiti kepakaran dia, *where some of their disciplines they do not have anymore. They closed down.*

Contoh *geriatrics.* Sudah tak ada lagi. Contoh *maybe* tak cukup. *Then insurance company* juga akan lihat hospital ini tak cukup dia punya syarat. *They will withdraw, no need to be in the list* hospital punya panel. *Because* kalau dia punya *customers* pergi sana *for certain particular critical* punya *needs* itu, dia tak ada *coverage*. Dia tak ada *treatment*. Senario macam ini *yes*. Dia boleh lihat di mana hospital tidak lagi jadi panel kepada satu-satu syarikat insurans. Tapi *worse case scenarios on misconduct* contohnya. *I don't think we are able to say anything because that is something I think MoH can answer you better*.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Just like to put the discussion in proper perspective. Now so far as you are concerned from your perspective you are advisors. Layman* boleh cakap tak *you are insurance agents, right?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Okay. From your perspective you get percentage from whatever policies being sold. Your bottom line is the percentage. [Dicelah] The commission. If the premium increase etcetera. issue to your advantage as well, am I right? Before I ask a question, I just try to put the perspective first. That means if the premium increases it is also to your advantage. Because you got percentage out of it.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Okay for example our commission bracket is six years commission. If the repricing taking place after six years. We won't get any single cent. We still give the savings to our…*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *That means you are six years.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Alright. That is the perspective, we are clear. Now my next question is what are the trend people taking life insurance right now? Can you share with us? What is the trend? It is going upwards or downwards? Life insurance as well as health insurance. What is the trend right now? With what we have been discussing now, what is the trend? Is it going up? What is the percentage going up?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *The 2024 statistics are not out yet. However, comparing to 2023 and 2022, very, very small percentage of growth. About two percent. [Dicelah]* Ya.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Is that for both health insurance as well as life insurance?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *It is a combined portfolio of life and medical.*

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Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Life and medical. Do you have a figure that separate that two? Life as well, how?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *It can actually log into LIAM portal to get all this details. LIAM. LIAM has all this details.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *It takes little bit more time from there. If you got the information, can you please share with us.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Okay. For example, these details for example. These details we were not able to tell you in percentage but as mentioned just now, as overall. Overall, the growth was very minimal. I think that's because post-pandemic era. Just because of that.* Tetapi, *what we experience. many insurance companies we know that quarterly. there's been growth last year. Not double digit. Certainly not double digit.*

Certain standard growth about four to five percent. We are looking at that but nothing is confirmed yet because the reports are not out yet. Is just February now.

We estimate by next month those— by the first quarter we will receive full report of the performance of the industry for 2024. So, generally the increase has been very minimal.

Tuan Sim Tze Tzin [Ahli PAC]: *How many percent our population in Malaysia are actually having a medical insurance? You do know that?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *There are two types of reports that we saw. Generally, from Bank Negara's reports we saw that 45 to 48 percent are insured. However, there was another study I forgot the source. It said*

naturally actually only 28 percent of Malaysia are insured. But I wouldn't know the authenticity of that source though. So, Bank Negara one is about 45 percent and above of insured population.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, then you guys are in insurance business for very long time. So, the issue suddenly cropped out because of sudden increase of premium. But I'm sure last time maybe this, do you experience the sudden hike of insurance premium also? When was it? How did the government address that issue at that time?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *Okay, In our— here is the chronologically— in chronological order we have prepared this for you. [Sambil menunjukkan senaskhah dokumen]. Let me recap for your benefit.*

The actual increase, repricing exercise was introduced in 2020. Supposes to take effect in 2020. Tetapi, disebabkan pandemik *and lock down, Bank Negara instructed insurance companies to postponed* dia punya *repricing and insurance companies say at the most* dia boleh *postponed* satu tahun sahaja. Kalau tidak kadar kenaikan itu— *the increase will even be compounded further. Which after that in 2021, the repricing exercise started and we were having multiple of engagement with Bank Negara and the also with LIAM and Malaysia Takaful Association (MTA).*

Di mana *we were already alerting them that if you can't sustain, please curb certain practices.* Contohnya, *like what we explained just now. Creating to many unperforming pools and increasing the risk factors further and repricing.*

We knew very well this repricing is not going to stop because of how it was been treated. Cara ia dilayani *is like you are not solving the problem. You are not actually finding a solution. You are just postponing another problem that's going to come.*

So, kita buat banyak saranan. *One of those to control the annual limits of a medical insurance. Not to give a blank cheque to the hospital by giving you RM10 million annual limit, RM5 million annual limit, for what? Very impractical.*

So, one of the reasons why medical bills seem to very high is because the sense of entitlement by the public also, you know. To give you that, I have RM1 million coverage in this. Saya nak guna *RM1 million* ini. *So,* yang dia boleh dapat *treatment day care*. Itu pun dia nak *to be admitted, you know. Demanding to be admitted. Why? Medical insurance.*

That sense of entitlement has grown over the years. But, that's people's rights also. So, we have given enough alert to Bank Negara and also LIAM on this continuously.

Tuan Sim Tze Tzin [Ahli PAC]: *My question is that over like 20 years ago, is there a sudden hike like this? 40 to 70 percent.*

Encik G Saseedaran Gengadharan [NAMLIFA]: *No.*

Tuan Sim Tze Tzin [Ahli PAC]: *No. It has been quite reasonable. How many percent less than 10 percent or four, five percent, three percent?*

Encik G Saseedaran Gengadharan [NAMLIFA]: *It was only based on age band. All right,* kenaikan premium *medical* ini *what we are experiencing today is repricing.* Dia kata tak mampu. Kena naikkan dia *punya price.* Tetapi, ada satu lagi kenaikan mengikut jadual*. Based on age band*.

Let's say you buy a medical insurance standalone medical insurance. Okay, standalone medical insurance. Dia tak ada apa-apa. *No life cover. No disability cover. Nothing. Only medical* sahaja*.* Dia panggil *standalone. Standalone* ini, premium dia akan naik ikut jadual lima tahun sekali. *Five years once of increment.* Bila *you* beli, kita beli pun kita sudah tahu apakah premium kita masa umur 60 nanti. Dia boleh merancang.

So, that has been the trend. Tetapi, sekarang ini kenaikan dia ialah *repricing and also on the age band. Where the senior people. Senior people above 50 are suffering the most because these two aspects.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Any questions*? Ada lagi? *All right*, kalau tidak ada. Saya ingin mengucapkan ribuan terima kasih kepada Yang Berusaha Tuan Krishnan Appanu, Presiden Persatuan Kebangsaan Insurans Hayat Malaysia dan juga Penasihat Takaful Keluarga (NAMLIFA). Juga, terima kasih saya ucap pada Yang Berusaha Tuan Nelson Tan, Timbalan Presiden dan juga Yang Berusaha Tuan G Saseedaran Gengadharan, Mantan Presiden NAMLIFA di atas kerjasama dan juga komitmen yang diberikan untuk sepanjang prosiding ini dijalankan.

Jadi, untuk itu saya tangguhkan prosiding ini pada pukul jam 12.46 tengah hari. Terima kasih.

Encik Krishnan Appanu [NAMLIFA]: Terima kasih puan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ada apa soalan?

Encik Krishnan Appanu [NAMLIFA]: Kami diberi peluang hari ini untuk memberi saranan dan juga maklumat apa yang kami dapat dari pihak kami dan kami harap dalam masa yang akan datang kami diberi *also* peluang yang sama untuk kami berkerjasama dengan PAC. *Thank you*.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih banyak daripada pihak PAC juga. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 12.46 tengah hari]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Rabu, 26 Februari 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Life Insurance Association of Malaysia (LIAM)
Encik Mark Steven O'dell [Ketua Pegawai Eksekutif]

(ii) Persatuan Insurans Am Malaysia (PIAM)
Encik Ng Kok Kheng [Pengerusi]

(iii) Malaysian Takaful Association (MTA)
Encik Mohd Radzuan Mohamed [Ketua Pegawai Eksekutif]

(iv) AIA Malaysia
Encik Ben Ng Kee Heng [Ketua Pegawai Eksekutif]

(v) Great Eastern Life Assurance (Malaysia) Berhad
Dato Koh Yaw Hui [Ketua Pegawai Eksekutif]

(vi) Prudential Assurance Malaysia Berhad
Encik Lim Eng Seong [Ketua Pegawai Eksekutif]

(vii) Allianz Malaysia Berhad
Encik Zakri Mohd Khir [Pengerusi]

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

RABU, 26 FEBRUARI 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Tuan Haji Azli bin Yusof [Shah Alam]

Tidak Hadir *[Dengan Maaf]*
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Puan Vivian Wong Shir Yee [Sandakan]

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Cik Jackie Mary Fernandis [Penasihat Undang-undang II, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara, Parlimen Malaysia]
Puan Siti Hajar binti Mohd Taib [Pegawai Tadbir (Seksyen Sinergi dan Kolaborasi Strategik)]

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Ng Yee Hang [Pegawai Komunikasi]

(samb/-)

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Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah Makro]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) (Bahagian Perkhidmatan Sosial)]
Puan Noor Diana Mohamad Jusoh [Ketua Penolong Pengarah]

SAKSI

Life Insurance Association Of Malaysia (LIAM)
Encik Mark Steven O'dell [Ketua Pegawai Eksekutif]
Puan Nancy Tan Boon Kian [Setiausaha Eksekutif]
Puan Norizan binti Hassan [Ketua Komunikasi Korporat]
Cik Ainatul Najlaa binti Baharuddin [Pegawai Perhubungan Awam]
Puan Rashidah Abdul Rashid [Pegawai Perhubungan Awam]

Persatuan Insurans Am Malaysia (PIAM)
Encik Ng Kok Kheng [Pengerusi]
Encik Chua Kim Soon [Ketua Pegawai Eksekutif]

Malaysian Takaful Association (MTA)
Encik Mohd Radzuan Mohamed [Ketua Pegawai Eksekutif]

AIA Malaysia
Encik Ben Ng Kee Heng [Ketua Pegawai Eksekutif]
Encik Heng Zee Wang [Ketua Pegawai Kesihatan]

Great Eastern Life Assurance (Malaysia) Berhad
Dato Koh Yaw Hui [Ketua Pegawai Eksekutif]
Encik Loke Chang Yueh [Ketua Pegawai Kewangan]

Prudential Assurance Malaysia Berhad
Encik Lim Eng Seong [Ketua Pegawai Eksekutif]
Encik Ankur Bassi [Ketua Pegawai Kewangan]

Allianz Malaysia Berhad
Encik Zakri Mohd Khir [Pengerusi]
Dr. Muhammed bin Abdul Khalid [Pengerusi Allianz General Insurance Company (M) Berhad]
Encik Sean Wang [Ketua Pegawai Eksekutif]
Encik Charles Ong [Ketua Pegawai Eksekutif]
Encik Syed Sher Al Jaffree Syed Sobri [Pegawai Strategi Kesihatan]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

RABU, 26 FEBRUARI 2025

Mesyuarat dimulakan pada pukul 2.32 petang

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
***mempengerusikan Mesyuarat**]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh* dan selamat petang. Salam sejahtera saya ucapkan kepada Naib Pengerusi PAC, Yang Berhormat Puan Teresa Ko; Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas; ahli-ahli ex-officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara; dan juga Penasihat Undang-undang wakil AGC.

Yang Berhormat Ahli Mesyuarat sekalian, petang ini PAC Parlimen akan meneruskan prosiding peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan Malaysia dan juga Bank Negara Malaysia. Sebagaimana semua sedia maklum, ini adalah merupakan prosiding bagi mendapatkan penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans, caj hospital swasta termasuklah rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan juga faktor luar seperti pandemik.

Yang Berhormat Ahli Mesyuarat sekalian, hari ini yang hadir di hadapan PAC— hari ini ramai ya, petang ini ramai. Yang Berusaha Tuan Mark Steven O'dell, Ketua Pegawai Eksekutif Life Insurance Association of Malaysia; Yang Berusaha Tuan Ben Ng Kee Heng, Ketua Pegawai Eksekutif AIA Malaysia. Boleh angkat tangan? *So,* okey. Terima kasih. Yang Berbahagia Dato Koh Yaw Hui, Ketua Pegawai Eksekutif Great Eastern Life Insurance Malaysia. Tak perlu bangun, angkat tangan pun okey, ya. *[Ketawa] [Sambil mengangkat tangan]*

Yang Berusaha Tuan Ng Kok Kheng, Pengerusi Pertubuhan Insurans Am Malaysia (PIAM); Yang Berusaha Tuan Zakri bin Mohd Khir, Pengerusi Allianz Malaysia Berhad; Yang Berusaha Dr. Muhammed bin Abdul Khalid, Pengerusi

Allianz General Insurance Company (M) Berhad; Yang Berusaha Tuan Lim Eng Seong, Ketua Pegawai Eksekutif Prudential Assurance Malaysia Berhad; Yang Berusaha Tuan Mohd Radzuan Mohamed, Ketua Pegawai Eksekutif Persatuan Takaful Malaysia (MTA).

Jadi, terima kasih saya ucapkan daripada kami PAC kerana semua sudi dan juga komited untuk hadir di hadapan PAC bagi memberikan penjelasan dan juga penerangan pada PAC pada hari ini. Sebelum saya menjemput saksi untuk memulakan pembentangan dan juga memberikan penjelasan, saya maklumkan kepada semua ahli mesyuarat sekalian bahawa prosiding PAC adalah tertakluk Akta Rahsia Rasmi 1972 dan juga Peraturan Mesyuarat 85, Peraturan Majlis-majlis Mesyuarat Dewan Rakyat sehinggalah prosiding ini selesai dan juga dibentangkan di Dewan Rakyat.

Jadi tanpa— sebelum saya menjemput Yang Berusaha Tuan Mark O'dell untuk memulakan pembentangan, saya ingin bertanya kepada setiap kita punya saksi yang hadir pada hari ini ada seramai lapan orang, boleh maklumkan kepada PAC siapakah yang akan memberikan pembentangan pada PAC pada hari ini? Sebab saya dapat slaid hanya ada dua. *So,* bermakna hanya dua *presentation*, betul? Ya? *I mean...*

Beberapa Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Daripada Alliance ada satu *then* daripada LIAM, *the* PIAM dan juga Malaysian Takaful Association ada satu, betul ya? *Alright*, jadi saya tanpa membuang masa saya dengan ini mempersilakan Yang Berusaha Tuan Mark O'dell untuk memulakan pembentangan. Dipersilakan, terima kasih.

Encik Mark Steven O'dell [Life Insurance Association of Malaysia (LIAM)]: Terima kasih. *First of all, want to thank the PAC for the opportunity to present the insurance industry's position in this matter. I also want to thank you for indulging my presentation in English. Although I have been in and out of Malaysia for the last 25 years, learning foreign languages is not one of my strengths. I have my good friend, Radzuan, here to help me if needed.*

I prepared the presentation basically to first show a little bit about how health and insurance works, talk a little bit about the global situations because this is not just Malaysia's problem. The COVID impact last seven years claims issues or claims ratio, resist behind claims inflation and real-life examples and then our current propose navigation. Sorry, I just trying figure out how to advance the slide.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Siapa yang *control* slaid? Okey.

Encik Mark Steven O'dell [LIAM]: Oh. *[Ketawa] Okay, okay.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Alright*.

Encik Mark Steven O'dell [LIAM]: *Next slide. Alright. So, first we have just to a simple illustration to show how medical insurance works. You have premiums coming in from policyholders into reserves and those reserves— coming out of those reserves are claims [Tidak jelas], expenses, commissions and profit, if any. Expense distribution cost and profit are quite steady and general fluctuate very little, the biggest variable is claims. When the fund is depleting, the premium must be raised. Down at the bottom you'll see a table of standalones and this is for LIAM. I'd like you know that LIAM members they write about 75 percent of the individual's business in Malaysia and some of my numbers are from LIAM only. This is showing LIAM's standalone.*

The first column, premiums. It shows that premiums, the second column is the claim ratio. The third column is expenses and the fourth is profit or loss. And you'll see that the claims ratio in 2021 were lower due to the COVID but they shot up precipitously in 2022 and 2023 and 2024. In 2024 it's just a draft number, we haven't release that number yet but that should be accurate.

And then expenses are shown down there that there is a little bit year-by-year but is fairly steady between 20 and 25 percent. One of the things that you can see is that this block of business has been losing money. For the last three years, -6, -15, -16 which put the insurance industry in a difficult position in terms of sufficiency and sustainability. I give you a comparison. These last three days, myself and our team we were calling around our ASEAN neighbours to find out what kind of claim ratios they have to face with and I think it's quite relevant.

So, we are looking at 92.96 for 2023 and not all our associates have 90— have 2024. But Singapore is at 75 percent, Vietnam at 48 percent, the Philippines is at 74 percent and Thailand at as 65 percent. The only one there is in real difficulty is Indonesia is at 135. So, you'll see that our 90 numbers are quite high relative to our neighbours.

■1440

Now, as I mentioned, this is not just Malaysia's problem, this is a global problem. The table on the top left talks about global medical inflation and as compared to normal inflation. You can see the last two years have the top 10 percent which is hasn't seen since 2015. The bottom table shows by region and you see the far right, 11.1. That's where the Asia Pacific region is at 11.1. Next slide. [Merujuk pada pembentangan slaid]

A little close to home. New Zealand for a reason we are not sure is leading the pack, but Indonesia has 16.2 percent inflation, Malaysia is tied with the Philippines, Thailand, Singapore and Vietnam all double digits. So, you can see this issue with the exception perhaps both Australia and Japan is affecting everyone. Next slide.

In 2020, you look at the impact of COVID-19 on claims. Prior to COVID-19, the industry did a study on four million claims on 2013 to 2018 and showed a bit more than eight percent annualized increase in total claims each year. Since COVID-19, claims have escalated. The figures below are for LIAM members. The average increase in claims over the last seven years has been 14.34 percent. So, you see that during COVID-19 and understand it in 2020 and 2021, a lot of people avoided going to hospital. They only think need to go, then they go. Then end up being perhaps more severe cases, but the claims actually went down in 2020 and up mostly in 2021. But then in 2022, it was like COVID-19 revenge. Most of that 33 percent increase came from volume increases. In 2023, temporarily the bit and its low encouraging to see 2024 at only 14.4 percent. Still high, but relatively low compared to the previous two years. We hope that trend won't continue.

When you look over to the right, you see the claims ratio and then anything—this does not include expenses. This is just the claim ratio. Expenses will run 20 to 25 percent. But when you see individuals in the 19s, then you know that the total numbers are going to be in the red. Same with investment-linked riders, a medical plan has also attached to a life insurance policy. The claims ratio there is equally high. The expense is not to say mass in an individual. The expense for IOP is spread out amongst the other different revenue streams. So, they are not equally comparable, but you can see that both of them are very high. This claims ratio did go down slightly in 2024. This is a very fresh number, four percent. We seriously do hope that trend continues.

Make a couple of notes, you might see this claims ratio has grown at a slower pace than claims due to premium revisions along the way. So, you get premium revisions even though the claims are being going up. The claims ratio doesn't go up this fast because the premium has been revised. Many insurances have a claims ratio above 100 percent. This is just the average. But, the large hospital groups have enjoyed their earnings margins of 20 to 25 percent. So, we feel that the private hospital really needs to come to the table to do more to help ease this crisis. The cost of operating standalone MHIT has about 20 to 25 percent in the last three years pushing the entire line of business in a loss-making territory.

Now, another point is— this is part of the mitigation fact, we have stood up a claims database. It goes all the way back now from 2018 up to 2024 and will be similar by the end of March. It shows 2021, 2022 and 2023, those three years averages to be in average 16.1 percent per year which as we know, is not sustainable. Next slide. Okay.

This study was done by actuarial partners help to identify a number of drivers of claims inflation. Covers the first three— a little bit of briefing because I think you all be quite familiar with those reasons. I will spend a little more time on fourth to seventh. Next slide.

That medical treatment is certainly a driver of medical inflation. As you know, things keep evolving, they evolve every year and the— whether the minimally invasive surgeries or whether the immunotherapy treatment from oncology or robotic surgery is all of this will reduce— usually quite expensive and the relevant is that Malaysians seeking treatment by a private doctor through a private health hospital expect to get the latest in technology and treatment. Next.

Imported equipment, supplies and medicines. Hospitals and doctors need to import much of the equipment, supplies and medicines to provide the best treatment. This is almost sold in US Dollars no matter what the country of origin might be. So, the imported equipment, supplies and medicines are subject to the rise and fall of the Ringgit against the Dollar. As you know, except for the recent months strengthening of the Ringgit, this band fairly strong depreciation. Actually, the Ringgit has depreciated nearly four percent a year from 2012 to 2024. Again, not count in the recent strengthening. So, the fact is hospitals and doctors have to import a large amount of their consumer vows in US Dollars also adds to inflation.

I won't cover too much on non-communicable diseases is because we all know that the high risks of diabetes, high blood pressure, high cholesterol and obesity will later lively to hospital intervention and chronic illnesses. So that is more of a lifestyle factor, but nonetheless, it is a serious factor.

Number four, I want to talk about ageing and I think this is one the most acute problems that we face with the answers not clearly at hand. Most policies across the world are based on— premiums are based on age. They are based on age because the incident rate or utilization is also very dependent on age. As an individual age increases, the higher average claims threaten policy sustainability. I like you to refer to the table on the right. This was taken a couple of years ago, so the premium may or may not be outdated now. But, if you look at the green shaded field, this is an annual premium for male and female standard life, typical 100 percent cashless cover, the premium is RM12,689 a year. Now, you look to the further column, with

eight percent inflation and two age changes, age 70 and age 75, the premium will reach RM67,000. So, this is to me one of the most secure problems that we have because this will tell you that almost no senior will be able to afford the health medical insurance by the time they pass 65 or 70 years old.

There are a lot of countries that the government helps in this way. In Singapore, when I look at the basic coverage that they have, it looks clearly like they smooth out the subsidies for the younger ages and smooth out the premiums for the older ages. That's one way you can do it. In countries like the United States, they have a national scheme called Medicare. But for private insurance, the situation has been very serious for senior years. I count myself amongst them.

And this slide, really tells you why. This is the— in scenery or the chance of a person in that age group needing to go to the hospital in the year. You can see that above 70, it really exceeds 50 percent. When you get to those kinds of numbers, you know the proposition of private insurance becomes almost unviable. So, this is one of the problems that we really hope to solve over the next couple of years while we run these interim measures. Next slide.

■1450

Increase benefits and policy design. This is one way we can blame ourselves. I don't mind. I think we should be honest with each other. There are two pieces to this that really contributed to inflation.

One is the cashless card. The cashless card was first introduced about 25 years ago or so. What is does is it tells the hospital that they have insurance and it gives them a number on the back to call and to get the pre-authorisation. Once they get the pre-authorisation, the patients will not have to pay a deposit. Well, they may have to pay a minor deposit for incidentals but they won't have to pay an expected essence of the bill and they will be admitted.

The second issue that really contribute to inflation is most of the plans sold in the last 10 or 15 years has been at 100 percent benefit as charged. So, this is really sort of an open check book for providers to charge what they like and our policy is actually support that by saying that will pay as charged even though there is a clause that says that we will pay after the usual reasonable and customary fee it is very difficult to enforce.

I want to give an example here too because there is a lot of anecdotal evidence about additional expenses diagnostics that are prescribed for patients that are insured. I have a good friend who is a doctor and his father needed an appendectomy. He has an appendicitis and he tells me that appendicitis can be diagnosed through blood, urine and physically examination. But yet the doctor

because we assume because he was insured ordered an endoscopy and MRI for an additional RM10,000. This, we think is an examples of overprescribing diagnostic especially to insured patient.

Next slide is lack of information. Patients, almost always lack information needed and have to rely on practitioner advice. Costs of procedures are often not disclosed up front. Although there are more and more hospitals that disclosing a range of cost, they're still generally not disclosed.

Comparing cost and quality of outcome is impossible to compare between providers due to the lack of public information. With the lack of good data, patients are left to assume that the higher costs providers must provide better health outcomes. That is not necessarily true.

Further when you look at the bills— so to the right is a bill. [Merujuk pada pembentangan slaid] This is my bill actually. This is from a shoulder surgery I had a year and half ago. The point that I want to make here is not the amount but the jargon, you know.

So, a patient receiving this bill will have a lot difficulty understanding what is necessary, what is what et cetera. Like what I always curious was the Bair Hugger. I learned that a Bair Hugger was a blanket that they put over you during surgery to keep you warm. But I didn't know that. [Ketawa] Things like an infusion pump or PCA machine. These are just terminology that the average patient would not have any knowledge off.

I want to make a point also about nursing fees. You see a few times on here daily nursing fee is called Game Ready nursing. But in recent years they've split. They split this fee into multiple fees. So, you have your daily nursing fee, you have your prescribing medication fee, they charge you for the little plastic cup they put the pills in.

Then jokingly I think somebody has said every time you pushed the button, they call the nurse, they charge you. [Ketawa] So, this is the real problem. This hinders the ability of a patient to actually question the bill.

Next slide is waste, fraud and abuse. I just want to give a couple of examples of provider abuse. It's interesting because I think when provider— maybe there are some providers who are abusing because of money and maybe some of providers abusing because they think they are legitimately helping the patient.

I give you an example, my own example again. I had arthritis in my thumb. Thankfully it dissipated now. But the provider who is a very prominent hand surgeon had recommended to me that the treatment he wanted to give which was a protein-rich plasma was not going to be covered under my insurance. But he would charge

the insurance 10 times the amount of something that would be covered which is hyaluronic acid. I said to him never mind I pay cash for the bill and I will settle later with the insurance company. But this really is out and out fraud. But I really believe that he felt like he was trying to help me as a patient.

I also remember— I see YB Sim is in the room and we were on a panel together a few weeks back. YB, you had commented about I think it is a constituent of yours who had a cataract surgery, a husband and a wife. The wife— I believe you said they wife was insured and her bill comes to RM6,000 which was the maximum the policy would pay. But the husband was uninsured and then his bill came to RM2,000, RM3,000 which was well at 50 percent less.

Lastly, I have an example from one of our members who was insured, didn't declare that he had health insurance when he went to the hospital. Upon discharge, he was being able to negotiate a RM8,000 discount.

When he went back to the hospital to get them to fill up the form that he needed to claim, the hospital told him unless you give us back the RM8,000 discount or we not going to fill up your form. [Ketawa] It's a true story. So, these things are happening and these are all contributing to the high cost of claims in Malaysia. Next, and we are almost done.

Next, the option for policy holder and certificate holders. There are almost always— the policyholders almost always left with an option of reducing cover, reducing the annual limit or select plans with lower benefits, looking at plans with co-pay can be less expensive, reviewing policy or certificate to reduce of the level of life sum assured or maybe a basic plan with a rider or all option that the policyholders have. There are no ideal options for policyholders looking into maintain the same coverage at a lower premium.

Second to last, this is from the AON report that was quoted earlier in the presentation. You look at the Asia Pacific. These are already ranked in order of mitigations that the industry has trying and tried.

Wellness initiatives, we have many members who have wellness initiatives to try to help change the lifestyle of their insured for the better. Cost containment, whether you are using a TPA or whether you have inhouse team, cost containment is on top of everyone's mind. Plan design changes right now because of— thanks to actually Bank Negara policy document a year ago. We are heavily promoting plans with co-pay because plans with co-payment especially co-insurance have been proven to lead to lower or maybe more sustainable rating crisis.

Lastly, access and delivery restrictions. I'm sure you probably going to ask us later about the panelling of hospitals because it has been an issue, it has been out in the media today. That will fall under delivery restrictions.

Another example of access restriction would be you have to see a primary doctor first before you refer to see a specialist et cetera. That is practiced in a number of countries but it's not practiced here. Malaysia is one of the most accessible— healthcare is one of the most accessible things in Malaysia compared to another jurisdictions.

Last, I want to conclude with just a couple of pages and we've sent this to Bank Negara and so we are working with them on trying to prioritise and implement these recommendations and responses.

■1500

First of all, we're in favour of appointing independent consultant paid for by insurers and hospitals to analyse and recommend stakeholder actions to reduce claims inflation. I know this is time sensitive but there are experienced consultants out there that could add value to this process.

The interim measures offers assistance to customers at risk of losing financial protection due to inability to cope with repriced solution. We aim to strengthen sales and disclose practices and improve communication and transparency around repricing. This has been— many of us attended the open door, I guess you called it open door session on Friday and this was one of the complaints and we heard it loud and clear.

Number three, policy of the co-payments. We're seeing a take up, an increase take up rate although still many new policyholders are opting for policies without co-payments. But co-payments especially co-insurance where the policyholder pays a percentage of bill up to a certain maximum has proven to lead to reduce the buffet syndrome and lead to more responsible consumption.

ITOs are encouraging and assenting healthier lifestyles through no-claims bonuses, perhaps not all have but many have no-claims bonuses now. Establishment of an industry-wide claims database and actually an all-admissions database would be even better, then we would be able to claim those who are insured against those who are not insured.

But the claims database will allow us to look for waste and abuse across the whole ecosystem. Because right now, it's very difficult to have a discussion with one doctor about one patient. There's always a reason why this patient needs this or needs that. But when you see patterns across the whole ecosystem, then you can open up different kinds of conversations.

Develop a long-term sustainable medical product together with Bank Negara. We have our first meeting scheduled next week and we'll see what progress we can make. If we can be successful in that way, then insurance and takaful operators can offer top-up schemes to the basic plan.

One thing that would help would be to exempt group insurance from eight percent SST. About a third of our insured or four million people have group insurance and that includes a lot of B40 members. And if the group insurance was exempt from eight percent SST, we think it would make it more attractive for more employers to come on board.

Next— eight, insurance to consider to develop suitable and streamlined repricing framework, more like annual repricing. Part of outrage by the consumer has been of this 40 to 70 percent rate increase which is not apparent that it covers multiple years. And we think it might be more tolerable for an insured if there are more frequent but much smaller rate increases.

Nine, providers and insures need to better align regarding costs and consumption of healthcare services. Cost containment measures must be adopted by providers. The insurance and takaful industry support the adoption of diagnostic relating group pricing which is really a fancy word for package pricing that takes into account comorbidities.

This is where hospital will get an agreed lumpsum for a certain procedure and they're to make the best use of that. Therefore, driving efficiency rather than billing for fee for service which is pushes them to add more fees, add more services.

This I think in my opinion is the number one problem that we have is the economic conflict between the provider and the payer. The provider wanting to basically sell or have the patient consume as much services as possible and the payer wanting to have necessary and adequate treatment to get the patient well. And they're at odds because in one hand, the shareholders want to make profit and the other hand, although insurance shareholders want to make profit, the profit is much lower at least in recent years. The total cost is really what the issue is.

10— work with MOH require the use of generic drugs and control pricing of all drugs. It's very interesting to note and I have the book here— APHM issued a fact book. In it, it says that 48 percent of the private hospitals profit comes from pharma, 48 percent. That's a very big number.

There's another 10 percent number that comes from diagnostics. But the 48 percent number really stuck out. We want to request private hospitals to freeze costs for the same period that insurance and takaful operators are SST capped, premium

increases. The cost of the interim measures if inflation is not brought under control is well over RM40 billion to insurers and we think that the hospitals need to do more.

Second last, the Rakan KKM which is a pilot program by MOH— we are supportive of that. We hope that can lead to benchmarking for private care DRG.

Last and maybe, it needs to go unsaid. But last, all stakeholders including insurance and takaful operators, private hospitals, doctors, regulators, policyholders, all must come together in whole-nation-approach to address the challenges contributing to rising costs in premiums.

Thank you, that's the end of my presentation.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih, Tuan Mark O'dell atas pembentangan tersebut dan saya bukakan untuk sebarang persoalan daripada Ahli PAC. Silakan Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, Datuk Wira Pengerusi. *Mark, I want to ask a few questions.*

Encik Mark Steven O'dell: [LIAM]: *Sure.*

Tuan Sim Tze Tzin [Ahli PAC]: *First of all, we know that medical insurance, when we first bought—* okeylah, *let say 20 years ago. You know your record and you age what, you pay something. Then, it's already planned until end of your policy life.*

So, when we bought, we all know what we are getting in, fair. However, the problem arises when you have this massive repricing which happened like last year or two, starting last year. So, this caused uproar because the problem is that we sign into a contract and now you change the game, alright.

So, this is major problem where consumers and your policyholders are fed up with you. I'm sorry, I'm not saying you but the industry.

Encik Mark Steven O'dell: [LIAM]: *Understand.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, this is I think the industry must— they are your loyal customer for 20 years. When they reach retirement age, when they have no income, they're slapped with thousands and thousands per month. And your repricing is not 40 to 70 percent. People complain to me the highest 186 percent. And when we listen in the Dewan, they're up to 250 percent a year.*

So, this is where the major issue where I think the failure of your actuarial department or your management to plan a proper plan. So, please don't blame the government for coming hard on you guys. But you should look into yourself and I mean your industry must look into— what happened to you guys? How do you plan it? Alright. This is first question.

Second question is that, your pooling— your pool is unfair for people who stay in the pool, loyal to you and you attract— you come out with a new attractive pool,

attractive, you know you literally attract the healthy people to move to other pool and leave the pool dying, the existing pool.

I think this is also a wrong design. And why should insurance company come out with so many RM1 million, RM10 million unlimited claim pool which is, you know on average you know people maximum claim is about RM100,000. If you want to claim likely said— if you want to claim up to RM500 thousand to RM1 million, you probably going to die anyway. There's no point that you have this kind of design of RM10 million.

So, I think insurance companies must self-reflect as well. Some of your things are not proper and that caused medical inflation. Over to you.

Encik Mark Steven O'dell: [LIAM]: *Thank you, YB. I think when it comes to premiums increasing of course— this is not an excuse, it's just a reflection. When I go back, I was here in 2000 when medical plans started to become very popular.*

■1510

The old type of plans was fixed benefit nature meaning they had inner limits for everything. You know. Inner limits for different classes of surgeries. Inner limit for operating theatres and inner limits for many-many things and the history of those premium was very steady and we did not foresee in this, you can rightly blame us, we did not foresee the level of inflations that would lead to the kinds of premium increases that we have seen and raised in years. We did not— as I mentioned earlier, the two things that led to— that really contribute to inflation are the cashless card and 100 percent as charged. You know when companies introduced those, they might have looked at those as innovation but actually it ended up being just the wrong things to do, actually, in hindsight and forgive me your second question was?

Tuan Sim Tze Tzin [Ahli PAC]: *Youre existing the pool...*

Encik Mark Steven O'dell [LIAM]: *Oh, the pool.*

Tuan Sim Tze Tzin [Ahli PAC]: *The dying pool.*

Encik Mark Steven O'dell [LIAM]: *Actually, I have to agree with you YB, the pools need to be greater, bigger, they need to be opened in new business because once you get a closed pool as you know, as you said that pool will get older and less healthier and those members of those pool will see perhaps a higher-than-average rating crisis. So, this is one of the things on our agenda to work out, hopefully we'll work the solution with Bank Negara.*

Tuan Sim Tze Tzin [Ahli PAC]: *To me is cruel, it is injustice and you are treating your loyal customers in such a cruel way, is heartless to me. I am sorry to use very strong words because what happened in America and its coincidence just*

last year when these things were brought up, United Health— what do you call CEO being gunshot and the assassinator became an instant hero.

Encik Mark Steven O'dell [LIAM]: *Right.*

Tuan Sim Tze Tzin [Ahli PAC]: *I am not blaming, I am not saying Malaysians like that but I think the industry must look into yourself and says hey, look this is excessive, this is wrong and there is something has to be done to contain that kind of massive 186 percent, 215 percent increase, that's cruel to me.*

Encik Mark Steven O'dell [LIAM]: *I hear you, thank you.*

Datuk Ali anak Biju [Ahli PAC]: *Chairman, thank you very much. I got two questions actually. One, is it there— one of the presentations just now said that making loss, insurance company making loss because as far as I know, I don't hear any insurance company making loss. Is it making loss in the premium itself or whatever the overall company making loss? So, which insurance company that is making loss now? I do not know. That's one.*

A second one is, the private hospital loss itself, profit 20 to 25 percent that is excessive, but the insurance company, are you targeting 20-25 percent profit also?

Encik Mark Steven O'dell [LIAM]: *No, sir. No, sir.*

Datuk Ali anak Biju [Ahli PAC]: *And then third one, I see the scenario just like dilemma here between accessibility, affordability and quality. So, insurance plays a very big part of this health issue in this health dilemma cost. So, we want the insurance companies to be more alert, more responsible. I don't say you are not responsible* tapi *but more responsible. So, to let those who contributed the premium for 10, 20 years, they got a fair deal at the end of the day. So, these another three things what I want you to comment on it.*

Encik Mark Steven O'dell [LIAM]: *Okay, thank you. Maybe if we can go to the first slide. Here is where we talk about loses, right? First, I want to explain that every company has multiple funds. There's a life fund, there's fire fund, that non-fire fund, there's investment-link fund, there's the medical fund and the profit that you are seeing are from fund other than the medical fund. The medical fund is one that is spent as you can see here in this case, this example of standalone, have been losing money for the last three years.*

Now, it spends— say that why if you making so much money on other line of business why can't you suffer losses on this line of business? My answer is that you can become the shareholder pocket. It doesn't come from another fund because that is not legal, it comes when shareholders' pocket and that maybe fine for a period but it's not sustainable, it's absolutely not sustainable, we need to have a sustainable medical fund that works. Sorry, YB you had another question …

Datuk Ali anak Biju [Ahli PAC]: *What is your target of profit?*

Encik Mark Steven O'dell [LIAM]: *Oh.*

Datuk Ali anak Biju [Ahli PAC]: *20, 35 percent?*

Encik Mark Steven O'dell [LIAM]: *No* lah*. No, I think, I have asked this on many of our members, I do not run the company anymore, so, I cannot say but I think 10 percent is the most common number I hear when I talked to the CEO about profit margin.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry, your 10 percent comes from your which part because this pool is losing money, right. Sorry, it comes from expenses or what?*

Encik Mark Steven O'dell [LIAM]: *No, you see on the right side the expenses distribution commission and profit. It would come from the balance left over after distributing claims, expenses and commission.*

Tuan Sim Tze Tzin [Ahli PAC]: *Expenses of 20 percent something is quite high. What is that expenses for?*

Encik Mark Steven O'dell [LIAM]: *That is— in this case for the standalone insurance, the commission is 15 percent, the average paid by members would be a bit less than that because there are some policies that become orphan than the commissions are not paid anybody. So, maybe about 13 percent or so comes from commissions and the rest comes from administrative expenses to process the pre-authorisation process to claim, overhead, etc.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Where did you get this figure 2023, 92.96 percent, the data? Where did you get— I mean it's very high, very high 92, almost 93 percent, almost 94 percent.*

Encik Mark Steven O'dell [LIAM]: *Right.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Ya, where did you get this figure?*

Encik Mark Steven O'dell [LIAM]: *These are figures that are reported to us and send to Bank Negara that actually comes from each from our members.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Can you please explain more on the claims?*

Encik Mark Steven O'dell [LIAM]: *So, what the claims means 92.6 percent, it simply means that at every dollar, at every ringgit, 92.96 percent goes to pay claims.*

Datuk Ali anak Biju [Ahli PAC]: *Okay. I have another question. When you look at this look like unsustainable and you request for the increase in the premium from Bank Negara, so, what are the steps, what are the procedures that justify that will eventually allow by Bank Negara to allow for the increment? How many years of*

process of data that you take that eventually Bank Negara agrees, okay, we increase the premium.

Encik Mark Steven O'dell [LIAM]: *Ya, I don't have the template but there is relatively a voluminous amount of data that is submitted to the Bank Negara and they meant to turn around within 30 days actually but often takes many months because there are often questions, they are asked, they go back and forward, back and forward, back and forward. But the data will include claims, expenses and I am not privy or I am not prepared, I guess to go detail of the data at this point.*

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Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Okay, just like to the— your presentation started with slide number 2 ya. In other words, from slide number 2 it shows that your narrative in this proceeding, you're telling the proceeding that you are not making money. That fact you put in slide number 2 ya. Okay, so that is something that reflects on what you are explaining here.*

At the same time, correct me if I'm wrong ya. How I see is quite natural, understandable but you emphasize in this proceeding that your interest— number one interest is still the shareholders. Correct?

Encik Mark Steven O'dell [LIAM]: *I won't agree with that actually. I think the number one issue is sustainability.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Sustainability of?*

Encik Mark Steven O'dell [LIAM]: *Of the fund in order to maintain and enough reserve in order to pay all claims to presentative the fund.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Okay. Then my next question is, you give this data from 2020 onwards?*

Encik Mark Steven O'dell [LIAM]: *Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *What about before 2020? What are the percentages for example?*

Encik Mark Steven O'dell [LIAM]: *Ya there is another slide, maybe the next one. Next one, next. Okay. This is not the same data but it is some of the same data. It talks about the total claims and also talks about the claims ratio for 2018 and 2019. We also have data that date probably back to 2013 but we thought it most relevant to look at what's happened since COVID-19 and what has happened in the area claims ratio and total claims are just prior to COVID-19.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Ya, okay. Then in your— coming back to slide number 2 again, you highlight on the standalone LIAM only data.*

Encik Mark Steven O'dell [LIAM]: *Yup.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *What are the other steps if you can share? Are they making losses as well or not?*

Encik Mark Steven O'dell [LIAM]: *They generally are…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *What are they, please?*

Encik Mark Steven O'dell [LIAM]: *Okay, there's group insurance.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Okay.*

Encik Mark Steven O'dell [LIAM]: *And there is— what they called unit directing riders to investment-linked policies.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Investment-linked policies.*

Encik Mark Steven O'dell [LIAM]: *Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, what are the performances?*

Encik Mark Steven O'dell [LIAM]: *Go to the previous slide again with the— ya, if you look at— I don't have the group here because the group in the reason is not here because the group is outside the scope of the in terms of measures, I didn't include the group. So, forgive me for that. But the claims ratio here I stated for individual standalone and for ILP I'm on the right-hand side.*

You see the claims ratio for the unit deducting riders actually higher than the individual. Now they're not equally comparable is why they're shown separately. The individual has very distinct components of claims, expenses, commissions and profit if any. With ILP rider is not loaded for— directly for commissions, commissions are paid under basic plan. And only some of the expenses may be attribute in the ILP and deducting riders but it's not disclosed.

So, I couldn't compare the two accurately together. But if you look at the numbers, if you look at just 2023 and 2024 of about 102.3 and 97.66 is not hard to see that with a bit of expense that you pushing over 100 percent.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Ya, but you have been highlighting these 2023, 2024 issues. I'd just like to have some idea what happened many, many years before COVID-19. Are you making a lot of money or not?*

Encik Mark Steven O'dell [LIAM]: *I can't tell you no but I'm not prepared to share you the data. I don't have the data with me and we are happy to return with the data or to get you the data later YB.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Okay, can you please share a little bit? Yes, okay.*

Encik Mark Steven O'dell [LIAM]: *I can, I can, I can.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Last but not least just like to check, if you can share what are the bonuses that you have issued for the past few years or to your employees.*

Encik Mark Steven O'dell [LIAM]: *Oh! That I have to ask my members in the room.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Ya.*

Encik Mark Steven O'dell [LIAM]: *[Ketawa] And maybe we might have to claims that distract from the record they actually...*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Bonuses I think you declare. I mean is not, is not…*

Encik Mark Steven O'dell [LIAM]: *I just— solve it out there.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *I mean we got to be fair in the sense that you are not making money, but what are the bonuses— that bonuses will give you some indication of how bad that situation is.*

Encik Mark Steven O'dell [LIAM]: *I understand the— I understand the rest— but the companies are making money, there just not making it from medical insurance, right. But anyway, I open up for comments from…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Ya that's the thing, that's it close to the people making money— there is no issue of making money. But why we are saying that you make money and you take the profit out of it but at least you give back to the people because I made to understand that all the insurers in Malaysia are all localised already. So, the insurance company being localised in Malaysia, I think you got to have— after COVID-19 people going to that process in that situation that face of their everybody's life and now we are in a situation like what we are right now.*

Do you have any corporate obligation to the country or to the people to look into this and rather than continue what are you plan to do?

Encik Mark Steven O'dell [LIAM]: *No. I think it's more than a wakeup call. But the bonus question I have to leave to my colleagues if you want specifics.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Please, just to share. So that we have a good feel how is the situation in this industry.*

Encik Mark Steven O'dell [LIAM]: *Maybe in terms of month of salary or something might be reasonable. Any volunteers? [Ketawa]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *I mean we go one by one you can tell us.*

Encik Mark Steven O'dell [LIAM]: Mr. Lim?

Encik Lim Eng Seong [Ketua Pegawai Eksekutif Prudential Assurance Malaysia Berhad]: *So good afternoon. Maybe I go first. For Prudential on the average the staffs will be getting about three months, three months of salary.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *How about the CEO admin salary?*

Encik Lim Eng Seong [Prudential]: *That will go in terms of senior management you will go up to 10 months. All right, but of course, it ranges but as averages of the staffs is about three months.*

Encik Mark Steven O'dell [LIAM]: *Next, Mr. Dato Koh.*

Dato Koh Yaw Hui [Ketua Pegawai Eksekutif Great Eastern Life Assurance (Malaysia) Berhad]: *Hi, hi. Hi, good afternoon. I think it is quite similar during a good year it will be around three, four months you know and back year we have going down to even one month. Yup.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, assuming 20— after COVID-19 is a bad year, so how many months?*

Dato Koh Yaw Hui [Great Eastern]: *In fact, if you look at the presentation just now after COVID-19 2020 and 2021, it wasn't really a very bad year. You know if you look at the claims pattern and all this, during that two years is what actually quite okay. It is 2023 and 2024 when the claims coming so badly. From the medical point of view, I think that business has been losing a lot of money.*

So, the other businesses where we make money— in fact, we also taking risks since 2024 we make money is because the investment climate has been good. Ya, so that's why 2024 we probably— I think in terms of profit it will be better for 2024 for us. So looking at a good year, the amount of the bonus that the staff will be getting is probably between three to four months on average.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *How many months?*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara] Top management.*

Dato Koh Yaw Hui [Great Eastern]: *Again?*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *On average just now, how many months?*

Dato Koh Yaw Hui [Great Eastern]: *Three to four months each.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Ya, okay.*

Dato Koh Yaw Hui [Great Eastern]: *It will depend on the performance of the individual staff for instance. Ya, the average will be three or four months.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Madam Chairman, that means you losing money on this sector. This sector represents how many percent of your overall business.*

Dato Koh Yaw Hui [Great Eastern]: *If you look at medical business it's about 20 percent of total profits.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Does that across the board to all insurance companies?*

Dato Koh Yaw Hui [Great Eastern]: *I do not know, that is for my company.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Yours. You are from? Sorry.*

Dato Koh Yaw Hui [Great Eastern]: *From Great Eastern.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Great Eastern is 20 percent, Prudential, sorry…*

Encik Lim Eng Seong [Prudential]: *For us YB, it will be about 50 percent of our business.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Five zero?*

Encik Lim Eng Seong [Prudential]: *Five zero. So the impact of this is significant.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Quiet a big range if you can share all others, I think…*

Encik Mark Steven O'dell [LIAM]: *Sorry YB, we have a number here just from my colleagues. For 2023, 22 percent of the business was medical on health and insurance for takaful and conventional combined, 22 percent, combined, combined. Next.*

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Encik Ben Ng Kee Heng [Ketua Pegawai Eksekutif, AIA]: *So, YB if I may supplement. I think clearly in terms of bonus and compensation normally the HR will do a proper benchmarking, so we're able attract and retain good talents in every company and as well as the industry. So, we go through the normal process, so we can't be that far off in the industry among the company. But I think certainly you know many of the insurance company here, some of the company has been here for 100 years, some have in here for 70 over years. So, we really here for long-term.*

During the COVID-19 for example, the insurance industry has also supported with the COVID-19 testing fund for example and also had extended the period where customers can pay premium. I think in some of the statistic that we see from ISM, the medical inflation rate in the past few years has been going up by about 15 percent per annum. But yet the insurance company also fully support the interim measure from Bank Negara which basically the premium even in the next two to three years, one, it doesn't follow the recent year trend but it also didn't cover for the past few years when the medical inflation were going up quite high.

So, I think that's the industry in terms of the commitment and support for the long-term for the country. I supposed what we want to add here supplement is that because in insurance is about the pulling off the risk, so it's quite important that every line of business is pretty much self-sufficient on his own. That means the life insurance cover as one, medical insurance is one. Reason simply because life

insurance is a long-term promise to our customer, so we have to protect the family and also for generations to come.

So, that is why you know to maintain solvency, it's important that each line of business is properly price. Just like in the bank you know. When the bank makes a lot of money it would not be a situation where credit card who don't pay the bill they continue to spend money you know, or you expect a corporate banking to support, to subsidise a retail banking for instance. Because each line of business needs to be [Tidak jelas] for healthy and sustainable development of the financial sector and hence this is what a lot of the focus of the industry is trying to do-lah.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Ya, *fully understand, I fully understood. Sorry, you are from...*

Encik Ben Ng Kee Heng [AIA]: *My name is Ben, I am from AIA.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: AIA. *So, AIA your bonus is about three, four months as well?*

Encik Ben Ng Kee Heng [AIA]: *I think is some total compensation. Yes, I think we're benchmark around the same other company but of course different company have different fixed variable structure. I can't comment.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Ya, *roughly*.

Encik Ben Ng Kee Heng [AIA]: *Probably.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Your— for Prudential just now is 50 percent on medical, Great Eastern 20 percent. So, far as AIA is how many percent?*

Encik Ben Ng Kee Heng [AIA]: *It could be bigger because I mean— we could be probably in terms of the claims. Claims to profit is multiple times because we also do group insurance. We have a lot of employers buying insurance for the employees, so it could be 20, 30 percent of a profit coming from— yes, in a both part*-lah, *yes.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi...

Encik Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad]: Yang Berhormat, nama saya Zakri dari Allianz. Maklumat untuk jawapan ini ada dalam pembentangan saya. *So,* saya boleh— saya tundakah masa saya buat pembentangan itu, ada maklumat ini. Berkenaan dengan Allianz lah.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Elok juga *that particular question* jawab dulu sikit *kut.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *That particular question on bonuses* dengan yang itu.

Encik Zakri Mohd Khir [Allianz]: Saya akan jawab sekali dalam *presentation.* Memang dah ada dalam pembentangan sayalah. Okey.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *All right*. Sik, selepas itu saya bagi Kubang Pasu dan Bayan Baru.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *So, your proposal to appoint an independent consultant funded by the insurance industry and hospital raise concern about potential conflicts of interest. Why? They truly be impartial in their analysis and recommendation.*

The second, the co-payment policy aims so prevent over [Tidak jelas] the healthcare service, but how can it be assured that this not overly burden to B40 and M40 group. Why means struggle to pay additional cost? Thank you.

Encik Mark Steven O'dell [LIAM]: *Yes, thank you YB. On an issue co-payment I think you know there is always a going to be a cap, you know. If there is deductible, I think the most common— the minimum deductible I think is RM500 and common insurance often would be five percent or 10 percent to the bill up to maximum maybe RM3,000, RM5,000, RM10,000. That'll be different. There'll be many different flavours available in the market place and the months ahead. Your first question again, sorry?*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *What the…*

Encik Mohd Radzuan Mohamed [MTA]: *Conflict of the interest.*

Encik Mark Steven O'dell [LIAM]: *Conflict of interest, yes thank you. I think we would welcome an appointment of a consultant by the PAC. [Ketawa] You don't have worry about us in conflict of the interest. I mean we will be completely transparent and you can approve the consultant. [Ketawa]*

Tuan Sim Tze Tzin [Ahli PAC]: *That's not our job. [Bercakap tanpa menggunakan pembesar suara]*

Encik Mark Steven O'dell [LIAM]: *Understand, understand. But I mean we would be happy to delegate that to somebody who would be more impartial. [Dicelah] Yes, perhaps Bank Negara.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Yang Berhormat *Chairman. I don't know whether to speak Malay or speak English but speak Malay Mark, Mr. Mark O'dell would not understand me.*

Encik Mark Steven O'dell [LIAM]: *Radzuan can help me.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay. [Ketawa] Well first, I just would like to ask you why the last 14, 10 years from 2014 to 2024*

there was an increase of 143 percent insurance coverage for health. That means average of 14.3 percent a year. This is exorbitant I think by any standard.

Recently the increase is even much higher, 30, 40 percent. I want to quote or not to quote, I just want to give an example of one person who receive a letter from one insurance company. I don't want to mention the name of insurance company.

Asking him— asking to pay higher premium within one year. Now, he's paying RM860 per month. This letter says, from 15th December 2024 he has to pay RM1,198 per month. This is a really tough for anybody. You see people are now terminating policies, notification massive premium increasers especially those who are 60 years and above they are all retired, they live on their pension.

Before they were receiving maybe RM10,000 but now they are getting only RM4,000 or RM5,000 month and yet even though they had been paying insurance for the last 25 years, 30 years is so much money. Their money in insurance company and now once they don't pay the increase, that means there is a lap and there is no more for them. Is this fair by any standard, is this fair? To me it is not fair at all. Maybe later on you can response on this thing.

The other thing is I just want to know the basis. What are the you are basis for this kind of increase? If is says five percent a year still high but reasonable. Acceptable, but 14 percent, 20 percent I don't think that is reasonable at all.

To be honest with you I never buy any insurance and now I think I made the right decision. Imagine if I bought the health insurance 20, 30 years and I had been paid all together maybe RM40,000, RM50,000 but now I can't afford to pay then it's all burned, right? So, this is very important issue.

Another thing is there were claims by private hospitals, not one, many. Insurance company is asking them to give discount from hospital.

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If they don't follow, you will terminate them from the lists of your insurance company. What is the reason behind this? I want to know.

I want to— I don't to quote the name of insurance company, but I have their profit and loss account. For the first six months of 2024, at the group level, 30th June 2023, RM803 million profits, right. In 2024, 30th June as well, 30th June, RM1.06 billion. Then, you say that you not making money? For the fact that you have been paying bonuses three, four months, sure you make a lot of money, right? Nobody gives that kind of bonuses if you don't make a lot of money, a lot of profits. At the company level, the same company at the company level, from RM723.9 million to RM984.34 million, RM200 over million for only one year. Don't tell us that you not

making money, you only making less profits and all that. I think something serious must be done lah*. If not, there is a big implication behind all this increased in health insurance.*

People, there many people said to us during the public hearing, they have to terminate their insurance. They cannot afford to pay anymore, now they have to go to government hospital. Even though there were a lot of money paid to the insurance company. What is going to happen? It affect the whole of Malaysia health system. Many people will turn away from private hospital and go to government hospital. As you know, government hospital already overcrowded, overcrowded. Even, private hospital already crowded. Sometime people go there with very ill and yet, they cannot get room or ward. So, you are making the whole of our national health system in the very bad shape. So, I would like to have to your response. Thank you.

Encik Mark Steven O'dell [LIAM]: *Thank you YB. First, I just want restate again that yes, we have members that are making sizeable profits. But its not emanating from the medical book of business. The medical book of business needs to be sustainable. If its not sustainable, then we will find players pulling out all the medical business.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But Mark, I wish you can give the breakdown, not like standalone just now. Breakdown all these companies, how much your consolidated profits, how much profits from health insurance, how much profits from life insurance. You know sometime this insurance agent, they meet the people, "Okay, you take health insurance RM60, you pay a month. But you go for this investment-linked, life insurance and other insurance you have to pay a lot of money." Yet, they only pay RM60 for the health insurance. That is not fair. Many people complained about this. Thank you.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *You can give the details. If you don't have it now, you can give it later to the secretariat.*

Encik Mark Steven O'dell [LIAM]: Ya, ya. *I will do my best to put it together. Yup.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ya. *You give it later, right?*

Encik Mark Steven O'dell [LIAM]: *Yup.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, thank you.*

Encik Mark Steven O'dell [LIAM]: *Why YB, in the individual…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *You can answer the rest of the questions.*

Encik Mark Steven O'dell [LIAM]: Ya, ya. *On the individual cases, if later I can get some the details and might be able to approach the company and get more relevant comment.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The discount 10 percent? Insurance company asking for discount 10 percent from…*

Encik Mark Steven O'dell [LIAM]: *Oh, oh, ya. Well, you know, the hospitals, they really have like I say, they really have no incentives to control costs. They are on per item ala carte pricing basis. Its really left the insurers almost no choice, but to keep pressing for discounts and all to get the total bill down in order to keep the fund, the medical fund as sustainable as possible. When it comes to— when you say remove them, it's not like the customers cannot go to their hospital and claims, it's just the cashless facility which is I know it's not just— but I mean, it's the cashless facility that is removed if somebody is coming of the panel. But I do want to say that reviewing of the panel is a regular exercise and companies hospital are added or subtracted from the panel based on criteria put forth by each insurer.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Mark, I just want to make this clear. As far as PAC is concerned, we are not taking side. We are not taking the side of private hospitals or taking side on the insurance companies, which is want to get information…*

Encik Mark Steven O'dell [LIAM]: *Understand.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *To see where we can go from here. What I know is few private hospitals that I talk to, their profit is very low. Even without that 10 percent discount, five percent compared to insurance, their profit is low. They have to spend a lot of money on expansion of hospital, adding more hospital because the great demand and all that. So, this is the information we get and we see how to resolve all this issue.*

Encik Mark Steven O'dell [LIAM]: Ya. *I think we can definitely agree on the need to be something fixed, that is broken. We are committed to work with the authorities to do the best we can to do that.*

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Datuk Wira Pengerusi. *Okay, like this. I want to say that this PAC is a neutral platform for you to say your peace, okay. You can give your information et cetera. We might be critical, but we will be critical to everyone as well. We will be fair. But however, I want to see that your slide number 17 and 18. I look through the slide, your twelve recommendations is mostly about you know, other people. Co-pay you know, Rakan KKM, request private hospitals to freeze costs. But I don't see that your industry say that, "Hey, I am going to do this to reduce the cost. What are the reforms I want to do." I don't see that. I*

hope that when you come here, you tell us and the public because we are with the public that, "Hey, insurance company, we are committed to do reform, to save costs, to safeguard your future." I want to see this, but I am not seeing that. Can you response to this, please?

Encik Mark Steven O'dell [LIAM]: *Ya. YB, I think there is number of things on the recommendations that are definitely in ITO space. Okay, one is the consultant— we can set that aside for now. The inter measures is quite significant that were agreed to Bank Negara. They— if we don't get inflation under control and survey that we did with our members and Radzuan was just showing me the costs to takaful operators is between RM4 billion and RM5 billion. So I say, you know that, that's quite significant sum of money that the ITO are putting up. Also, encouraging healthier lifestyle with no claim bonuses, establishing our database publishing the average costs of common procedures, publishing the annual medical costs of inflation, try to come up with the long term sustainable medical products together with BNM. I think that all squarely in the ITO space.*

Tuan Sim Tze Tzin [Ahli PAC]: *I see. Like this— okay, these are some of the things that you have to do, okay. Because the government finally comes in, okay. So, I want to say is that, I want the industry to have a commitment to the people of Malaysia as well as your policy— the people who are loyal to you which committed so much with your company. Give something back to them.*

Say for example you see, now all your products— I mean just now you reported that you have bonus for three or four months for your average workers, 10 months for your top management, okay. You took all the— you took the profits from every pool and you give bonus and also your shareholders. You give dividends and et cetera. But during your presentation, you say that, "Oh, I cannot cross-subsidy because medical pool, it has to be medical." But you took every pool for your shareholders— dividends and your bonus, but you cannot cross-subsidy. I don't get it.

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What I would say is, okay, in every business there's of course, there are businesses who are doing well, sometimes doing bad, sometimes bad weather. So, actually, you diversify. That is the whole idea that insurance— big insurance group is to diversify and you cross-subsidy, okay. I think now you are, to me, I find that you are increasing your medical insurance because they are not making money 50 percent, 70 percent, 186 percent. But when the situation has improved, that kind of premium will not fall down again. It will be maintained as 186 percent alright when

you know maybe— this is a reaction of post-COVID. The extra claim is because of people they postponed their treatment. Now, they come and claime.

But let's say in two years time it has gone down, but your 186 percent of increase will not get down, come down again, okay. There are two questions. Number one, how do you, as a group, actually cross-subsidy medical? I think it's fair to ask because you still make billions of ringgits like what Dato' Koh has said. Number two is that what you call, how do you— can you make a commitment that one day when it goes down, inflation go down, you go down, you cut, you give a discount to the insurance premium.

Encik Mark Steven O'dell [LIAM]: *Thank you, YB. On the issue of the cross-subsidy, actually all the profits from all the funds there are all aggregated together in the shareholders fund. So, when the cross-subsidies the money that I just mentioned the RM45 billion all come from shareholders, they come from the shareholders' fund.*

That fund is an aggregated of the profit that comes from each of the individual funds. What I meant to say maybe I didn't say it clearly is that each of the fund themselves have to be sustainable on their own. That is part of the FSA. But the subsidy and it has come and companies, they have come up and make commitments and have agreed with Bank Negara to put up, to hold the increases to not more than 10 percent and that adds up to sizeable amount of money.

When you talk about inflation, when things go up, when things go down. I was told and I believe that basically medical inflation I don't think we are ever going to see it go down, honestly. You know when you look at the investment and treatment, you look at the way the Malaysians have to buy overseas. When you look at the health of the population, the aging population, I think there will always be a core medical inflation rate that we are going to have to deal with. It's just my opinion.

Tuan Sim Tze Tzin [Ahli PAC]: *No, what I mean is that now the medical inflation, according to Bank Negara is about 10 percent, okay. Then, but your insurance premium goes up 40, 50 percent, alright. So, one day it might go down to eight percent or seven percent inflation. So, will you revise your 50 percent down to 20 percent, maybe 10?*

Encik Mark Steven O'dell [LIAM]: *Of course, the insurance will make their judgement on what the inflation trend is. When we talk about 40 percent this is also a little bit of misunderstood. Those are almost always multiyear increases you know, in insurance company will— and the practice varies. Some of them may raise their premium every year, some may raise their premium every three to four years. If somebody is coming up with the 40 percent increases not for one year, is for multiple*

years looking ahead and they hope they can keep that premium at that level for several years going forward.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Okay, Datuk Wira.*

Encik Ben Ng Kee Heng [AIA Malaysia]: *Sorry, maybe if I may just supplement a bit.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Okay.*

Encik Ben Ng Kee Heng [AIA Malaysia]: *Thank you for— different YB also gives us their assurance. Sometimes when we being asked question, but it is important to get the assurance the PAC is neutral. You want to look at the raw big picture.*

So, actually over the years, actually globally, medical insurance I'm not aware any country, or any market that come with guarantee premium rates. Now, the reason here is because people are living longer, but they are not necessarily living better. For example, in the old days, when someone buy a policy 20 years ago, there was no MRI technology. So, those days you only cover X-rays. Maybe now there's MRI technology and in those days maybe there's a monofocal lens but the insurance company also covers multifocal lens right now.

So, some of these things do move, do evolve with time, hence the medical insurance is not something that can be strictly carved in stone to become very fixed. As a result of that, so, this one medical insurance simply requires a closer management to make sure yearly the premium and the claims have a more natural correlation relation, a healthy relationship between the two.

So, obviously, sometimes when people get a very big increase in premium, sometimes it's because of age. So, there are two factors, age specific. Just now, I think Mark shows in the slide for let's say 60 years old and above I think one and two would probably use the hospital services, for instance. So, in that circumstance— some of this because of age. So, because insurance— the likelihood to use the insurance will go a bit higher. So, some plans maybe cost that. So, I think when possible, we also try to explain to the customer a bit clearer how much is it is due to inflation and how much is it is due to age. So, those are the things.

Of course, the industry I think as a result of what— as a result of interims measure so clearly if you increase the rate once every three years or five years, that is why you have a big quantum. So, I think a more you know, staggered increase in rates will also allow our customers to be able to better plan their finances. Obviously, I think in terms of sharing more education and disclosure, I think that is also good for everyone. That is something obviously the industry is committed to do.

So, clearly, in our business for medical business is quite simply premium claims and expense. So, in terms of the medical claims, so, the insurance company of course, we want, we are very supportive of MOH direction to encourage the used of generic drugs for example to also very supportive of initiative like DRG because we believe those things will lead to a greater efficiency of the usage of the healthcare resources.

Today, the prices do vary greatly and how the charging systems are also quite varied greatly. I think YB Sim just now you mentioned about some of the differences in the hospital bill. So, a Panadol can cost 40 cents to RM1.60 per tablet, you know. A glove can be charged, cost as much as RM40 per glove and some hospitals will charge throwing garbage every day for RM50 even though there is already a room and board charges. Some hospital will charge putting a needle into and then another charge to takeout the needle out in doing a blood test.

So, some of these things we do need support. It is a whole of a nation approach that we need. So clearly, I said you know many of the insurance companies have been in Malaysia for long time. We are definitely very committed. We want to make sure there is sound financial management so that to protect long-term solvency of the industry and sustainable medical insurance for everyone. Otherwise, you will just lead to more people using public healthcare. So, I think in terms of the ultimate objective, I think we are very aligned.

Dr. Hajah Halimah Ali [Ahli PAC]: *Datuk Wira, because I* nak pergi bahas kejap sahaja.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, last question.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Slide 17 number seven. I'm quite interested and I want to understand what exactly do you mean by this exempt group insurance from eight percent SST? What is the cost implication? Right now, you said there are currently four million employees. So, if the government, you are asking the government to exempt eight percent SST, right? So, what is what? Is it saving to you? Or…*

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Encik Mark Steven O'dell: [LIAM]: *No. No, no.*

Dr. Hajah Halimah Ali [Ahli PAC]: *...What are trying to imply here?*

Encik Mark Steven O'dell: [LIAM]: *Yeah, thank you YB. I think what we are trying to imply here is that we can make the premium eight percent cheaper to the employer if we can do whatever the SST and therefore encourage more employers to take it up.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Just in case— this is just in case. If the government agrees to exempt you from this eight percent SST, what is the amount? That's why I said cost implication just now to the government. What is the amount we're talking about here?*

Encik Mark Steven O'dell: [LIAM]: *I don't know. Ben, if you know that one or not.*

Encik Ben Ng Kee Heng [AIA]: *So, YB, thanks for the question again. I don't have exact numbers but in general, if you look at most countries— so, in terms of providing basic health cover for the population, they usually come in three— what we call three pillars. The first pillar is the government and the second pillar is the employer because employers also have social responsibility because Malaysia has about 17 million workforces, last checked the internet source.*

So, if you look at the stats from Mark, I mean there is only a few million there's being provided health insurance. So, employees work 9.00 to 5.00 and a lot of people 9.00 to 9.00 also. So, there is a role for employers to play in terms of providing supporting basic healthcare for Malaysians.

Then, the third one comes an individual responsibility. So, in this case, they could either not buy insurance or they buy insurance— individual insurance on themselves. So, clearly, if you look at the cost. So, in most markets if you look around ASEAN. So, if you look at— I think the last time if I recall correctly, we looked at the market like Thailand and Indonesia. So, they don't have extra tax, service tax like this on something that basic health insurance covers for the employees.

In Singapore, Singapore has SST but Singapore can claim input tax credit. So, hence you still net to almost a very small on net-ligible service tax. So, what we trying to say here is that— because a lot of B40 are actually employed. Most of the people are actually have a job. So, if the employer has a reduced friction cost, then we can encourage more employers to provide medical insurance cover to their workforce which many of them are actually B40. When they do that, the employees get better medical cover and they also don't have to— necessary go to public healthcare and further increase the pressure on the public healthcare system.

So, I think we see this is an opportunity to encourage— I mean the good thing is I think the government has done the great job over the recent years. We're enjoying more economic prosperity. So, perhaps this one is something that employers can do more for the employees.

Encik Mark Steven O'dell: [LIAM]: *YB, I'll be happy to try to qualify that for you later.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, thank you. [Dicelah] We have another one presentation. So, it's already 4.03 now. So, I would like to call upon…*

Encik Zakri Mohd Khir [Allianz]: Terima kasih...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan Radzuan ya?

Encik Zakri Mohd Khir [Allianz]: Ya, terima kasih Yang Berhormat. *[Dicelah]* Saya daripada— pembentangan saya ini adalah berkenaan— khususnya daripada syarikat Allianz Malaysia Berhad. Data-data kami ini memang khusus untuk Allianz sahajalah. Tadi itu untuk industri.

Allianz Malaysia Berhad adalah satu syarikat yang tersenarai di dalam Bursa Saham Malaysia. Maknanya data kami memang dipaparkan dan diterbitkan dalam Bursa Saham. Saya mungkin ada enam slaid dan saya teruskan.

Pergi slaid yang ketiga, kejap. *[Merujuk kepada pegawai] [Merujuk pada pembentangan slaid]* Slaid ini saya nak menunjukkan pecahan di antara perbelanjaan kesihatan, sumber pembiayaan. *So*, kalau kita tengok yang paling besar sekali dari segi pembiayaan adalah daripada kerajaan KKM yang warna biru tua itulah.

Kedua terbesar adalah *out of pocket expenses.* Maknanya orang yang menggunakan hospital swasta tapi dia bayar sendiri. Hari ini yang kita *duk* bincang ini hanya adalah isu lapan peratus. Maknanya lapan peratus daripada *population* Malaysia menggunakan *medical insurance.* Maka dia membeli insurans kesihatan untuk membiayai kos-kos isu-isu kesihatan. Okey.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ini *refer to Allianz* ataupun keseluruhan?

Encik Zakri Mohd Khir [Allianz]: Ini data Allianz— ini keseluruhan tapi ini untuk negara semua.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Maknanya untuk keseluruhanlah.

Tuan Sim Tze Tzin [Ahli PAC]: Tapi Bank Negara kata *45 percent?*

Encik Zakri Mohd Khir [Allianz]: *No, it's only eight percent of the population that buys medical insurance.*

Tuan Sim Tze Tzin [Ahli PAC]: Tapi Bank Negara dia pernah umum bahawa *45 percent* yang ada insurans. Saya tak pasti...

Encik Zakri Mohd Khir [Allianz]: *I cannot talk for Bank Negara but I'm presenting to you from this…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Daripada mana data ini? Mesyuarat PEMANDU?

Encik Zakri Mohd Khir [Allianz]: *Yes, we have…*

Tuan Sim Tze Tzin [Ahli PAC]: *This is medic,* MAHB itu makna?

Encik Zakri Mohd Khir [Allianz]: *This is health expenditure, health expenditure.*

Tuan Sim Tze Tzin [Ahli PAC]: *Health expenditure,* bukan insuranslah?

Encik Zakri Mohd Khir [Allianz]: *No, this is not insurance but, basically only eight percent of the population of Malaysia buys insurance. [Dicelah] No, I'm sorry…*

[Beberapa Ahli berbincang sesama ahli]

Encik Zakri Mohd Khir [Allianz]: *Sorry, eight percent of total expenditure. Sorry ya, sorry.*

Tuan Sim Tze Tzin [Ahli PAC]: *Eight percent of total expenditure,* bukan insuranslah?

Encik Zakri Mohd Khir [Allianz]: *Yes, yes, correct. Eight percent of total expenditure.*

Tuan Sim Tze Tzin [Ahli PAC]: *How about rephrasing a bit? Sorry*-lah.

Encik Zakri Mohd Khir [Allianz]: *Eight percent of total expenditure.*

Tuan Sim Tze Tzin [Ahli PAC]: *Expenditure on health, correct?*

Encik Zakri Mohd Khir [Allianz]: *Yes, on health. On health.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Private.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *[Bercakap tanya menggunakan pembesar suara] Eight percent expenditure on health is been paid through insurance?*

Encik Zakri Mohd Khir [Allianz]: *Yes, correct, correct. You are absolutely right. Sorry. My apologies, when I convert from BM to English, sometimes I get lost.*

So, okay. Ini peningkatan kos perubatan. *So, this our experience.* Ini kira *experience* daripada Allianz. Dalam tiga tahun 2022, 2023 dan 2024, bilangan polisi kita meningkat. Kenaikan purata untuk tiga tahun adalah dua peratus. Tapi tuntutan puratanya ia naik sampai 22 peratus. *[Dicelah]* Ya.

So, punca utama peningkatan kos perubatan adalah bilangan tuntutan semakin tinggi. *The case is increase. So, basically were saying 12.9* peratus setahun bilangan tuntutan dan *5.9 percent it is basically increase in average claims amount per case. I don't speak for the rest of industry but I speak for Allianz. This is what we are experiencing.*

So, any increase in premium for us goes according to this. So, I just want to verify that there is a verification process in which how we then increase our premium. Okay, right.

Slaid nombor lima. Sini saya nak bagi contoh jenis-jenis atau kekerapan tuntutan perubatan. *So,* bilangan tuntutan pesakit *inpatient* melonjak 23— data-data Allianz ya, 23.8 peratus dari 2022 ke 2024. Jauh melangkaui paras pra pandemik. *Before pre pandemic it was completely different.* Bilangan tuntutan 2022 – 45,696, 2023 – 54,472 dan 2024 – 56,047.

Bilangan tuntutan bagi tiap 100 pemegang polisi maknanya ia peningkatan tiga poin. *From 10.4 to 13.2, so it's three points increase.* Contohnya, gastrik, cirit-birit, saluran pernafasan, jangkitan saluran pneumonia, *lung infection, dengue, fibroid and wound, cancer* memang teruk sekarang dan kes-kes koronari jantung.

Slaid yang kemudiannya. Ini slaid yang kita nak bincangkan fasal kita nak bentang tentang inflasi perubatan ataupun *medical inflation. So,* faktor-faktor yang *basically— factors that are causing the medical inflation.* Satu, permintaan perkhidmatan kesihatan semakin meningkat. *So,* orang kalau demam sikit-sikit pun sekarang memang dia nak masuk wad ataupun digalakkan masuk dalam wad. *So,* peningkatan pada kita memang 41 peratus *increase.*

Tokokan tertinggi maknanya *markup* dari segi ubat. *So,* kalau kita ambil *[Tidak jelas]* untuk kita punya— katakan *gastro* punya isu tokokannya, *markup*-nya 284 peratus.

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Kemajuan teknologi, *use a technology medication, robotics* memang lagi-lagi mahal kalau dari segi doktor tiu buat satu prosedur dengan gunakan tangan dia. Pembaziran dan penyalahgunaan, ujian diagnostik, *imaging,* rawatan tanpa keperluan klinikal, makna dia kadang-kadang dia cakap, "*Just in case why don't you go for a scope?"* Tetapi sebenarnya tak payah.

Kalau katakan kita ada sakit perut kah apa, selalunya prosedur dia buat *stools sample, sample* ini sebelum ini tapi adakala kebanyakan doktor kata, tak apa *just in case you* buat *scope.* Ini dan kemungkinan besar banyak kes ini tak ada apa-apa pun, *so scope* dia *clean.*

Tapi kalau kita ikut *clinical practice guideline— sorry, diagnostic related group* punya *guideline,* dia *actually* kena *follow that stool sample may come first before* dia buat *scope for example. Something like that, all right.*

So, cancer treatment memang *increased,* itu memang ketara. *The numbers of cancers especially breast cancer among women has increase substantially. Then the rest, the next last one,* biasa kita tahu bahawa nilai ringgit yang jatuh, makna dia

mesin kalau kita beli dalam *US Dollar,* kos untuk membayar balik lagi tinggi fasal kita dalam ringgit.

Slide lapan. Ini yang kita tanya fasal *profit* dengan bonus tadi, kan? *So*, saya harap saya boleh menjawab soalan itu dalam *slide* ni. Allianz, keuntungan kita 2024, RM1 bilion memang besar. 60 peratus daripada itu datang daripada insurans am. Makna dia kereta, kebakaran dan lain-lain. *Marine insurance,* pembangunan, rumah. 40 peratus daripada insurans hayat, *life insurance.*

Daripada 40 peratus itu, enam peratus diperoleh oleh insurans kesihatan. Dalam insurans kesihatan, kalau kita tengok *pie chart* tu, 88 peratus adalah untuk tuntutan, tiga peratus komisen dibayar kepada ejen, enam peratus adalah untuk *management expenses,* perbelanjaan pengurusan dan hanya tiga peratus adalah margin.

So, dalam RM1 juta, kita dalam Allianz tahun 2024, kita perolehi RM60 juta *profit* daripada *health insurance.* Yang kita buat insurans ini adalah daripada kelas-kelas yang lain. Saya rasa kalau saya berhenti kat sinilah. Boleh tanya soalan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Kalau saya tanya boleh, tanya dulu *Chairman,* sila.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Page* lima, menyatakan bilangan tuntutan, boleh kongsikan dengan PAC berapakah bilangan sebenar nilai polisi dalam jumlah RM?

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Nilai polisi dalam RM?

Seorang Ahli: *RM5.84 million. [Bercakap tanpa menggunakan pembesar suara]*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Slide number* lima.

Seorang Ahli: *Slide number* empat. *[Bercakap tanpa menggunakan pembesar suara]*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Empat, *sorry.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Slide* lima, kan?

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Empat, empat. Lima itu 84 juta.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Sorry,* okey.

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Total claims.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Sebab dia punya bilangan polisi. Ya, muka surat empat, *sorry.*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Itu jumlah dia dekat situ RM484 *million involving 483,000 policies*.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Jumlah polisi. Contoh, 466,000 jumlah polisi tetapi actually dia punya nilai dalam RM itu ada tak? *Do you have that* nilai? Contoh saya beri polisi...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Can I pass it?*

Encik Sean Wang [Allianz Malaysia Berhad]: Dengan izin YB *Chairman, the total— because we are unit deducting rider as Mark...*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Come, come.*

Encik Sean Wang [Allianz Malaysia Berhad]: Dengan izin YB *Chairman, we have our claims amount is RM584 million. The cost of insurance that we charge I think is around RM650 million to RM700 million.*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Which is the representation of 88 percent of the…*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Boleh terus saya ke *slide* nombor 10. Dalam maknanya usaha Allianz untuk memastikan ejen memberikan maklumat yang tepat dan tidak berat sebelah ini kepada pemegang polisi, adakah ada...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Ada, ada.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: ...Ada dai punya panduan, garis panduan...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Ada garis panduan, kita ada *training,* kita ada hantar macam surat *warning* kalau ejen itu tak telus.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Adakah ada kes yang sebelum ini yang di-*report* oleh pemegang ini yang ejen ini dia tidak...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Kami dari segi sejak tahun lepas, sejak peningkatan masalah ini jadi, kami dapati bahawa peningkatan *complaint* kami hanya satu peratus lebih daripada sebelumnya. *So*, saya rasa kita dapat kendalikan banyak masalah ini dengan dari segi perbincangan dengan *customer* dan dengan ejen.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Begitu juga dengan rundingan dengan hospital, dengan kos dengan hospital itu ya. Jadi, ada kalanya juga ada kawalan di situ, maksudnya sudah ada...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Kami bukan sahaja kawalan tapi kita buat rasionalisasi pada hospital kita. Pertama *patient care,* makna dia dari segi *patient* itu kena tunggu lama, dia *discharge* berapa lama.

Lepas itu dengan dia punya macam mana dia layan *basically* kita punya *customer*-lah, kan? Ada juga isu-isu daripada kos juga tapi kita berbincang dengan fakta-fakta dengan hospital, kita tak kata macam, *"You kalau tak bagi kita remove*

you from panel", kita tak buat macam tu. *So*, selama ini kita memang banyak perbincangan dengan hospital-hospital dan perbincangan ini agak progresiflah, tak adalah yang kata nak *complaint* yang kita ini menganiayakan dia orang.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Dalam tempoh berapa tahun ini, berapa kes maknanya pemegang polisi ini dah tak mampu nak bayar dan dia *surrender* dan akhirnya bagaimana? Dia orang akan terus di...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Satu peratus.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Satu peratus yang...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Daripada tahun-tahun— katakan tahun dahulu, *the attrition rate, so* katakan tahun dahulu lapan peratus normal *every year* memang *attrition rate* ini memang kebiasaan, memang tiap-tiap tahun ada orang tak semestinya *surrender,* dia *surrender,* dia kurangkan polisi itu. Dalam tahun yang dan sebut ini, dia naik ke sembilan peratus.

Tuan Sim Tze Tzin [Ahli PAC]: Disebabkan oleh *repricing...*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *We think that it is because of the repricing.*

Tuan Sim Tze Tzin [Ahli PAC]: *What is the demographic* dia umur berapa agaknya yang *surrender?*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: Oh.

Tuan Sim Tze Tzin [Ahli PAC]: Yang *nine percent* itu, biasanya mereka umur berapa yang— *you* ada data kah tak? *Like* umur 20 hingga 30 berapa peratus *surrender,* yang 30...

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *I don't have the information now, but I can give it to you because it's…*

Tuan Sim Tze Tzin [Ahli PAC]: *But your guess is going to be like the older, retirees, full surrender*-lah*. Can we say logically?*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *No. Not actually…*

Encik Sean Wang [Allianz Malaysia Berhad]: *Not necessary.*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Not necessarily retirees. Some people surrender the policies because basically they need the cash. So, they just do it out of that. But the reason for that, numerous. If you want a granular expiration, we can submit to the PAC.*

Tuan Sim Tze Tzin [Ahli PAC]: *We were interested to know the extra one percent who surrendered because of what, is it because of— that mean the demographics…*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *The one percent.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay.*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Maybe the CEO Sean can answer.*

Encik Sean Wang [Allianz Malaysia Berhad]: *YB, I think on the demographic, we will come back to you. But essentially, it's one percent movement on the year-on-year basis from eight percent to nine percent like what Chairman Zakri has mentioned over here.*

Encik Charles Ong [Allianz Malaysia Berhad]: *I just thought that one to give you the information. What we did was we look at the in 2024, those customers subjected to repricing and those customers not subjected to repricing and I compare the lapse rate and those subjected to repricing is one percent more than those do not. So, we do not see any adverse trend because of repricing, additional lapse.*

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Tuan Sim Tze Tzin [Ahli PAC]: *But because maybe Bank Negara step in very quickly or else it will be worse* lah ya. *Okay.*

Encik Charles Ong [Allianz]: *Agree, agree. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, I want to ask*— kalau boleh Datuk Wira Pengerusi, ada beberapa soalan yang saya ingin tanya. Disebabkan oleh baru-baru ini kita difahamkan bahawa hospital-hospital, mereka *complain* lah ya *because you have a few circulars goes to them, a few letters you ask for 25 to 30 percent rebate okay. And then just response never mind and then if let say if they don't give you that rebate, they might not be your panel again hospital. [Dicelah]* Diskaun itulah.

Then also we received one letter that from AIA is that substitute brand names drug is equivalent and/or equally effective generics drugs, okay. So, because we know that of course this is the part of the cost cutting exercise but some of the treatment may not have the generics, right? So can you response how to— I mean AIA lah*, later AIA please response* ya. Ada AIA? *Then we are also received complaint about this claim rejection has going up because of I don't know why but recently the claim rejections on certain medical procedures is being rejected.*

And doctors are complaining that insurance company actually dictates what they use, dictate what kind of scan, dictate what kind of procedures and dictate like— if let say you do this, we are not going to cover that. Can we get some response on all these complaints.

Encik Zakri Mohd Khir [Allianz]: *YB, I represent Allianz. We do not interfere with medication with the doctor for one okay and we do not interfere with the procedures administration okay. So, whatever we do is always vetting excessive of over treatment, in respect to this okay. That's all.*

Tuan Sim Tze Tzin [Ahli PAC]: *Jadi the 20 to 30 percent rebate? [Bercakap tanpa menggunakan pembesar suara]*

Encik Zakri Mohd Khir [Allianz]: *No, we don't ask for— we have a forum with the individual's hospitals and we go through their particular pricing with us and we are experiencing a very good response from them in respect to how we feel that there should be charging us. We don't bully them.*

But, we have removed panel hospitals who are inactive that means people don't go there. That one I must tell you, so in case like one year only two persons goes to that particular hospital because Allianz we have the largest panels in Malaysia which is a bit too large. So, we just done a rationalisation. So, some we have removed for housekeeping issues.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay let say if they are removed from their panel doctors, can they still pay and claim?*

Encik Zakri Mohd Khir [Allianz]: *Yes of course, of course that one.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. Alright.*

Encik Zakri Mohd Khir [Allianz]: *YB, the credit facility given via the cashless is actually literal credit facility, it's like a credit card. So, we are giving a bit of extension of credit card to a customer so that there can use that credit when they go to hospital. So, I think one of the issues like Mark mentioned, it has not been used very wisely but all of us we are guilty of that particularly not really educating people in respect to that.*

Tuan Sim Tze Tzin [Ahli PAC]: *Response from other insurance company please.*

Encik Ben Ng Kee Heng [AIA]: *Ya hi YB Sim. Since you mentioned about the letter from AIA— so from AIA. So firstly, I think nothing in the letter that says we want to dictate on mandate the practice of the doctors. Like I explained earlier you know obviously things like generic drugs that doesn't mean its cheap drugs is no good. Generics drugs this are all what we are always stressed is where clinically appropriate and this are all approved by the Ministry of Health. So obviously, what we care the most— given our long term presence in Malaysia. I mean long term reputation looking after customers is our number one priority.*

So all we're saying is we support Ministry of Health initially in generics drugs, DRG. Of course, we also encourage effective use of the healthcare resources. Healthcare is not luxury is— we are saying some, these simple diseases and maybe you know if you don't need to be hospitalised if it's flu, if its symptoms is not very serious perhaps you know it could be treated on outpatient basis. And some of the treatment if that can be done on the outpatient or daycare like chronoscope. When I

used to live in Taipei, I mean I do chronoscope but never once I lived stayed overnight in a hospital.

But in Malaysia a lot of scope are still done on the overnight basis. So, this are the kind of the thing that we always stress the importance of where clinically appropriate for them to do that ya*.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry. But what if because some of the customers they bought your policy insurance is because they want original drugs. So, once you remove this, they have no choice. You see. So how you are going to address this group of people who wanted this.*

Encik Ben Ng Kee Heng [AIA]: *Ya so like I said YB Sim we are saying that we basically request the hospital to manage on cost efficient. So of course if the customer really insist of using that drugs, then of course then the doctors and hospital are in the position to decide what is best for the patient* ya*.*

So, one more thing just to clarify just now because talk about cashless a few times. So YB, over the years I think increasingly I think our customers do expect insurance company to do more because like a lot of customers, they always tell stories that, "oh my friends went to hospital because he has a medical card. The hospital prescribes this, prescribe that and prescribe ABCDE."

So over time, I think there are a lot of customers they don't claim. Actually, when I meet sometimes hospital friends. So sometimes he will also complaint to insurance company ourselves but I told them, "You hear the complaint from the 10 percent of the people who claim but we have to look after 90 percent of people who don't claim every year." And why the price has to keep going up and why there have to hear stories like you can walk in the hospital with a medical card.

And literally can get a medical check done. You know medical check can cost RM500 to RM2,000 or RM3,000. So, all these things just because you pay a buffet price doesn't mean you can waste the food right I means that is not something that we want to encourage. So hence therefore I think insurance company we have to do more in terms of the fraud, waste and abuse and that's why just now I can share with you example of Panadol, example of drug cost, example about how the bills.

Because I think we await to the 90 percent of the customers who are not claimed in a given year and of course cashless or not cashless panel, our customers are free to seek treatment in other places lah *then of course later on they can pay and file.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey terima kasih Datuk Wira Pengerusi. Saya nak bertanya soalan ini secara umum kepada semua syarikat insurans tetapi khusus kepada Allianz ya *because you* baru bagi

presentation ya. Pertamanya, apakah langkah-langkah yang telah diambil oleh syarikat insurans untuk mengurangkan premium insurans yang dikenakan kepada pemegang polisi? *Did you do it positively how you going to reduce* kenaikan itu.

Kedua berapakah jumlah pemegang polisi yang tidak menyambung polisi mereka setelah premium polisi naik baru-baru ini? *We just like to know what the data like* dan apakah alasan yang diberikan oleh mereka untuk tidak menyambung polisi berkenaan.

Encik Zakri Mohd Khir [Allianz]: Okey, alasan tidak menyambung memang ekonomik lah. Dia tak boleh *afford* lah ekonomik. *So,* itu— alasan tak menyambung memang ekonomik, makna dia tak boleh *afford*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What*, apa langkah-langkah *you* untuk...

Encik Zakri Mohd Khir [Allianz]: *So* sekarang kita dari segi, dari segi...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Untuk mengurangkan premium insurans.

Encik Zakri Mohd Khir [Allianz]: Ya okey so memang ada *dedicated hotline* makna *client* kalau dia rasa dia tak puas hati ataupun dia susah dia kena telefon dan kita akan bincang. Kita, bukan ejen, kita syarikat induk lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Bincang.

Encik Zakri Mohd Khir [Allianz]: Bincang okey.

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Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But, in general, what is your proposal?*

Encik Zakri Mohd Khir [Allianz]: *Our proposal, client should not...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What do you have in mind?*

Encik Zakri Mohd Khir [Allianz]: *The proposal is that the client should not be not terminate his policy and client should not leave without his insurance.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Even though* kalau dia *lap, many months lap.*

Encik Zakri Mohd Khir [Allianz]: *No, we offer him to comeback* lah, ya. Macam kes kalau dulu macam dia *lap before the* Bank Negara ini *then we offer them to comeback, okay at the price that has been established by Bank Negara. Okay, that's what we do.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey. *The other question is* kalaupun Bank Negara bagi *10 percent interim three years* ya...

Encik Zakri Mohd Khir [Allianz]: Ya. Kita patuh, kita patuh.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *...How do you see the next after three years first going to happen?*

Encik Zakri Mohd Khir [Allianz]: Okey. *Very good question, very good question.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Do you think you'd increase 50 percent with you cover* balik yang *three years dok* naik?

Encik Zakri Mohd Khir [Allianz]: *So, if I may say, basically, the next three years again, this is the truth,* syarikat insurans akan rugi fasal inflasi kesihatan akan naik, kos perubatan akan naik, teknologi akan naik. *People are living longer, mortality* lagi tinggi. Maknanya, orang sekarang hidup *90, 92* ya tapi kos untuk kita nak *preserve humans you know is increasing. So, you live longer but the medical cost to keep a human being living longer, it will increase. So, it's a question in fact. How many percent? I cannot say, sir but...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *It will increase even though* orang tak mampu bayar?

Encik Zakri Mohd Khir [Allianz]: *No. I am just saying the cost of inflation, inflation cost will go up. How we going to respond to that? I actually don't know at this present moment because we are governed by Bank Negara and we have to have a discussion with Bank Negara in respect to this. But...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey. *This last question* ya, *but* kata ada lagi ya, ini *last question for the time being.* Ada cadangan supaya insurans ini, *coverage* dia juga termasuk *health screening to policyholders*, termasuk *health screening.* Apa pandangan?

Encik Zakri Mohd Khir [Allianz]: Okey. *Health screening…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ada orang yang bertanya saya.

Encik Zakri Mohd Khir [Allianz]: Okey, betul. Insurans ini dia sepatutnya benda itu mungkin terjadi, kemungkinan. Kalau *health screening,* kemahuan. Benda yang kita nak buat benda itu, *so* dia berbeza sikit. *So,* kalau kos *health screening* kalau dimasukkan dalam insurans maknanya saya rasa syarikat insurans akan masukkan kos itu terus dalam inilah fasal dia bukan kemungkinan, dia— *more or less* kepastianlah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Fair enough, fair enough.* Ya, *thank you.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Pengerusi.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *One question.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Mic* tutup *already*?

Seorang Ahli: Oh, Betong.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Oh, Betong ya. Okeylah Betong bagi *you* dulu.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Short one ya. Okey, maybe general question. I think I have been insured for the last 30 years. I took in the 90s medical insurance. My questionlah, you are looking at the advancement of medical technology, you are looking at the people are living longer. Nowadays the average life expectancy now longer compare to 15, 20 years ago.*

Are you all ITOs able to develop, so-called policy you know whereby tailored to address all these issues, affordable not burdensome especially people who once they reach 60 years old that is where most. They already are retired from their works and they don't have a regular and fixed income.

So, are your ITOs able to develop a policy that can suit all these people by 60 years they will retire but they still continue but it will not be burdensome for them to pay the premiums, maybe at least remain the same as what they paid for the last 20, 30 years. That's my question. Thank you.

Encik Mohd Radzuan Mohamed [Malaysian Takaful Association (MTA)]: *Assalamualaikum. Radzuan from Malaysian Takaful Association. I'm filling on behalf of takaful industry. Okay. For— Yang Berhormat, basically last year MIFC, Malaysian Islamic Financial Center had come out with the position paper, right. In the position paper basically, there is one initiative called post-retirement medical takaful.*

That is the initiative right, okey just to clarify. So, the hypothesis that being used you know, this is some project that the takaful industry is currently working with the MIFC to ideate the idea, [Tidak jelas] is that a lot of working population in Malaysia are depending on the employer benefit while they are working. And typically, they're not basically buying any medical insurance or takaful in that sense.

What happens when they are no longer under occupation and they retire for example. So, they are left with the situation where they have to go basically to find their cover and typically will be a bit expensive, I mean not affordable for them. So, what we actually proposing for the MIFC which MIFC has included in their position paper is to look on the solution of this. Is there something that we can actually pay now and benefit it later at the same rate that you are paying now, right?

So, we have been working on that aspect with a lot of our actuaries. In fact, all the seven out of 11 of our takaful operators are interested to be part of this, right. We had sat down with the MIFC to discuss about how we can make this possible. We also engage with one of the tops. Basically actuarial partner— actuarial firm which is actuarial partner to look into this. Some ideas are tuning out.

So, the thing is that, it is always at the top of our mind on how to address this issue of rakyat *that they retire without any protection. If they can have something like YB mentioned, something that the pay now but will later not— because they have their employer benefit while they are working, why they want to pay for full policy, they should pay some part of it. By the time they retire, they still pay that much.*

However, when we work with the technical team which is the actuarial, one thing that keeps coming as a stumbling block for us to achieve this is they are not aware where the medical inflation would be at that time you know that person is retiring. Because that is the assumption that they had to make basically. Even though we try many other methods like what we do we just fix like for example, the benefit RM150,000, anything more than that you pay yourself but RM150,000.

Even that also is difficult not knowing what is the medical inflation at that particular time because actuarial they based on this assumption. But we don't stop, in fact there is part— it's still on the table. There are lot of alternatives available but it is not retiree friendly. For example, deductible. You can pay deductible after 80 percent, they pay about 20 percent. By the time you retire, you have to pay full amount. So, it doesn't really serve the purpose, right.

So, which is why, we know that there are members that have this as their part of their internal benefit. One of the big banking groups have it as an internal benefit. However, internally they know the medical experience of their workers. So, it's easy for them to manage when we want to extend this to the general population, then you know there is the project that we have currently working. Just to impress upon that we do look at this even prior to the whole issue on this.

We did mention also about the awareness that we try to give to our policyholders as well as our contributors together with LIAM and PIAM we come out with this MHIT awareness programme call "Ambil Tahu, Barulah Tahu" you know about what is medical insurance, how you can make sure your, the proper utilisation and so on so forth because we hope that we will be able to address areas that we can address. Medical inflation we cannot address. But the behavior you know, the operational process, we always looking into how to improve on that, insya-Allah.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Pengerusi. *Before I ask one question, I've got two scenarios I'd like to share ya. First scenario is— if I think of myself lah. When I was young, young family take up policy. Then after two, three years I contribute every month without fail and alhamdulillah* sihat, *never go to the clinic, never go to the hospital, after three years got a child. Not enough fund, I surrender the policy because I got to pay for my children.*

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Then after that, another agent come and sell the policies, I tukar *the policy again. Then, my children started going to hostels, I needed the funds. I surrendered the policy, I pay every month without fail, I did not abuse the facilities, I mean did not go to— alhamdulillah,* sihat*. I did not go to the hospital, I did not go to the clinic, I did not use a single cent. Then after that, my children grow, after taking up the policy, then agent came in, I joined again. [Ketawa] Paid monthly without fail, then my children started going to university, I got to stop the policy because not have enough funds. Then, the thing goes on and on and I'm at the end of the tunnel right now. [Ketawa] [Dicelah]*

In other words, the situation is like that, that you pay without fail and you don't get— Then I keep asking myself, come on lah*, I should get sick* lah*. I should use this policy. [Ketawa] I mean it starts thinking that way you know, because you pay and you don't use the facilities. That's one scenario.*

Second scenario, yes, you go to a public hospital— I think everybody knows about it, public hospitals you got to queue et cetera, et cetera, et cetera, you pay RM1. Then you take up a policy, you go to the hospital, a private hospital. Recently my daughter got an accident, got eight stitches, she is— she is working at the public hospital, okay. With that scenario when even if you are working in the public hospital as a pharmacist, you still got to go to the queue et cetera, et cetera. So, she decided to go to a private hospital.

Now, going to the private hospital, she got eight stitches and the private hospital, of course, you stay overnight. We do the CT scan, we do everything. If you are a policyholder, would you feel that, as a patient, I cannot say that you no need to do a CT scan for me. You already stitched up my head, eight stitches, you don't have to go CT scan." I mean as a patient, as a policyholder, I cannot say that. But, the doctor decides, the hospital— then she goes overnight, one night, CT scan et cetera, et cetera. So, now in your presentation, alias presentation also, you are saying about pembaziran*, over treatments et cetera, et cetera. I think is it fair under that scenario to say as a policyholder, to say that, "Oh, you are over treatment. Excessive treatment et cetera, et cetera." '*

From the insurance perspective— I mean insurance companies because I think you got— can you come down a little bit lower to look at the people perspective?

Encik Zakri Mohd Khir [Allianz]: *Ya, okay. So…*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Although— sorry. Although you are talking about a small percentage, you are talking — I mean relatively, relatively. In terms of numbers, yes, there's a substantial number. But in terms of percentage,*

it's low. But, you have got to come down and take a look at this, at us. Okay, thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya Pengerusi, saya nak *just* sambung YB Wangsa Maju, pandangan Wangsa Maju.

You see, I have a problem when I hear from the public that those who have an insurance policy, then the insurance company who demands the hospital to give a discount. This is what exactly what our YB Wangsa Maju said, because you demanded 25 percent or 30 percent discounts from private hospitals, therefore you know, they do overtreatments for him. Asked him to stay back in the hospital, give them more, all the extra treatments and all that to make up the gap, the loss. I think it should be the same price with those who come out from pocket. They all should pay the same price. That's one.

Number two is that you know, when we buy the car insurance, we have such thing called NCD you know. So, like what YB Wangsa Maju said, like— I mean even like me, I had never been hospitalised before. I bought insurance life, medical— now I got a medical card. I am the client to Great Eastern, AIA and Prudential here, okay. For information. [Ketawa] So, ya lah. *Since young because my friend is a Great Eastern insurance agent. So, you know, I* beli dari dia dululah. *Okay, I never spend a single cent, utilise medical insurance. By right, if you even can give me NCD, I will be very happy to continue to pay. That means sometimes some of the very not major issues, I don't need to claim from the insurance company. But maybe when I come to ages of 60, 65, 70, you are going to give me some certain percentage or so-called saving from this medical insurance policy, then that will be— that will give me extra you know, an incentive to continue. Even if you ask me to pay 80 or 90, maybe you know, I also will continue. That's my view.*

Then also, just how our— you know, one of the CEO, he mentioned that only one percent of those premium— those who pay medical insurance premium are affected. I am not very sure about such a figure. It's such a big hoo-ha. I just want— I just received an email when I checked my email, my lawyer friend complained to Bank Negara over one of the companies here. He says what you know, in the year 2021, he paid the premium of RM6,900. 2022 jumped to RM15,000. 2024 jumped to RM16,700. Now this year jumped to RM18,300. So, 2025 compared to 2021, it's three times you know. So, when you say that it's only one percent what they call that, affected, this one percent from initially RM6,900 jumped to RM18,000, it's three times you know, leap. I think it's a bit too high, right? That's why it's such a big hoo-ha you know.

I think your— I mean all this— the insurance industry should ready think of what YB Wangsa Maju say you know, those who you know, stop for a certain time and all that, they can apply to your company and after that, they can continue, but with the what we do you call that, more reasonable amount. So that, you can keep more customer like this. Now, more and more quit and close, don't want to pay insurance. It's a loss to the whole industry is going to be an impact to the whole industry. Okay.

Encik Zakri Mohd Khir [Allianz]: *Can I answer both questions? One from the perspective of overtreatments,* kita gunakan *Clinical Practice Guidelines. So,* kita tak pakai kalau— kita tak kata *judgement doctor. Judgment doctor* itu sepatutnya mengikut *Clinical Practice Guidelines. So,* kalau orang datang, *there is prescribe guidelines, so* dia kena ikut dia. Saya tak kata semua tapi kebanyakan doktor *private*, swasta di Malaysia dia tak gunakan CPG *guideline*, dia guna lebih. Okey, dan dorongan dia saya cakap, dorongan dia adalah fasal dia mengaut banyak lebih keuntungan daripada segi kena buat benda itu. Saya kata tak salah daripada pesakit itu tak salah, tapi dorongan daripada hospital. *So*, kita punya data kalau ikut *Clinical Practice Guidelines,* sepatutnya tak boleh buat, tak buat tapi dia buat. Itu yang data kita bezalah. Okey.

The answer to your question YB Teresa is it's one percent of lapse cessation increased, not one percent premium. That means the previous years was eight percent lapse cessation. When this thing happened, there was a one percent increase that we saw.

In the case of Allianz, normally we have an average of eight percent, then now we see nine percent. So, one point increased.

Tuan Sim Tze Tzin [Ahli PAC]: YB Pengerusi*. Okay*, *I want to ask the insurance company. The Bank Negara gave all this ruling since January 15th. So, first is that no increase, 10 percent increase for three years. So, is this a prospective or retrospective? Say for example, for me, I got my letter of increase of 50 percent. I also have to declare why and who I buy from* lah*, right? [Ketawa] I bought from Great Eastern, okay, 50 percent increased. I was like, what? I have been paying 20 years okay, 50 percent, all right. Never go, never claim, all right. So, I got it like I think is October, all right or maybe earlier. I forgot, I think in October, November I got the letter. So, then— So, the ruling is January 15th. So, do I have to— is it retrospective or is moving from January 15th? That's the first question.*

Second is that, a lot of complaints out there is that your interpretation. Different companies have different interpretations. Some say it's only a certain group.

Some is retrospective. Some prospective. Some they still come out with 20 percent. I still got those kinds of letters.

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So, I want to see what the industry is doing. I mean how can do something against the ruling of Bank Negara? Okay, that's question number one. Then, the 60. Moratorium for the 60 years old. Moratorium, sorry, now is only 4.50 pm, usually PAC meeting is three hours and above. So, please bear with us, you know.

Second question is that this moratorium for 60 and above. We are told only the lowest band. But when we read the Bank Negara's announcement, it doesn't say it's the lowest band. Okay. So, why is that?

Then, the third question is this the people who are actually lapse of surrender or they couldn't pay they automatically restore. Is it implemented? Because we also hear in the public hearing that some people are not being restored. So, please come out with some explanation on this first. Then I have other questions.

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *YB, from Great Eastern. On behalf of Great Eastern I would like to thank you for being a loyal customer of Great Eastern. [Ketawa] Also I think if you are not cleaning, I think on behalf of other policyholders in the pool to thank you because eventually the pool utilises your whatever premiums that you pay and non-claim.*

So, on your question on whether or not you enjoy 10 percent, you say that you received the letter last year in 2024 October ya*. So, in 2024 for Great Eastern, there will be two batches of increase. One is starting effective July 1st, and the other one effective October 1st. I think you will be in this two.*

So, according to Bank Negara yes, you enjoy the 10 percent. You enjoy the 10 percent going forward. So…

Tuan Sim Tze Tzin [Ahli PAC]: *July also. July batch also? [Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Yes, yes. So, starting from 2025 automatically whatever you pay the 50 percent it will be reduced 10 percent that you are paying. So, for the Great Eastern I do not want to commit on other people. For Great Eastern we make it automatic. Anybody who has bought, who's policy actually experience an increase in 2024 will automatically be reduced to 10 percent.*

Tuan Sim Tze Tzin [Ahli PAC]: *Other companies please. I'm not asking for myself. I'm asking for the public out there. Other companies.*

Encik Lim Eng Seong [Prudential Assurance Malaysia Berhad]: *YB, I can go first. I think for us we have yet to implement it but in short yes, we are applying it forward not backwards. So, we have not…*

Tuan Sim Tze Tzin [Ahli PAC]: *Only January 15th and onwards? [Bercakap tanpa menggunakan pembesar suara]*

Encik Lim Eng Seong [Prudential Assurance Malaysia Berhad]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *On 1st March onwards?*

Encik Lim Eng Seong [Prudential Assurance Malaysia Berhad]: *Yes, because we have not done a repricing for medical inflation in 2024. So, we are applying the 10 percent January 2015 onwards. In fact, to be precise is March 2015 onwards.*

Encik Charles Ong [Allianz Malaysia Berhad]: *YB, for Alliance we are also prospective. So. All the 2025 January onwards, it will be all subject to 10 percent increase.*

Tuan Sim Tze Tzin [Ahli PAC]: *Did you do a reprising in 2024? [Bercakap tanpa menggunakan pembesar suara]*

Encik Charles Ong [Allianz Malaysia Berhad]: *Yes, we do a reprising in 2024. For those blocks, all customers they can actually come back and apply and then we will actually grant them the…*

Tuan Sim Tze Tzin [Ahli PAC]: *That is not fair to the people who didn't come back to you.*

Encik Charles Ong [Allianz Malaysia Berhad]: *No, we make it public, we make to all. They know that this is…*

Tuan Sim Tze Tzin [Ahli PAC]: *Why not applies to everyone since you are going to prepare to grant everyone. If everyone comes to you, you grant it. Why not do it one go?*

Encik Charles Ong [Allianz Malaysia Berhad]: *I think we probably are looking into how these people, what is their response.*

Tuan Sim Tze Tzin [Ahli PAC]: *But it's not fair right. Some people who didn't come so they have ultimately deferred. I think it's unfair.*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *We will take it under advisement. But YB, insurance is whether you like it or not, the contributions of the many to pay the misfortunes of a few. So, there will be a large block who would not claim and there will be a few who claim.*

So, in this issue we will go back and discuss. But we— whether you want to blame our actuarial but that basically it. So, we have to have enough money to collect

from the people who don't make the claims to pay the people who actually make the claims. That is the nature of insurance.

Tuan Sim Tze Tzin [Ahli PAC]: *No, I'm looking at the fairest side also. It's not fair if I go and you know approach and I get the— and then while my wife let's say she didn't. She is busy, didn't go and she has to be punished. [Bercakap tanpa menggunakan pembesar suara]*

Encik Zakri Mohd Khir [Allianz Malaysia Berhad]: *Yes. On the personal level, I agree with you. But when we run the numbers, the numbers don't necessarily say that it would be positive hindsight.*

So, hence any retrospective elements, elements retrospective will go through a process and we then have to look at it again. That is the what we do in practice. I'm not say you are wrong. I'm just saying that that is the practice that we do.

You may be right as far equity is concerned but I'm telling you the hard facts are we all financial institutions, we are governed by certain rules and stuff like that and this is it. But as far as Allianz concerned, we make it very public that you have to come forward and then request for it.

Tuan Sim Tze Tzin [Ahli PAC]: *Meaning Bank Negara is not giving very clear instructions to ITOs, is it?*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *I think YB— YB sorry. Bank Negara instruction is clear that for any repricing happened in 2024 you can— insurance company can decide to approve as and when you receive the request from the policyholders. So, it's up the individual completely to make a decision.*

Like for instance as I'd mentioned to you YB for Great Eastern we have taken the stand to give all. Meaning that we don't wait for people to come in because we also like what you have mentioned it could be probably for people who does not hear about it if they don't come in subsequently if they come in to us, I think it is easy for us to match by giving to everybody. So, we are. As I said I'm only speaking on behalf of Great Eastern.

Tuan Sim Tze Tzin [Ahli PAC]: *The issue on lower band and also the— what you call surrender, not surrender one, yes the people who surrender recontinue.*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *People who surrender YB, this is a little bit tricky where sometimes when people surrender it is not because they are not, they can't afford it. Sometimes they— they just think that they do not want it anymore.*

So, we just want to make sure that the person who come back actually come back and say I surrender because of the increase and I can't afford it. For this group of people, we will immediately reinstate. Not an issue.

But there are people who are actually that every year they were people who come and surrender and said I don't need. I prefer self-insured. I don't mind to go to general hospital. The price again it is a reason why they surrender. So, we just want to clarify that instead of immediately reinstate them and then they say I do not want it, you know. Why are you reinstating me? So, we are making it very clear. So, for us with the policyholders our communication has to be very clear. That is actually very upfront from Bank Negara to ask as well. Most importantly is communication to them.

Tuan Sim Tze Tzin [Ahli PAC]: *60 years old, 60 years old lowest band. [Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Yes, 60 years old I think if I'm not wrong there is Bank Negara is also talking about lowest band. Again, this is for Great Eastern.*

Great Eastern for 60 years and above we have checked you know. Actually 50 or 50 percent of 60 years and above actually enjoy that one-year waiver which means you know 60 percent, 50 percent of whole block of 60 years old are actually in the lowest. It's not the lowest plan.

It's actually in one plan which is at the lowest category that like room and board which RM100 room and board. So, 50 percent of them do enjoy.

Tuan Sim Tze Tzin [Ahli PAC]: *I think the issue here is that the Prime Minister announced it in the Parliament and it doesn't look good if the people out there and see there is a discrepancy okay, of only the lowest band is being given. I think that has to be addressed.*

It looks very, very bad. Of course, I don't know the final ruling by Bank Negara but I think that is not right. If let's say 60 percent moratorium them moratorium-lah*. Only one year what? Right. Okay.*

Okay another issue I want to raise is about these new plans of RM10 millions, big new plans which I think most of the people only claim up to RM100,000. If let's say people who are— you need RM5 million, RM10 million, unlimited claim I think it's unrepairable that person, okay.

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So, mostly we go into hospital less than 100 percent. I would say 95, 99 percentile. So, why are insurance companies still giving that kind of thing? Then, this has actually added to the cost inflation.

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *YB, can I just explain a bit on this. In fact, every year we are scanning the market and do a lot of survey on consumer needs for instance. I think today, just over the last few months…*

Tuan Sim Tze Tzin [Ahli PAC]: *Can you turn on your mic?*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Oh sorry. Ya, it's on. Can you hear me? Over the last few months, when we have this more than, let's say five million, eight million, it's additional rider to what the plan, the basic plan that you have. So, we don't actually just put into the basic plan, which means we created another rider for those people who really needed it, would buy that plan. So, whatever claim experience that is experience, it's only for that group of people who decide to buy more.*

Just I'd like to let you know YB today, I tell you it's very sad to see where cancer claims for instance, over the last few months. I've seen a lot of cases where the claims come in per admission is over a million dollar. Particularly, cancer. So, they're in the ICU for 60 days, you can calculate and I've to sign it you know, over— and to be fair, we received a lot of appreciation from this type of policyholders to come in and tell us it is insurance company that give them a chance to live, you see.

So, there are people who needed these things and going— you know, from now onwards you can see, the treatment cost it's going to up a lot. In order for them to get good treatment, yeah if you have only RM300,000, RM200,000, it is insufficient YB. So, we are saying that it's only for those who truly needed it. So, we don't force into one plan, you know. So, they have to that add on a rider and the claims experience would be calculated based on that group of people. So, it's don't affect the basic plan group.

So, again we are reviewing this every year and the treatment has becoming very sophisticated and there's a lot of new needs from the policyholders.

Encik Zakri Mohd Khir [Allianz]: *YB, maybe I can add. So, I understand that it's a lot noises. Let me give you some positive. So, the issue of on co-pay and deductible. I've many friends who comes in, when I told them there's a deductible and you can actually bring down your premium, you take little portion of the risk yourself and many of them do welcome this. They said I didn't know this can be done.*

So, there's also a positive aspect in respect to this as well, people who actually feel that "oh, I don't need to spend so much, I can manage my risk from say RM0 to RM10,000" for example not everybody but some and they also say that, "yeah, I like cheaper premiums to get it" these all of us are actually experiencing this at this present moment.

But, coming back to Dato Koh's cancer, I've a colleague, we paid about RM2.6 million to keep her alive for six years for cancer. So, there are…

Tuan Sim Tze Tzin [Ahli PAC]: *But not many cases, right?*

Encik Zakri Mohd Khir [Allianz]: *Yeah, but it's not something like what Dato Koh said for it— we don't do it but other companies do it. It's voluntary if you want. It's there, it's available. But nobody forces you to, it does not have any bearing…*

Tuan Sim Tze Tzin [Ahli PAC]: *Sure, you're pooling the existing healthy people to move to the new pool. That's the problem.*

Encik Zakri Mohd Khir [Allianz]: *Oh, okay.*

Tuan Sim Tze Tzin [Ahli PAC]: *And leave old pool dying.*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *YB, this is again you are perfectly right. This is one of the issues where a pool become unsustainable because the healthy life are moving away. Something this healthy life don't move away from my company, there're actually move away to other company.*

So, it is something that is happening which I always say that it becomes the right of the healthy policyholder. Then, they have a choice to then shop around for the best policy they think— may not be in the same company.

If we look it into our experience, each time when we do repricing, there're only about two to three percent of them actually leave the pool and these two to three percent of them, though it is not much but as you have rightly mentioned, small number are actually people who does not want buy anymore but larger amount of people are healthy life and say "hey, I have a choice, I will shop around" and there's where in Mark's presentation the repricing cycle actually makes a lot of different.

Meaning that, you see the Great Eastern reprice today and another company does not reprice. They thought it is cheaper over there and they buy. But, when their repricing cycle happens, they would say, how come mine also increase. So, one of the things which we experience today is repricing cycle. So, how do we then be able to let the policyholders know to compare what are they're paying when compare to other insurance company.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Yang Berhormat Pengerusi, sedikit. Mohon respons, antara objektif PAC kita membuat prosiding kenaikan premium ialah kita nampak tidak ada konsisten persetujuan awal di pihak ITO. Dalam jawapan oleh Timbalan Menteri Kewangan kepada Parlimen pada Disember tahun lepas, beliau sebut bahawa syarikat insurans dan takaful telah bersetuju untuk menyemak kembali harga premium supaya tidak ada kenaikan. Itu janji disebut oleh Timbalan Menteri Kewangan. Maknanya sudah pasti saya lihat ada perbincangan dan persetujuan di pihak ITO dengan kerajaan.

Namun, apabila tahun ini Januari nampak sudah tidak ada komitmen itu dan peningkatan sehingga disebut *capped* tadi sampai 10 *percent.* Jadi, sebenarnya apa yang mungkin dijawab kita kepada *public* sendiri dan juga kepada— walaupun ada

juga disebut soal kos di hospital. Tapi persoalan besarnya itu maknanya komitmen kita sendiri di pihak ITO itu untuk kita ini juga *protect* hal dengan *public* ini. Terima kasih.

Encik Zakri Mohd Khir [Allianz]: Ya, YB memang dari Bank Negara arahannya kita kena *cap* kata 10 peratus untuk tiga tahun. Itu memang setiap tahun, selama tiga tahun. *That means moratorium 10 percent increase only* untuk tiga tahun.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Kalaulah kalau dia tak ada moratorium, adakah akan ada kenaikan?

Encik Zakri Mohd Khir [Allianz]: Oh, mesti. Terus terang saya cakap mesti. Fasal memang ada inflasi perubatannya. Memang naik.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Datuk Wira Pengerusi. Saya nak tanya *maybe this is layman, we are not specialist* dalam bidang insurans ini. *How exactly you derived the amount of increase of premium? And who does it in your company?* Macam mana *you derive at 10 percent and 20 percent, 30 percent? What is your projection for the coming years and all that? So, that's one.*

The other thing, I'm just wondering kalau seorang itu dia bayar insurans perubatan dia dah 30 tahun. Mungkin campur-campur berpuluh ribu. Kalau dia *lapse* dan dia nak *terminate.* Adakah dia dapat balik *certain amount of money back to them?* Dapat tak? *That's number two.*

Number three, I want to go back to the rebate or discount I said just now, 25 percent and 30 percent. Is there a possibility that this is done at the expense of lower quality of medical service to them, low priced medicine dan sebagainya?

The other thing did I nak tanya *Allianz— I better do it all it together,* membangunkan dalam muka surat— tak ada ya. Mungkin *you've answered just now but was not very clear to me.* Membangunkan produk insurans mampu milik dengan ciri-ciri kawalan kos. Apa yang dimaksudkan dengan perkara ini?

Encik Zakri Mohd Khir [Allianz]: Banyak soalan itu. Saya buat satu-satulah. Macam mana kita *calculate premium.* Kita— ia punya *influence* dia *cost of claim.* Maknanya kalau peningkatan insurans kesihatan *inflation, then* premium akan naik lazimnya. Kecuali ada golongan-golongan nyawa yang baharu masuk dalam kita punya *pool of life, then* mungkin dia akan ini— *Ss,* memang merata dunia sama macam itu. Itu memang hakikatnya insurans premium akan naik. Bukan kita nak tapi memang hakikat ia macam itu. Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tadi fasal, *I was quoted attracted to* membangunkan insurans yang mampu milik.

Encik Zakri Mohd Khir [Allianz]: Okey, yang mampu milik. Okey, mampu milik ini. *So,* kita sekarang insurans ini ia polisi yang lama YB. *So,* kita kena ambil orang daripada muda dan kalau kita boleh ambil dia dengan memberi keterangan yang lebih bahawa polisi ini dia akan jadi macam sekian ini, sekian-sekian ini, ia akan jadi begini. *So,* kita boleh *start* daripada ini untuk macam mana dia guna untuk masa depan. Mungkin lagi *economic,* lagi murah— *certain illness,* dia kena faham. Kita bagi tahu dekat dia yang *this thing you don't have to do this, you have to do that. So, we start educating the consumer early in respect of insurance policy.*

The insurance policy is not a pay all. I'm sorry, it's not a pay all. When I started insurance for 50 years ago, basically it was— sorry, 40 years ago, you only can claim up to 85 percent.

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Today, we have moved away from that, now you pay off because of marketing, we all compete with one another, so we shot ourselves in the foot. We actually did not educate ourselves, in respect to this. We should go back to those days we tell all the customers, we actually pay 85 to 90 percent of your claim off, the 10 percent you have to bear yourself. That is what is normally acceptable throughout the world, actually. So, when people have to pay for themselves, they are more careful. Kita, *we don't. We give you a credit facility to go into a hospital and the hospital have used that as a credit card because you got a medical card, it's a downpayment for admission and you can go. I am not blaming anybody; I am just telling that is the scenario that we are facing now.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You anticipate because all this issue now.* Kenaikan premium yang lebih tinggi.

Encik Zakri Mohd Khir [Allianz]: Oh ya, ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:...dia akan *discourage the young people.*

Encik Zakri Mohd Khir [Allianz]: *No.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]:*...to buy…*

Encik Zakri Mohd Khir [Allianz]: *So,* kita cuba *tell the young people it is expensive but there is a way for affordability, perhaps you buy— start with lower limits and then as you have a higher income, you increase your limits, okay. So, more on a basis of affordability. Okay, right.*

So, you shouldn't make claims on small issues. Like if you have smaller deductible. So, you take care the first RM5000 for example, you tak buat *claim because* kalau kita bayar *from zero to everything, they eat up the premium. So,* benda-benda macam ini kita buatlah, kita buat— *that's how we can make a little bit*

more affordable. Kalau *you carry a deductible, I guarantee your policy will be more affordable, that's for sure.* Maknanya, *you* bayar sikitlah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Based on the current situations, what is the response like among the people* yang nak beli insurans ni? Sebab dah dengar macam-macam isu kenaikan ini, ada apa-apa kesan terjejas tak?

Encik Zakri Mohd Khir [Allianz]: *Demand* tak terjejas.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak terjejas?

Encik Zakri Mohd Khir [Allianz]: Tak terjejas.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That's interesting.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You* nak tambah? *You* tambah, *then I continue.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, boleh. Kita go— *it's still very early, 5.15 only. We have a been to 7'o clock, so just bear with us. I want to ask about this— what do you think about— okay, now you have problems with the hospitals. Now, you issue* surat, *hospitals complain back, you know you fight* lah*. This is market practice* lah. *We won't intervene much on this, but there is a tussle and then there's also a but, the* pesakit *also complain about say claim rejection, last time they can get this. Last time they go, can get— cancer can get this scan, now cannot. You know that kind of things are coming, we got a lot of complaints like this.*

So, what do you think about— what is your opinion about a healthcare commission to have these negotiations between hospitals, private hospitals and insurance companies as well as what do we call the clients, the pesakit, *patients, okay. That is question number one. Number two, what is the industry thinking about national health insurance? These are two questions.*

Encik Zakri Mohd Khir [Allianz]: *Individual answer or you want industry answer?*

Tuan Sim Tze Tzin [Ahli PAC]: *Individual, what's your opinion?*

Encik Zakri Mohd Khir [Allianz]: *Okay, let me go first because we are A as Allianz. So, first thing is national insurance health, yes. Okay, this is my personal experience, in 1994 I was part of the team to convert, to explore the conversion of a particular fund into a national health insurance. So, but all I can say is if you started that, this is also like EPF. Your contributions from the company and in the individual and then on the sliding scale, the government will reduce that expenditure on this. So, in 35 years, which will be somewhere around. Now, we would already have*

national health insurance. So, national health insurance actually has been taught about— whether government many years ago, and projects were actually done. I just want to mention it because some of the Minister are no longer around, okay.

So, secondly, the question is commission. I think what we need is ombudsmen. For us as well. So, if for example hospital wants to claim us, fine but we also must have vice versa that we can also complain about hospital and each of the hospital has breach clinical practice guidelines then they should be also hold up in respect to that. So, I think it's a two-way things and customers also should be able to complain for, if I may use, excessive amount of money being paid cause a lot of them are paying out their own pocket, which we actually don't see because they don't complain so much, you see? So, this is the reality for us.

Tuan Sim Tze Tzin [Ahli PAC]: *Others?*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: *Thank you very much, YB. You were talking about healthcare commission. I think I do not know how this commission is going to happen but I do know that— I thing going forward like the concern is insurance company be in insurance companies or the government, or the rakyat, I think we really need to do something in order that the premium remains affordable for them to have quality healthcare.*

With— for the insurance companies, for us, we also don't like to see increase in premium because it is very tough for us to announce to the agents, for agents to announce to the policyholders though it is within the contract. So, we have done our very best every year, YB to look at— just now you were saying that what has been company doing? For instance,, we have actually done a lot of things to make the whole process very efficient, that's all we can do.

Like we digitalised things, we hire a bunch of doctors to actually detect fraud, so that we are able to reduce the wastages. Those we are already doing and I am sure if you ask the hospital, hospital would also say they have been doing a lot of things. So, in this case, that's why we are suggesting here to get somebody who is experienced in doing these things whether locally or outside Malaysia where they have experience and there are a lot of international consultants who are able to advise us do a study for both insurance companies and say what more we can and also for the hospitals and they can do and put some KPIs and timeline, so that we can really see results there.

Today, we don't have much time. It's only three years. If three years nothing happens, on the fourth year, shareholders will come after the company and say we cannot continue losing money. So, and the rakyat *is again crying and what can we do on the fourth year, premium is going to increase.*

So, we think that is probably one of the things we could do by having experts to tell us what else insurance companies can do and what do you call this, the hospital can do like for instance, we have been pushing very hard for DRG which is very effective. We have seen already overseas doing it but here they have, a lot a resistance. We do not know why. So, there are a lot of applications of AI, for instance.

So, I believe the consultants will be able to eventually advise the government and also be able to put in KPIs for all the stakeholders to follow in order to achieve the results we want. So, that is number one.

Number two is YB, on what do you call this national health scheme. You have brought a very good point just now why the premium has been increasing, not for everybody, for certain cohorts, for certain group of people where they are no more new people in the group to subsidise. So, the group is not big enough. If you have a national health scheme where the whole Malaysians are in it, so, there is no way for you to run away. It would be in that group where you are able to support because it is all about pooling. It is all about the law of large numbers that I subsidised you when I am young but when I grow old, somebody will subsidised me. So, if a national health scheme will be good to cover you on the basic coverage, anybody who wants to above that. You can buy additional cover like what has happened in Singapore today.

So, I think it is a good idea to get everybody in because it is a national service if you look at it. Like kampung, *you subsidise me, that's why just now YB and YB Teresa, 25 years I have bought insurance, I never claim. I never claim but I know whatever premium I pay, has been used to subsidise those people who are claiming. You know but when I started claiming, then other people if they don't use, it will be used to subsidise me.*

So, now the subsidy has dropped to the level where there is no subsidy anymore. You know, if you don't reduce the claim experience to below 10 percent where the limit that's given to us, then insurance company will have to pump in money, in this case, not for the benefit of rakyat *to me* lah *because hospital is still going be charging us same. The money will go to hospital rather than rakyat.*

So, that is how I look at this. I think national health scheme maybe the solution but of course, there are challenges that both the government and the rakyat *will be facing. So, I leave it in the good hand of the government. But that is…*

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Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I want to go back to my earlier question regarding the increase of premium. How do you arrive at a certain amount about percentage? Is it in line with the increase of medical costs or do you have your own calculation? The amount is based on medical costs then you*

increase more all the insurance companies should be the same in term of percentage. But now you can see inconsistency in terms of the increase. That's number one that you can answer.

The other thing possibility, what kind do you have another policy like one they terminate, they can get a certain amount of money back, not fully subsidiary other people, right? To be honest, if you put their money, if I terminate surely I want to get some money back, not 100 percent. Like I don't know if certain insurance they have such a thing.

Another thing I want to repeat again, about this rebate and discount. I'm pretty certain that there will be at the expense of the quality of service, certain treatments they don't do it or medicine lower quality, lower price all that. So anybody you can respond? Thank you.

Encik Zakri Mohd Khir [Allianz]: *The last question I can say is I don't think any of us would get involved with the actual want to see the quality of care.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm talking about the hospital, when do you ask them to give the discount?*

Encik Zakri Mohd Khir [Allianz]: *They should not do it. Obviously, they should not do it and they must not do it, there are— they should uphold the hypocritic oath by not doing this, they supposed not to do it.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Tak, they should not do it but their force to do it.*

Encik Zakri Mohd Khir [Allianz]: *I don't think there are many very poor hospitals.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Just like we say, some people say, they shouldn't increase the premium but they increase the premium.*

Encik Zakri Mohd Khir [Allianz]: *With all due respect. YB,* kalau hospital yang besar dia tak ada hospital yang miskin Yang Berhormat, dia hospital mungkin— *regional hospital* yang kecil-kecil dekat Alor Setar kah dekat Kangar mungkin, mungkin itulah tapi kalau macam KPJ, IHH saya, saya tidak...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak *confident* lah.

Encik Zakri Mohd Khir [Allianz]: Saya tak *confident* yang— dia memang buat untung dan dia seharusnya tidak boleh buat perkara ini.

Encik Sean Wang [Allianz]: Yang Berhormat, kalau saya boleh tambah. *I'm from Allianz, Sean Wang. If the impression is from a CT scan to X-tray for instance,* itu tak bolehlah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak boleh ya?

Encik Sean Wang [Allianz]: *I don't think that hospitals are doing it, I'm not to sure what are the basis of conferring* kalau ada itu mungkin boleh kemukakanlah bagi dekat *insurance company* kalau ada betul-betul *yang for instance* memang betul kalau hospital yang menyatakan pihak insurans ini yang mengambil langkah ini untuk menurunkan kos itu disebabkan itu daripada CT scan itu kalau jadi X-ray itu, *I rasa we want to know as well*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That one impossible* lah?

Encik Sean Wang [Allianz]: *Ya?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That one impossible.*

Encik Sean Wang [Allianz]: *Ya, ya.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm talking about certain medicines, certain treatments. From CT scan to X-tray of course cannot. [Ketawa] I'm a technical person.*

Encik Sean Wang [Allianz]: *So, treatment is very relative as well* YB kalau saya boleh kemukakan fakta sayalah kan*. Every treatment has a different prognosis. So* kalau *you take a different pathway, right. So, in my opinion, why is it some of the cancer costs escalate to more than a million* pun *there are different categories of drugs as well, right? I give you an example of Thabiso for instance there are three generations. So the cheapest one being probably RM200, RM300 per pill per day. There is also the most expensive one up 2,100 per pill, right? Obviously, there are less side effects and stuff like that.*

Jadi kalau kita hendak mempertikaikan kualiti itu, *is also relative to how much is it. Doesn't mean that you pay a policy and you deserve 1,100 or* itulah persoalan dialah kan. *So, the range is very, very big. So, for me, we* sentiasa itu *patient care. I think my chairman has mentioned* tadilah kan*. For us, we will never compromise, right? So, as an industry also I don't think we are in a position to cut corners just because you are under pressure by the medical inflation.* Yang itu kita tak boleh buatlah *and* kita takkan buat. *So, I just want to assure* YB-YB di sini.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *How do you derive the amount increase certain percentage? How do you derive 15 percent, 20 percent, 30 percent?*

Encik Zakri Mohd Khir [Allianz]: YB yang ini kami hendak minta tolong YB. Kita banyak definisi *in terms of medical inflation. So, if we can have one standard*

definition, we actually did recommend to MOH that if you can come and join Consumer Price Index (CPI)…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *We should.*

Encik Zakri Mohd Khir [Allianz]: *If we can have one definition of medical inflation then all of us can talk at one page.* Buat masa sekarang *definition* dia berlain-lain.

Encik Sean Wang [Allianz]: *Ya, must we read the point that the definition is to be standardized about what Bank Negara has shared with the government and all that,* tak boleh kita cakap yang itu salah, ok*ey. If you look at Allianz* punya slaid ini, *we apply a different methodology. In my opinion, it's the correct methodology where the inflation cannot be only measured by the cost phase.*

Frequency has increased. [Dicelah] So, itulah dia punya percanggahan *if you like— So it is just not that if you want to measure frequency, I think one of the YB has mentioned earlier on that* government *hospital* pun dah penuh. *Private hospital* penuh tak pernah kita dengar, kan?

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dua-dua penuh.

Encik Sean Wang [Allianz]: *So that's the issue of overcrowded is not in public settings but also in private hospitals. Actually, the occupancy rate* sebenarnya *more than 100.* Ada juga *facility* yang dia orang tengah— *in the miss of convert into rooms.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You means* kalau dah penuh *that mean cost will go up, medical cost will go up?*

Encik Sean Wang [Allianz]: *Absolutely, demand-supply, you know.*

Encik Zakri Mohd Khir [Allianz]: *Supply demand* ya. Kalau *demands need, supply will...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not necessary, to me not necessary.*

Encik Zakri Mohd Khir [Allianz]: *But in this case, we are saying supply…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *It's not necessary you want to increase the cost if the* hospital penuh *because it is the same.*

Encik Zakri Mohd Khir [Allianz]: *Ya, but we say the hospital— because their building new infrastructure, new wing, so they want to recruit back.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh! That one reinvestment. This one never investment.*

Tuan Sim Tze Tzin [Ahli PAC]: *I think we…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *We can put a certain amount on profit into re-investment but that doesn't mean that the cost will increase.*

Encik Zakri Mohd Khir [Allianz]: *The cost test increase ya?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I don't know.*

Tuan Sim Tze Tzin [Ahli PAC]: *That one we ask him tomorrow, tomorrow.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Tomorrow. [Ketawa]*

Encik Sean Wang [Allianz]: *And also, if I may direct a little bit. I give a bit pointer since you are seeing them tomorrow, right? So just— I'm not— trying to demonize…*

Tuan Sim Tze Tzin [Ahli PAC]: *The next week* lah*, next week.*

Encik Sean Wang [Allianz]: *So people and all right ya. So, we talked about robotics and stuff like that. I just want to add one more point*-lah, *insurance company we are not here to deprive the best care for the patient, okay?* Memang kalau ada kemajuan dari segi teknologi itu*, we embrace and nobody can deny the robotic, per perform a much better job than the best surgeon in Malaysia* pun, *right?*

Because of the position, because of the healing will be much better. The stitch work no human hands can perform better than a robot. Okay, we accept that tapi *what is the repercussion of that right. We are not seeing the benefit of that. Why? Because the same patient that being performed by a surgeon and also the robot by right the amount of time you spend in the operating theatre should be shorter. Number two, your laying off stay in the hospital should be shorter.*

Yang itu yang kita tak nampak, yang itulah yang kita pertikaikan. Bukannya boleh guna robotkah tak boleh. Itu bukan— *that's not our expertise. Our expertise is look at technology, given the best care to the patient but at the same time, there will be benefit to all. It cannot be* semata-matanya sebab *you have ROI*, sebab *you invest, and then you get to reap all the profit.* Tak bolehlah, yang itu tak bolehlah. Okey, terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, speaking on this inflation rate ya because I read at your presentation, they say 19.6 percent, Bank Negara says 12 percent, or 10 percent forgot. Then I read your letter Allianz's letter to your customer is 19.1 percent. Your presentation 19.6 percent, your letter is 19.1 percent okay 0.5 percent. Okay-lah I can accept that but the issue now is how to define this and then that is a huge repercussion on everyone because you based on your actuarial scientist based on this data. So, I have a serious problem with this because nobody seems to know what is real medical inflation in this country. Am I right?*

Encik Sean Wang [Allianz]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, what is the industry coming together to defy it? Can someone assist Bank Negara to come with coherent methodology, yes.*

Encik Mark Steven O'dell [LIAM]: *YB let me comment on that. We had expect negara as a result of our studies from 2019 to tell us to set up a medical claims database. And one of the deliverables of this medical claims database is to come out with an annual rate of inflation every year.*

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Inflation is made up as were said I think by Allianz comments colleague is made up of the cost of care and the number of people who claimed, right. So, we just stood up this database actually, and it'll get more granular as the years go by. But right now, we have an unaudited number. We are waiting for the audit to come but the unaudited number for the inflation rate for 2021, 2022, 2023 is 16.1 percent.

So, there is another number I can't throw out there. [Ketawa] There are so many numbers going out there. I think Allianz number is specific to Allianz. The number I just quoted is the entire industry.

Every company would have something a little bit different. But what we trying to get at is, if there is a number let's say it's 16.1 for instances, and we're satisfied with the methodology then we would like to see company's be able to adjust their premium in some fashion with some relevance to the annual inflation rate.

Tuan Sim Tze Tzin [Ahli PAC]: *And 16 percent is scary.*

Encik Mark Steven O'dell [LIAM]: *It is scary.*

Tuan Sim Tze Tzin [Ahli PAC]: *I mean, what on earth things go up 16 percent per year, if you compile it five years is going 100 percent.*

Encik Mark Steven O'dell [LIAM]: *Yes, yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *I think to me is ridiculous and scary. But…*

Encik Zakri Mohd Khir [Allianz]: *We need to come to an agreement of how do we define medical inflation.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I was going to say that. You mentioned like about right. You all have different definition.*

Encik Zakri Mohd Khir [Allianz]: *Yes. So, like frequency and severity is must be included because we are also said you cannot just say differential in price. It must also include utilisation of medical services as well. Like we see an uptake in people going in and being admitted into hospitals as well. That also basically…*

Tuan Sim Tze Tzin [Ahli PAC]: *But the issue is the inflation is because of the usage of the glove, the medication, the theater, the doctors. It's not because of more people going there. It cannot be like that.*

Encik Zakri Mohd Khir [Allianz]: *More people going in means more utilisation of gowns, of gloves and everything…*

Tuan Sim Tze Tzin [Ahli PAC]: *But you have to understand, gloves can be produced and per piece is dropping.*

Encik Zakri Mohd Khir [Allianz]: *[Tidak Jelas]*

Tuan Sim Tze Tzin [Ahli PAC]: *The price is dropping. It cannot be 16 percent I don't get it. I mean and the machine MRI machine, you can do it…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Higher volume means lower cost. Higher volume means lower cost.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yes, higher volume means lower cost.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Again, the theory.*

Encik Zakri Mohd Khir [Allianz]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: *And then your machine, okay you can use it and reuse and reuse. There is no way that you can go up.*

Encik Zakri Mohd Khir [Allianz]: *I understand. Our numbers like I said, were listed is there, verified but we are saying, like I said. But that's why I'm asking we should have one uniform methodology…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, I want to ask you the questions since you say about definition. What is stopping us from coming out with common definition for the whole industry?*

Encik Zakri Mohd Khir [Allianz]: *I don't know.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But you all I mean…*

Encik Zakri Mohd Khir [Allianz]: *I mean you can. I mean can stop…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *…Provides service to all the hospitals. They are all the same.*

Encik Zakri Mohd Khir [Allianz]: *No. Hospitals not…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not one provides the insurance to Indonesia or Thailand. This is all in Malaysia.*

Encik Zakri Mohd Khir [Allianz]: *Yes. But hospitals, YB…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You have the cost.*

Encik Zakri Mohd Khir [Allianz]: *Hospitals not necessary will give you the statistics so easily. Not to us, yes. So, this is from real expenditure.* Maknanya kita bayar baru kita dapat sebenarnya. Kita tak boleh dapat daripada dia *willingly data* yang ini. Kita...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, whatever percentage you decide based on you own* inilah *data. Not from hospital.*

Encik Zakri Mohd Khir [Allianz]: *No, no. All from data.* Kita daripada data kita, pengalaman kita.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, you have to be transparent*-lah *both sides. See.* Kalau tidak…

Encik Charles Ong [Ketua Pegawai Eksekutif, Allianz Malaysia Berhad]: *YB, if I may say something*-lah*. I think number one we have to talk about utilisation, okay. For example, in the past, they hospitalise you when necessary.*

Over the last two three years what we have seen is the hospitalisation has actually increased a lot. For example, if you have a gastro, is it necessary to go for hospitalisation? I think we heard some examples.

So, if they actually increase in the hospitalisation means the utilisation, also means the frequency. That is part of the inflation rate. So, not only the price per glove, nursing rates, those are one thing, those are average cost. But utilisation we have seen in our in Allianz experience that has actually been increase in the utilisation.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The cost should be per person, per capita.*

Encik Charles Ong [Allianz]: *Per person correct. So, the overall claiming population…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Yes. How can more the cost be higher. The more the cost should be lower.*

Encik Charles Ong [Allianz]: *…Has actually increase. In our slide, we actually show that the average, cost per person has actually increased. Almost from— yes…*

Encik Zakri Mohd Khir [Allianz]: *Five points…*

Encik Charles Ong [Allianz]: *Yes. Average cost 5.9, utilisation is actually 12.9, add up to be about you know for here 18, 19 percent, okay.*

Then I'll also want to explain about cohort, okay. Sometimes you ask the industry. Industry will take all the companies 14 conventional players, 11 takaful players they average it out. Then if you see look at Allianz, we actually say that 19.6 percent latter 19.1 percent. 19.6 percent is all my blocks. 19.1 percent was for that particular block, cohort by cohort, okay.

Those cohort for example, in fact your first question YB Sim, Yang Berhormat*, you know you look at 20 years ago I sell this medical then after that the cohorts will go into the new blocks with a better benefit is another cohort.*

So, the first cohort it will be close, new cohort. Then of course it continues to have a new cohort because we continue to sell new business, okay. Some cohort can be three, four years depending on the benefits that you want to provide, the group of people you want to put them together.

Of course, the older block of the cohort, 20 years ago, these people are aging, getting older. But they are already in one cohort that they share, okay. This are the claims experience increase in terms of frequency, they go hospital more. The treatment also more expensive.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not that we don't believe you all, we just want to get…*

Encik Charles Ong [Allianz]: *Sorry?*

Encik Zakri Mohd Khir [Allianz]: *Yes, yes, yes.*

Encik Charles Ong [Allianz]: *Thank you.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *…More into it, the deep dive.*

Encik Charles Ong [Allianz]: *Yes, sure. We also want to share is how we price it is based on that particular cohort. In the…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay. I would like to ask, we have few insurance companies here, Allianz, AIA, what else ya…*

Tuan Sim Tze Tzin [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *…Great Eastern…*

Seorang Ahli: *Prudentials, GEG.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay.*

Seorang Ahli: *Great Eastern* boleh nampak kah? *[Ketawa]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Can you all of you tell us, Allianz how many percent you increase recently? Great Eastern how many percent you increase recently and all of you. I want to see whether it's consistent or different. That's all.*

Encik Charles Ong [Allianz]: *All different. [Bercakap tanpa menggunakan pembesar suara]*

Encik Sean Wang [Allianz]: Lain-lain. Lain-lain kohort, lain-lain *company* semua lain-lain.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Doesn't matter. I want to know the… [Bercakap tanpa menggunakan pembesar suara]*

Seorang Ahli: *Average*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Get the percentage. [Bercakap tanpa menggunakan pembesar suara]*

Encik Sean Wang [Allianz]: Boleh.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Don't go into complex matter cohort, cohort. [Tidak jelas] [Bercakap tanpa menggunakan pembesar suara]*

Encik Sean Wang [Allianz]: *Okay, sure.*

Encik Charles Ong [Allianz]: *So, in 2024, okay on average, I think is about 20 to 30 percent of my total customer in medical business, they are subject to repricing.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay.*

Beberapa Ahli: *How much.*

Encik Charles Ong [Allianz]: *Okay. On overage is about 40 to 50 percent. We actually show that— okay let me explain for this why inquire 40 to 50 percent. Yes, maybe I pause here first.*

Encik Zakri Mohd Khir [Allianz]: *Okay. So, that for Allianz*-lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Berapa persen? *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: 40.

Encik Charles Ong [Allianz]: *40… [Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [GE]: *For Great Eastern is between 30 to 50 percent. In fact, it depends on different cohorts. If fact for us ya…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The average out the cohort*-lah. *[Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [GE]: *No, no. It's between 30 to 50 percent as I've said. What is more important here is we have make the assumption on the claims. Yes, on the claim experience.*

If the claim experience over the next three years is able to reduced, then we will— yes, YB. The 30 to 50 percent for us is for the next— when we look at the claim experience that we are experiencing. We are saying that by increase 30 to 50 percent in the next three years I don't need reprice anymore.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Dato Koh Yaw Hui [GE]: *So, if today if our negotiation with the hospital for instant is effective. If we are able to bring the claim experience down then we be able to extend the three years to four years and five years.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, is not...*

Dato Koh Yaw Hui [GE]: *The next five years you don't need to reprice.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *It is not per year*-lah, *not per year*-lah.

Dato Koh Yaw Hui [GE]: *No, no, no. This is stable for year.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What about AIA, AIA?*

Dato Koh Yaw Hui [GE]: *It's stable for a year. Is 30 to 50 percent.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Is two three years.*

Dato Koh Yaw Hui [GE]: *For three years and that depends very much because we have made the claim experience assumption.*

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Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, about 15 percent per year average.*

Dato Koh Yaw Hui [Great Eastern Life Assurance]: Ya, *it's about 15 percent. There about— close to the which is very close to our current inflation.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: AIA berapa? AIA berapa?

Encik Ben Ng Kee Heng [AIA]: *Yes. So, for AIA YB, last year we have some cohort again. The quantum is different by cohort. One cohort is at 25 percent and another cohort is at 40 percent. The reason the core at 40 percent is because the product was launched five years ago. So, its hasn't been adjusted the price for a long time. But, its respective right now we all follow Bank Negara interim measure guidelines right now. So of course, the one of the things you know, may I take the opportunity to also talk about 60 years old because many of us here either 60 or going to cross 60 very soon including myself.*

I am still quite troubled with the discussion around like when I was as kid. My parents try to encourage me to become a doctor, but because my biology is not good enough, so I am ended up in insurance rather than as a doctor. But, all the things is about saving life. So, I'll be quite uncomfortable if doctors and hospitals are compromised care because of profit. I hear about the investment that to make into technology and all that, actually not very well known by everyone. Actually, insurance company in January, we don't make money in the first year when we sell a policy. I think the policy, January depending on product could take three to seven years to start to make money for life insurance. Actually, that one actually takes time. These are investments.

The other thing is YB, is all the insurance company have to set aside what we called required capital, reserved and required capital. So, its not like premium is higher than claims, we can straight away take the profit. We…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What is the required capital for AIA?*

Encik Ben Ng Kee Heng [AIA]: *The required capital like in company like AIA is in the billions. So, we have set aside these billions of required capitals. So that one I think is important I thought to be fair to the industry. Actually, we have a long period to you know, to invest as well and we also have to set aside required capital. I just want too also just comment on the OH. Actually recently I— because I think insurance product is only one part.*

Actually, I like what EPF did recently. What they tell Malaysian, at ages 55, you need to have RM240,000 savings to retire because you probably going to live another 20 years. So, but RM240,000 is obviously not enough based on the discussion we had and that's how we know even not enough just to cover for the medical costs. So, I think I will say maybe together the industry and the government can look at how we can first, improve on the education.

Secondly, just now we also talk about deductible. So YB, I have roughly—I lose count. Probably I have 20 insurance policies myself…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you. Thank you for the info. So…*

Encik Ben Ng Kee Heng [AIA]: *I have never used policy, but for the medical insurance, I pay 50 percent of someone of my same age because I buy high deductible plan. Because I'm fortunate— because employer cover. So hence, the thing is its not about the government only, there is role for government, individual, but there is also perhaps the role for employer and see we can encourage the employer to do more.*

Thirdly, I think its important for savings. I think in the Singapore case, Singapore has a basic product called MediShield for everyone. But, Singapore also mandate in the CPF, you must have savings for use for medical. So, its important that you know, we also educate— but also get people to take ownership about the future medical needs as well. For once in some way also there will need some public funding, whether it's for public healthcare also for a needy group because there will always be a segment of population that will need help from the government. Thank you.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you. At least, today we learned a lot about insurance. [Ketawa] Next week we going to learn a lot about private hospital.*

Encik Ng Kok Kheng [Pengerusi Persatuan Insurans Am Malaysia (PIAM)]: *Sorry.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You and me will both have the same, something common. I worked in Taiwan before, Taipei for three years. [Ketawa] Thank you.*

Encik Ng Kok Kheng [PIAM]: *YB, sorry. I know I haven't been speaking at all. I think all this additional information like you want to find out from the insurance company, individually, what their increases has been and how they do their pricing. That there is a discipline and there is a structure to it. There are pricing policies that insurance company have to come out. So, they do follow a very strict guideline in accordance to regulations that Bank Negara provide.*

I just wanted to— I mean I just thought that maybe we should also come to look at what really is the basic problem why we are having this meeting here today. Because as an insurance company, I think we are just the consequence of something that has happened. The consequence is that they need to price their premium up and what cause the price of the premium to go up. Its basically the other things that's happening. One of them is medical costs inflation.

I was very interested when we look at the statistic that Mark O'dell provided earlier of course, from the industry. When I look at Japan, their inflation— medical costs inflation is 0.9 percent, Australia is advanced country five over percent, but all the rest are close to the 10 and maybe even more than 10 percent. I think we don't even have to talk about the US, probably the highest in the world. I think if you all know what happen there is people have to find the job to get insurance cover. If you don't have a job, they cannot afford insurance. The insurance companies have to control the costs.

Therefore, they imposed these things like you know, maybe even controlling the hospitals and even the treatments to the extend that we have this recent incident why the United Health CEO got shot you know. Because he was trying to control the cost as well. Its for profiteering basis. But I think the important issue is the medical costs is still going up. We are part of you know, the entire chain. So, I think the information that you want I think, we can provide to you. But just an interesting thing is that how do Japan keep it at 0.9 percent?

Interesting is this morning we had discussion with a group of Japanese insurers came to visit. As you know, I asked them this question you know. They said

that in Japan, they whole medical thing, is actually with a lot of effort there is done by the government. The government is very much in control. The ministry is managing because they even determine how price of certain treatments and drugs and so on are managed you know. They said that medical insurance premium increased all this are not an issue for them. When I explained to them our issue that we are currently facing, they were quite surprised you know. So, we did talk to them and perhaps, there is something that maybe in our future you know, engagement with them will could find out from them what they do.

But, it's not from insurance industry. I think is the whole ecosystem including the way the government manage it— I put that as priority, that national health scheme. Having a national health scheme may not solve our problem. Because your national health scheme costs can also go up. Because it's related to medical costs, right? So, if you have a national health scheme, somebody's got to pay for it too whether it's a sharing basis or whatever. But if you don't manage that part of the costs, the costs will still go up.

I remember in Australia when I was there, they have Medicare for the last 30 over years. Everybody pays a premium from their salary. I think its automatically deducted. That has also gone up, you know. I think from when they started, it was like one or two percent from everyone's salary. I am not sure what the increase to— I think its… [Dicelah] Ya. *So, but they manage it as a whole country system. So, I think this an area we really have to pay attention to as well. Otherwise, each one will be having their own you know, agenda and its going to be very difficult. That's what I thought. Ya, thank you.*

Encik Sean Wang [Allianz]: *If I may add YB, so I think closer to home, NTUC will be a very good case in point to study. So, they had been into quite a rough cycle as well. But having it is not good enough. There will be volatility as well. There are times that the basic plan. Honestly, they are losing money as well anyway.*

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So, it depends on saluran *and sponsorship from government and also the private sector also. So, it has to converge somehow, right? Since the band is back,, I would just like to give some number YB you asked about required capital just now and I don't mind sharing from Allianz. Of course, my business is not as big as AIA. Of course, they need to put aside billions of dollars but still on the individual basis for health insurance, every ringgit that I write, so now we are deviating from P&L. No longer profit and lost. Now we talk about the balance sheet, right.*

So, I have to put aside 50 cents. Just imagine if we have to run this business so and so every ringgit of top line that you put in you have to also sendiri *you got to*

fork out capital and put there 50 cents. So, it's not as lucrative as it looks like when you just look at P&L but the cost of capital is also something that wish you have a very different conversation and hope APHM and also the private hospital they invest in equipment ant they don't need to default their balance sheet in that sense when it comes to financial discipline, case in point. Thank you.

Encik Mark Steven O'dell [LIAM]: *Can I add a little bit to especially to what YB Sim was asking earlier, I didn't get the chance to respond. You talk about the commission. We've tried on our own actually. We try to get the doctors and the hospitals together with MOH and Bank Negara and the association and we realised that we had no authority, you know. We can't come together and decide on something to do together because that is anti-competition.*

So, depending on how this sort of commission thing might be set up, it could be quite useful to settle grievances between parties. I just want to say also we thought a lot from time to time about national health insurance or national health insurance scheme. Generally speaking, I think the industry is in favour of a national health insurance scheme. Also, where if any part the private sector could play on that.

Lastly, I just want to comment that I'm glad it came out that the price increase is a multiyear because there is a misconception that if somebody raises their premium 40 percent is just for that year. It is usually for two years; three years could be for four years. Every company is on the different schedule or scheme in terms of how often they reprice. Thak you.

Tuan Sim Tze Tzin [Ahli PAC]: *YB Pengerusi, I want to raise another issue which is investment-link. During our public hearings, a lot of people talk about investment-link. They also feel that this sometimes is actually you promise something but deliver another thing. Say for example, investment-link the first six years, most of— bigger chunk of the money actually goes to the agent, okay as their commission. Only after the six years the money actually goes into the pool, to the investment fund. The investment fund also there are management fees, the professional fees of several percent. Sometimes up to 10 percent.*

So, to them it's that actually they put in they actually don't get that kind of money to actually you know after six years only they can see something goes into that really the investment. So, this is something I think the industry must look at because I think that is also not fair to the people who pay for that. Can you comment on this please?

Encik Mark Steven O'dell [LIAM]: *Ya. First of all, there is a thing called the minimum allocation rate which by Bank Negara rules include even the first-year part of your first-year premium must go and be allocated by units. So, it is not true that it*

will take a number of years before there is any value in the policy. But there is an amount, it's 160 percent over six years that goes towards the total compensation. I agree with you that probably not the bulk but more than half will go to the agent. Then, as you know, there are layers, right. There are two layers right. The management fee is usually one and half of two percent. For bond fund, it could be less than one percent.

But I think the what happened and this happened in a few years back actually. They came into play sustainability regulation. Now, it used to be you could sell investment-link at you know, almost let's say any premium. You know, for any duration, the policy would last as long as the premium was sufficient to pay for the cost. But then they put in this regulation that you have to set the premium that is sustainable rightly so for a certain number of years according to what you are telling your customer that this coverage is going to last for. So, if it is going to last for 65, you have to have enough premium to last you until 65. So, what happened is now, every year, everybody gets the sustainability statement. If they close to the line and the investment doesn't perform well, they may be asked to top-up more premium. If not, then they will say that your policy will sustain itself until whatever age that you expect. But I think it's not quite as bad as maybe you were told. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, ada apa soalan lagi? Tidak ada ya? Jadi, bagi pihak PAC.

Tuan Sim Tze Tzin [Ahli PAC]: *Maybe last question. Dr. Mohamad. You are former policy advisor to the Prime Minister. Can you advise us in this meeting? Thank you.*

Dr. Muhammed bin Abdul Khalid [Allianz Malaysia Berhad]: *Of course, I can. But before I say that maybe I'll reiterate some points while we are here for clarity. We increase at least from Allianz, we increase our premium not because we want more profit, because the cost has increased. We should show how the cost has increased. Drugs, equipment as well as the number of people that go to hospitals. Cost increase, you have to increase your premium. Like even you sell nasi lemak, cost increase, you increase the price. Like any other business. That number one.*

Number two, well like I said, cost increase not because we are at extreme profits. We show earlier our margin is only three percent on medical. As Allianz Group, we make more money on general. You buy cars mostly you insured by us. So, margin is very small.

Number three, can we not increase our premium? Very difficult because then you cannot sustain the pool in the long run. Number four, it is in our best interest to ensure that people still buy insurance and they are protected. That is why when our

CEO just now was mentioning you, come to hospital we never question how you treat them. You want— when you are sick, if I'm sick, you are sick YB, you want the best. We want the best for you. We never question. So, our priority is the patients. We didn't negotiate with the hospitals, so we pay number one.

Number two, as a listed company, a private company, we have a duty to shareholders also. For Allianz, almost 30 percent is owned by locals. Our second largest shareholder is EPF. Third largest, SOCSO, also has shares with us. So, we have duty for our shareholders. I think the important point that I want to raise here also Allianz is a very responsible company. I will come to my final point later. We invest a lot in Malaysia, we are not 100 percent owned by foreigners, Malaysians own also this company. We have a duty. National building is our duty.

I want to 'action' sikit*. We think we are the only one who sponsor, big sponsor of Malaysian Paralympic, we sponsored for Paris and we just signed for Los Angeles. Not only to sponsor, but also for athletes who retired. We train them, so, they can become an agent and they can become self-fiscally independent later on. We do a lot also insurance Rahmah, on general. We are the first. I can share we met the last* arwah *Minister. We said we want to do Rahmah; we were the first to launched our Rahmah product. That to set the context what we do and why we are here*

Now, to answer your question what do we do? Can we maintain the price? The answer is no. The second, if we cannot maintain the price, can we manage it? The answer is yes. For Allianz, we try to manage, we negotiate with hospitals. We have our direct line. Before you go to a hospital, you can call us. So, you try to reduce number of people that go to hospital. Now we see a lot of people that sakit sahaja terus hospital, sakit sahaja terus hospital. *Because like one of the YBs said, you pay so much, you never claim.* Masuk hospital *might as well. So, we want to reduce, they want to reduce that. Negotiate with hospital, number two. So, the increase will still remain.*

Number three, how do we maintain this? Is private insurance is the problem or public hospitals? If you are sick, where do you go? In terms of priority, this is not my priority. This is personal opinion ya*. Type* pula *is* Hansard kan nanti. *I would focus on public hospitals. I will not focus on private. The spending on out-of-pocket, Zakri showed earlier, 36 percent out-of-pocket those who do not have insurance. That is the bigger issue. If the discussion later on one of the summaries, how do we ensure every Malaysians not just those who buy insurance have quality access and timely access to public healthcare. You know our medical condition is not good, maternal mortality has increased, stunting has increased, overweight has increased, wasting*

has increase. We are not healthier. I would focus on public hospitals. I would not focus on this. That will be my comment. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, bagi pihak *Public Accounts Committee* (PAC) saya ingin berterima kasih kepada Yang Berusaha Tuan Mark Steven O'dell; Ketua Pegawai Eksekutif Life Insurance Association Malaysia, Yang Berusaha Tuan Mohd Radzuan Mohamed; Ketua Pegawai Eksekutif Persatuan Takaful Malaysia, Yang Berusaha Tuan Ben Ng Kee Heng; Ketua Pegawai Eksekutif AIA Malaysia, Yang Berbahagia Dato Koh Yaw Hui; Ketua Pegawai Eksekutif Great Eastern Life Assurance Malaysia dan Yang Berusaha Tuan Ng Kok Kheng; Pengerusi Pertubuhan Insurans Am Malaysia dan Yang Berusaha Tuan Zakri bin Mohd Khir; Pengerusi Allianz Malaysia Berhad. Ada lagi tak?

Yang Berusaha Dr. Muhammed bin Abdul Khalid; Pengerusi Allianz General Insurance Company (Am) Berhad dan juga Yang Berusaha Tuan Lim Eng Siong; Ketua Pegawai Eksekutif Prudential Assurance M. Berhad. Terima kasih saya dan PAC ucapkan kepada semua kerana sudi hadir di hadapan PAC bagi membekalkan penjelasan pada hari ini. Sebelum saya— di sini saya ingin mengumumkan penangguhan prosiding PAC pada pukul 6.02 minit. Sekian, terima kasih.

[Mesyuarat ditangguhkan pada pukul 6.02 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Selasa, 4 Mac 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Federation Of Private Medical Practitioners' Associations, Malaysia (FPMPAM)
Dr. Shanmuganathan Ganeson
Presiden

(ii) The Association Of Specialists In Private Medical Practice Malaysia (ASPMP)
Dr. Sng Kim Hock
Penasihat dan Bekas Presiden

(iii) Dato Dr. Lee Boon Chye
Mantan Timbalan Menteri Kesihatan

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

SELASA, 04 MAC 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Datuk Ali anak Biju [Saratok]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Puan Vivian Wong Shir Yee [Sandakan]

Tidak Hadir *(Dengan Maaf)*

YB. Tuan Haji Azli bin Yusof [Shah Alam]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Mazidah binti Mohamed [Ketua Penolong Setiausaha (Seksyen Sinergi dan Kolaborasi Strategik) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Siti Noor Akmar binti Zulkafli [Juruaudit (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Ahmad Syahir bin Roslan [Pegawai Tadbir (Seksyen Sinergi dan Kolaborasi Strategik) Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam (JPA)

Encik Nor Zahidi bin Abdul Rahman [Ketua Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)

Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)

PKPj Suzana binti Alias [Ketua Cawangan (Bahagian Penyiasatan Tata kelola)]

Kementerian Ekonomi (KE)
Puan Noor Diana binti Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K), Bahagian Perkhidmatan Sosial (Bahagian Infrastruktur dan Kemudahan Awam)]

Jabatan Akauntan Negara (JANM)
Puan Noor Azira binti Abd Rashid [Akauntan]

SAKSI

Federation Of Private Medical Practitioners' Associations, Malaysia (FPMPAM)
Dr. Shanmuganathan Ganeson [Presiden]
Dr. Steven Chow Kim Weng [Pengasas]
Dr. Lim Kuan Joo [Penasihat]
Dr. Chang Chee Seong [Ahli Jawatankuasa dan Mantan Presiden PMPASKL]

The Association Of Specialists In Private Medical Practice Malaysia (ASPMP)
Dr. Sng Kim Hock [Penasihat dan Bekas Presiden]
Dato' Dr. Ahmad Faizal bin Mohd Perdaus [Ahli Jawatankuasa Reformasi Kesihatan ASP. MP]

Lain-lain
Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

SELASA, 04 MAC 2025

Mesyuarat dimulakan pada pukul 11.32 pagi

*[**Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin***
mempengerusikan Mesyuarat]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh.* Selamat pagi dan salam sejahtera Ahli Yang Berhormat, Ahli-ahli PAC Parlimen Kelima Belas, ahli-ahli ex-officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen selaku wakil daripada Jabatan Peguam Negara.

Yang Berhormat ahli-ahli mesyuarat sekalian, hari ini PAC Parlimen akan mendengar keterangan dan juga penjelasan berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan juga Bank Negara Malaysia. Sebagaimana semua sedia maklum, prosiding ini diadakan bagi tujuan mendapatkan penjelasan mengenai faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan juga caj hospital swasta, termasuklah kos perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan juga faktor luar seperti pandemik.

Dalam usaha mencari jalan mengurangkan impak peningkatan premium insurans kesihatan dan juga kos perubatan serta memastikan akses kepada penjagaan kesihatan yang berkualiti, adil dan juga mampan bagi semua lapisan masyarakat, PAC berpendapat adalah wajar untuk kita dengar penjelasan daripada pelbagai pihak yang terbabit.

Yang Berhormat ahli mesyuarat sekalian, hari ini hadir di hadapan PAC adalah Yang Berusaha Dr. Shanmuganathan Ganeson, Presiden Persekutuan Persatuan Pengamal Perubatan Swasta Malaysia (FPMPAM); Yang Berusaha Dr. Steven Chow Kim Weng, mantan Presiden ataupun pengasas FPMPAM, ada hadir? Yang mana? Okey. Yang Berusaha Dr. Lim Kuan Joo, penasihat FPMPAM; Yang

Berusaha Dr. Sng Kim Hock, penasihat dan juga mantan Presiden Persatuan Pakar Amalan Perubatan Swasta (ASPMP).

Seorang Ahli: Belum sampai. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Dr. Sng belum sampai ya. Yang Berbahagia Dato' Dr. Ahmad Faizal bin Mohd Perdaus, Ahli Jawatankuasa Reformasi Kesihatan ASPMP...

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [Ahli Jawatankuasa Reformasi Kesihatan ASPMP]: Saya.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: ...dan juga yang ini *special* sikitlah. Yang Berbahagia Dato' Dr. Lee Boon Chye, mantan Timbalan Menteri Kesihatan yang mana telah pun berkhidmat daripada 2 Julai 2018 dan 24 Februari 2020. Selamat datang saya ucapkan kepada semua yang hadir dan juga memberikan komitmen kepada PAC bagi memberikan penjelasan pada hari ini.

Sebelum saya nak menjemput saksi-saksi memulakan pembentangan dan juga memberikan penjelasan, saya nak maklumkan kepada semua, kepada ahli mesyuarat sekalian bahawa prosiding PAC ini adalah tertakluk kepada Akta Rahsia Rasmi 1972 [*Akta 88*] dan juga Peraturan Mesyuarat 85, Peraturan Majlis Mesyuarat Dewan Rakyat sehinggalah prosiding ini selesai dan juga dibentangkan laporan tersebut di Dewan Rakyat.

Jadi, tanpa membuang masa, saya dengan ini menjemput Yang Berusaha Dr. Shanmuganathan Ganeson untuk memulakan pembentangan. Dipersilakan Dr.

Dr. Shanmuganathan Ganeson [Presiden Federation of Private Medical Practitioners' Associations Malaysia (FPMPAM)]: Terima kasih YB Datuk Wira Mas Ermieyati selaku Pengerusi PAC, YB Puan Teresa Kok, Naib Pengerusi PAC; Ahli-ahli PAC yang lain dan para hadirin sekalian.

Saya sebagai Presiden Gabungan Persatuan Pengamal Perubatan Swasta Malaysia mengucapkan terima kasih atas undangan untuk membincang isu-isu berhubung dengan peningkatan premium insurans. Saya ada beberapa slaid dan saya akan usahakan dalam bahasa Inggeris seterusnya.

Can we have the slides for that? The ASPMP's slides. Yang dari *Federation* punya. *Okay, while they are fixing the slides, the Federation of Private Medical Practitioners' Associations of Malaysia was formed in 1999. We have about 5,000 members and we comprise of state medical societies from both West and East Malaysia. [Merujuk pada pembentangan slaid] So, we have people from Kedah, Perlis, Penang, Perak, Selangor, Wilayah, Pahang, Sarawak, Sabah. We have associate members on the other states.*

So, our team today, myself as President. I've been President for the last two years. Next is Dr. Steven Chow. He is the founder and immediate past President and he will enlighten some of the issues. Dr. Lim Kuan Joo is representing public health. He is actually the first Malaysian to graduate with public health from Europe. So, we are honoured that him here and Dr. Chang Chee Seong is a committee member and past President of the state society of Kuala Lumpur / Selangor.

So just an introduction. We are facing the medical cost inflation rate. That is a significant challenge for both the doctors and patients and that is the reason we are here today, I guess. Look at the statistics on the inflation rate. 12.6 percent in 2023, more than double the global average which is 5.6 percent and it increase by 12 percent in 2022.

So, what does the insurance say, they say that price adjustment is inevitable but Chia Chu Hang of the EMIR Research, he is an assistant researcher. He came up with these figures. Allianz in 2019, profit before tax RM365 million. In 2023, went up to RM577 million. Prudential Assurance Malaysia, RM573 million. In 2023, it was RM1.42 billion. 147 percent increased.

Now for the hospitals, the Association of Private Hospitals in Malaysia explained that private hospitals are by design business entities. That allows patients to make voluntary choices regarding the treatment.

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The rising costs are too great for private hospitals to absorb unless they increase their prices. But again, Chair points out look at what the financial report suggests. IHH Health Care, which operates 18 private hospitals, made RM1.04 billion in 2019 and went up to RM4.05 billion in 2024. KPJ Health Care's profit before tax 2019 RM217 million, in 2023, they went up to RM370 million. So, these are big figures.

So, let's now look at the causes of medical inflation. For this, I will pass over to Dr. Steven Chow to continue the presentation.

Dr. Steven Chow Kim Weng [Federation of Private Medical Practitioners' Associations, Malaysia (FPMPAM)]: *Thank you Dr. Shan, YB Puan Pengerusi; YB Dr. Lee Boon Chye. I was the President of the Federation. We just short term calls it, ya for at least 20 over years. I'm not a GP. I'm a dermatologist in private practice in a private hospital. I think it's important we be all on the same page. Otherwise, it will be an argument looks like cows come home.*

Has the cost of health care gone up over these past 20, 30 years? The simple answer, yes. The absolute cost has gone up. The absolute cost. Number two, why is this so? Okay. We talk about medical inflation in a very simplistic way the total cost

divided by the number of years, okay. That's the simplistic way. But if you look at the cost of medical care or going up, there are many factors. It is not a simplistic thing, you know. I totally disagree with the Minister of Health's recent comment that to control this issue, alright DRG is the answer, okay. Display of a medicine cost in the GP's clinic is the answer. It's too simplistic. It's more complex than that.

Why has our budget for health care gone up? It's very simple. The population has grown. Dulu, *what 25,000 on million people. Now, we have 30 over million people, alright. The standard or the benchmark of medical health care has gone up. Simple example, a head injury. A head injury in 1970's, when Dr. Lim Kuan Joo was practicing and Dr. Lee Boon Chye was practicing in the hospital system. You admit the patient, keep them for 24 hours, do what they call a head chart. The head chart is where the nurse waking you up every 15 minutes and record. Is the patient conscious bla, bla, bla, bla, alright. 24 hours later, alright, he is okay, you go home. At most, you will do a skull X-ray. Am I correct? Same page, isn't it?*

But today, in 2025 if someone comes in with a head injury, if you do not admit him and they do not have a CT scan, at least, then you are in deep trouble. If this case ever goes to the court.. Likewise, a child with a fever and a rash. Okay, the GP will say, "Oh, this is a viral rash, measles perhaps". But can you let this go today? No man, you better investigate this child for dengue, it's a little joke lah. *Maybe for leprosy also, okay. Or else we will be in deep trouble. So, the standard of care expected by the patient, expected by the public, expected by the Members of Parliament here, they are quite different and definitely, expected by the court, okay. And, this produces increased medical legal litigation cost which are more apparent right now.*

Now, insurance blame doctors. When they fail to blame doctors, then they blame the hospitals for increased cost, okay. Alright, and they will give all sorts of reasons, all sorts of data to prove that this is cause for the medical inflation, okey. Hardly ever blame themselves. Today, the insurance control the flow of patients to doctors and hospitals. Private hospitals I'm talking about. Public hospitals are not being controlled yet. These are simple terms. The middleman of the industry. The middleman of the industry decides. You want to see a doctor, please go to the middleman. Doctor, you want to see this patient, please go through the middleman. Am I correct? The middleman does not work for free. He works for a fee and this fee can easily mount year by year.

What has insurance done over the years? Over the past 10 to 15 years? I'll share you the story of a company called ING. In the year 2010, they were B-I-G. In that year, they tried to arm-twist the doctors. "Doctors, we want 30 percent of your professional fees. Otherwise, you will be taken out of the panel". True story. The

doctors fought back. Not a big number of them but in various hospitals, they fought back and the insurance gave up. Now, insurance they tell private hospitals, "If you want 40 percent cut from this, 50 percent cut from this or we will take you off the panel". Why they do this and how do they manage to acquire this process? It's very simple They now control the industry.

They bought in cheap. They sold their policies very cheap. Companies bought in and now, they control the industry. It's time to harvest. They are not here for the charity or prize. They are not here for charity. They are here to make money and when they are done with their bidding, they will leave. They will sell off. Company has sold off before leaving unpaid bills, you know. This is on record. Companies—insurance, and then sales have sold off leaving unpaid bills. So, where is this cost of our medical inflation? Not the doctors, not just the medicine costs, okay. The whole system needs regulations. Proper regulations of the industry, so that the cost can be controlled.

You can't just say regulate the doctor, regulate the hospital but not regulate the other middleman business. We have asked for the open letter to the PM in 2023, "Please enact regulations to regulate the business of medicine". Okay, this open letter was sent to PM and then followed by a petition by more than 2,000 over private doctors. Okey, we'd like to know is this measure correct or wrong? Are we barking up the wrong tree? And this particularly message is not just new you know. We have been bugging this for the past 20 years since a year that 1998 when the Private Health Care Facilities and Services Act was passed. I think I will reserve further comment on this but the bottom line is the doctors are not to be blamed. It's a multi-factorial issue, okay. The DRG is not the magic bullet. If you follow the history of the DRGs, in America, around the world okey, you will clearly see that DRG is not the answer, it's not a silver bullet, okey.

Countries that have gone to risk phase, now we are entering that phase, alright. From that phase is now next step is value-added health care. This is a well-trodden commercial process. We have an excellent system in Malaysia, we should nurture it, okay. Where do we go wrong? I think reforms are needed. Definitely, reforms are needed. But in the process during the reform, we must bark up the right tree, okay. The GP's is definitely not the right tree. Our system is in danger. We are at the eye of a perfect storm. Why do I say that?

The healthcare system in Malaysia is like a stool, a three-foot stool. Bangku tiga kaki. *The health of the entire population sits on this stool. The public health system is breaking down. COVID-19 accelerated it. So, you see resurgence of*

leprosy. TB, malaria. Something is going on you know. It shouldn't be there, alright. The hospital services which are our secondary care, also got problem.

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He got brain drain issue. He got inequality system, mild disputation of manpower resources. That system will break down. Then the primary care which is the third leg is also being sawn off. GPs are not able to survive. The GP system the solo practitioner 40 percent looking over 60 percent of patients were longer be tenable. Then that breaks the whole system will collapse. Whatever we do please do not deform the system Yang Berhormat Pengerusi*. Thank you.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *I think we can go further to the presentation.*

Dr. Shanmuganathan Ganeson [FPMPAM]: *These are the causes of the medical inflation. Dr. Steven Chow has actually given his point of view on all the issues talked about the stools, the three legs, all three legs and danger of breaking.*

Let's quickly go through this next slide. Number one, pandemic we learnt a lot lessons there. Lot of logistic challenges during COVID-19. Demand outstrips supply during the time. So, hysteria— because we couldn't getting like masks for example. How to approach the patients. Doctors saw patients from a distance and so on. The next one is higher over cost. Put medical, non-medical and also the currency with the ringgit being low.

Underutilisation of primary care. Luckily during COVID there was a public-private partnership. For the first time the government worked with the GPs to do both the detection of COVID-19 and also subsequently the vaccination. Primary healthcare is very cost effective. But what we see policies from the ministry, policies from the insurance, public perspective itself and all these that now tend to bypass the GP.

Look at insurance claims policies. They only allow claims with admission. Even the simplest of thing need to be admitted. That's a cost. Outpatient or daycare procedures actually reduce cost. We should go for that. Procedures at the GP lower the cost. They make use of the one great asset in Malaysia, the GP. They are not being used. They also look at the rising premiums due to other things. Extended coverage, pandemic coverage, post COVID syndrome, critical illness and so on. These also give rise to increase in insurance premiums.

Practice of defensive medicine. This is too much of a good practice. Then for every patient they bring in too many sub specialties and specialties to look at them and increase the cost. Moral hazards. Now in public health moral hazard is an issue

we need to quickly put in all the checks and balances to overcome these hazards whether it is on the doctor side, whether on the patients themselves.

Rise in healthcare cost. I let Dr. Chang say a few words on this.

Dr. Chang Chee Seong [FPMPAM]: *Hi good afternoon everyone. My name is Dr. Chang. I am general practitioner. I would like to just share my experience as a GP. I've also experienced working in a private hospital in an emergency department. You see for healthcare cost when we talked about cost of healthcare there's a lot of other things rather than just professional fees.*

During pandemic a box nitrile gloves that cost RM15 in 2019. In 2020 the cost is RM45. At one point it went up to RM60. After pandemic we know that when price goes up it hardly comes down. Now the box of same nitrile glove compared to four years or five years ago is about RM28. Almost a hundred times increase in price. When we talk about healthcare cost it always was— people always think of doctors are charging a lot. Professional fees getting more. But if you check your facts the GP fees schedule has not changed for 33 years. Even the specialist price they are all regulated. There is a maximum charge for the specialist as well.

If we can be one very sure about one thing, medical inflation is not caused by professional fees. That is very sure. I think the specialist and any other doctors here can attest to it. Even in the public sector if you talk about professional wages, public servants' wages has not gone up that much. It is definitely not comparable to inflation. I just want to say that if you want to look at what is the cause of rising healthcare cost, I think you will have to look at the bigger picture and investigate more clearly.

Dr. Shanmuganathan Ganeson [FPMPAM]: *Thank you Chang. These are the questions that we should be looking at. Dr. Steven you would like to go through that?*

Dr. Steven Chow Kim Weng [FPMPAM]: *I want to follow up on what perhaps we should learn from history. Where are we in the Malaysian context say compared to the rest of the world. Particularly the US. We have entered a stage of commercialising of healthcare. Look. Four Ministers ago, we brought up the term. The Million Dollar Doctor Syndrome. That means for a family to educate a son or daughter in medicine it will cost them a million dollar. When this son or daughter comes out, he will have to find a way to repay these million dollars.*

Not only healthcare delivery has been commercialised, even the very education of it has been commercialised. Can you address the other end without addressing this and no way. Your reforms must be right through. In the US they have gone through this. We can draw valuable insights from their lessons. The US system is very clear. The first phase was so-called the indemnity phase where it was just

cost plus reimbursement. Just like what the insurance use and MCOs used to do. Fee for service. So cheap. They bought in the whole system very cheaply. They sell to you. This led to cost escalation.

Then they go to a second phase to control cost. Talking about DRG pricing. This shifted the financial burdens on to hospitals. What are we are seeing now. Creating mergers and selective closures. Some hospitals are closed. A lot of GP clinics are closed. Why do I say that? Who wants to be a GP today looking after the real sick people with dengue, blood pressure, diabetes? No. They'd rather do aesthetic work. One patient is enough to pay for the whole day of collection in the GP clinic. So, you're gonna have systems where either the GPs are merged or bought up. It's happening by local and as well as foreign entities. No one wants to be a GP anymore. When this system is then bought up, what will happen. It will be commercialised as well. Now can you imagine your 6,000, 7,000 or 10,000 GPs half of them do not want to practice anymore.

The older guys have said look I am tired. You got his regulation, that regulation. Now you got e-invoicing. He's 60 years old, 50 over years plus you are talking about e-invoicing. It will require more cost. He has to buy a new system. He had to employ another clerk to just run the system every day. In the past one GP with two nurses, or clinic staff can look after thousand of patients. Now we cannot do that. All these regulations will increase cost and kill off the system. Then you got all your other reasons why they should not to practice to be a GP. And can you imagine when your GPs are knocked off. Your government clinics will be totally swamped.

■1200

So, that is the DRG phase. Where they shift financial burden onto hospitals and as well the GPs.

When this is done, they will go on to performance-based pricing. That's yet to come but you've got a rising signs of it coming. Pay for performance only. The patient doesn't get well you don't get paid. What sort of business is this? What business model are we talking about?

So, we got to learn from these historical shifts that is clear cut in the US, in the UK and we must— I urge the PAC to advise the relevant government authority or person that there are potential pitfalls. Before we even enact any board or reforms, get feedback from the bottom. We have always use top to bottom.

All the directives brought down into the private sector have been top to bottom. I think it's about time to do what we used to say bottom-up. For instance, this

recent directive virtually saying that you will address a system by DRG as well as by displaying over medicine cost.

How much medicine cost are we talking about? People pay more for their sick dog or cat to see a vet than for their father or the children to see a doctor. Am I correct? If I'm wrong please correct me.

*You pay more for your pet to see a vet. When you pay RM60 to see a doctor to address your problem immediately plus its medicine, there is a lot of noise. I think if you give the doctors a consultation, the GPs consultation fee of RM120, they give you the medicine free-*lah*. Free. Should a GP get a RM120 for its medicines?*

Now, what can be cheaper than this system? One doctor two staffs looking after thousands of patient. This the cheapest in the world, the most cost efficient. Do not in whatever you recommend deform the system. Once this system is gone it will never come back again. Thank you.

Dr. Shanmuganathan Ganeson [FPMPAM]: *Thank you Dr. Steven. Let's move on into the next slide. In fact, you want to address that? The open letter.*

Dr. Steven Chow Kim Weng [FPMPAM]: *Yes. So, this is not new. This is something that let's say we have been watching from the back, from the ground. That this system is not tenable. Various people say the system is not tenable because GP charge so much for the medications, hospital charge so much on medication. But your denominator is wrong. Your denominator is a public sector which is virtually free. When something is free, RM1 also too much already. It's not that we are not giving input, we have seen this, we are alarmed by it and they say, "Let's write a letter to the PM." And we did.*

When couple weeks later, we even petitioned the PM. But, I have yet to see any Members of Parliament to say something needs to addressed, these doctors' concerns are quite correct. I have yet to see a single Member of Parliament bringing up this issue because this was an open letter. And we in our years going around to the grassroots we have produced in fact things that we can give back to you bottom-up. We produced a book called "Maladies and Remedies in the Malaysian Healthcare." This is the book that we produced. Two government, three government ago. [Sambil menunjukkan senaskhah dokumen]

We wanted to have each and every Members of Parliament read this book and this book is written and contributed by people who are on the ground. Who have worked in rural areas, in Orang Asli areas, on the streets of Kuala Lumpur. And this is the book I wish I would like to present, Dr. Shan to present to all of you here. We have run short. We have asked the second printing and we will produce enough to give each and every Members of Parliament this.

Dr. Shanmuganathan Ganeson [FPMPAM]: *Thank you.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Wait. Like to interrupt a bit. Dr. Shanmuganathan, you'll have four presentations, right? Can we go straight to the four presentations because I know you'll have a lot of grouses. We have been listening to this for the last four days. Okay, because you know why today there is a Constitution amendment in the Dewan Rakyat. So, we also need to go down to vote and all that.*

So, I appreciate if you all can go through the slides and also find that the slide that you show here is a bit different from what we have. [Sambil menunjukkan senaskhah dokumen]

Dr. Shanmuganathan Ganeson [FPMPAM]: *Yes. We updated it the…*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay. Yes, can you go on.*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Okay, let's move on a bit faster. Next slide. So, what are the ways that we can think of to reduce healthcare cost? I think the GP as a gatekeeper is very important compared to those who have an insurance and all to see the GP first before they can advance to see the specialist or go for admission unless it's an emergency. Next, I think the idea of co-payment is very good. It will have to reduce overuse of health facilities and health services.*

Thirdly, we have a big gap those above 60 who are not insurable under the conventional insurance. This is one area that we should look at to see how to insure them. At least after 70 years old. I think the insurance people can do it. They have got a lot of money. They are making billions. So, we should ask them to consider to look at this. This aspect to cover the senior citizens a bit and there is a lot of demand for this every time we have a meeting with old people, they said, "I'm 60 years old and I can't get insurance." I think one area we can look at.

Next is the regulations and the cost of compliance. Let's go to the slides. So, I have address this and next, go to number four. Now, regulations when they're made you should actually look at the cost that you need to impose on the providers and to the patients. Talking about health regulation.

Under the PHFSA, PHFSA itself increase the cost of running a clinic, maintenance of the clinic, many fold. And again, like I said, GP fees didn't go up everything else went up. So, take a relook at the recommendations of the Malaysia Productivity Corporation. There was a very good book on deregulating unnecessary regulations. This was I think in 2016, I think. But sad to say there was no action. Very good recommendations there, but nothing came out of it.

Next, skip this slide. So, in fact last week we presented challenges faced by private medical practitioners. Just go to the next slide. These are all the issues that the providers have. GP fee schedule, technician, the foreign entry or foreign equity into primary care, dispensing separation, unregulated MCOs, micro-regulation via the Private Healthcare Facilities and Services Act, rising costs of medical negligence and one more was the repeal of Pathology Laboratory Act, without a replacement act and also we want to know what's going on for the National Healthcare Financing Scheme engagement.

Next, so these are the recommendations. Revise the fee schedule, have a flexibility on the price display requirement. The price display is not a matter of transparency, but for the GPs it is going to kill them. Because patients are not going to want to medicine at the clinic and we got two revenue sources. One is the consultation and one is the mark up on the drugs. You take away the mark up, we can't run the place. Where do we pay the salaries, rental and et cetera. I'm sure you've heard a lot of this.

Next for the TPA, you need to establish clear regulation. Now, there are unregulated. They can do anything the like. They can have all kinds of regulations imposed on the GPs. They can act judge, jury and executioner in many of the issues that raised within the doctors and the MCOs. Also, PHFSA regulation need to be revised.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *can you tell me more about this TPA you act as a judge, as an executor. How do they do that? Can you explain to us please.*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Sorry, I didn't get that.*

Tuan Sim Tze Tzin [Ahli PAC]: *Can you explain the role of TPA that you said that they are also judge and also executor. What do they do that makes you feel that like that? Thank you.*

Dr. Shanmuganathan Ganeson [FPMPAM]: *So, we take a situation the doctor has billed for a certain amount let's say RM20,000, right. And then, the TPA pays RM10,000 or not at all.*

■1210

And so, when the doctor now goes to the TPA to say, "Look, why haven't you paid me?" And then, the TPA will say, "You have not done this, this, this, this. A, B, C, D. So, we cannot pay you.", right? This is the true case. It does happen. So, where do the doctors go from here? So, they did an audit and then they found some fault. And then, they don't want to pay based on that. You're talking about the huge sum where the total over the two years was about RM420,000.

So, this is what I mean. They are doing whatever they like.

Dr. Steven Chow Kim Weng [FPMPAM]: *Dr. Shan, let me just give a simple example to YB. Okay, if a certain person comes and says it's a genital complaint. Comes to see me. He carries a guarantee letter. I am not privy to what has been signed between the person company and insurer or the person and the TPA itself. Let's say, I examined him. He has a sexually transmitted disease.*

So, I, as a doctor I've seen. Okay, I've even prescribed treatment. And then, six months later, three months later, he comes to tell me, "Hey, it's a sexually transmitted disease. We do not pay one you know?". The patient has been treated and gone. "We do not pay for this. We do not pay for preexisting". Until and unless you have seen the patient and investigated the patient, how would you as a doctor know that this is a sexually transmitted disease or not?

It is as simple as that. It's a cache 22. But the moment you have seen, you have seen. You are responsible, you will have to treat. But then, the patient said, "I got the GL. I don't need to pay". Thank you.

Dr. Shanmuganathan Ganeson [FPMPAM]: *Okay, we go to the— where was I? So, yes. So, number four, protect local ownership in primary care. We are quite alarmed that there are foreign entities now controlling primary care. Just a matter of time, everything— the decisions on primary care will be made overseas.*

Number five, we need to look at PHFSA and regulations…

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry, Pengerusi…*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Actually, federation also…*

Tuan Sim Tze Tzin [Ahli PAC]: *Do you say local ownership— foreign ownership in primary care?*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Can you tell us more about it?*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Okay. So, we have foreign entities now coming in, forming groups of— piling up groups of clinics and we think that they will now take over the primary care business in the country.*

Tuan Sim Tze Tzin [Ahli PAC]: *Who are they? Can you tell us more specific?*

Dr. Shanmuganathan Ganeson [FPMPAM]: *There's one group of Sumitomo which is the most prominent at the moment.*

Tuan Sim Tze Tzin [Ahli PAC]: *Japanese?*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. All right, thank you.*

Dr. Shanmuganathan Ganeson [FPMPAM]: *Thank you. All right. Number six, I think for medical negligence cases, we need to look at alternative dispute*

resolution (ADR) which is needed to stop going to the court. I think including for the government itself and the lawsuit and all to coming into millions. It is just unimaginable. Only now at the tip of the iceberg, the cases five, 10 years ago coming up now. We are already alarmed. What more? In five-year times, there are going to be many, many more cases with all these various lawsuits for medical negligence.

Number seven, we need to keep an eye on the Pathology Laboratory Act. We must not have the vacuum that there's no act, where the standards of laboratory test are concerned. Lastly, we actually appeal to have private practitioners be involved in the National Healthcare Finance Scheme.

Thank you. I think that's all.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, terima kasih. Siapa lagi *panelist* yang selepas ini? *We have four— yes?*

Dr. Lim Kuan Joo [FPMPAM]: Yang Berhormat Puan Pengerusi, *I will be very brief. I think we have been talking a lot on healthcare costs. Rising healthcare costs. I think the* Dewan, Ahli Yang Berhormat ini *must distinguish between— know the difference between rising healthcare costs and rising spending in health because healthcare cost rise is inevitable. Inflation, people— the drug price increase, healthcare costs will increase.*

But spending is quite different. Spending cost plus demand. There are two types of demand. One is supplier-induced demand. That means the doctor will say, "I will do this test. I will do that test. I will refer you to the…"

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Excuse me Dr., can you introduce yourself? This is for the sake of recording because everything you say will be recorded.*

Dr. Lim Kuan Joo [FPMPAM]: *Yes, yes*.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Your name and your organisation.*

Dr. Lim Kuan Joo [FPMPAM]: *My name is Lim Kuan Joo. Dr. Lim Kuan Joo. So, there are two types of demand. One is supplier-induced demand. That means the doctor will try to give you and the best word in medicine is overservicing. The second type of demand is the patient demand. The patient demands, nowadays are very sophisticated. They will be more pervasive who want to see specialists. I think you are very sure. They will bypass the GP, they want to see a specialist.*

And of course, the demands, there are many other causes of demand. Patient demand, sophisticated more public. But— so, we have to distinguish— and of course, apart from supplier-induced demand, we will have this moral hazard of patients demanding. Patients. That means demand from patients.

The last one which I want to emphasize which affects spending is the profit margin, especially in the private sector. You can see the Dr. Shan has put down many increases in profit of all private hospitals. So, as I said, we should distinguish between cost and spending. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, terima kasih Dr. Lim. *Next.*

Dr. Sng Kim Hock [The Association of Specialists in Private Medical Practice Malaysia (ASPMP)]: *Thank you.* Terima kasih Puan Pengerusi Jawatankuasa Kira-kira Wang Negara. *Thank you for allowing The Association of Specialists in Private Medical Practice to present. Is my first slide on? We are the…*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *You are Dr. …?*

Dr. Sng Kim Hock [ASPMP]: *Dr. Sng Kim Hock, I'm an adviser and former president of this association that represents specialists in private medical practice. So, we are a very small niche group. So, we just look after the specialist. Although we work together with our federation brothers here and MMA. So, thank you for the invitation. I will give the first 12 slides a run through and then Dato' Dr. Ahmad Faizal will continue.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Which one is your slide? Is this the one? High private healthcare?*

Dr. Sng Kim Hock [ASPMP]: *Yes, yes.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *This one is yours?*

Dr. Sng Kim Hock [ASPMP]: *I'm now on the third page. Does everybody have a copy? Never mind, you are not missing much until the slide comes. So, I'm on the third slide and I'd to say that we work alongside and we appreciate— because we are the frontliners. As I mentioned in one or two forums, The Associations of Private Hospitals Malaysia doesn't represent us, we represent ourselves.*

Since the GST came in and the tax came in, we are considered independent contractors. Most of us are not part of the hospital, as salaried but we are independent contractors. There are some coming in as salaried or staff of the hospital but most of us are independent. We saw the fate of what happens to the GPs over the years because in the 60s, 70s, GPs were doing very, very well. If we allow what is happening, it will happen to us too in the future. So, we are not boasting that we don't care about our brothers in GPs. We are together. They sync, we sync. We sync, they also sync. Okay, next slide.

So, the private hospital came in 1974. Sebelum itu, sebelum itu. *Perhaps, in 1932 Negeri Sembilan had the first maternity hospital. Then 1974, fast forward, after Assunta was Pantai Medical Center. It's 51 years. And you know, in the 50 years it's*

flourished like a— so much, you know. We were formed 25 years— in fact, after the Private Health Act which was in a way not in our favor. Next slide please.

So, we all agreed that there's escalation. We are not denying that— we are shocked. Okay. We heard in Penang, I was there, that the appendices have gone up to RM33,000.

■1220

I checked with my colleagues, the doctor's specialist surgeon only gets RM1,500. Just to give you a perspective, the specialists get RM1,500, RM33,000 was that bill in Penang and I asked around is now in the mid RM25,000. They are our so-called employers and partners but to say old technology, appendix has no change in technology. The skill is the same. So, we cannot explain many things but we come to that at the right point.

I think next one, those health system have been mentioned but just give you the data. 149 government hospitals will flourish to 212 medical centres and 71 percent of the beds are in the government while private is 29 percent. So, we are co-partners with the government. So, my first letter, sort of to— we got insulted in the sense that the government wants to apply DRG on the private sector when there is no healthcare system. One healthcare financing system. When there's a known have a nonprofit fund. This is now not a non-profit making. So, to apply it on the 212 private healthcare centres as they did with the 1998 thing, is actually not right because we helped the industry, we grew and Malaysia recognised as one of wonderful centres to retiring because of these.

Current numbers, we have 82,000 doctors of which 18,000 are specialists but this includes the private health specialists to explain the numbers. In private it's 6,000. In fact, the members are growing so fast even for my association. I can't keep up. We can't keep up with them. They are growing so fast. This is as 2024. We admit that for every new private hospital is going to sub from the government sector. We heard in Penang and also in the Parliament that while we want to look at healthcare, we must not forget the government public sector must improve.

I'm a division one officer pensioner but if I get sick, I do not go back to the government hospital. I treated many Ministers. I treated many Senior Ministers in private and asked, "Why do you come here?". For obvious reasons.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I mean, I'm quite surprised to see the figures, 18,000 specialists, that means majority of them are in government hospitals?*

Dr. Sng Kim Hock [ASPMP]: *Of course. It has to be. It should be but their private— now, public health are also considered specialists. Dato' Dr. Ahmad Faizal wants to clarify?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Just a clarification point, YB. All specialists include public health physician, Masters in Public Health. Most of the administrators, hospital* pengarah, pengarah bahagian *in KKM et cetera will be also included in the 18,000. But they are not clinical specialists. If you minus them— we don't have the exact figures for that. If you minus them, there are probably about 14,000, 13,000 specialists overall. So, 6,000 represents about 40 to 45 percent.*

Dr. Sng Kim Hock [ASPMP]: *The other thing YB Teresa is that all the specialists in private centres most of them came from the government centres after many years of service. Of course, some came through the TalentCorp programme where we went all over the world to pick them back. So, those few are the rare ones. But most of us had served the government full service. So, we are the same people. It's not that we are different people.*

In 1999 when I started, it was only about 10 percent who were insured, you see, and now it could be 50 to 70 percent. Some centres more, some less. What I'm trying to say is that the industries have grown. Anything in private would grow. Hospitals grow, therefore, insurances grow along with it. That's the phenomenon. So, as leaders planners we hope that you must protect the industry and not allow it to go down.

So, we support that something has to be done, that healthcare is right for everyone. We heard it from the public time and time again. One thing I want to pick up which surprised me in Penang. The NUTP Association, National Union of Teachers, all are pesara*, why do they need to have a group programme to buy to private healthcare? To me that's ridiculous. You are all a group of retired government servants and you are going to buy in.*

So, it reflects how can it be? In the end everybody wants to go to private health. Nobody wants to go to the government hospitals. That's not the way. We also cannot cope. So, it has— we must grow together. That's the point. We must always allow the free market. If you put in the regulation per regulation, I haven't seen the book about the regulating health service. I think I we will kill the industry.

Here, I passed to Dato' Ahmad Faisal. I think many of you know him and his work in MERCY. He's the President of MERCY. Over to you.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [The Association of Specialists in Private Medical Practice Malaysia (ASPMP)]: *Bismillahi Rahmani*

*Rahim***.** *Assalamualaikum warahmatullahi wabarakatuh*. *Very good morning,* Ahli-ahli Yang Berhormat, ahli mesyuarat. *I will be very brief and direct to the point. I'm Faisal. I'm a respiratory physician in a private hospital, although, I have that other life which Sng mentioned.*

So, the total national health expenditure has grown, as you can see there and the percentage of the GDP, however, has slightly dropped but private healthcare contribution is increasing. That is until 2022 and from our latest observation, 2024 will even be higher. Health tourism is both a plus and the minus, Ahli-ahli Yang Berhormat. *I think in both the PAC's public hearing, YB Sim will testify to this that they were both positive and negative on healthcare tourism and its impact on private healthcare course.*

There are some hospitals, for example, who have different charges for foreign healthcare tourists as compared to locals which are supposed to be higher for the foreign healthcare tourists and that will be correct. But there are some hospitals who either as part of their strategy, have equal or even less charges for foreign tourists which is not correct. Which is then both the alleviation or healthcare cost for tourists and also subtraction causes distortion in private healthcare cost. This is something which needs to be looked at in interdisciplinary approach by multiple Ministries including the Tourism Ministry.

So, I will start with the good news. The good news is most private hospitals are accredited and are good. 13 are even accredited by JCI which is the highest form of hospital accreditation at the moment. Almost all our doctors are trained and fluent in English. So, almost everyone can see our doctors. Easy access to see private specialists. The private GPs are correct. I think it has become too easy.

In actual fact Yang Berhormat*, I don't need as a respiratory physician, I don't need to see you if you have cough and runny nose for five days. But you do, you come and see me. You actually need to see me after you see the GPs two or three times. Not better after three weeks, then you come and see me. But at the moment, people are coming to see me after three to five days. Why? Because the market is distorted. Some people with good insurance coverage, good outpatient coverage can actually do that. This include people who work in Khazanah, PETRONAS, Maybank, all the major GLICs, their coverage is unlimited. So, it's cues the market.*

Referral from GPs is even not required for some of these people. Of course, if you are cash paying and if you are wealthy in Bukit Damansara, Bukit Pantai et cetera, that's another story. But we are talking about people with insurance. We are talking about people with insurance. So, but they are good points. So, you can, if you are sick or your son or daughter or grandchild is sick. I said grandchild here because

now we see a rising trend with the sandwich syndrome, with the sandwich generation that we have at the moment. It's you, grandparents who are now paying for the grandchildren because the parents cannot afford to. Because they make only RM3,000 a month, you make RM30,000, you pay. So, that's because— of course, grandparents care for the grandchildren.

Yes, you will see your specialist of choice. Actually, Ahli-ahli Yang Berhormat*, if you go to any major public hospitals in the the Klang Valley and Penang and Ipoh at the moment, I believe YB Lee Boon Chye is now practicing again. The queues and the crowds are just as overwhelming and as long as any public hospital. It's just that Malaysians are brand-conscious. So, when they pay, they don't complain too much. So, because they think that is worth it to wait.*

Tuan Sim Tze Tzin [Ahli PAC]: *Doctor.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: Yes.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *I want to go back to the last slide. You are talking 13 private hospitals accredited by JCI. Out of 212 private healthcare centres. Am I correct?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes, correct, YB.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yesterday we met MMA. One of the complaints by MMA is that too much regulations and JCI is too high of standard. Correct? We actually don't have— because one of the problems of the cause is the standard too high. Then, when you build a hospital with JCI standard, it costs a lot. So, they are talking about maybe we have to have class one, class two, class three kind of hospitals instead of everything must JCI.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *We have a Malaysian standard already. MSQH it's called. Malaysian Standard and Quality Healthcare accreditation for hospital.*

■1230

All the hospitals in the major chains: KPJ; IHH; Sunway will have MSQH accreditation. That is the first level accreditation now. Now, when we talked about 212 hospitals, there are a number— we don't have the exact numbers, but about 60 to 70 which are smaller hospitals, all around the country mostly stand-alone hospital which are not affiliated to any healthcare group. They maybe the ones who are not accredited so much even by MSQH. So, you do already have a system MSQH which is available for hospitals— not every hospital needs to go to JCI standard

Dr. Sng Kim Hock [ASPMP]: *Dato' Faizal, can I chip in? I mean if I were a Minister of Health, I'll say forget JCI, cost millions and will be pass down to the patient. If we are rich at certain level, MSQH or locals then it is good enough. This is my*

opinion. Otherwise, everybody would end up spending million just to get the JCI and it is not forever. Every few years you will start all over again. That is my personal opinion. To me, no need JCI.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Thank you Dr. Sng.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Actually, yesterday was a doctor from Sarawak, he suggested to have budget hospital.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *It is doable, YB. In countries like our neighbouring countries, there are so-called budget private hospital. Now let me just tell you, one group in Malaysia particularly, Columbia Asia, actually models itself as in between secondary to tertiary group hospital. They purposely do that because of that their hospital if you go out all of the standard size, standard modelling, standard architecture and standard services. They do not want for example to take too complicated cases, rare diseases et cetera et cetera. They will refer to other private hospitals if the patient comes to them. So, there is already a model. So, Columbia Asia is you know originally from the US of course where in US because of the insurance issues there, there are hospitals which in different tiers.*

So YB Sim is actually hitting on the right note there. Yes, it is possible, it is possible. If everyone is part of an ecosystem and understands their place, not everyone is chasing the biggest bug. Ya, so okay.

Dr. Steven Chow Kim Weng [FPMPAM]: *Can I and want to support you. I think YB— Steven Chow again, this health tourism dollar, has got the moral hazard. Guys flocked over here to get treated. Why? Because it is cheaper than their own country. It is better than their own country. So, our emphasise on health tourism and JCI, right has got a moral hazard. It is going to make our Malaysian healthcare, private healthcare even more expensive. But we ourselves are putting money to attract guys to come over.*

Dr. Sng Kim Hock [ASPMP]: *But Dr. Steven…*

Dr. Steven Chow Kim Weng [FPMPAM]: *Let me finish. No, I don't interrupt you, you don't interrupt me. Okay,* ya.

Dr. Sng Kim Hock [ASPMP]: *…But in our group MM2H is— must be cannot stopping tourist. The silver hair programme must be supported by a good healthcare system.*

Dr. Steven Chow Kim Weng [FPMPAM]: *Okay. MSQH is good. But the bottom line even in the budget hospitals, the standards in court will be the same. It will never get say "oh, this is budget hospital." Cantonese [Bercakap bahasa Kantonis]. It will be the same. You will charged by the same standard.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *True. Which is why if you do it purposefully and as part of an ecosystem. It can be done. If you do it— if it is done not in that way, it can be hazardous because yes medical litigation et cetera will not take that into account.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, come back to medical tourism that you mentioned just no. When we met with MOH, Minister and team, they said that the foreigners when they come to our hospitals, they have to pay 25 percent extra. How about private hospital? Today, do you charge them 25 percent extra?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Like I said YB, that is supposed to be the case. In most private hospitals at that moment, that is true. However, we have seen, in some instances that this is not done and to attract more health tourist, the prices have been brought down or done in packages that are the same as locals. So that distorts the situation for locals.*

But even if you increase it and maintain it at 25 percent, what we heard at the PAC's public hearing were it is indirect effect which is then the hospital then in advertently the next year will then increase or inflate their drugs pricing or their slipper pricing et cetera, not based on local figures but based on what they already charge for the foreigners. That would also happens. So, all this little, little small thing adds up to all the ridiculous pricing that you see like Dr. Sng said, there is no justification.

I met a very senior surgeon for a RM37,000 appendicectomy. He gets only RM1,500. So, 10 years ago that was only less than RM20,000. So where is the RM15,000 going to and coming from? So, this is the big, big question mark.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, mungkin nak tanya *further question to you. How many percent of the public hospitals doing that? I mean decreasing the cost compared to our local people.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *You mean private hospitals?*

Dr. Hajah Halimah Ali [Ahli PAC]: Ya, ya *private hospitals*.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Not many. The majority will have the 25 percent increase. So, this would be the minority and they will guise it up a promotions for their— because they do have for example, understandings with hospitals or group of communities in Indonesia. In Dumai, in Tanjung Pinang, in Batam, in Riau. These are the favourite areas where you actually have already collaboration between the healthcare groups here, the healthcare group there or community group there.*

So of course, when they go and promote, they will say that this is the price that we are supposed to charge you according to our Malaysian Health Tourism et cetera but you know we can give you this package. So, then you can come for slightly less cost. This attracts people. I must say that this is not technically you wouldn't be able to say they are very wrong in this— they will say, "oh we've got so and so volume and so and so much revenue which is good for the country et cetera et cetera." So it is very thin line.

So, this one is just a letter. The four percent— two of our colleagues are two are not here with us today Dr. Musa and Dr. Rajendran but we sent this to the public because we certainly worried about the unsustainability long term of both the public and private healthcare systems in the country. I wouldn't elaborate. I think Steven has done a lot of that.

So ladies and gentleman, I think we had the figures for 2023 and 2024 we are still waiting. For 2025, the expected inflation rate for Malaysia is amongst the highest in the region at 16.4 percent. This region Ahli-ahli Yang Berhormat, *has got the highest rate of medical inflation around the world, among the highest. But if you look at the three countries around us which are Indonesia, Philippines and Singapore, you look at Indonesia and Philippines at a first glance, the association of private hospitals when they meet you, they will say look, we are not too bad. Why? Because Indonesia and Philippines are higher than us. Yes, but the Indonesia and Philippines are starting from a very low base. If you've been there, you will know that their healthcare system is one thing in many, many areas. So, when they inflate by 18.99 percent, it is not exactly the same as ours inflating by 16 percent.*

A more correct comparison of our private healthcare would be to Singapore which also has inflation but theirs is at 12 percent and of course theirs is integrated system where most of their private hospitals— most. Not all. Most of their private hospitals are actually integrated with their public system, into groups. The Jurong group, the Sembawang group et cetera, patient can go from public to private, private to public. But of course, they have national health insurance, CPF et cetera, et cetera. We don't.

But only very few private hospitals in Singapore like Mount Elizabeth are truly private and outside the system and they cater for their health tourism which is includes Malaysians, high net worth income Malaysians as well as Indonesians and for their wealthy. So, it is very different a ball game if you want to compare with Indonesia and Philippines. So in short, we are still in trouble because if this is true for this year, we are going to be in trouble next year.

So ladies and gentleman, I'll just go through very briefly but very pointedly. What are the rising healthcare cost in hospitals, private hospitals.

■1240

One is the inflated insurance premiums. The insurance premiums are inflated. There is no other way to say it because the amount that is charged now is totally unreasonable compared to what they were charging just three years ago. And, they gave the reason of the escalating private hospitals bills which is partly— which is true but that cannot alone explain why they are inflating.

Their inflating of the private medical insurance has also got to do with like Shan and Steven presented just now YBs, is the pandemic. The pandemic really hit the insurance industry hard. Not in terms of premiums but in terms of their investment returns, et cetera, et cetera. This is something that they will not tell you. And all these has caused them to increase their insurance premium.

Now, escalating private hospitals bills. Definitely, yes. We are private specialists as Dr. Sng said, 90 percent of private medical specialist do not work for, employed by or are directly answerable to the hospital they work in as in an employee-employer relationship. Myself and Dr. Sng are both not employed by our respective hospitals, by our respective groups.

We have our own contracts and we pay rent for our clinic's [Tidak jelas]. Okay, just to make sure you understand that. So, the escalating— and Dr. Lee Boon Chye pays as well I think, yes. So, no exclusion for former ministers. So, escalating private hospitals bills therefore, do not benefit the doctors.

So, if you see today, it's out in the news, "KPJ Healthcare revenue increase from RM3.26 billion to RM3.92 billion last year, profit increase to almost RM400 million net profit." None of that money comes to me, okay? I'm working in KPJ. None of that money. Not a single cent.

So, in fact the groups like IHH and KPJ take percentage of our income. We actually contribute to that profit. So, I pay 10 percent as well as Dr. Lee in the KPJ Group. So, if I make a thousand ringgit, a hundred ringgit directly goes to the hospital. So, I only make RM900. I do not know what Sng's rate are in Pantai.

So, new technology diagnostics and therapeutics true, to a certain extent. So, to a certain extent this is true. Laparoscopic procedures are now more tenable, more feasible, they also reduce hospitals stay. They're supposed to reduce hospitals stay.

This is funny thing Ahli-ahli Yang Berhormat. *Laparoscopic procedures are supposed to reduce hospital stay and therefore, reduce hospital cost and reduce billing whether it be in private or in public. The problem is in private hospitals it's not seen like that. It is seen like a novelle, Nuovo approach.*

Therefore, it becomes more expansive as compared to your traditional appendicectomy, your traditional cholecystectomy removing the gall blader, the laparoscopic one will be more expansive. So, it's a bit ridiculous because it is actually counter to the initial initiation of this laparoscopic procedures. That is just an example.

ROI non-treatment will be talk in detail later but in short, private hospitals charge you for their equipment. The problem is it is never-ending charge for the ROI. It's like they keep spending on the same machine every year. That's not true, unfortunately.

There is a cap to it and we have some suggestions. Drugs and devices mark up, yes. Of course, like GPs, private hospitals will mark up prices for drugs. The problem is later we will see that it is beyond reason. And again, in private hospitals doctors like myself, Dr. Lee and Dr. Sng don't make money from the drugs. We do not make money from any of the drugs markups.

Doctor's bill capped since 2013. It was introduced in 2006 for specialists, earlier for GPs. It has been revised once in 2013 and it has not been revised after that. So, all your inflation in that occurred from 2013 until now, has got nothing to do with doctors' bills, okay? In the private hospitals.

An example which I lived with a staff today is a bill form like this [Sambil menunjukkan senaskah dokumen]. In the bill form, there are limits to how much a private specialist can charge. You can't charge more. If you charge more especially for insurance, they will call you up. They will call you up. And even subtracts without you knowing.

Number eight and number nine are together. Number eight, number nine, number ten are together actually. When Dr. Sng joined private practice in 1998, he earned more than his CEO. Nowadays, his hospital's CEO earns more than him. His Group CEO earns multiple, multiple times more.

Tuan Sim Tze Tzin [Ahli PAC]: *Can you tell us how much is the CEO's pay?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *[Ketawa]*

Dr. Sng Kim Hock [ASPMP]: *It goes up to RM100k… [Bercakap tanpa menggunakan pembesar suara]*

Seorang Ahli: *On mic. [Bercakap tanpa menggunakan pembesar suara]*

Dr. Sng Kim Hock [ASPMP]: *I think it goes up to RM100k.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *It does. It does go to six figures,* Yang Berhormat *and this does not includes stock options, et cetera, et cetera. Just like any private company. Why? Because of number nine. Because actually because now you find just like the private GPs were worried that groups will take over solo and partnership GP practice. That has already happened in private*

healthcare since the 90s when Tun Daim in our healthcare townhall— MOH townhall in January, Tan Sri Bakar, the advisor to MOH said to us all that he remembers meeting Tun Daim when we was Finance Minister and Tun Daim actually asking the question whether he's making the right decision in allowing them Pantai to list. The first listing of a private hospital.

So, what's had happened since then over 30 years is that it's become just like any other corporate business. So, everybody wants a six figures salary. If you are a [Tidak jelas]. Everybody has demands of perks and privileges, business class, travel, et cetera, et cetera, six stars hotels, you have to return to shareholders, et cetera, they pay their board of directors as the same any other private company.

So, now yes and no to number 11, Yang Berhormat. *Higher salaries for skilled staff nurses and paramedics. Why I say yes and no? Yes, it's higher than perhaps 10 to 15 years ago. No, because if the paid accordingly, we wouldn't be facing the problems we have now which is our nurses and paramedics leaving the country.*

So, no. They don't pay as much. Not proportionally. New staff nurse still earns at the moment below the Klang Valley living wage which about RM2,700, yes. Next please. A new staff nurse.

Of course, sorry. The last point patient factors. I think this has been described and yes, we have to acknowledge this is a real problem not of at anyone's making. This is how our country is going.

The country is aging. And by 2030 and by 2035, this problem will explode, Ahli-ahli Yang Berhormat sebab *the numbers of aging will increase. Depends on your definition whether you are 60 or 65. Either way it's going to explode.*

Both for public and private healthcare. And this is something of course that we cannot stop. NCDs we can but NCDs we can only stop if there is more investment in primary healthcare. NCD means non-communicable disease like diabetes, hypertension and hyperlipidaemia, et cetera, et cetera. Next.

So, inflated insurance premiums. So, we appreciate BNM's directive to cap premium increases but I think YB Sim again will testify to this in the two public hearings we've heard that some of the insurance companies are not really following this directive at the moment. This is because there is no law to actually make them do so.

That's the directive. Ada beza ya. Arahan dengan undang-undang. *If you really want to push and shove, then only the law can matter. Not just directives. So, there are infringements at the moment even as we speak and now, co-payments to discourage unnecessary admission and investigations.*

Like Shan, we agree that this could be a way forward and ambulatory care and ambulatory surgeries are a way forward and they should have been prioritised from the very beginning but they were not.

Now, let me tell you also Ahli-ahli Yang Berhormat, *that the insurance are not blameless here. It is not all the fault of the private hospitals or the private pharmaceutical or private equipment companies. Private insurance prior to this crisis and I am sure you all have personal experience on this as well either yourself or your families. Private insurance generally only covers for admission.* Betul, kan? *Only covers for admission.*

What does that mean, ladies and gentlemen? If you want to do an MRI scan of your knee because you have a locked knee syndrome or something like that, you need to get admitted. Okay.

■1250

Now, doesn't that increase healthcare costs already? But prior to 2020 this was our insurance industry stand. Why? Because they thought their actuary calculated before 15 years ago if they did this, they would have less payout, they thought. But the situation has changed. The public has changed. The people who bought insurance 30 to 40 years ago hardly claimed. Until they were really sick. The people now especially in the last 10 years, especially young people now, claim for almost everything. Because that's the way they've been brought up. Also, because private insurance is like that.

So, now even for things you don't need to get admitted, you get admitted. So yes, only now since this crisis— so now both Prudential and AIA have come up with memos emphasizing and asking private hospitals now to tukar arah *(change) and now prioritise outpatient care, prioritise day care procedures. So, the MRI now should not be done in daycare. The problem is for outpatient most of the insurances, personal insurances do not have any coverage for outpatient. Some have a very small. Maybe RM1,000 which is not enough for any CT scan or even a full consultation with the specialist with drugs, with x-rays and blood tests.*

This is the problem. It's like saying something but doing another. It's very unengineered of them actually. They have got themselves into this trouble also. But now they are trying to backtrack but when they backtrack they are not compensating. What they should do if they do that, they should increase the outpatient coverage. Even extend outpatient coverage to GPs for example. But that's not happening. Of course, the National Health Fund is probably the first answer to this YBs before we go to the National Health Insurance.

I won't spend too long here. So, basically, at the moment, even the first part of the insurance is cute. If you work like I said depends on who your employer is. So, if you work for Maybank, Bank Negara, all the banks, Bank Negara, Securities Commission, PETRONAS, Khazanah if you occupy your work time at the Twin Towers, you are covered for as long as you work for anything, for everything and anything. But if you have your personal insurance only, there you are. Because those people can do scams as outpatients etcetera. But your personal insurance, nope. If you want to do you have to have out-of-pocket payments.

At the moment, what we are suggesting is that, to elevate this situation. In the Health White Paper, there is mentioned of two things. One is the National Health Fund and the other is National Health Insurance. So, before we can get to National Health Insurance, we need to have the National Health Funds. The National Health Funds will provide funds for both the public sector which YBMK wants and also for the private sector as well as enhanced investments for primary healthcare which is badly needed. That will reduce specialist treatment and also visits to hospitals etcetera, etcetera. Later we can go on to National Health Insurance if we have enough players to actually support the National Health Insurance Scheme.

Ahli-ahli Yang Berhormat, *it will surprise a few of you to know that Indonesia a country which has a per capita income lower than us, but due to the political will of the former President, President Jokowi has had a National Health Insurance in place now for the last eight years. But of course, when you say Indonesia, again, they're starting from a very low base. Their base is very low. The demands of their people are very low. Their people's National Health Insurance covers for very basic things. The problem for us is— of course, if we want to start that way, it probably will not sell with our public especially the middle class. So, we have to find another way instead of just the government and paying for it. There has to be other people also chipping in. Possibly the same people for example Khazanah etcetera, who are now paying for their staff anyway and skewing the market and also, the pension funds of course etcetera.*

Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, I think this is a very interesting issue which we want to— PAC also wants to know whether the feasibility of National Health Insurance. The reason is that of course, the Healthcare White Paper wanted it but we all understand that with this kind of political climate to have National Health Insurance is going to be unpopular and actually because we right now already have almost free public hospitals— almost universal healthcare.*

Then now if you force people to come out with money to carum *into National Health Insurance that's going to be problematic and politically untenable. So, the*

KKM actually came out with a suggestion which is to have almost a basic healthcare insurance, basic level targeting maybe M40 or maybe B40 also to pay for basic healthcare instead of going straight to National Health Insurance. What do you guys think about this suggestion? Thank you.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Before Dr. Lee comes in, we would say at the moment, comprehensive insurance coverage is having one even at the lower base for the M40 and the B40 is actually better than nothing, having nothing at all.*

One way as Dr. Koh Siow Ching has illustrated in a few papers of his which I am sure YB Sim is aware is that there'll be payroll deduction for those who can instead of just relying on the tax-based. Because our tax base at the moment, is very, very poor. But we take your point YB that yes, it is politically untenable at the moment for any deduction that is outside of the current already done. But it may be something for the government to work.

That's why we said that for Malaysia, we don't see it happening with all the middle class and T20, the lower T20 paying as well. It cannot work just like that. You need to have other players come on which may include the private healthcare groups, which may include private insurance and the pension funds. Thank you. Next.

Now, is there unbridled private hospital charges? We've been very frank here YBs. Myself and Dr. Sng have worked for a long time in private healthcare. I have worked for— going into my 16th year now. Dr. Sng has more than 25 years. So, we do empathise with private hospitals when they have real cause. They do have a real cause and they do have real issues with maintaining a certain amount of returns. For those purposes, we are with them. We support if they say they need to pay for genuine things, we do. However, we also are not happy and we are equally shocked by the rise in private hospital bills like we just said the appendix is just one, sinus surgery is another. Now it's costing RM25,000 to RM30,000 when you can do it for RM10,000 to RM12,000 only ya, etcetera.

More importantly, we cannot accept some of their practice which includes an unrelating charge for ROI never ending. The more than 100 percent increase sometimes in markups for both medical and non-medical items. We think this is because the corporatisation of medicine by private healthcare groups has changed the perspective. I've read YB Sim's suggestion yesterday in The Edge, I don't know whether that can be done. I don't think it can in the current circumstances. But some form of regulation, if we turn it around YB Sim the presence of government on the boards of these major healthcare chains should actually work to reduce medical inflation. Because they should be able to tell the private healthcare group's CEO,

"Hello, we are not happy. You are charging too much etcetera". This is wrong if you are doing this unjustifiably.

But unfortunately, we think and we've told this to the Prime Minister Advisory Councils, Healthcare Reform Taskforce which we presented earlier in late January that we think there's also a conflict of interest there which I think in one of the PAC Public Hearing it was brought up as well. The government also must take this into account. If you want to reduce healthcare costs, you cannot allow these private hospitals to make unbridled profit year on year, on year, on year. Yes, it will affect you a bit because you have KWAP there, KWSP there, you have etcetera, you have Khazanah there in IHH.

■1300

So, but yes, everybody needs to play their role. So, investors, pay top dollar so they expect high returns. So, the pressure then comes on the Group CEO who then transfers the pressure to the CEO. In group likes KPJ and IHH, it's even worse. Each individual hospital is built differently within the group. Each individual hospital also competes within themselves. This happens. So, every hospital has to show the group that they make more money this year. Otherwise, the CEO, the hospital's CEO job is on the line. So, this is the way it's being done now. This is the unsaid thing. This is the thing behind the scenes. That if you don't take this into account, we can talk until tomorrow about regulating this, regulating that. They will find a way to get around the regulations because of this. So, this is one of the issues.

So, PAC, but you have the power. The PAC, MoF, MOH actually can do this. There is a difference between profiting and profiteering, ladies and gentlemen. So, RM100,000 bill which we presented recently to the PMAC for tendon achilles repair is absolutely ridiculous. A tendon achilles is the seeing at the back of your leg here, a shin. Named after Achilles the Great Warrior. So, the repair now at one of the private hospitals in the Klang Valley, hit a bill of RM100,000. RM10,000 only, 10 percent only were doctor's charges. Which include the surgeon, anesthetists, ward rounds, et cetera. Where's the other 90 percent? So, 35 percent supposedly was for the implant.

But ladies and gentlemen, the implant, they already marked up a 100 percent. So, there's another RM60,000 here that the hospital is making free from anywhere. From the slippers, to the bathroom, to the linen, to the toilet paper. Everything is being charged extra. So, unfortunately for you, the most difficult albeit will be how to manage the non-medical item charges. That one is very difficult. I don't envy you. I don't see how you can do that. So, yes, we agree in the private medical specialist association they need to be some regulation. But essence said during the very

beginning, not the DRG as Dr. Steven Chow also said because it will kill the entire industry and also inhibit treatments.

So, how much— this is another, this I'll go very quickly here. If you look at mergers and acquisitions. You can find it in The Edge. The pricing. The standard pricing for a private hospital to be building one is RM1 million per bed. That's standard. I think people from the FPMPAM can agree to that. So, if you are building a 200 beds hospital, it should cost you about RM200 millions. But if you look at the acquisition price here when people take over hospital, they are way above that. Way above that. So, up to five, six million. IHH, when they took over Island Hospital in Penang paid RM8.4 million. So, obviously, when it's supposed to be only about RM5 millions.

Now, when IHH takes over Island Hospital which at about RM500 millions. Okey, lah *RM600 millions worth. But when they paid RM8.4 million— so, this RM8.4 million per bed is huge. RM8.4 million per bed is huge. It's more than RM500 millions, of course. And so of course, IHH will then say to you FPHM will come to you and say we need to recoup our investment. But aren't you supposed to make this investment only if you are doing very well? And you can absorb some of this cost. So, IHH is building Gleneagles in Kuching which is good for the people of Kuching at RM400 millions. I think it was in the papers. It will be ready by 2028.*

Maybe that one is reasonable because Kuching has not had a private hospital before this of that level. But some are the groups are buildings blocks, building new blocks. KPJ Penang built a new block in Seberang Jaya et cetera invited Yang Amat Berhormat PMX *to officiate. Luckily,* Yang Amat Berhormat *didn't buy the bait and actually, said in his statement that he will not allow charges to go up. [Ketawa]*

So, there is no need sometimes or, people— the private hospitals need to look at their investment and see whether it's really necessary. If you want to build, build lah. Tetapi, janganlah *pass all the costs over to the patient.*

So, influence of new technology. Now, Ahli-ahli Yang Berhormat*, new technologies do not always, do not must equate standard treatment or are as effective. Many robots are in the picture now. Robots are not necessarily better than standard treatment. In prostate treatment, for example the removal of the prostate by a surgery is still the gold standard. But like just now, like the laparoscopy, some hospitals now use robot as a reason to charge more and because it is not in the schedule, because robots are new. They now can charge even more. They can charge even more and now, so you see, YB. If you are a personal insurance holder, you won't be able to afford it.*

If you are a middle-class person. Even you are a YB lah*. You may not even be able to afford it. Because it will be six figures. If you, if however, now this is how the market is skewed. If you work for Khazanah, Khazanah will pay. If you work for Public Bank, Public Bank will pay. So, there you see. So, it starts a precedence and so, a new charge is in the market now. So, if you do robotic heart surgery or robotic knee surgery or hip surgery. The cost is a lot more. Your personal insurance won't cover but it will increase the price and there you go your 16.4 percent medical inflation.*

Now, this is not to say, ladies and gentlemen, that technologies are not good or technologies are not necessary. In systems where private and public are integrated, like Singapore, there are new technologies, there are robot but only Apex hospitals have them. Who are, which are Apex hospitals, ladies and gentlemen? They are usually teaching hospitals. Your university hospital. In the US, some of these hospitals, teaching hospitals are private. But their ownership is complicated there. They have both Federal, states as well private ownership, endowment fund, et cetera. Places like Mayo Clinic, Cleveland Clinic, Harvard all have the latest but they are multiply funded.

So, it's a totally different scenario from our side. So, in our side now, every private hospital will want the same robot now. When it is not necessary. But there is a place. We are not saying there is no place. That should be a place for it in both public and private. But only a few hospitals. This is where we said just now if hospital like Columbia Asia can do that, can position themselves. Other private hospitals should also do the same. But at the moment, it's free for all. So, this is what happening.

Drugs and devices like the…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Before you move on. About this technology. Mentioned about robot. What is the choice, what is our choice?* Kalau doktor itu dia, hospital itu dia nak guna robot itu *and then we go there and in the end, most hospitals* yang bagus-bagus ini *will use their robot. What are our choices, as patient?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes, this is a problem, YB. I must admit. So, first and foremost if…*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Can I interrupt?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes, please.*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Actually MOH*─ Saya Dr. Lim Boon Chye, Mantan Timbalan Menteri. *MOH has got a medical*

technology assessment unit to assess whether such medical technology can be used in Malaysia or not. So, before that can be used, it has to be registered, approved by the medical technology unit under Bahagian Penyelidikan.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Thank you, YB. And to add to that answer, answering your question, YB, is that well of course, if educated people like yourself, it will be very easy. You asked the doctor. You asked the hospital, it is the only way? Is this the goal standard? Are you sure? How many have you done before? Et cetera, et cetera and all that questions will then lead to you saying whether it's your choice, whether you want to do it the usual way the old way or by robotic. What are the advantages of doing it this way as supposed to that way?*

The problem is of course, ladies and gentlemen, most people will not be asking these questions. Yes? And so, the most people again either personal insurance holder or even people who work for those big companies which I have mentioned but if they don't have the to be frank, the intellectual capacity to challenge the assumption and the doctors, they won't ask and they will just go along.

■1310

And so then, it will lead— you're right. It will lead to then a precedence being set and later on everything will be done that way. And then, the charges will increase again.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *So, now drugs and devices. For the GPs, I must take this opportunity to state our ASPMP supports for the GPs. Ladies and gentlemen, we cannot allow the GPs to die. We cannot allow it. The GPs are the cornerstone of any healthcare system and if they go away, at the moment, we are already at the risk of losing the single proprietor GP and the partnership GP.*

Most— some of the newer clinics now are all chains. It's still okay if the chains are owned by doctors. It will be a sad day when the chains are all owned by non-doctors and there's a single senior doctor there who was designated as the person in charge (PIC) who then— it's kind of fraud a bit. If you ask me, he's then applies for the license. You give him the license but actually somebody else is running the whole business.

So, we must support the GP. And for the GPs, the drugs and the way it's managed. Until their seven-schedule fee is revised, we agree with them that their seven-schedule has to be revised because otherwise as Dr. Shan pointed out just now, those clinics cannot survive. But in the private hospitals case, it's slightly different YB. YB, the problem now is, in private hospitals, which is beyond the control

of myself, Dr. Lee or Dr. Sng. We don't have any say in the pricing of the hospital's drugs. None. Zero. Even the pricing of the Panadol sold in our hospitals. We cannot say anything.

So, the problem is the markup. The markup is way beyond what is marked up by the GPs, by the pharmacies and way beyond what you deem as reasonable. We are talking— we conservatively put there 50 to 100 percent. There are drugs which are much more than that, their markup. 200 and 300 percent. You will think that only rare drugs or drugs that are very expensive are the ones that they markup very much. No. Sometimes, it's the common drug that they mark up a lot. Why? Because the volume is there.

In some hospital groups, this pricing is not even determined by the hospital pharmacy. It is determined at the group level and different hospitals within that group will have a different price for Panadol, at different hospitals. This happens. So, the price for the same medicine in KPJ Ipoh will be different from the same drug in KPJ Damansara. You don't need to have three guesses to know which one will be more expensive.

Dr. Hajah Halimah Ali [Ahli PAC]: *Can I interrupt?* Sakit hati lah dengar...*[Ketawa] I'm the only medical doctor around these PACs members. When did does this profiteering phenomenon— from what I see, the conclusion that I get is doctors are the tools of other people getting money, getting rich,* kan? *So, when did all those started? What spurred it?* Macam mana that seolah-olah *doctors are out of control. You are just the license for the people to make money.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Funnily of course, funnily again, the private hospital group cannot function without doctors working and nurses but also cannot actually even build one and set one up without one particular doctor agreeing being the PIC and holding the license. This is true even for private hospitals. Some— a registered medical practitioners with the MMC needs to hold the license, otherwise they cannot open hospital.*

So, but yes, doctors being— in general YB Dr. Halimah, three reason. One, I think is the nature of doctors. Betul, *seriously* cakap. *Doctors are very good people generally.* Ada *exceptions. Ada a few rooks here and there. But most doctors like my senior colleagues here, Dr. Shan, Dr. Lee, Dr. Sng, oh my god, they're just so good people. I— very kind people. As long as they get to treat patients and see patients, and see patients happy, that makes their day. The problem is of course, we have been taken advantage of. So, that's number one.*

Secondly, just like the previous slides just now, I think the impetus was when the corporatisation went into full force. There's nothing wrong with companies being

public listed, I think, if the intention is measured from the beginning. The problem is I think it was allowed to go unchecked. So, corporate culture ini sama sahaja dengan *corporate culture housing developer* ataupun *corporate culture construction company. You make your buck while you can. You make hay while the sun shines. The group CEOs rarely stay, for example, for more than three to five years. They know they will go. While they are there, they make sure that things are running and profit is made. Otherwise, they will lose their jobs. So, this is part of the entire scenario.*

Now, the third reason is I think we have to give credit to some of the other factors. Like Dr. Chow said, they are other factors. So yes, big pharma is also at fault. Original drugs, we import most of our original drugs and import even half, more than half of our generics from India. So, the problem is our drug prices will always be high. We have a very— we can actually produce more of our own generics but we don't. So, this is the problem.

So, all these put together and equipment are almost all imported either from Japan or from the West. So, the problem there is then there is no check and balance on the ROI.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, YB Chairman...*

Dr. Hajah Halimah Ali [Ahli PAC]: *So knowing that, that is a problem statement. Doctors outside there, thousands of doctors there, as victims of this phenomenon and you are being blamed. The doctors are making lots of money. That's the narrative.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Because people don't— people can only see what they see. So, they don't…*

Dr. Hajah Halimah Ali [Ahli PAC]: *Yes. So, what's the solution? Other people are making money, doctors are being blamed.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes. We are getting to that YB. Next slides please.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *YB Chairman, just before you move on. First*, saya nak tanya fasal yang M1 itu. *What does it mean?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Okay, sorry. Medical inflation* (MI).

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *What?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: MI.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Sorry, MI. What is it?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Medical inflation, YB.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, okay. Then, I want to ask you next question. It's the matter between generics drugs and original drugs. Generally, generic drug is good enough or they have any side effect?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Okay. For most instances, for most conditions, generic drugs are as good as the originals. For most. Now, there are situations where the original will definitely be better. Cancer patient. I think your— our MMA colleagues yesterday had an oncologist with them, presenting. Yes, she would have told you about the difficulty of insurance covering for cancer medications, cancer treatment, et cetera. Novel one, et cetera. So, cancer is an exception where generics generally cannot play a role. That's one.*

Rare diseases or autoimmune diseases, although— mind you, most autoimmune diseases standard treatment requires the use of steroids. Your run off the mill prednisolone, hydrocortisone, it's good enough whether generic or original. It's only when the specialist wants to use more refine medication like immunologics and the monoclonal antibody, et cetera. Those don't have replacement.

So, to answer your question, for most conditions can replace with generics? For a few conditions, cannot. Yes.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But for normal patient they don't know about all these details.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *They don't.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Whatever doctors recommend, they just take.*

Dato' Dr. Lee Boon Chye: *Can I give a contra view? I think all drugs are registered under MPRA and DCA Ministry of Health. All generics, the content of the generics must be the same as the original when the patent expired. So, by right, the efficacy should be the same. Of course, there is always a placebo effect when patient buy the original, use original, they feel better because they pay more. So, we cannot always discount the placebo effect as a result of generic versus the original. So, even for cancer treatment, by logic, they are more difficult to reproduce, more difficult to get the generic.*

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So that is something where we should consider but I would support generic-first policy not just maintain Ministry of Health but also to private sector. Thank you.

Dr. Sng Kim Hock [ASPMP]: *I just add one sentence that ginkgoes has 50 different generics. So, some are good, some are not good. Sometimes when they*

submit, they maintain it. Subsequently we don't know. So, the question goes back, we must depend on the good generic company like Sun Pharmacy.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Establishede company. Good established company.*

Dr. Lim Kuan Joo [FPMPAM]: Yang Berhormat.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sila, sila. *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Lim Kuan Joo [FPMPAM]: *I'm Dr. Lim Kuan Joo. I retired from government in 1999. In the 20th century, we had condition where when generics were introduced. It must produce bioavailability. That means if the proprietary drug, the original drug if you follow, 100 percent will go into the blood.*

But we do not know in the generic if you swallow whether 100 percent will go into the blood or only 50 percent will go into the blood. So, it was a necessary for all those producing generics to show the bioavailability figures.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *Thank you YBs and Dr. Lim. So, just want final example here. I forgot to mention, MOH actually YBs, currently run a very good program using generics for Hepatitis C treatment. If you were to buy the originals, it will be in the hundreds thousands ringgit per patient per year.*

So, they've worked with French company which is co-funded Médecins Sans Frontières (MSF), the humanitarian medical relief organisation. They produced this for the last four years now. MOH has the details.

Seorang Ahli: *From Egypt. [Bercakap tanpa menggunakan pembesar suara]*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *From Egypt. So, the Hepatitis C treatment is just as good. So, to answer YB's question. Most generics will work just as well. So, next slide.*

Dr. Steven Chow Kim Weng [FPMPAM]: *Could I just support your comment? There was a question of when did all this begin. How did doctors end up as sweatshop workers in the healthcare industry? It's a very sad state, you know? But unfortunately, it is purely regulatory.*

All the restrictions imposed is on the practice of medicine on the doctor. Where are your regulations for the business on medicine? You got no regulations on end sales, you got no regulations for the so-called employees benefit services companies or the so-called middleman? This all started many, many decades ago. When MCOs came in, MCO Act was never incorporated, at all. Up to today still talking about it.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *Thank you Dr. Steven. My next slide very quickly. So, we are also proposing— this is just one part of it. The one part that can be objectively managed.*

Like I said, your challenge YBs will be the non-medical items that the hospital charges which can go up to about 40 percent of the total hospital bill. That one will be the more difficult one. This is easier. Just to give you an ideal on how we are proposing to do it.

So, we are proposing a value-based approach on equipment whereby payers pay for the exact value of services. Of course, this is unlike the DRG which averages cost of limit without taking into account, all these things, drugs, equipment, et cetera, et cetera.

So, just for the equipment alone, our approach includes the hospitals declaring the cost of the instrument of the machines. So far, if you want to buy a new MRI machine, buy. But declare to MOH. Declare to LHDN, declare to everyone that needs to be declared to, what the price is at sale, at buying. Then, declare the ROI that you are expect to get and the margin, the reasonable margin over how many years.

The ROI must have declaration of life span. So, some instruments can last 15 to 20 years, ladies and gentlemen. Bukannya tiap-tiap tahun kena beli pun. *So, if somebody's buying laparoscope or a bronchoscope every year, something's wrong. Something's wrong there. So, currently even though—the current practice they will charge for as long as they have the machine. So, if the machine is with the hospital for 20 years, it's for 20 years they will be charging for the ROI.*

What we are suggesting in our formula is that the ROI now will be calculated over more reasonable time frame. Maybe five to eight years. So, then the cost of services charge and bill must be based on the calculator ROI.

Once ROI is achieved, so if the machine cost RM250,000 and you've got you money back, subsequence charges should be reduced between 20, 30 maybe even 50 percent including your mark up. You can still make money. The hospital still makes money. But what doesn't end, you can increase reasonably the next year but not including for the ROI. So, this is very important because at the moment, this is what the hospitals are doing. This is free money.

So, they've got the ROI already after four years. But in the fifth, sixth, seventh, eight, nineth, tenth, they still charge you for it and every year is increases by 10 percent, five percent, eight percent. So…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Can you give example the machine you use?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *Very easy. Let's say ventilator machine or anesthetic machine which can also double up as a ventilator machine in OT, in OT ladies and gentlemen, in the operating theater. They can cost anything between a quarter of a million to half of a million ringgit, the standard one.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, why the policy hospital in terms of this depreciation. How many years depreciation? To take care of their cost?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *Usually they will have depreciation over seven to 10 years.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, after seven, 10 years they are one book value.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Then, they don't have to charge more.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *By right, YB.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Just for maintenance only. Charging maintenance cost.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *By right. Yes. But that's not reflected in the patients' bills at the moment. This is the problem.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Cost of the time high.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *The problem.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Fully depreciated but still high.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *Yes. So, actually is very simple. It's not rocket science even, YBs. If I and Dr. Sng and our—actually this came from our brilliant colleague Dr. Rajan who is urologist, who deals with many instruments. So, he sees it every day.*

So, he's like aghast at the way the hospitals are charging. Because we know that the machines are already well and worn used and the ROI has long been return and it's all profit now. But there's no reason for it to keep increasing and to charge it to the patient.

Now, if it's a cash-paying patient and he is as intelligent as you are YBs, you will ask the question. But unfortunately, like I said, YBs how many people who are insurance covered, who are covered by insurance even your children, let's say your children who have insurance look at their final hospital bill? Most patients don't even

look. So, insurans dah bayar, dahlah. *RM34,000. Who cares? That's between the insurance and the hospital.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm quite fortunate, I don't have any insurance.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *But your children might.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *They cannot touch me. [Ketawa]*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPM]: *So, this is the problem. So, the bill will be transparent to everyone. So, this can be applied to maintenance of building for example. To be fair, to be fair to the private hospitals. Some of the buildings are older.*

KPJ Johor Specialist for example, KPJ's first hospital was built in 1981. So, it's more than 40 years old. So, the main block does deserve some maintenance billing. So, fine, but not new block. New block shouldn't equip the older block.

Now, this is another thing ladies and gentlemen, whether ROI, whether drug mark up, whether the non-medical charges mark up, the government needs to put into play or bring MyCC into the picture. Again, within these four walls, we know that the major private hospitals group at least talks to each other and so their charges are about the same, for main things.

So, if that continues then even if we try this mechanism, it may not work so well because they won't bring down the prices, everybody keeps increasing their prices every day.

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When we presented to the PAMC healthcare reforms task force, checked by the distinguished economist Prof. Yeah from Sunway, I actually laughed when we said, "This is the only industry at the moment in the country where competition doesn't bring prices down". If you don't believe me, you go and see. Competition amongst the private hospitals actually escalates prices on year. Why? Because of all of this.

Dr. Hajah Halimah Ali [Ahli PAC]: *Competition is complementing or synergizing.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes.*

Seorang Ahli: *Coalition.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Coalition is the better word perhaps.*

So ladies and gentlemen, what we are proposing here in terms of— this is just for the equipment but it can like I said be translated into other aspects as well ya.

So, this values-based approach. So, you pay for what you get, the value of what you get. If it is a new machine, you will a bit more. If it is an older machine, you don't have to pay that markup for the new machine.

As opposed to the DRG which will not make any difference here. Between that old machine, new machine, sama saja, okey. *There will be no difference. The exact value of services results if DRG results in an adequate complete, incomplete value of treatment. As importantly here is that no third-party involvement is necessary here for this type of regulation. If there is a body that regulates after this either a new body or a body under MOH or MoF, you don't need to have a third-party involvement. Whereas in the DRG, the insurance would be involved. They will make sure that their size of the pie will not be reduced markedly. There is no conflict of interest whereas in DRG there will be.*

So be quick ya. *Ladies and gentlemen, the private medical specialist after hearing out because to be fair, we heard the arguments for DRG by some experts from MOH as well as some experts including Prof. Syed Aljunid who I believe PAC will be calling, who is originally in this group but was move to another group, I think. So, it is good that you hear from him.*

We are not saying that the DRG per se is bad, the DRG YBs, is a tool to measure patient episodes. So, you come and see a doctor or come to emergency and see the nurse, you will be treated. That episode is documented properly and can be used for charging. What we are asking for is that please pilot it first if you want to try and pilot it properly. The shortest on record at the moment is Poland. Average is 7.4 years because Chile took 18 years. Taiwan whom some people you read now in the news is being used as an example, fine. But do we have the same system as Taiwan, okay? Do we have a more or less integrated system? Do we have coverage for most of our B40s and lower M40s? We don't.

So that is why Tan Sri Bakar is saying— Tan Sri Bakar is our eminent advisor to MOH, even if were implemented, he advice to MOH, it is not with the big bang. Not start tomorrow in all hospitals ya. *That may lead to some unwanted consequences which we would go through shortly.*

So, the DRG, good tools? Ya, *it can be used for a straightforward appendix ladies and gentlemen, it is good because instead of the hospitals now reaching RM37,000 for an appendix and if this crisis had not happened, by 2027 I think it reached RM50,000 which is ridiculous. Instead, the DRG for a simple appendix may be able to give RM20,000 – RM22,000 packages after taking into account all the inflationary factors et cetera. But it requires further analysis because it involves people processes and technology and in all our hospitals, KKM is different from*

university hospitals, university hospitals are different from private hospitals. They all run differently. They all treat their patient differently. It is too detailed for me to go into now but we can share those in more detail in writing a letter.

So, the pilot as YB MK *has stated should start with* Rakan KKM *which is trying to pilot. We don't know how well they will go yet and select MOH's hospitals and university hospitals. A word of 'caution' here ladies and gentlemen, UKM tried, didn't work. UMMC tried, it still using but look at where UMMC is with the cost, with the fees. The reason their fees twice now in the last few years while using the DRG. So where is this? We need more study.*

So, hybridisation might be necessary. Yes. Voluntary private hospitals as well they don't want to volunteer maybe each of the major hospital groups; Sunway, IHH, KPJ may volunteer at one or two of their hospital. What we are suggesting is hybridisation which is the DRG perhaps but also with value-based care with the new mechanism on ROI on the equipment, a new mechanism on drugs mark up. Again, we are not saying hospitals cannot mark up drugs, they can but insurance be excessive and beyond reason.

Why must pilot the DRG, ladies and gentlemen? This goes to the crowd of the matter YBs. The patient, we, like I said, the specialist is very concerned about the patient if you rush the DRG. Why? Because you must make sure that there is no limitation of essential necessary proven treatment to the patient. A package must not mean that Dr. Lee or Dr. Sng cannot give what is the correct treatment for that patient. The correct treatment must be given, must be delivered. If the cost is the real cost is RM10,000 and if you allow a 20 percent markup for the hospital then it is RM12,000. The DRG package cannot be RM9,000 okay. Cannot be like that. So, that is one.

Now, our worry is however which relates to number 2 is that when they are at number 3 is that when they are complicated and complex patients, this would become even more difficult. So, if you have a straightforward appendix in a 25-year-old young man, that's fine. If you have 65 years 65-year-old lady with diabetes, with COPD and a carpal tunnel back as well spinal problem as well, coming in with the appendix, needing appendicectomy and then she goes into sepsis.

Now Prof. Syed said, "Never mind. She goes into sepsis, we can upcode". So, the DRG allows for upcoding. So, we can upcode. So, we can increase it from RM15,000 to RM25,000 package. The problem with that is again if it is straightforward. If it is not, if the patient has diabetes, how does diabetes factor in here?

For your information YBs, even now in the current system, if you have diabetes, do you know what happens in the private hospital? Ini yang betul-betul

jadilah. Ini bulan puasa ini. Tak boleh cakap tipu. *[Ketawa]* Apa yang betul-betul jadi, okey, *is that Dr. Sng and I, usually will not write your diabetes. Why? If we can. Because if we write, there is a very high chance that the insurance will deny your cover, your claims. Unless you have declared before they know about it and you are paying an extra premium.*

So, kita tanya ini *patient. So,* kalau *you* masuk YB, kita tanya *"YB, ada insurans ya? Pakai insurans ya? YB masuk ini pakai insurans ya? YB ada kencing manis ini insurans tahu ke tak tahu? Kalau tak tahu, you nak kita caj kah? Ke you nak bayar sendiri ubat insulin ini? Kalau you tak bayar sendiri, masuk dalam hospital chargers".* Kalau insurans nampak, *there is a chance* yang kalau dia tak nak bayar insulin sahaja tak apa. Dia *cancel the entire admission* punya *coverage and there you go. RM30,000 you have to pay yourself.*

So, this is what really happening. So, when Prof. Syed presented this at the MOH town hall, people like myself and others were laughing and so I got up and told this to the crowd. I told TKSU there that number 3 would happen. Number 2 and Number 4 will happen. So, hospital sekarang ini kalau *you rush the DRG and the packages are limited, the hospitals will tell the accident and emergency department, "Eh, dia punya DRG pakej berapa ya? Untuk apa ini? Banyak itu je? Tak payahlah". Sent the patient away.*

So, now they wouldn't do it that way because that is wrong under the Private Hospital Healthcare Act. They will find a way to do it, so you cannot charge them. [Ketawa]

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They will say no bed available lah, *okay. ICU bed* tak ada lah. Kalau *complicated case* ya...

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa pembesar suara]*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]:*...and then, you have to go somewhere else. Where will these patients go to? Because, of course, if you are a millionaire staying in* Bukit Damansara, *it doesn't matter. If your insurance burst or your DRG package burst, you can pay. But if you are on your personal insurance with the RM50,000 limit, but you are, now DRG says not RM50,000 for this particular problem, RM22,000 only, okay?*

So, you have only RM3,000 cash in your bank. The bill comes— the bill comes— the bill is on day five of your admission, the bill is already RM30,000. What

are you going to do? You cannot go to another private hospital. It will cost just as much. And so, you go to government. So, I told TKSU kita akan hantar— *number four. Half treated patients in an untimely way to your hospitals. We will send because if the DRG packages burst and if you are not a millionaire, we will have to send you away and that will happen more and more if you rush the DRG.*

That is why, we are pleading with you, with the PAC and later we get the chance to present to PSSC Health, we will say the same thing, to advise the government. Don't rush the DRG before you do proper piloting. Please pilot at the different hospitals. Not just one type of hospital and assume that what works in one type of hospital, will work in another because it most probably will not. Most probably will not. And also, to ensure, no systemic lost financially. In Indonesia, where they started DRG and the National Health Insurance, so, the last two years has come at a cost to the government. So, the government has to fork out the bill for the difference. So, if the government of Malaysia is willing to do that, then well I'm fine.

I think we are coming to the end. So, yes please pilot. Bawah, bawah. Kita dah habis masa. *So*, atas. Okey. *Insurance and seriously consider the ROI for expansive equipment. Insurance, hospitals, specialists, family practitioners, GPs, pharmacists, pharmaceuticals, big pharma, Bank Negara, MOH, must all be there together. What cannot happen, ladies and gentlemen, this is coming— I'm speaking on behalf Dr. Sng because as past president, he had to endure this when the GST came, when TNB, for example ask for 10 percent discount. What happened in private hospitals? Do you know? So, with regards to TNB, the 10 percent discount was taken from doctor's fees. [Ketawa] Doctor's fees. You can check this now. You can check this now. Doctor's fees.*

It doesn't even make sense. So, picture this. About 10 years ago, TNB goes to the private hospitals and say, your charges are getting too high lah. *We need a discount. You want to remain on our panel, we need a discount. So, give discount* lah. Sepatutnya diskaun lah yang hospital bil yang RM10,000, RM20,000 itu. *Doctors after all,* dapat RM1,000 sahaja, kan, RM1,000 sahaja. *So, 10 percent* potong mana? Potong yang doktor. Ini macam mana jadi? Jadinya YB, kalau tak ada *oversight,* kalau tak ada *oversight. If you allow them, sorry to say, the group CEOs of both the insurances and the private hospital groups will get together over cigar,* lepas bulan puasa nanti. *Over cigar and over coffee or whatever else and they will decide. And where will they cut the DRG, [Tidak jelas] DRG? First and foremost, they will cut the doctors.* Kita *limit*-kan lah doktor ini.

And there's already an example in the decanting programme at the moment between MOH to private hospitals for certain conditions. It is not in the slide. Sorry,

because we thought it will be too much for— there are already too many slides. So, again, we can provide to you this in writing. For the decanting at the moment, for angiogram and angioplasty and cardiac bypass surgery because MOH is facing a crisis. Serdang Hospital, Penang Hospital, Alor Setar Hospital, the centres for cardiothoracic surgery, overloaded as well as for cardiology. Patients wait six months. Patients can die. I actually had a second uncle where actually passed away because he was too late. The appointment in Serdang.

But, besides that. So, there is a need to decant to private hospital. But what's happening in the decanting package? The private cardiologists doing the angiogram, angioplasty, have to take further cut to what they are already giving. They already agreed initially on a certain price but then they took a further cut. So, this is the situation. We don't want the private doctors', specialists' fees to be further cut because it is totally unfair. They are the only part of the equation at the moment. Just like the GPs which have our fees regulated. I will leave this to the secretariat. You can have a look, okay.

Dr. Hajah Halimah Ali [Ahli PAC]: *Are you*— macam *you* separuh-separuh apa *about DRG* ini. *You are for or against it? And then* kejap *you* kata buat *pilot* lah, apa benda tu. *If you are against, against* lah.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *We are against it but we are also realistic. We know the government and yourselves will want a solution. So, all we are saying is, if you don't want to do to because yes, the ROI, etc. means that you need to have another oversight body. Meaning that either you set it up within MOH or empower CKAPS now to be more that what it is now or empower a new department in Bank Negara or MoF or you have to set up another one stop agency. The easier way which is why MOH is pushing for it, is the DRG. The easier way but we are telling you the DRG has got pitfall, if we are not careful.*

So, and the major pitfall is for the patient, first and foremost. The limitation of treatment tadi, etc. the transfer of treatments who are half treated etc. But yes, we also want to make our chase because based on previous experience, we are the ones who will get fried. And, the big boys, the private insurance and the private hospital groups will still make profit in the hundreds of millions a year, if not more.

So, the last two slides are just a reminder that we have to work together. Why? Because although, some idealists say we should increase our allocation on National Budget to healthcare even more, now it is already more that ever before. We appreciate that the current government and the current Health Minister but also to understand that if we were to actually compare— bawah sikit, bawah sikit. *No,* atas,

atas sikit, *sorry. So, that's the expenditure of Federal Government as well as MOH expenditure.*

So, unfortunately, if we were to be idealistic, if we were to be idealistic, the five percent of the GDP allocation to the Health Ministry will mean that— bawah sikit, bawah sikit. Tak, tak, *sorry,* atas sikit, atas sikit— *will mean that it's already 32.3 percent of the National Budget which is unrealistic. Unrealistic. So, we cannot go there. We recognised this. We cannot go there.*

So, that's why everybody has to work together and around the National Health Fund as in the White Paper and then, later find the way to get multiple stakeholders to buy in into the National Health Insurance. Our own National Government allocation will not be enough. And just imagine here now, if you rush the DRG and like in Indonesia, you have to foot the bill for the gaps. It will be— it may be a disaster for any government. Not just this one.

So, but yes like the private GPs, we also say it's time, ladies and gentlemen for the government to do something about this. It's time to prepare the nation. Tell the nation somebody has to stand up and tell everybody, that RM1 per visit is no longer sustainable. After all this was done way back. Just after independence. So, it's not realistic anymore because if you have better primary healthcare, better public hospitals services, better GPs, you will reduce medical inflation because less people will need to go to hospitals, need to be hospitalised especially need to go to expensive private hospitals. That will in turn force the private hospitals to rationalised. They will be forced to.

And in private hospitals, in converse, in private hospitals, the only important department is the finance department, okay. [Ketawa] The other departments; x-ray, physiotherapy, all like Dr. Charles said just now, sweatshops. So, this is the only important department.

■1350

They have lawyers, some of them even have bouncers. Now because systems are computerised, if you don't pay up— the last visit you saw Dr. Sng, the next time you want to see Dr. Lee the same hospital you cannot. Because the system will show you are owing RM500. They won't allow you to see Dr. Lee in the same hospital. They take their fees seriously. I think it's time the government does so as well with of course provisions for the B40. That one I leave it to Dr. Halimah, YB Halimah to fight in Parliament. Yes, the B40 need to be protected. But not to this extend. Not to the extent of distorting the entire healthcare system.

RM5 should be good except for B40. B40, you work out the formula. There are some visits we are told with MOH in the MOH transformation office they should

get their heads together, crack their heads together and come up with something. Because in 2024 the collection is only 6.2 percent of the MOH allocation. Less, YB? Dr. Lee says less. If it's less than RM1 billion— RM700 million, it's very bad. Of course, the public healthcare system is not able to upgrade. Then they have phenomenon like Dr. Sng is saying— former Parliamentarians, former Ministers who used to go, who used to like to go to GH. Be it in Ipoh, JB, Kuala Terengganu because they got special treatment. They are VIPs. Now no longer go to these general hospitals. Now they turn up at private hospitals. Not very good.

Last but not least this is just a rough calculation. Even if we less it for the B40 you can see that we can make a lot more for MOH. Maybe up to even RM8 million if we increase the price for the M40 and the of course the T20. Yes, although— again it's a political minefield I understand. I understand. It is not that we don't understand. We understand. But sometimes you have to bite the bullet for the country. With that ladies and gentlemen kami mohon mencadang terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Thank you very much. Dr. Sng you want to say something is it before you leave?*

Dr. Sng Kim Hock [ASPMP]: *To take leave because of clinic— I can't. Sorry.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, okay. Thank you.*

Dr. Chang Chee Seong [FPMPAM]: *Sorry can I— To answer Dr. Halimah and also YB Sim regarding when this happen is when corporatisation. Again, YB Sim you asked about judge, jury and executional for the TPAs. Let me tell you the story of Sumitomo. 2019 Sumitomo bought over two TPAs from Ekuinas. The value of the transaction was not disclosed but it was a couple hundred millions. They sold two TPAs to Sumitomo in 2019. Since 2020 Sumitomo has been very active in buying over private GP clinics. Up till now I think I believe they have bought over 200 clinics.*

First of all, they buy the TPAs who are supposed to manage the claims from the clinics. Now they are buying over the chain of clinics to serve their TPAs. This is confirmed. You can check the source. They have bought over TPAs, they have bought over clinics. The next I am telling you is hearsay, the next step they are planning to buy over private hospitals.

Dr. Hajah Halimah Ali [Ahli PAC]: *To complete the chain. [Berucap tanpa menggunakan pembesar suara]*

Dr. Chang Chee Seong [FPMPAM]: *To complete the chain. What will happen once they complete the chain?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Dr. can you give your name so that for the Hansard.*

Dr. Chang Chee Seong [FPMPAM]: *I am Dr. Chang Chee Seong.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Dr. Chang Chee Seong. From?*

Dr. Chang Chee Seong [FPMPAM]: *From the Federation of Private Medical Practitioners.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay thank you. Okay I invite the next who will be the presenter? Dr. Lee, is it? The last one.*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Yes. Hopefully the last one. Thank you. I am Dr. Lee Boon Chye,* Mantan Timbalan Menteri Kesihatan. Terima kasih kepada PAC kerana menjemput saya untuk turut menyertai prosiding hari ini*. Let me continue in English. I think even though I am a practitioner I am not here to represent the doctors. I am just looking at the overall pictures and hopefully give some short-term suggestions and some long-term suggestions as well. Can I have the slides?*

First of all, we need to understand the so-called healthcare inflation. The often-quoted figure is always 10 to 20 percent based on this AON Survey. While the slide is still going on, this 2022 Global Medical Trend Rates Report. I think the 2024 is coming out soon. But you need to understand what is AON. AON stands it is market research company. What do they research? They actually research medical premium for health insurance. They don't research medical cost. They research medical premium and serving big corporations companies and so on. They got the report which show that in Malaysia the yearly increase of healthcare premium is increasing by 10 to 15 percent.

That's what we have been quoting. Medical care inflation which is increasing by 10 to 15 percent. But is this true? If healthcare inflations stand to 15 percent every year it will mean that our total expenditure for health should be increased by 10 to 15 percent every year. But if you look at the National Health Expenditure Account given by this Bahagian Perancangan KKM *I think this was presented in December last year. Hardly two, three months ago. It is in the website. It is a public document.*

In actual fact you can see that the total for expenditure— I think it will be difficult for me to— I wasn't a good print out but let me elaborate. Later you can share the email to everyone.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I think all of us got a copy.*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Okay. You look at the total health expenditure is about RM80 billion in 2023. It was about four, five percent increase compared to one year before. If you look at per capital that means you divide the total expenditure divide by population. Per capital expenses is*

about RM2,500 per year, per person. Compared to previous year the inflation the extra expense is only about four percent increase. How do you get up with this 10, 20 percent inflation?

Now even you go to DOSM inflation statistic, healthcare inflation contributes only about one to two percent in total. It is not a big thing. But then the medical health— so-called medical card insurance premium has been increasing by 10, 20 percent. That's true. We know for a fact.

■1400

But we need to know why. If you look at the total health expenses. The total health expenses, a big chunk 53 percent of it comes from public sector. Meaning Ministry of Health. A portion from Ministry of Higher Education, apart from Ministry of Defense and also some government-linked investment companies (GLIC) and private sector actually contribute about 47 percent. Out of all this 100 percent total about RM84 billion expenses for health, only 10 percent involve this medical card insurance. That means some are private, some are corporate medical card.

So, when you're talk about medical card premium inflation it's actually a small segment of the total expenditure for health. It's not the total health expenses which are increasing by 10, 20 percent. So, I hope that's clear. Then, the next thing we need to understand is one of the main problems is because I think…

[Ahli-ahli berbincang sesama sendiri tanpa menggunakan pembesar suara]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ada masalah tak boleh *show* itu *slide* kah? *Show* Dr. Lee.

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *In the e-mail, in the e-mail.*

Siti Noor Akmar binti Zulkafli [Parlimen Malaysia]: *[Bercakap tanpa menggunakan pembesar suara]* Kita tak *receive your email*. *Where is it your…*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *You have the pen drive or not Dr. Lee?*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *I don't have a pen drive.*

Tuan Sim Tze Tzin [Ahli Parlimen]: *You have the email now? So that we can... [Bercakap tanpa menggunakan pembesar suara]*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Who can I send it too? I send to YB Sim? WhatsApp.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *No, no, no. Aida, you* bagi *e-mail. Give your e-mail. [Bercakap tanpa menggunakan pembesar suara]*

Puan Aidahanie binti Baharuddin [Parlimen Malaysia]*: You want to WhatsApp? [Bercakap tanpa menggunakan pembesar suara]*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Who WhatsApp number? I don't know if I can WhatsApp to you or not.*

Puan Aidahanie binti Baharuddin [Parlimen Malaysia]*: 013-3012828 [Bercakap tanpa menggunakan pembesar suara]*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Cannot because you are not my contact. How do I?*

Puan Aidahanie binti Baharuddin [Parlimen Malaysia]*: Just scan mine. [Bercakap tanpa menggunakan pembesar suara]*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *How do I? I don't know. I got the file. Okay.*

Puan Aidahanie binti Baharuddin [Parlimen Malaysia]*: Just scan mine. This is your setting. [Bercakap tanpa menggunakan pembesar suara]*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Setting, what?*

Puan Aidahanie binti Baharuddin [Parlimen Malaysia]*: This is mine. [Bercakap tanpa menggunakan pembesar suara]*

Dr. Lim Kuan Joo [FPMPAM]: *YB, since you are waiting can I give some comment?*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Yes, please*.

Dr. Lim Kuan Joo [FPMPAM]: *Am I allowed to give some comments, YB?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, yes. Dr. Steven, is it*?

Dr. Lim Kuan Joo [FPMPAM]: *I'm Lim.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Dr. Lim.*

Dr. Lim Kuan Joo [FPMPAM]: *Dr. Lim. This is regards to the previous Speaker. Where he's questioning us about DRG. Okay, let me give you an example of South Korea. Korea implemented the National Health Insurance. What happened? They wanted to use DRG but the doctors protested. So, they went, they use fee-for-service. Just like in Malaysia. Fee-for-service.*

What happened in Korea? Five years later the National Health Insurance company going bankrupt. Not enough money because fee-for-service is just servicing. Over servicing maybe. So, what happened was Korea used alcohol and other sin tax to boost up the National Health Insurance fund. Now I think they are moving towards DRG. So, this is history of DRG and fee-for-service.

The next thing we should be looking into the future. We should be looking in the future and method of financing. Look at Singapore. Singapore is now doing value-based care. Which is care for the whole cycle of care and based on— Singapore has third to capitation. Not fee-for-service but capitation. But capitation based on bundle payment for the whole cycle of care.

That means prevention, promotion, hospitalisation or outpatient care and then after that rehabilitation. So, it will be nice if PAC look at value-based care. Which is now the mode new fashion for the 21th century. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Thank you. Value-based care. And we also know that like in Korea, the government doesn't allow the hospital, private hospital to go listing, right? To be listed in stock market. And recently— and also they don't allow something that what private hospital to go for profit, profit-oriented. I think Japan also the same.*

Dr. Lim Kuan Joo [FPMPAM]: *I think the right word would be healthcare profit. No profit at all or profit with a conscience. You must make profit but you must have a conscience. If no conscience means* habis*.*

[Ahli-ahli berbincang sesama sendiri tanpa menggunakan pembesar suara]

Dr. Lim Kuan Joo [FPMPAM]: *YB, since…*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Sorry, technical problem. The 5G doesn't live up the standard. Still sending. Take note. [Ketawa]*

I'll continue okay. So, I think first, medical card premium inflation is real. Number two, healthcare inflation is real. Private hospital charges increase is also real. But the overall total expenditure for health is not increasing as much as what the inflation figure show.

Why? The answer is why. Actually, this we must give the credit to Ministry of Health and the public sector. Because this are the public side which is dampening the overall inflationary impact. Because the price the population pays for their healthcare doesn't increase very much when they go to government hospital.

So, the overall inflation is capped down because of the public hospital. So, then I come to that. We are spending about 53 percent of the total expenditure for health by the government and I think the number, the amount is not sufficient. If you go look at the peers, most of the other countries spend much more, 60 percent, 70 percent or 80 percent or 90 percent. And for these countries to spend higher percentage of higher expenditure of coming from public sector they are cheaper. They spend less. Because the government has got the ability to control cost, number one and the government also had the ability to ration. Whereas in private hospital

setting, you cannot ration because when the patient demands for it, it's extremely difficult for the doctors or for the hospital to say no. You have to. Both demand-driven and also supply-driven.

So, you cannot ration. Whereas the public sector can ration. That's why you can control cost. So, for us to reduce the overall healthcare inflation, one thing we must do is to increase the expenses under Ministry of Health. At the moment, is about RM40 over billion. I think to be realistic you need increase up to about to RM80 billion in total. So that we can live up the standard of our peers.

■1410

I think you can go to— this is the one I said I… [Tidak jelas] [Merujuk pada pembentangan slaid] The per capita is about RM2,500 in 2023. In 2002, is RM2,400. It's hardly about four percent inflation per person based on the total expenditure in health. This is DOSM. Only 1.2 percent of the total inflation is due to health.

As I said earlier if you look at the total expenditure for health, 43 percent is for the Ministry of Health, other Federal agencies. Out of pocket, 26 percent. The big chunk, private insurance, some corporate insurance and the total of all these so-called— today we are talking about all the medical card inflation. It's only about 10 percent of the total expenditure for health. Okay, next. This is the same. It's just a small portion. [Merujuk pada pembentangan slaid]

Who are all these people who are affected? Actually, those who are affected are M40. Of course, T20 is also affected but to them, I think the additional 50 percent, 100 percent to them is nothing. But the main chunk is actually the M40 who are affected. So, as I said, the 10, 15 percent is actually health insurance premium inflation and all the reasons have been said which I will not elaborate on in terms of the inflationary pressure on healthcare expenses, okay? MoH and the public healthcare providers are the main factors which mitigate, reduce healthcare inflation.

So now, we come to why the medical insurance premium increase by 10 to 15 percent. This is data in [Tidak jelas]. If you look at the healthcare cost across age groups. That means every year, how much of healthcare costs you consume? If you are younger, 18 to 24 years old, you are much healthier, you consume less. When you go older, 55, 65, you consume much more. Of course, you go to the extreme age, for most of them, they probably sort of don't go for treatment. They accepted the aftermath, so they consumed less.

This thing is important because our medical card business started about 30 years ago. At the beginning of the business, a lot of the insurers in order to corner the market, they sell it cheap so that they can corner the market. This is the same practice like Uber, like Grab, like a lot of tax companies. They sell it cheap; they

cornered the market and then they got the commanding power to demand the final price. That's number one.

Number two is a lot of them bought when they are at the age of younger age group and by now, they are reaching this age. If they bought 30 years ago, imagine they are 34 years old, they bought. Now they are 64 years old. When they are 64 years old, their consumption of healthcare money is easily five to 10 times more than before. To cover that, of course, the insurance premium will have to increase year by year. As you get older, the rate of increase will be exponential. So, that's all.

This is just another illustration. [Merujuk pada pembentangan slaid] Because when you are older, emergency department visits increase, hospital admissions increase, ICU admissions increase, ventilation increases. So, all these contributed to the increased cost. So, it's not surprising for Malaysia that medical card premium insurance increases by 10 to 15 percent. All the new markets like the Philippines and so on, they are going to experience the same thing. They will be higher until another 10, 20 years before the cost stirs up a plateau. That's what I'm trying to say. [Merujuk pada pembentangan slaid] About our public factor, expenditure compared to other peers is lower compared to a lot of the countries including Thailand, Turkey, the Republic of Korea, not even Indonesia.

Of course, we cannot always blame the private hospitals because the private hospitals provide choice for the people. I think I heard a lot of arguments about community hospitals, specialist hospitals and top-tier hospitals. I think it is extremely difficult for policymakers to try to intervene, micromanage all these because— even though I'm not 100 percent believer of Adam's myth, but I think we still allow the invincible hand to handle part of this.

Let the market determine as far as how they want to build the hospital and how patients want to choose whether they want to go to a budget hospital or a five-star private hospital. That should be the choice of the patient. As I said, the public sector has got the ability to [Tidak jelas] and control overall costs.

This is a similar slide in America. As you get older, that consumption of healthcare will increase. But I draw a line, a red line there. [Merujuk pada pembentangan slaid] Why the red line? This red line is important because if we want to control the cost, we should have an insurance policy which covers from cradle to death, whole life coverage.

If you allow the insurance company to profiteering from the policy, they will definitely go for the lower expenses group where they can make money. That's why by the time you reach 65 like me, uninsurable, cannot get a medical card. Can, now

can, but you pay an extremely high premium. The reason is clear. So, we need to have an insurance policy which covers from cradle to death, the whole life coverage.

So, that's why I said there's a need for a universal national health insurance scheme to cover from cradle to death. But before you do that, one thing you got to be— one thing has to be done. First, the public healthcare facilities which have a dampening effect on healthcare inflation have to be strengthened and be the dominant supplier of healthcare services. If you don't do that, once you integrate, you open up, all the patients flock to private hospitals. It is not going to reduce costs; it will blow up the healthcare insurance budget. So, you need to have a non-profit making public hospital, private healthcare facilities as the main anchor of the whole ecosystem.

And to strengthen that, number one, you must have an internal review to make the public hospitals, public healthcare facilities more efficient.

■1420

I've written the paper. Sharing it with some MPs. If you are willing, I can share with all of you. One of the main things is, number one, electronic medical record. That should be the priority. I think under the next five-year Malaysia plan. There should be a substantial allocation for electronic medical record. Without doing that, I think the government hospitals are not going to be run efficiently.

Number two, need to be decentralised decision-making. At the moment, all the decision- making is done at Putrajaya. It's undesirable. You should have decentralised, delegates, more responsibility to the general hospitals, to the JKN, state health officers and so on. So that, they can be more responsive and more efficient and take out more responsibility. They also got to instil and solidify a patient-centric culture. I mean patient-centric culture. I hate to say that because I know MOH has done fantastic job over the years. Improved a lot over the years. But patient-centric culture is still very much lacking.

I am a practicing cardiologist. I routinely see patients who are admitted to hospital with chest pain, with shortness of breath, treated by physician medical officers, staying in the ward for five days, 10 days, one week, discharged home without an essential basic test done and given appointment for echo, for stress test, five months, 10 months, one year down the line. By then, the tests become irrelevant. The patient may not require. Either they are dead or they go to somewhere else.

So, these are the things where MOH should look at and make sure that they look at the work process and instil a patient-centric culture. Of course, there's a need for more money for the public healthcare facilities including Ministry of Health. As I

said, I give arbitrary figure in my report. It should be easily within next few years. State up to about RM80 billion allocation.

The ultimate objective of the national healthcare policy should be universal cover everybody, equitable. It could be assessable to everyone and it must ensure quality. Today, we are only looking at the 10 percent of the medical card which should be looking at the total expenditure for health because that's what policymakers should be looking at, the overall. How can we make the healthcare system better, good quality at the minimum cause? That should be our decision as to where the money is coming from. I think that is up to each and the policymakers to decide subsequently. I think I have— before I end that, by rights, should end that I got addendum. Although I know addendum is sensitive.

Record breaking medical negligence compensation. These are the few examples. Ministry of Health paid out RM9.45 million. Another case RM8.6 million and the recent case, Columbia Asia pay up RM4.5 million by the hospital, by the doctors RM2 million for medical negligence.

The calculation for the compensation includes directors' fees of the patient and allowance and so on. That's why they come out with the judgement sum of RM4.5 million. By the way, if you go to Bursa Kuala Lumpur, you search the highest renumeration of a CEO of a public listed company in Malaysia is RM113 million per year. So, imagine that if the hospital were to take this patient and run into trouble and got the lawsuit, with this, it would end up multibillion dollar compensation. So, what— my last point. A few points I want to suggest.

Number one, on this. I think the legislators should consider put a limit on the medical negligence case. A limit. Number two, the standard for judgement has shifted. In the old days, the standard of judgement on negligence was based on prevailing acceptable practice. Now, no more. Now is, you must conform to best standard. When you want to say conform to best standard, there will be a lot of defensive medicine. A lot of doctors would do investigation. Imagine that you got a headache. If I don't do a CT scan for you or even MRI for you, I got a lawsuit, I can be sued for medical negligence.

So, there will be a lot of unnecessary investigation, unnecessary intervention. I always say, it takes a lot of courage for the practitioners to withhold investigation and be told treatment for patient. There's a lot of courage. They need a lot of conviction just to say, "No, you don't need this". But with this sort of medical negligence case, I think it would certainly shift.

The second suggestion, my opinion. Price control for the hospitals, I think it's not possible. You put one price control on the drug, they got always they can put

glove, they can put tissue paper, they can put other things. There's no end to it and you cannot micromanage. The government is not in the business of micromanaged how a hospital would charge. What you should do is you should ensure transparency. One way to ensure transparency is the insurance company has got all the bills of all their insured patients and I will encourage them to publish all the bill.

You got CABG, bypass operation done at Damansara, cost you how much? At Pantai, cost you how much? At Gleneagles, Island Hospital, cost you how much? You publish. Let everybody sees and people can choose where they want to go, based on their choice. Because even if you want to manage, you say like, "What is a reasonable price?". I always say, "You go to a roadside store, you pay RM5 for a teh tarik *or a coffee, you complaint like hell". But you go to Starbucks. You pay RM15, you are quite happy. But of course, there's one different. The difference is before you walk into Starbucks you know that you are going to pay RM15 for a cup of coffee. But when you walk to the hospital because of the information a symmetry, you cannot say what you want, what you need.*

■1430

The patient doesn't have a choice of what they want, what they need and what price it is. They were actually got no say. So, there is no way where the government can micromanage the price. The only way I think a lot of market be more transparent, publish all the data on the regular basis and patient got the choice. Insurers also got the choice and don't keep it secret. I know they are keeping it secret. I don't know for what. You know they don't publish. They have all the data. The insurers have got the data, hospital got the data. Of course, the hospital wants to keep it their secret but what should the insurer keep it a secret? Publish it so the competition can happen.

Number three, Bank Negara should make co-payment mandatory. I think this is something where we are all agree which will reduce the total premium cost. But it should not be optional. It should be mandatory. Otherwise, there will always be other ways of going around and the practice of packaging health insurance with other financial insurance product has to be transparent on the part of insurance company.

Lastly, I concur with a lot of others about this DRG. I think at the moment, is not wrong to start exploring but if you were to start like a big bang, it is going to be disastrous. I think all the reason has been allude to.

So, I think the most important thing is while we are looking at this medical card insurance premium inflation, we should be giving— using this is opportunity to push for a national health insurance. This is the best time. I'm not saying that we

should implement the policy now. We should be instilling the idea that in years to come, that should be the way forward.

Don't talk about our GDP not per capita, GDP not to the standard. No. When Singapore did it, it was about our level now. Indonesia can do it. Can't we do it? It must be— something must be wrong. You know we certainly can do it.

So, I think I hope that Ministry of Health can look forward, strengthen the public health sector, plan for a national health insurance in next five years and going forward as to how do you fund the national health insurance premium. I think the policy maker can decide either coming from the general taxation or coming from the portion of the salary of the individual population.

But of course, the B40 has to be subsidises and MOH should technically divert themselves from being a service provider, regulator, policy maker. They should divert the survice provider to separately under a non-profit organization so that they will not be sort of conflict of interest. When MOH does that, the allocations from Ministry of Health, will be very much less. A big chunk of allocation for services— for klinik kesihatan *for the hospitals, I think would be easy about 75 percent of this. Can be used to pay for the insurance premium to subsidise the B40 and the M40.*

So, I think that's all I have. You have any question; I will be happy to answer. Thank you, Chairman.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih Dato' Dr. Lee Boon Chye atas penerangan itu tadi. Saya kemukakan pada Ahli Yang Berhormat sekiranya ada soalan. Saya nampak Bayan Baru dan juga Betong.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi. Kalau saya boleh tanya*, what is your take on this Rakan KKM program? Do you think that is the way to solve some of the premium economy?*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Oh, I think that is one— this is a short-term measure to sort of public-private partnership. I think it is a good idea and it actually utilises the access capacity some of the private hospitals like MRI machine or CT scan or even services like cardiothoracic surgery, cardiology services. So, it helps maybe…*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes YB Sim. Just to continue from there. Three aspects.*

Number one, the whole framework has not been presented yet but if the premium economy is limited to government hospitals only and specialist from government only and services provided by that particular government hospital only, there are risk of it not working very well because you will be actually putting the CT scan machine or the MRI or the laboratory services. This has happened in some

universities which has private wings whereby they have two minds now whether— and so they have no choice because in private wings the patient is paying. So, then they do the private request first. So that has to be looked at carefully.

Like YB Lee has saying, the best way for Rakan KKM *to go forward is actually eventually to be in inclusive of private specialist as well as private services which can be made available. Now that is some work to do there especially in terms of the services. Because eventually, if you go that way, the private hospital would again charge a premium for that MRI for the CT scan. Perhaps it can begin by allowing private specialist to take part. There are many private specialists who actually want to give back a little bit of their time.*

But there is no way to do that now. This will be a precursor although it is too early yet. A precursor if manage correctly, it can be a precursor to that integration which all of us are talking about which is still a few years down the road, which would need the national health insurance in place et cetera. But until that happen, it can be a precursor to that. However, if it manages badly, it can go sideways ya.

Because what happen in some universities— just to share because I was in university before as well as in KKM. You will have some senior specialist especially consultants nanti *devoting more time to the* Rakan KKM *clinic and neglecting the public clinic* ya. *Doing more* Rakan KKM, *premium economy surgeries and neglecting the public surgery even though by competency, they are supposing to be there at that public procedure. Saying meaning there is complicated surgery and so the senior consultant has to be there, not just the young specialist. But instead, because there is* Rakan KKM *case going on which less complicated, he goes there. So, we have to safeguard these things. That is why if there is inclusion of private specialist, this would help lessen the burden. So, it is a good idea.*

I think YBMK other rationale is because the national health budget cannot be increase yet and he needs more funding to upkeep and also upgrade MOHs' facility which we all want. So, he is saying Rakan KKM *will provide some of that funding. Well hopefully so but we have to see it especially if you implement the DRG as he is saying he is willing to and he will be a piloting. So, one of the targets of the pilot would be the* Rakan KKM *programme. So, it is a good idea but the proof is in the pudding* YB. *So, we will see how it goes and there are some cautionary things that we would highlight to you.*

Dato Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *I think some of the things is they actually decant some of the cases outside to private hospitals.*

■1440

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *That one already happening now.*

Dato' Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *Yes.*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *That one is a…*

Dato' Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *So, they go on a sort of a fixed price…*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Yes.*

Dato' Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: …*Basis, but those are very selected cases. Safe, simple, straightforward cases. The moment there's a complication, it transfers back to MOH.*

That's why one of the thing about the DRG is if you set a DRG too low, then the private hospital will pick and choose and complicated cases will go to public hospitals and only simple cases will be [Tidak jelas] done by private hospitals.

Of course, they say you cannot waste code but that way, who does the coding? It's the hospital who does the coding.

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Exactly.*

Dato' Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *The hospital will always try to code as high as possible so that they can get and how are you going to check the coding?*

Dato' Dr. Ahmad Faizal bin Mohd Perdaus [ASPMP]: *Exactly.*

Dato' Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: *It's not easy. At this point in time, I think the DRG is a bit premature. It will better to have some pilot and because— take for example. I look at, say China's model. They have full health insurance.*

If you do MRI— of course in Malaysia, if you do DRG, you get the standard charge. But in China, they got to go to extra detail. If you are ordinary MRI, 1.5 Tesla which is a lowest grade MRI you can only charge that much. But if your MRI is three Tesla, which is a better MRI machine, then you are allowed to charge higher.

So, if you want to do that, it would be extremely difficult. First of all, you need to have a lot of data, a lot of monitoring and a lot of enforcement and if you don't have a digital system— computerised system of medical record, it's virtually possible for you to monitor and enforce or to regulate. China is different. They are all totally digitised. They know when you charge MRI RM1,000 but you using a lower grade MRI, straight away they know you overcharged. But we cannot. We have no— we don't have the data and the capacity. Thank you.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Datuk Wira Pengerusi, *just a short one. I want to— since the GPs are here. Just want to seek*

your view of the idea of this GP only prescribe and then the patient will get the medication from the pharmacies. What's your view on that?

Seorang Ahli: *Maybe I can answer…*

Dr. Shanmuganathan Ganeson [FPMPAM]: *I will answer that. So like I said earlier, the current model of GP clinic we have a— we can charge consultation and then we give medicines for which then we have a markup which you can use to cover the overheads. So, there is a dispensing separation. That means we only just prescribe and the patient then, get the medicines elsewhere. Then we lose that part of margin.*

Now, clinic today is not sustainable with just the consultation alone. In fact, we've calculated the— just for inflation, the current RM15 to RM35 should actually we set RM70. Just for inflation. Not including all the other overhead— the salaries, the rentals, the indemnity fees, et cetera. Now, if you— when we did the calculation to include all the other overheads, then that consultation is now RM250. Can you imagine going to a clinic to pay RM250 for consultation for cough and cold?

So, that is where the markup on the drugs is so important. If you want to keep the consultation at RM70, we must allow the dispensing to continue.

Dr. Chang Chee Seong [FPMPAM]: *I want to add on, on that as well. YB, do you have friends who are living in Australia or UK? Or even in the US.*

We have a lot of patients who are Malaysians living abroad for decades. When they came back to Malaysia, they see a GP and immediately they get their prescription, their MC and their consultation from the GP. They walk out. They very happy because it is one point of care, one stop. I go there, I get all my procedures done. I do my blood test, I get my test done, I get my medication and I go back home. Okay.

In a way, the GP has been practicing something like a DRG for the past 30 over years. It's pretty standard. You go for a cough and cold usually cost— it used to cost maybe RM50 to RM60. Over the past five years maybe it has gone up to RM80 to RM100. And it doesn't run much from GP to GP. Unless you have a special investigation done and say you have done an influenza test. We have been practicing so-called unspoken DRG for the past 30 years.

But if dispensing separation happens, that said that means the fees schedule will have to be revised. And then you will be paying say RM70 for a GP consultation and you walk out with just a consultation receipt and maybe a medical certificate for the day off. And the you have to go buy your medication from the pharmacy.

And what if the pharmacy that you go to do not keep the specific antibiotics that the GP prescribes? Then you having the fever, having your sore throat, having a

headache, having a joint pain, will have to go look for another pharmacy. So, in the end, cost will not be lower. But you have a lot more trouble. Terima kasih YB.

Dr. Lim Kuan Joo [FPMPAM]: *Can I, can I, can I add to that? I'm Lim Kuan Joo. Do you know what will happen in countries in some countries in ASEAN where there is dispensing separation?*

I work in Indonesia as WHO consultant for two years. There, because they cannot dispense ubat-ubat biji-biji semua, *every patient that comes, they give an injection and then, they will charge the injection. That's why Indonesian patients when they come to Malaysia, they always ask for* suntikan *because in Indonesia, the GP will give the* suntikan *first, and then they will go buy medicines from the dispensary.*

Dato' Dr. Lee Boon Chye [Mantan Timbalan Menteri Kesihatan]: YB Pengerusi, *sorry.* Pandangan saya, *I think while we are— a lot depends on whether Ministry of Health is moving forward with a National Health Financing Scheme or not in the next what, five, 10 years.*

I do not think it is desirable to rock the boat at the moment. It's better to maintain the status quo while you are focusing on planning for the next five, 10 years. That's my— otherwise, certainly when we do the separation, the cost is going to go up, for sure. Thank you.

Dr. Lim Kuan Joo [FPMPAM]: *YB, can I say— can I add a— spend two minutes to add something else?*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *One minute I give you. Because I want to finish it at 2.50 pm.*

Dr. Lim Kuan Joo [FPMPAM]: *Okay, okay. Because I will tell you my experience since I was doing healthcare financing in the Ministry of Health since 1985.*

At that time, we called a consultant and we named it National Health Security Fund. We don't want to call it insurance because in the Islamic religion, they don't want the word insurance. So, we say National Health Security Fund.

When that fund came out and we went to government, we presented to the government NDPC, the top planning body of the government, there were many prerequisites that if you implement National Health Security Fund, you must have the following pre-conditions. And one of them is you must improve the public hospital. You cannot have third-class wards where center beds ada, *side beds* ada, *corridor beds* pun ada. *Because the patient pays the premium for insurance and you are giving him this type of third-class treatment. No way. And, there were many other criteria I will not because in the— no time.*

The second thing, the final thing I want to say is that, that National Health Security Fund was shelved. When I retired it was completely forgotten. Then, in 2005, we called in another consultant by the name of Carol from Australia.

The consultant had a look. By the time I went back to Ministry of Health after retirement to help in the National Health Security Insurance, Carol had a look at the whole system in Malaysia. He says, "Ayoyo, the private sector is like that. Government sector is like that."

So, he says it is better for Malaysia, first of all to start with voluntary health insurance. Where government sponsored voluntary health insurance whereby the people will buy voluntary health insurance. And that was supported by the previous minister. And maybe Yang Berhormat *here was there.* Subramaniam *supported voluntary health insurance. After that I don't know because after that my contract also* habis.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Thank you Dr. All right, so* terima kasih di atas penerangan dan tambahan itu tadi. Dan, jam telah pun menunjukkan pukul 2.50 petang. Saya ucapkan ribuan terima kasih sekali lagi di atas kehadiran dan juga komitmen semua.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tiga jam. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: YB Seputeh kata tiga jam lebih dia sudah ni sebab tadi saya keluar sekejap. Dia terpaksa mempengerusikan.

Yang Berusaha Dr. Shanmuganathan Ganeson, Presiden Persekutuan Persatuan Pengamal Perubatan Swasta Malaysia; Yang Berusaha Dr. Steven Chow Kim Weng, Yang Berusaha Dr. Lim Kuan Joo; Yang Berusaha Dr. Sng Kim Hock—dah balik ya?; Yang Berbahagia Dato' Dr. Ahmad Faizal bin Mohd Perdaus; Yang Berbahagia Dato' Dr. Lee Boon Chye dan semua yang hadir pada hari ini untuk sama-sama memberikan komitmen kepada PAC bagi memberikan penjelasan.

Sebenarnya banyak perkara yang telah pun kami juga belajar sewaktu dalam prosiding-prosiding berkaitan dan pastinya, apa juga yang kita ambil maklum balas pada hari ini adalah demi kemaslahatan seluruh rakyat Malaysia. Kita buat yang terbaik. Terima kasih sekali lagi dan saya tangguhkan pada jam 2.51 petang. Terima kasih semua.

[Mesyuarat ditangguhkan pada pukul 2.51 petang]



MALAYSIA

LAPORAN PROSIDING (HANSARD)

Isnin, 10 Mac 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH dan BNM

(i) The Association of Private Hospitals of Malaysia (APHM)
YBhg. Datuk Dr. Kuljit Singh
Presiden

(ii) KPJ Healthcare Berhad
Encik Chin Keat Chyuan
Presiden dan Pengarah Urusan

(iii) Sunway Healthcare Group
YBrs. Dr. Khoo Chow Huat
Pengarah Urusan dan Ketua Pegawai Eksekutif Kumpulan (Operasi Hospital dan Penjagaan Kesihatan)

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

ISNIN, 10 MAC 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] – *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] – *Naib Pengerusi*
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]

Tidak Hadir *[Dengan Maaf]*

YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Datuk Ali anak Biju [Saratok]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Cik Fatin Izzati binti Mohd Radzi [Pegawai Tadbir (Seksyen Sinergi dan Kolaborasi Strategik), Parlimen Malaysia]
Cik Jackie Mary Fernandis [Penasihat Undang-undang II (Pejabat Penasihat Undang-undang), Parlimen Malaysia]
Siti Noor Akmar binti Zulkafli [Juruaudit (Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Puan Faizah binti Rahmad [Pegawai Kadet]

HADIR BERSAMA

Jabatan Perkhidmatan Awam (JPA)

Puan Ilyani binti Md Razak [Ketua Penolong Pengarah (Perkhidmatan)]

(samb/-)

HADIR BERSAMA *(samb/-)*

Kementerian Kewangan Malaysia (MoF)
Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Encik Ng Yee Hang [Pegawai Komunikasi (UKK]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
PKPj Suzana binti Alias [Ketua Cawangan (Bahagian Penyiasatan Tatakelola)]
Encik Mohd Nadzri Bin Ibrahim [PKPj]

Kementerian Ekonomi (KE)
YBrs. Dr. Nik Rozelin binti Nik Ramzi Shah [Timbalan Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K), Bahagian Perkhidmatan Sosial (Bahagian Infrastruktur dan Kemudahan Awam)]

Jabatan Akauntan Negara (JANM)
Puan Noor Azira binti Abd Rashid [Akauntan]

SAKSI-SAKSI

The Association of Private Hospitals of Malaysia (APHM)
YBhg. Datuk Dr. Kuljit Singh [Presiden APHM]
Puan Erica Lam [Bendahari APHM]
Encik Anwar Anis bin Anis Ahmad [Setiausaha APHM]
YBrs. Dr. Tan Hui Ling [Ahli Lembaga APHM]
YBrs. Dr. Kamal Amzan [Ahli Lembaga APHM]
Encik Timothy Wong [Sekreteriat APHM]
Puan Nurhanania binti Azlin Shah [Sekretariat APHM]
Encik Stanley Lam Kean Fatt [Ahli Lembaga APHM]
Puan Deborah Chow Yik Kuen [Sekretariat APHM]

KPJ Healthcare Berhad
Encik Chin Keat Chyuan [Presiden dan Pengarah Urusan]

Sunway Healthcare Group
YBrs. Dr. Khoo Chow Huat [Pengarah Urusan dan Ketua Pegawai Eksekutif Kumpulan (Operasi Hospital dan Penjagaan Kesihatan)]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

ISNIN, 10 MAC 2025

Mesyuarat dimulakan pada pukul 10.01 pagi

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
***mempengerusikan Mesyuarat**]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh* dan selamat pagi, salam sejahtera. Yang Berhormat Ahli-ahli PAC Parlimen Ke-15, ahli-ahli ex-officio PAC dari Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen selaku wakil daripada pihak AGC.

Yang Berhormat ahli mesyuarat sekalian, hari ini PAC akan meneruskan prosiding berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, KKM dan juga Bank Negara Malaysia.

Sebagaimana semua sedia maklum, prosiding ini kita adakan bagi tujuan untuk mendapatkan penjelasan berkenaan dengan faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan juga caj hospital swasta. Ini termasuklah kos perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan juga faktor luar seperti pandemik.

Jadi dalam usaha untuk mencari jalan, mengurangkan impak peningkatan premium insurans kesihatan dan juga kos perubatan, serta pastikan akses kepada penjagaan kesihatan yang berkualiti, adil dan juga mampan untuk semua lapisan masyarakat, PAC berpendapat bahawa adalah wajar untuk kita mendengarkan penjelasan dan juga penerangan daripada pelbagai pihak untuk isu ini.

Jadi untuk pengetahuan semua, prosiding ini Dr. Kuljit, hari ini adalah prosiding yang ke-11 sejak PAC memulakan mesyuarat berhubung dengan isu ini pada 24 Februari yang lalu. Jadi, kita telah mendengar daripada— penjelasan daripada 45 orang

yang mana mereka semua melibatkan pemegang taruh dalam industri kesihatan dan juga penjagaan kesihatan.

Jumlah berkenaan ini tidak termasuk input dan juga maklumat yang diperolehi oleh jawatankuasa ini semasa mengadakan dua sesi pendengaran awam yang mana pertamanya berlaku di Pulau Pinang dan yang keduanya di Kuala Lumpur pada 21 Februari yang mana seramai 700 orang telah pun menghadiri untuk kedua-dua pendengaran awam tersebut. 100 orang telah pun memberikan maklumat dan juga penjelasan kepada PAC.

Yang Berhormat ahli mesyuarat sekalian, jadi hadir di hadapan PAC pada hari ini adalah Persatuan Hospital Swasta Malaysia (APHM) iaitu yang pertamanya Yang Berbahagia Datuk Dr. Kuljit Singh, Presiden APHM. Yang kedua, Yang Berusaha Encik Chin Keat Chyuan Naib Presiden APHM. Yang ketiga, Yang Berusaha Encik Anwar Anis, Setiausaha APHM dan ahli-ahli dedikasi yang merangkumi penjagaan kesihatan KPJ Berhad, penjagaan kesihatan IHH dan juga Kumpulan Operasi Hospital dan Penjagaan Kesihatan Sunway. Jadi, saya ucapkan ribuan terima kasih kepada semua yang sudi dan juga memberikan komitmen untuk hadir pada hari ini.

Sebelum saya menjemput saksi untuk memulakan pembentangan pada hari ini, saya ingin maklumkan kepada semua ahli mesyuarat sekalian bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 [*Akta 88*] dan juga Peraturan Mesyuarat 85 sampailah prosiding kita ini selesai dan juga dibentangkan laporannya di Dewan Rakyat. Jadi tanpa saya membuang masa, saya dengan ini menjemput Yang Berbahagia Datuk Dr. Kuljit Singh daripada APHM untuk memulakan pembentangan, dipersilakan. Terima kasih Datuk Dr.

Datuk Dr. Kuljit Singh [The Association of Private Hospitals of Malaysia (APHM)]: Terima kasih, selamat pagi. Saya Datuk Dr. Kuljit Singh selaku Presiden APHM ingin mengucapkan ribuan terima kasih kepada pihak Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin selaku Pengerusi Jawatankuasa Kira-kira Wang Negara kerana telah memberi peluang kepada APHM untuk berkongsi pandangan kami dan membentangkan data berkaitan isu-isu inflasi-inflasi kos perubatan dengan Yang Berhormat Ahli-ahli Jawatankuasa Kira-kira Wang Negara pada hari ini.

Kami ingin memohon kebenaran pihak Yang Berhormat Datuk Wira dan Yang Berhormat Ahli-ahli Jawatankuasa Kira-kira Wang Negara untuk meneruskan pembentangan hari ini dalam bahasa Inggeris untuk memudahkan pembentangan menjelaskan terma-terma perubatan yang tertentu. *If that is okay, we would like to*

proceed in English? Tanpa membazir masa, saya serahkan kepada rakan sekerja saya Yang Berusaha Encik Anwar Anis selaku Setiausaha Kehormat APHM untuk memulakan pembentangan kami. Terima kasih.

Encik Anwar Anis bin Anis Ahmad [The Association of Private Hospitals of Malaysia (APHM)]: *Assalamualaikum* dan selamat pagi. Jadi seperti yang dikatakan oleh Datuk Kuljit, saya akan meneruskan pembentangan dalam bahasa Inggeris, dengan izin.

So, our agenda this morning on behalf of APHM, I think what we would like to do is to take opportunity to share with respective YBs' and members of the PAC, our perspective and data that we have collected from analysis done by external parties as well some analysis done by APHM itself. And so, we have six agenda items which I hope we will be able to cover in less than an hour in the presentation itself.

But the six cover studies on profitability and billing structures in the private hospital results of medical inflation study that was undertaken especially on utilisation rates, results from the medical inflation study about medical cost increase and what has caused that increase in pricing.

Fourthly there is lot of discussion about charges between cash and non-cash patient, or insured patients in the hospitals so hopefully we'll be able to address that issue with some data that we have collected. Fifth is a list of measures and actions that we hope to share with the PAC during this three-year interim period as long as long-term measures. That will be six agenda.

So, perhaps the first item that we would like to share is about the levels of profitability in the private hospitals because sometimes, I think our understanding of what profit is could be very different and we are not saying either one is right or wrong but we certainly would like to explain and share what is a profitability in private hospitals.

So, from our study that we've done among the members hospitals and this study was undertaken by a third party is that our profit margin is actually quite slim and reasonable if you can say. Of course that can be argued whether it is [Tidak jelas] but 60 plus percent of the cost actually is direct cost and staff cost.

So, if you look at the chart itself, the waterfall chart. [Merujuk pada pembentangan slaid] It starts from the left-hand. For every RM1,000 of revenue generated in the hospital, firstly we deduct the discounts that are already been given. So, on average based on our study, discounts from hospitals are about 10 percent. These are discounts

to insurers, TPAs and others. And this discount is from hospital chargers. Typically, the discount is not from doctors' fees.

And then the next item in the waterfall chart is the doctors or the consultant fees. So, that is about 155. So, once we take away discount and the doctors' fees, we arrive at let's say a revenue unit of 1000. So, we are using the 1000 units to explain to you what the other cost structure between the hospitals.

Firstly, is direct cost. What we do mean by direct cost? That mean the patient is admitted and use sutures, you use consumables and operating theater, medication, all of this are direct cost. These are costs that we have to buy and we have to pay to the suppliers as we provide care to the patient. So that about 318.

Next is staff cost at an average of about 312. So, both of this is where we say over 60 percent of our cost is direct cost. Next is administrative and other expanses which is about 79 units. Then utilities, rent and maintenance another 74 units. Depreciation and amortisation that's 81 units.

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Finance cost, we take an average of five units out of the 1,000 and we finally arrive at our operating profit. So, operating profit here we say is 130 out of 1,000, or we can also say it's 13 percent. This excludes expenses related to bad debt write-off and so on ya. *Then from the operating profit, there is some other income. Again, we are being transparent and the hospital sometimes we have rental of space, revenue from carpark. I mean non-healthcare revenue* ya. *So that is about 10 percent and that brings our profit before tax to about 140 out of 1,000, of 14 percent.*

We would like to highlight how that compares to the profit before tax across selected healthcare industries and this is based on 2023 numbers. So, among the participating hospitals, where this study was undertaken by IQVIA, the profit level among participating hospitals in the study was about 14 percent or 13 percent. But private hospital groups, we find that consistent. So, whether it was a study or we look at listed companies and so on, is about 14 percent as well.

So that gives you that consistency between the hospitals that participated in the study, as well as available data publicly among listed entities. However, if you compare that to the industry average in Malaysia for industries in healthcare, that's about 16 percent. So, we are already lower than the average. And then if you compare to other industries which are supporting or part of healthcare in Malaysia, insurance is about 17 percent on average, pharma is about 19 percent.

However, if you only consider the originator companies, right, those who provide high-end original drugs, innovative drugs, their profit before tax is certainly higher between 30 to 40 percent. And then the MedTech or the medical technology companies are about 20 percent. So, what we would like to highlight to the PAC here is really within the various entities who's provide healthcare in Malaysia, hospitals are actually the lower end of profitability. Like we said, we can still argue, masih boleh dipertikaikan sama ada 13 ataupun 14 peratus itu adalah munasabah. *But the reality is, we are the lower end.*

And then the bottom part of the table actually shows you the profit after tax, right. We again, we are between nine to 11 for participating hospitals or 12 percent for private hospital groups. Allow me to elaborate further on the next slide. At the next slide where you can see is that the profit margins have actually— our study shows that is normalized after COVID-19, right, at about 11 percent and the direct cost is still maintained at about over 60 percent, 63 percent of revenue.

So, this is the same waterfall chart if you include the consultant fee, the direct revenue but what we are spending here is we ended just now, whether the profit before tax was at 140 out of 1,000. Now, after paying the taxes and so on, our profit after tax is close to 11 percent, just shy of 11 percent. But the key important matter here is that from the study itself it shows that our reinvestment level is extremely high in providing private healthcare.

Providing healthcare itself, I think that the same experience within the government hospitals, when you need a lot of investment to ensure that the hospital remains relevant, remains safe, equipments are up to date, ya. So, almost 95 units out of 1,000 is reinvestment. This is a very significant amount that is reinvested. Meaning that on average hospitals retained a small amount of their profit because of the nature of healthcare, where reinvestments are important ya. That does not mean that it is an industry that is not viable but it just shows that the nature of the industry requires reinvestment and we can talk about reinvestment in the latest slides, so if there is a question from PAC itself.

But the reason for reinvestment YB is that, irrespective of when you started your hospital. Of course, when you start a hospital, you incur a lot of capital costs. But in seven or eight years, you do need to refresh your technology. You need to put in additional new technology. You also need to put in a new patient safety initiative. You also need to upkeep your facility, whether it's your medical guests and all this. So that is a lot of reinvestments that need to take place.

And what we hoping today is really to share the fact that this is the nature of the healthcare industry. Maybe we move on to the next item. Like I said, we can come back to reinvestment and the need for it. But we want to also share some of the nature of how billing and cost structure is in private hospitals because— and we don't blame anyone, we don't blame the public and others to sometimes asked question as to why certain items or perhaps more expensive than what they can buy themselves, let's say in the pharmacy.

The reality is, the billing and cost structure and private hospitals in Malaysia, which has matured and developed over many years, is perhaps not— is not ideal but has developed in this way because partly of how insurance products are sold and how we need to cross subsidise and we will elaborate on this further. But if you just look at the chart here, what we want to share is, there are three buckets. One is items that appear in the patient's bill and examples of this are the drugs has given medical supplies, rehab, physio charges, operating theatre charges, medical officer fees, doctors' fees.

So, those are things that appear in the patient's bill. The next one in orange, are item that appears in the bill but are actually at the subsidised rate. What it means is we are not charging the actual of full amount for these items, which are in the patient's bills. So, one is ward charges and we'll get into an example for that. ICU, nursing charges and we will give you an example similarly for nursing care and charges that emergency departments and emergency equipment's. So, although these are in the bill, it is not the actual charge or is below the actual cost to us.

But it also a huge amount of items that's not in the bill and these are non-nursing staff costs. We cannot charge for our finance, our IT and so on those, those costs. Allied health staff cost. Again, we cannot charge for the pharmacist, the radiographer. These are the risks we don't reflect in the bill. Building cost and rentals, again, that's not reflected in the bill. Some hospital owns their buildings, some hospitals rent their buildings and again, there's obviously a significant cost to that. But again, that's not reflected in the bill.

General plan and equipment. Hospitals are 24/7 365-day facilities. We have to run our chillers, we have to make sure our operating theatres are at the right humidity, right temperature. All this equipment again, we have to maintain it, we have to make sure it is always available at up and up times is high, while this also not charge, right. Land cost when we developed the place, maintenance and general plan equipment, like I said,

not only do we have to have those chillers, humidifiers and so on, but we have to maintain it.

There's also a growing cost for IT and cybersecurity. The PAC may not be aware but actually most hospitals we also received cyber attacks, one thing to get into our electronic medical records and so on. So, over the last five years, we had to invest a lot more into cybersecurity costs because we have to protect our patients' data and so these are again, not reflected in patient's bill. And then utilities, for them are packed. Actually, for a private hospital, we do not receive any concessions whether from TNB or others, we pay the full commercial rates.

And for a large hospital, our utility bill on a monthly basis is RM600,000 to RM700,000 per month or even close to a million for hospitals which are 400 to 500 beds, right. So it's very significant, a million Ringgit a month just on electricity cost alone. So, those items are not in the bill. There's also another list of items which is not in the bills is where we have to provide redundancies and preparedness, and what do we mean by that?

By law, by regulation, hospitals must provide ambulance services whether their own or they have to contract someone. And for every hospital to provide whether small or big, it is a cost. Our ambulances don't run as regularly as perhaps, ambulance is from KKM or another's but we must provide ambulances. We must provide 24/7, three shifts and those staff costs as well. And also, the equipment and maintenance of both not just ambulance but also other equipment in the emergency department.

So then if we go to the emergency department itself, like I said is 24/7, we have to provide treatment rooms, emergency OT. Again, 24/7, 365, three shifts on staff, staff on call and it is perspective of the volume. This is again dictated by law, it is not by choice. We cannot say that because there are five hospitals in one area. Let's say you know in the middle of KL, we cannot say there only two hospitals provide emergency departments and the rest don't. It is a requirement of KKM and CKAPS requirement that we must provide an emergency department. But does that mean that all emergency departments are busy, all emergency are running that is not the case but we have to, for patient safety and because of regulations.

So, this like we said are redundancies and preparedness costs which is also not reflected in the bill.

■1020

So, the next slide is really detailing the same as to what I mentioned earlier, for the direct cost, what is cross-subsidised, the non-chargeable items in the bill as well as redundancies.

So, this is just summarising what was presented the earlier slide in a table. But allow me to take some examples of cross-subsidisation. So, if you ever seen a hospital bill for a single-room, we typically charge between RM200 to RM300 per day. Of course, the hospital will provide suite room and all that but really by and large, most hospitals either have two-bedded or single room and the bill what you see is RM200 to RM300 per day.

But if you think about the actual cost for a hospital room. It should really be much higher than what is charged in hotel rooms. So, if you look at the hospitals in KL where land cost is so expensive and everything else. Charging only RM200 to RM300 for hotel room where meals are included, at least three meals if not five. Breakfast, lunch, dinner and tea-time at RM300 or RM200 is extremely low.

And the actual cost for a hospital room or per bed is significantly more. To build and maintain it is between RM1 million to RM1.5 million per bed. I think KKM itself also acknowledges this is the cost of investment into per bed or per room.

The actual cost YB is really three to five times of that. But this not charged to the patient. I'll share with you why that is the case. But in addition to the cost upfront, there's also high maintenance cost. And why is that? Hospital room have got, again by regulation we have to provide air exchange. We have to make sure there is infection control. Hospital room by standard cannot use a split unit air con. We must have fresh air coming into the room. Which means we must provide chillers, fresh air intake. We must prove that those are maintained.

So, those, again cost us maintenance cost. We also must provide medical gas in the room. Medial gas, medical air. Now, we hope that patients don't need it, typically they don't need it when they're in the room itself. But this must be provided. Which means we must maintain medical gas plumbing. We must maintain a medical gas plant. We must do maintenance of that plant. At least two or three times a year. Make sure it's certified, have engineers certified it. And those are again cost related just for the room itself.

And then, nurse call system and others. And it has been advanced and provide better patient care, we also have got other systems in place we're looking at AI and all that to provide better safety for the patient. And all of that will go to the room cost.

So, it's RM200 or RM300 a day sufficient to cover that? Certainly not. So, where do we recover this cost from? Which is what we talk about cross-subsidisation. Unfortunately, we then have to charge this shortfall of three to five times in either items in the bill where we can recover the cost.

But the question is why? It is because on how insurance policies have been developed over many years. I think from the time that I've been working before my— before I had janggut *and* janggut dah putih. *The policy has been room and board at RM200. If we charge, let's say RM400 to the patient, but insurance policy says RM200 is policy coverage for room and board. If we charge above RM200, the patient will incur co-payment or excess fees. Which we want to avoid because we want to make it such that the patient does not to pay additional charges when they're come in under the insurance.*

So, because of how the insurance policy has been and there's been no change to that product structure itself, we have developed like over the last 15 to 20 years into a need to recover those costs in other item in bill. Unfortunately, that's how it appears that perhaps masks or gloves are— what is available in RM2 outside, it's at RM4, RM5, RM6 in the hospital. It is because we cannot recover these costs like room charges and all those are other items which is not in the bill.

Allow us to take you through a few other examples. So, one is room and this is just— a few examples and many that we can share. So, this is an equipment. It's an intra-aortic balloon pump and if you ask the doctors, we hope that the patients don't need to use it because these are used— these crucial devices that used when patient have got poor cardiac output. But we hope patients don't need to use it. It is there in case there are other cardiac output becomes very poor and we need to help their cardiac output to increase.

Now the cost to purchase this item is typically about RM300,000. And for hospitals who provide complex for procedures, having just one IABP is not sufficient. The doctors will also insist that there's some redundancy. In case one is already been used and unfortunately it's Murphy's law, it happens many often. When you have one critical patient who's using IABP and you only use it five times a year. That is the time another sick patient comes and then you need to use it.

We cannot say we only have one. Or the machine is under maintenance. So, we need to but at least two to provide safe care in the hospital. So, that is a total cost of

RM600,000. But, like I said, this is not an equipment that we hope to use. This is there to provide support during really critical illnesses in patient.

So, the frequency of use in the hospital is an average of only 10 times in a year. But in the bill what we charge per use is about RM1,500 when it's used.

So, let's go through some very quick breakdown. If you actually charge what the item should be charged as it should be around RM15,000. What do we say that? So, RM60,000 for two IABP units. Then, you give it a factor of 1.25 with five percent capital cost. Like I said, we need to provide maintenance for the equipment and so on and so forth and typically maintenance of equipment between 10 percent or 15 percent of the upfront cost of the equipment.

So, you take all that costs, you divide it by five years and 10 cases per year. What you should be charging, just at cost is RM15,000 per use. Hence, the subsidy actually is RM13,500. So, we have to again recover this from other parts of the bill. It is not that we want to but that is how the structure of the bill is, currently in Malaysia.

Now, let's go to a third example, which is manpower cost. Manpower cost in Malaysia, we share that with you has been increasing quite dramatically in the last couple of years especially nursing cost and we've heard it. We've got shortage of nursing, our nurses are leaving. But to retain them we certainly have to increase their cost.

I think as we speak, in between maybe another six months you will no longer be RM6,000 probably close to RM6,500. But, let's take this for example. It is requirement from MOH that in ICU we must provide one-to-one nursing. That means for every patient in the ICU, it is one nurse who's looking after the patient. If we do not provide one-to-one nursing, we will not get licensing for it.

So, we have to hire the staff, KKM or [Tidak jelas] will come and visit. They will look through our roster. They will look through our staffing. And then they will say okay, now that you have this many staff, I will allow you to license X many beds based on the fact that you must provide one-to-one nursing.

The cost per ICU's staff. Basic salaries alone already close to— salaries and allowances about RM600,000. Now, this is not included EPF, bonus, medical benefits and other cost. But we trying to keep it simple.

So, three shifts because we have to provide 24/7, times RM6,000, That's RM18,000 per bed. Okay. Another typical nursing charge in ICU is RM300 per day. Now, if you assume and this is cannot happen. If you assume 100 percent occupancies of the

ICU bed. That means at all time there is a patient. That is the revenue then to the hospital is RM300 times 30 days, that's RM9,000.

So, the cost is RM18,000. But our charges to the patient is RM9,000. That is a deficit of RM9,000. But like I said 100 percent occupancy is not possible in any hospital. Typically, when we talk about at 70 to 80 percent is already considered very high occupancy.

So, if you take 70 percent as typical occupancy. Then, our revenue is only RM6,300 and the deficit are even bigger. Again, we have recovery this cost from somewhere. And, that is where items that we can charge whether is consumables, medical supplies, drugs is where we have to mark it up perhaps a little bit more than what is expected from the hospital.

Now, these few examples point to the systemic issues of why like I said these items are charged like that. Significant portion of hospital cost actually is undercharged or not charged to the patient. We agree that this causes confusion. We agree that this is not ideal especially since hospitals are very transparent in the billing.

We are perhaps one industry which by regulation is required to put up a very transparent bill where you can see, scrutinise and also compare. Not many industries are asked to do this. And so, it does create confusion but it is by law that we are required and also a requirement of the payers especially, the insurance who want us to itemise everything and provide descriptions for it. So that they can decide whether the hospital is charging something that is to them fair, across the industry.

■1030

But we agree that this needs to be reviewed and— but this has to be done together with the PS, with the insurance or the insurance and takaful operators. Because they have to agree that for us to then bring down the mark up for medical consumables and drugs. We should be able to charge a lot more, three to five times more for our room charges, only then it's fair. They must allow us to charge our nursing at RM1,000 per day in ICU at least so that we can recover that cost. If they do not allow us to do that, we have no choice but to continue the cross subsidisation of cost. We would prefer that we charge the actual cost so that we can always defend it and explain to parties that "Yes, just like we put up the calculation here for nursing, we can be very transparent to say why are we charging you a RM1,000 a day because that is the cost of the salary that we paying to the nurses before any profit or mark up on it".

So I hope esteemed YBs of the PAC, this explains to you a little bit about why there is cross subsidisation of the bill and why perhaps there's this question around why certain things are marked up beyond what seems to be fair.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Pengerusi, saya nak tanya satu soalan. *Why did you all allow those patients with medical insurance to get discounted price? 25 percent or 30 percent?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay. So, YB you like me to answer that now or...*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Never mind, you all have this later* lah.

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay. Alright, wait, I'll note on your question and we'll try to answer that in terms of insurance.*

So YB if you allow me, I'll move on to the next part of the presentation which is sharing a little bit. I think we've provided— we've done two comprehensive studies. One is on profitability which is the earlier part of our presentation. But we've also done a comprehensive study or rather a third party has assisted us to do a comprehensive study on medical inflation especially you know what we've— the number has been quoted recently. So, the firstly what we want to share is the increase in utilisation rate is the higher contributing factor to what was the quoted number in the medical inflation study. What do we mean by that?

So, whether that is 12 and a half percent or whatever, if you look at the study that we've done over three years from 2020 to 2023, the average cost of annual insurance policy coverage in Malaysia has increased by about 15 percent. But what is contributed to that? I think we need to understand that that 15 percent increase is contributed by two factors. One is and if you look at the chart itself, 'A' is actually the increase in claims. Alright, that means that there are more people coming to the hospital, there are more people claiming from the insurance, there are more sick patients unfortunately coming to whether public or private hospitals.

Part B which is at 45 percent, that is the increase in cost. So, if you move to the right-hand side of the chart, what we see that on an annual basis, that eight percent increase is in terms of utilisation and seven percent is the increase in cost. So, if you combine that together is where you get that 15 percent per annum. Allow me now to share a little bit about the what are the factors that resulted in the increase in utilisation rate. This is aligned to what even KKM has been saying; we are an ageing population

and because of that the number of people seeking healthcare is certainly increasing year by year. But, also in Malaysia we have an issue with non-communicable diseases and the rise in NCDs. We see that NCDs are rising at perhaps an alarming rate and that is something that collectively private hospital, government need to do to tackle. But that is one major factor why there is an increase in utilisation rate.

Secondly, there is an increase of adoption of private healthcare. As more insurance is sold, as the percentage of Malaysians who have health insurance increases, it is only logical that you will see an increase in utilisation of people using the insurance of coming to the hospital because of the first factor that we mentioned just now. There's also an ongoing expansion of private healthcare. There are more hospitals. We see from the health facts published by KKM that the number of admissions in private hospitals has increased on what traditionally used to be 15 to 20 percent to now north of 30 percent. So, these three factors have increased the utilisation rate.

So, again if I— just go back to the earlier slide if you don't mind. The numbers from various studies and the number often quoted let say the 12.6 percent from the Aon study, even the Aon study itself actually takes both of these components. Increase in cost as well as increase in the utilisation rate.

So, if we now go to a study on medical trend rate. The often-quoted figure by various publications and all that is 12.6 percent. So, the first thing we want to say, "Well that is from one study", and I think we need a comprehensive government-led study so that we understand the number better. But that 12.6 percent is often quoted is from an Aon report. There's other report as well who look at medical trend rate but their results are slightly different at 10.4. Now, both point to a high number but what we are trying to elaborate here is there's actually not one number out there is the market, it depends on what study you see. So, people going to always pick a different study and say, "Well, it's higher or it's lower".

But, in the next slide what we want to explain is if we want to talk about medical inflation, is medical trend rate the right study to look at? So, allow me to just elaborate a little bit on the three different types of studies that are available in the market. So, one is medical trend rate, the other is medical consumer price index and the third is private health expenditure per capita. So, let's just go through medical trend rate very quickly.

The definition is actually the cost of providing medical cost per insured patient. Actually, the focus of this study like the Aon study is for insurance companies and employers, large companies to plan their medical budget. These studies are published

by insurance companies. Alright, so Aon is a broker for insurance companies. The key drivers in that study like we mentioned are two factors, average claim amount and also the utilisation rate. So, there actually two components in there. The limitation of this study is it is inaccurate in talking about the rise of pure cost.

Next, we look at medical consumer price index. Now, this is the definition of this is actually out of pocket spending on medical care by households. The stakeholder in focus are actually for the general public or government to decide on what is that rise in CPI, for medical CPI. These are published by government or economic ministries. So, this is not by a particular segment of the industry but by government or economic ministries and the key drivers are out of pocket expenditure, insurance premium, deductible. So, it takes into account are those factors. Not the increase in trend rates, not how many more patient are sick or how many patients are claiming insurance and there are limitations to that as well.

Very quickly on private health expenditure per capita. By definition, this is private health expenditure as a ratio of the population. The stakeholders in focus are households, private insurance, direct payment and these are published again by WHO and their supporting bodies. So, what we are trying to say here is we've been referring to medical trend rate as the inflation. But, is that the right indicator for us to look at? So, if you go to the next slide, when we say that Malaysia is above the average since 2020 to 2023, what we've been looking at is medical trend rate and what is contributed to that? It is not the increase in cost.

What I mean by that is if an item was RM1 in 2020 and the inflation is seven percent, in 2021 is RM1.07, in 2022 is RM1.16. So, that's an average inflation of seven percent perhaps. But in medical trend rate, it also incorporates that there are more people coming and claiming and that was the bigger component. The 55 percent of that number is because of claims rate. Unfortunately, in Malaysia the claims rate from 2020 to 2023 has been high. Now, it is not because we want more people to be sick, it is the same issue that KKM is facing and in the sense that there are a lot more sick patients seeking healthcare and that is what has driven that number.

But, if you look at the other two studies, and again we are not saying one or the other is right, the functions were different. The first study really was to look at how you budget your medical cost for the next year. So, your budget increase in cost, you also budget increase in utilisation. So, if you look at 12.6 percent, if my budget last year was RM1,000, I need to add another 12 to 13 percent in my budget. Because cost has

increased but utilisation also increased. But, if you look at the other two studies, Malaysia is actually below average. If you look at medical CPI and private health expenditure and again these are studies by independent parties, government economic ministries and WHO, Malaysia is below average.

So, we have to be mindful what data set we are looking at and for what purpose. I reiterate, we are not saying one is right or one is wrong where the purpose of the studies and the purpose of those numbers are different and for different purposes.

■1040

Allow me then to touch a little bit about what has contributed to the medical inflation. So, there are four key factors and of course others as well and I won't spend too much of time on this. I will touch on the main topic where suddenly increase in pharma prices due to the innovation of drugs such as biologics in the market and all these drugs and you know individualised medicine and so on.

These have certainly contributed to drug prices increasing because they are more advanced. Not because of the same item, not because the Panadol which was RM1 becomes RM1.12, but because there are now better drugs and better products in the market. Secondly, is that there's a 63 percent increase in import value for pharma and 88 percent increase for medical devices.

So, these import values are for various factors. It could be our exchange rate and so on so forth. With what is going on now, with changes in tariff and all that, we could expect because if certain items or parts are coming from China going to U.S for an assembly of an advanced medical equipment and the tariff is another 25 percent. This could again have an impact to us. If you buy something next year and those tariff impacts come back, this is where the increase in the import value of this pharma or medical devices will jump again. Can we control it? Unfortunately, we cannot.

Third is the medical staff increase. As we mentioned, our nurses including our other staff, radiographers, our health line staff are very much in demand. Whether it's down south across the causeway, whether it's in the Middle East, now UK, even U.S, they actively recruit our staff. We need to obviously pay them better. But, to pay them better, we also need to increase our bills.

However, in the last three years, we've been trying to not increase our charges but increase salaries and on average, basic salaries have increased by seven percent. When I say basic salaries which means allowances which have increased but a lot more

are not covered, benefits have also increased by a lot more. If you include those, our nursing salaries have actually increased per annum but at least close to 10 percent.

Finally, one of the factors in terms of rising medical costs is delays in regulatory compliance where approvals are between at least one to 3.5 months. What we are seeing now, I think with the pressure that KKM is facing, we actually feel bad for the staff in CKAPS. They are stretched and they can only count to us and visit us for licensing maybe in three to four months after we apply. Then, it takes them about another three to four months to revert back. It is because they are overwhelmed with the amount of work that they have to do.

On this last point, allow me to just elaborate a little bit. What do you mean— why does the delay in regulatory compliances create so much of cost to us? Let's take an example of a new hospital. If you build a new hospital, we have to then not just build it, equip it, we have to get all the staff in the hospital. Because before you apply to KKM and CKAPS to come and visit, you have to employ all the staff.

If you want to open 100 beds, you have to employ all the nurses that are required. If you want to open the five ICU beds, you have to show that you have one-bed times three, times redundancy, which means at least four nurses per bed. So, if you are opening five beds, that's four times five, 20 nurses. You have to hire all of them. You have to provide all the documents to MOH that I have already hired them and then CKAPS will come for a visit.

Now, this cost if you are opening a hospital of only 50 beds, the staffing cost is already at least RM1 to RM1.5 million. So, I hire the staff and then I apply to MOH. RM1.5 million times three months before they come for a visit. That's RM4.5 million. After they come for the visit, there will be some findings, you have to rectify and answer them, another three months, another RM4.5 million. RM9 million even before we open our doors to the patients.

So, this is what we mean by delay in regulatory compliance. It is the same when we open a new ward, if incurred the cost, if we do an expansion, it is the same. We have to do everything, apply to the government, they come and visit and they come and give us a license and already would have incurred RM2 to RM3 million. These are things that we know are a challenge for CKAPS and KKM. We are working together with them. They are trying their best. We are not saying they are not doing work. They are really trying their best but these are issues that we faced.

Moving on. Is then are we doing enough? Often especially payers or ITAs believe that hospitals are not doing enough in terms of containing cost and we wanted to prove this by having a study and there's detail to this study which we are more than happy to share. In our medical inflation study in page 22, it does elaborate on this further. But, if you look at between 2020 to 2023, the average in-patient bill if you assume at 2020 to be at 100 percent. If you look at items of pharmacy, diagnostic and lab, medical consumable, other medical cost, fees for consultation of other things, facility charges, admin and others. Those blue round boxes down there actually indicate the contribution to the incremental cost towards running the hospital. [Merujuk pada pembentangan slaid]

So, if we do not do any effort to contain the cost, the annual cost increase would have been 15 percent per year. However, because of our efforts, because of us absorbing those costs, the annual increase is seven percent which means we have contained that much of the cost. How do we do that? Yes, we actively negotiated with vendors, we talked to suppliers to bring it down. We've been doing it actively but at the same time, it's also because we have taken a hit to our margin, to our profitability. That is how we have been able to contain in that three years instead of passing a 15 percent increase, it was seven percent. Is seven percent high? We cannot say, "Yes, seven percent per year is still high".

But, if we didn't do anything, it would have been 15 percent. So, that's really, I think in terms of the first part of the presentation, about understanding hospitals, our cost structure and the challenges that we faced, YBs of the PAC. We wanted to share with you, these are challenges that we faced. Other things that we can do, I think these are things that we can discuss later in terms of solutioning. But a lot of it depends on policy and assistance from the government if we are to contain some of these costs.

I now move on to perhaps a second part of the presentation where lately we faced a lot of issues in terms of some of the data that's being presented. We have to acknowledge that. I think before this, before the PAC, before all this, we probably have not done enough to explain to patients why there's this perception that there is a difference in charges. So, on this slide, we've reproduced I think the data that was presented to the government about the difference between patients who are pay and claim and patients who are in the hospital using a guarantee letter from the insurer and two diseases dengue and pneumonia were used.

When this was first published, we really were scratching our heads because it is significantly different than our own data and our own experience in the hospital. But I like

to touch on a couple of things before we move on to the data from APHM itself. Now, the source of this data, we have asked for it. We have asked BNM to please share with us so that we can understand how that this variable came about, what was the source of the data. The reason for that is we have not seen despite asking perhaps even Bank Negara twice, we have not seen actually what— was this an apple-to-apple comparison and what do we mean by that?

When we say GL patient and pay and claim over this both admitted patients or was one a daycare and one an admission case. Was the length of stay the same? Was the dengue patient somebody who had complications who stayed for five to six days? Was the pay and claim being somebody who came for daycare, admitted and discharged on the same day as a daycare patient? So, these are questions which are important because the variable is too big and we cannot understand where it came from.

We also have to share with you that pay and claim is a very small number. Most patients do not want to pay and claim. So, we also are not sure what is the data set that was used. Although there's a number of sample size of 33,000 and 53,000, but how many of these were pay and claim? In our hospital, our experience is it is a very-very small number. A patient is either self-pay out-of-pocket or they are from insurance. Because if they have an insurance, they will want to go to a hospital where it is cashless.

YB Teresa, we will come to about the discount and cashless later because that is something that is important to understand. So, parking that aside. Like I said, pay and claim is a very small volume. So, our concern with this data is there is no indication of whether this comparison is for admission, patients with or without complication and so on.

Now, allow me to move on to the right-hand side and the data that APHM itself collected based on dengue and pneumonia cases in 2024. Our data shows that the variable is very small.

■1050

So, the multiple that you see which means is only seven or 14 percent of the difference. It's very small, right? It could be that the insurance patient pays a little bit less than a cash patient or in some hospitals, it could be that the insurance pays slightly more and the cash pays slightly less. It could be either way.

But the variable, what we are trying to say is, the variable is very small. It is not 400 percent or 300 percent but it is rather seven or 14 percent. These are based on 10,000 cases of dengue and pneumonia collected from various hospitals. But what is

important is that this all admitted cases. So, we make sure that the comparison of all cases were having admission and for admission of between three to five days.

So, it is important that we compare apples to apples. Now, why is it in our data that the insurance patient is paying slightly less? Now, the insurance product when they sell it to the public, the agents when they sell it, one, the key benefits that they say is," Oh, you can go to the hospital, you can use your card. You do not have to pay." They say is cashless. Now, cashless is not a policy or part of the agreement. Cashless is a benefit, which means— and we hope that doesn't happen. Which means if tomorrow all the insurance decides that they no longer want to allow cashless benefit, everybody must pay and claim. That could happen. Because that is not in the agreement when you buy the insurance. But that is a benefit.

So, when the agents sell it, they say, "Okay. You can use your cashless card. You can go to the hospital and you can claim." But for insurance to put a hospital on a cashless panel, they will negotiate with us. And that is why in the earlier profitability study, you saw that on average, you give a 10 percent discount to the insurer. It is because the insurance will come to us and say, "Do you want to be on the cashless panel? If you do, you must give us a discount. If you do not give us a discount, by and large, they will not put us on the panel."

*There are exceptions. We are not saying that this is 100 percent the case. If in a place, let's say in a rural place like— not rural-*lah*, a less developed place in Sungai Petani whether few new hospitals, they may say I need to put all the hospitals because there are less options. However, in most areas, especially major cities, they will require that you provide a discount to be on the panel. And that is why YB's, the cost of the insurance is lower. Another example which you find on most bills, insurance will say that I will not pay for registration costs. Now, most hospitals will charge RM10 or RM15 for registration. Even if we go to KKM, there is a registration fee.*

So, registration is only to facilitate the paperwork, documenting the patient, getting their details, putting it into the system, putting the patient profile into our EMR and so on. But insurance in their agreement will say you cannot charge for a registration fee. Already in the first line item, as the patient comes and registers, a self-pay patient is paying RM10 to RM15 to register, insurance patient is paying zero or rather, the charge to the insurance is zero. Because they insist that we cannot charge registration. Some insurance also says that we cannot collect deposits and so on and so forth.

So, what is driving that difference? If you look at our actual bills, it is really the insurance patients or the insurance bills has a discount on most light items but the cash-paying patient does not. So, that's the reality. Of course, if you come back to the data from the government, what drove this difference and what drives that difference? Why is the public saying that when I pay out of my own pocket is less but when it is insurance is more? Let's take one example. An insurance patient who comes with dengue who went to a GP before that, the GP tried to manage but the dengue has not resolved, the patient is now feeling quite ill, the white blood count is low and so on and they come to the hospital. They are seen by the doctor and the doctor decides they need to be admitted.

It is not so low that it is critical but it is low enough that the patient requires to be admitted based on clinical guidelines. If it's an insured patient, so the patient says, "Okay doctor, if you think I need to be admitted, please admit me." So, I'm admitted, the patient is monitored for the next few days until based on clinical guidelines, his fit enough to be discharged. So that bill is RM4,000 to RM5,000 for three days. Unless, take a patient who paying out of pocket and he comes to the hospital. And this is the patient who maybe is from the lower part of the M40 category, katakan*. Again, the doctor looks at his blood test and all that and he says that actually, you need admission. But this patient says, "I cannot afford. Actually, I have to work." Maybe he is a Grab driver, or whatever. He cannot afford to be away from work or he has his own business or he has got kids to look after at home or she's got a kid to look after at home and she said, "I really cannot be admitted or I cannot afford it and I don't want to be admitted." And doctors, out of their goodwill, may say, "Okay, never mind. You don't get admitted. Tomorrow, you come back and we will monitor again." So, that could be one difference.*

The other difference is again, I am a self-pay patient and the doctors explain that look they are a good blood test. There is a blood test, for example, the advanced blood test, that can show you that actually yes, you have dengue. And we can start the treatment straight away but that blood test is expensive. And again, most hospital doctors will explain especially for cash-paying patients.

"We need to do this blood test."

"Berapa ya doktor blood test ini?".

"Oh, RM300."

"Oh, mahallah doktor. Blood test biasa tak boleh?".

"Okay, we can do but the result will come a bit later. It takes a bit more time.".

"Tak apa doktor. Saya sanggup."

So, that difference now starts to drive— it is not because the same item in the hospital is RM300 to the insurance patient and RM200 to the self-paying patient. It is not because of that. It is because of humanitarian grounds. It is because of patient affordability that drives the variable. Doctor's fees are set at the maximum in this schedule of fees. We also have to agree that this dengue patient— okay, when the doctor consults him, the doctor will feel, "Okay, it is an insured patient, I have a right to charge RM230 and he will charge RM200." That is already from the schedule of fees.

But if it's a self-pay patient and the patient says, "Doktor, tolonglah saya. Saya kurang kemampuan." *And the doctor out of goodwill and humanity, charges him only RM100 because he is self-pay. Does that make it wrong? The RM230 is what the doctor deserves to charge. It is the right charge. But the RM150 or RM100 is out of humanitarian grounds. So, these things are what drive the variable between self-pay and insured patients.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Encik Anwar, Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: YB Pengerusi, terima kasih. *Just want to ask about this because what you say is a little bit different*-lah *from what we hear from public hearing and as well as social media*-lah, *okay.*

For example, the people who complain to us— cataract. Husband and wife are doing the same thing with one without insurance, one with insurance. The wife with insurance RM30,000. The husband without insurance, RM15,000. It is about a 100 percent difference. That's number one, case number one.

Case number two, okay, ACL. They asked when before admitted in Prince Court. Before admission, the patient asks RM25,000 if they pay cash. And then, once they told that they have insurance and then they revised it to RM40,000. At the end, they were charged RM36,000 to RM38,000, okay. That's about close to 80 percent difference.

And then another one, eye operation. Once they tell that they have insurance RM21,000 and then— okay, this is the girlfriend without pay cash was quoted RM15,000. Same doctor, same hospital. So, these are the things that we received from the public which is very starkly different from what you presented.

And then, another question is, do you— you mean you dispute Bank Negara's data and you dispute Bank Negara's data just now? Thank you.

Encik Anwar Anis bin Anis Ahmad [APHM]: *YB Sim, like I mentioned just now. It is not that we dispute the data, all right. I think our concern is what are variables taken into account in the data. If I answer that, the second question first in the data and that's why I think it is important to look at the two columns, right? One is pay and claim. And as I mentioned earlier, the volume of pay and claims is very, very small in almost all of our hospitals.*

So, we are worried whether these data because there is no— we are very clear. Our data is for every length of stay. For admissions, between three to five days. We've asked this question. This data that is presented by Bank Negara is it all admitted cases or does it include daycare versus admission? Or does it include outpatient at the ED versus admission? So, if you've taken outpatient at ED, daycare and admission and put it all together, it is likely that the pay and claim patients would have been on an outpatient basis because they do not want to pay out of pocket.

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They would have gone to that hospital, paid and claimed and then maybe gone to another, gone back to their hometown or gone back to another hospital where it is cashless and got admitted there. So, this is our concern. Without clarity on the data, whether these are all admissions, we cannot say whether the comparison is fair. We are not saying it's wrong but we need clarity and that's what we are seeking.

Tuan Sim Tze Tzin [Ahli PAC]: *The data set is so big.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Agree.*

Tuan Sim Tze Tzin [Ahli PAC]: *You know, if you average out it is impossible to be. Once you have a sample size that big, it is unlikely it is going to be difficult.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Thank you, YB Sim and again if I will clarify. Like I said, I think out of the 33,000 cases— if we can be told, how many of the 33,000 is GL and how many is pay and claim, it will give you some indication. Because as we said, in most of our hospitals, pay and claim is a very small number. Most patients do not want to come if they have insurance.*

Tuan Sim Tze Tzin [Ahli PAC]: *How much percent of pay and claim in most hospitals?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Maybe two to three percent. Very small.*

Encik Chin Keat Chyuan [KPJ Healthcare Berhad]: *If I may, YB, sorry. I think what we are trying to say here is not to dispel. We want to save for clarity, the*

understanding, right? How the 33,000 cases being spilt? All we want is an apple-to-apple comparison. Whether all these patients have the same severity? Are they all admitted patients? First.

Second, 33,000 because based on our data, same if I was going to ask myself, today, if I have insurance will I go and pay and claim later because the time it's ticking is very long for me to claim back my money, one second. If I already paid, why would I want to pay first, right? I would certainly demand for GL.

Most of the hospitals being the data for pay and claim is less than three percent. Less than three percent. No way you have 20, 30 percent pay and claim. All patients— you taka da *pay and claim, you* tak ada GL, *I would go to another hospital. This is also the reason why to a panel hospital is willing to give because most patients prefer not pay and claim. So, what we suspect— we don't have a fact because we are still asking from Bank Negara. If Bank Negara gives us the 33,000 cases, could it be a 50-50 percent kind of pay and claim versus GL or based on our data of 973 or 982? Could it be only a fraction of the 33,000 is the pay and claim and then the majority is actually GL cases? So, is that's the case exactly YB Sim like you said. Then, the data we will be have a question mark. That's one.*

Second, look at 1,200, YB, I'm sure YB on and off if your friends and family happened to go to a private hospital because of stomach upset, food poisoning, suspect. Pergi *stay over one-night* dekat *A&E. The next day bill, you might not even expect RM1,200. Even for simple food poisoning because of the antibiotic, because of the A&E, because of all the charges. So, we are looking at this dengue 1,200 versus our 10,000 cases across all four hospitals group. You can look at our cash and insurance with the same severity of three to five days, it is almost standard, RM6,000, RM7,000. Because why? It is impossible if a patient come to with dengue, it will end up only RM1,000 over* ringgit. Tak mungkin. *I'm just asking for a fact.*

If you check friends and family. Pergi hospital A&E *stay one night it's impossible RM1,000 over. So, we suspect low fact, if we are not comparing admitted patient to admitted patient but mainly maybe outpatient versus inpatient that comparison is wrong, YB, before I expect.*

Tuan Sim Tze Tzin [Ahli PAC]: *Please answer my first question.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, YB, on the first question, maybe I'm taking into two parts. One is, surely, we would like to see or have evidence of*

this patient, this patient we give example of a care track, 15 and 30. That variable is so big.

So, first part of it, if hospital is able to offer cataract at RM15,000 to cash pay and RM30,000 to the insurance, the first party that will come and knock us, is the insurance. Every year, if not every six months, they come to us with data analysis to show us this is your cost, this is your competitors' cost, this is the cost in the region around your area and so on and so forth and say, "You are higher than the average. You have to lower this or take this out and do it so forth".

If the insurance knows that in that hospital, cataract can be offered at RM15,000. The insurance will not be willing to pay RM30,000. That, I assure you, will be the first party that will come to us to say, "That is what you have to do". So, the question then is singer to this, is the RM15,000 and RM30,000 from the same hospital? My suspicion is highly unlikely. Can it be RM15,000 in one hospital and RM30,000 in another hospital? Possible.

Now, just like other things. Like ACL or implant and all that. Cataract, you can have a very basic monofocal lens being implanted or a high-end multifocal lens being implanted. That is what probably drives most of the cost. So, I have a very significant doubt or we will have very significant doubt if RM15,000 and RM30,000 are from the same hospital. Do hospitals provide certain incentives for patients for this kind of simple procedure for cash-paying patients? As in provide a package. Yes, it does happen, especially for senior citizens and so on. Hospital tries to help by packaging it.

Now, does that again, does that make it wrong? It doesn't mean— so, in the same hospital, it's possible. RM20,000 is your typical bill for a procedure but the hospital may say for self-paying patients is RM18,000. A smaller but the variable will never be so big. So, we would like to see these examples are quoted. Firstly, are they from the same hospital? Are they using the same kind of implants? Are they for the same length of stay?

So, if I go on to even from the same hospital, if we talk about ACL between cash and insurance. Even for ACL— I'm not the an orthopaedic doctor, so I hope the others can assist me a bit if they want to but for ACL, you can use your own ligaments or you can use external ligaments. That means a ligament from a third party. That itself drives away significant difference in the cost. Now, what are the clinical advantages, depending on what people want in terms of the outcome from the ACL surgery and so on. But yes, that can drive the difference.

So, if it is a self-paying patient, he may say, "Doctor, what are my options?". Worth it share, right? What are the options? So, the options are, "I harvest you own ligament and you have a scar on your leg and I'm implant it and your recovery is a bit longer or I use an external ligament where I do not cut your leg to harvest your implant and I put in an external ligament. Your recovery time also will be a little bit shorter". This drives a significant difference in the cost. This external ligament is the main difference in the cost.

Now, if the self-paying patient says, "No, I do not want the external ligament. Please harvest my own ligament. It's okay. I will bear the scar, I don't mind and I don't mind the recovery a bit longer. Yes, the cost of the ACL could be RM25,000 for the cash. If the RM40,000 for the insurance is wrong, it is not. If the standard of care is to provide shorter length of stay, no scar, no risk of infection to the patient and using external ligament, can that happen? Certainly.

So, we can be very transparent. If you want YB of the PAC, we can bring you two ACL bills that show you it's RM25,000 and RM40,000. We can explain to you why it is RM25,000 and RM40,000. So, I think healthcare is not like buying one standard product. There are so many variables. There are so many different types of implants. So, when the insurance patient comes who will be paying insurance for the last 20 years and he comes to the doctor and he tells the doctor, "If this is now the standard of care, will you provide me with a good implant? Where you don't harvest my own implant. If that is now the standard of care? That is what I want.

Why would the insurance patient say, "No doctor, never mind. Cut take my implant and reduce my cost to the insurance". They would not ask for that. They would ask for what is now the standard of care. But if a patient who cannot afford, do we say, "No, sorry. We still want to charge you RM30,000. I don't care whether you are self-paying patient. If you cannot afford RM40,000 go to KKM". But that's not what we do. We want to be able to provide options to the patients. I hope these two examples provide you some clarity. It is not as black and white as you think it is. There are a lot of variables to consider.

Datuk Dr. Kuljit Singh [APHM]: *Basically, medicine is not as straightforward and clear card in every individual, every patient, every human being is designed differently, the diseases present in different way. We must have that in our minds because I can tell this as a doctor because it is not the way man in the street will think.* Dia kata, *"Surgery itu sama saja tapi why this is",— because they don't understand.*

Even though sometimes you explain to a patient, they will understand but they don't understand the details of what happens when you do a procedure. Doctors will know this. If you are doing medicine— that's why sometimes I regret doing medicine. But medicine is always a challenge. It's not the way…

Tuan Sim Tze Tzin [Ahli PAC]: *Dr. Kuljit you are doing very well.*

Datuk Dr. Kuljit Singh [APHM]: *Very well in the sense that it is not an easy job. Probably I would be sitting with you all [Tidak jelas] easier. Our set is not easy. It is— whether it's public or private medicine is tough.*

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Dr. Kamal Amzan [The Association of Private Hospitals of Malaysia (APHM)]: Datuk, Anwar, *if I may*. YB Sim, *Madam Chair. I understand where* Datuk*…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Can you please tell us your name and also your position?*

Dr. Kamal Amzan [APHM]: *My name is* Dr. Kamal Amzan*, I'm a member of APHM board. So,* Datuk, Anwar*, and Mr. Chin mentioned earlier about dengue, they've also mentioned about cataract. But there's another diagnosis here pneumonia. So as a clinician, I am medical doctor, there are many patients who do not require admission. So, we are not here to discuss— we are not here to debate or dispute the data from Bank Negara. We are just wondering the categorisation of that data.*

Some pneumonia patients they are not admitted, YB. They are treated as outpatient, treated as day care, because they can take medication at home. So, under their policy scheme, they are not entitled to claim. Sorry, they are not entitled to cashless facility. So, they will have to pay and claim. So here we are not questioning the integrity of data provided by Bank Negara. We are just wondering the categorisation of those patients. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Continue*.

Encik Anwar Anis bin Anis Ahmad [APHM]: Okey YB*. Thank you YB Chair. If I can continue to the next slide. I think we wanted to really elaborate earlier just now. But now we want to move on into what the APHM feels are list of measures that we can take in the three-year interim period and subsequently the long term measures. So, here we have outline five items.*

So, firstly is on cost optimisation and efficiency. As we presented earlier, this is already part and parcel of our DNA almost right, we do our best not to pass it on but doesn't mean that we cannot do more, it's a continuous effort. If we stop doing

negotiation and cost optimisation, certainly the inflation to the patient will be higher. So, this is something that we will continue to do. We will continue in the next three years. Certainly, take even stronger efforts and perhaps we need some sorts of signaling that the other parties who are involved in the healthcare realm whether its medical consumables, drugs and all that must also help us in terms of containing some of this cost.

As I mentioned earlier, if the tariffs and all that between you know US, China and all this has an impact, we have to see what we can do in Malaysia. *Other interim measures that we can put in. Some sort of concessions from the government. Even to the drug and other company so that, together we can try and contain and optimise cost inefficiency.*

Secondly, in terms of price transparency. Datuk Kuljit as the President in APHM has been actually writing to KKM since last year. Saying that we are prepared to do drug price transparency and display of pricing for outpatient. We in fact put a deadline of 1st April. Now, this has changed a little bit because there was a townhall from Ministry of Health just last week. The week before rather. In the townhall, KPDN was there and we understand that there is some process of gazettement and all that is required for KPDN to allow KKM to be the party to monitor and take action and directive in all this.

So, we are waiting for a date from KKM on when that this can start. But, APHM itself is openly written to say that we support it especially for outpatient. For inpatient, there are some challenges that we like to discuss with KKM so that we can sort it out. We are concerned about medicolegal as well as patients' safety in terms of displaying inpatient price. But that is something that we have mentioned to KKM and we will have that discussion.

But we are prepared…

Tuan Sim Tze Tzin [Ahli PAC]: *Can you elaborate in detail what happened? Why you cannot in-patient you feel that there's a patient safety? Why is it related to that?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay. Maybe I elaborate first and the other board members can add to it. So, our concern is how it's displayed and where it displayed, right. We understand for outpatient, I think the process is the doctor has provided prescription, patient can then see the price and then decide, do I want to take it from the hospital, I don't want to take form the hospital, I want to go to a pharmacy, I want to go to another hospital, there is no patient safety issue, no danger.*

The patient can decide as long as they comply and they go and get the drug and they take it as per prescription. That's okay. For inpatient, our concerned is let say— and again you know, we have to take into account large hospitals, small hospitals. So let say in a smaller hospital where the price is being displayed. But there is only one or two alternatives to the drugs. Only one. There is no alternative to the drug and that is the price. Let say they patient was admitted in the larger hospital where there was higher volume and alternatives. That patient feels "Eh, in that hospital I only paid RM300, how come in the smaller hospital is RM500?"

Now the patient who is inpatient who requires the drug for the doctor to be able to continue the treatment say that, "If RM500, I don't want it." So, these are medicolegal questions that we are saying, what happened if the patient says, "I don't want the medicine or its too expensive I don't want to pay for it." Now, who will be responsible for this? What will the doctor do, what will the hospital do? That is why we are saying for inpatient, we need to take into account perhaps we need to have very clear public statement that the display is there but it is the doctor— in MOH FAQ it does say that it is a doctor who controls the prescription of the drug based on what is the appropriate medical care.

But what we are concerned is that the public misunderstands the fact that there is a display, I have a choice. Saya tak nak ubat ini. *What happens, right? So, this are medicolegal concern that we have in terms of giving it to the patient.*

You want to add anything Datuk?

Datuk Dr. Kuljit Singh [APHM]: *So, I give you an example why inpatient is not suitable. Inpatient could be operating room, emergency, and in a ward.* Cuba bayangkan *you have a full-blown heart attack— not you* lah, *patient. Got full blown heart attack and the doctor want to administer the drug, the doctor stops there and say the price of this drug is this much, you want or don't want. I am just giving you a real scenario. You want or don't want, this is the price. Maybe the patient may have a further heart attack.*

So, it is spectacle when you have a patient in your hands, it's very easy for us to make a policy but we don't understand the practicality of it. So, you have— and after…

Tuan Sim Tze Tzin [Ahli PAC]: *But inpatient and outpatient drug price is the same*-lah. *Consistent, right?*

Datuk Dr. Kuljit Singh [APHM]: *We'll come to that. I will answer the practical part of it. They will answer that part of it. So, how would you administer medication to the patient then after the medication is already administered, only then the patient comes to*

know this was the price because these are all emergency medications or some medications are given because out to the treatment care. So, that is where the practicality at the medicolegal will become a very big issue.

So, outpatient is fair because patient is not in any emergency note, no duress, patient can choose, "Okay I will not take the medication from here, I will take the medication from another source". Which is fair, the patient has got the right. Whether the price will be the same or the same, there is a reason to that also. Anwar.

Encik Anwar Anis bin Anis Ahmad [APHM]: *So YB*, *now our engagement with KKM* Bahagian Farmasi, *I think when this process started even couple years ago, I think the objective was one facility one price. But I think we have proven to* Bahagian Farmasi *in KKM and KKM fully understands this because they faced the same. The cost to provide medication for outpatient versus impatient, certainly is different. For outpatient, I give you the 20 tablets it is your responsibility how you take it, how you store it, whether you eat it, you don't eat it.*

For inpatient, we bare the responsibility. We store the medication, we serve the medication, we also take the medicolegal risk and all other risk if we give the medication and the patient has an allergy and so on and so forth. There is so many factors and KKM understands this. It is KKM who has informed KPDN and KPDN in the townhall said this is the first time that they are allowing one facility to display two prices.

They said this is because KKM has justified to KPDN. *So, in our engagement with KKM, KKM understands*, *KKM has justified to KPDN and like I said in the townhall, the DG of KPDN said this is the first time they are allowing it. Only for hospitals. So, there are good reason for it. So, we are not saying that we do not want to move towards it. What we are saying is we need to have proper statements, proper understanding. We need to protect the doctors and the facility. Because the patient refuses the medication and ends up having a complication. We should not be held liable.*

So, these processes we supported, we understand the reason for it. If I can add a little bit YBs, when APHM and *Datuk wrote to MOH about our willingness to proceed with price display for outpatient, we said that the right mechanism and the right tool for inpatient is really to advocate better patient bill estimation. Now we all do it already. But perhaps we can do it better. Now what do we mean by that.*

Actually right now, when the patient admitted in the hospital, there is always financial counselling. That means the patient is told for this admission, your cost maybe between RM20,000 to RM25,000. Now this financial counselling is held. Now, what we

feel is fairer to the patient is that they are told for admission and this become the standard of care that every hospital must do. So, what we saying is KKM should actually say that financial counselling and providing bill estimation should be part of the admission process.

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Of course, emergency we have to have other consideration for elective admissions, this should be part of the process so that the patient is told that at admission for elective this is your bill estimate. The patient can decide that, "I can get other opinions. I can also seek options in other hospitals." So in hospital A my bill estimation is 20 to 25, in another hospital 25 to 30. Patients can decide which hospital he wants to go to and he has that financial knowledge to make that decision.

So for us the better thing to do for inpatient is really providing the patient the knowledge via a good bill estimation and providing them with financial counselling. We actually put that in our recommendation to KKM that for outpatient we agree, for inpatient let us move towards this and formalising that hospitals do financial counselling and bill estimation. I hope that answers your question.

Okay, if I may proceed then thought the third item. In terms of long-term and sustainable pricing system. I think the word being used is DRG and we'll elaborate on this further but what we are saying is APHM, we are committed to exploring the reimbursement models. In our meetings with Bank Negara we have said that we are willing to pilot.

In our discussions with KKM, KKM also understand that they also need more data and we need to share more data. So that we can explore what are the right tools for us to use in terms of long-term sustainable pricing systems.

However, one key matter YB is that this must be aligned to the development of the National Healthcare System. We know that Protect Health has started buying services from the hospital. But you've also probably heard hospital saying that actually the cost that paid by Protect Health is— we're not really saying that we are losing money but it is almost as a CSR. It is almost at cost. Our doctors reduce their fees and hospitals reduce their cost.

Some and in many cases we lose money. But we are willing to do it to help remove that pressure for certain things from KKM hospitals. RM50,000 for a CABG is very often below cost. I give you an example. Cost for a bypass surgery in KL in a private hospital is between RM80,000 to RM100,000. You saw just now our profitability after tax

is 10 percent. That means out of that RM80,000, I deduct the doctor's fee, I deduct everything else left maybe RM60,000, out of RM60,000 profit is RM6,000 after tax.

PH Corp is paying us RM50,000. We are willing to do it because we know there is a one year waiting list for CABGs. We are not doing it because it brings us money.

So, our concern is if that is what some parties think is DRG or some parties think this is the model of payment, we will not be able to do it. Or we do it and in one year we close shop.

What we are saying is we need a commitment that we do this properly, study it but yes with part of the National Healthcare Scheme. Meaning that the budget from the government from MoF or whatever, you then allocate and you find out what is the right level of pricing base on complexity, patient care and so on and then you decide that this is the reimbursed model that we'd like to use. So, we are saying we cannot rush into it and we can elaborate on this further. Our commitment is we want to sit down with MOH, BNM and others and start to explore, provide data and study it.

The fourth item, I'll elaborate on this a little bit more is we need to improve the insurance product. We touched on it just now. Current insurance products say I buy the insurance your room onboard is RM200. No longer reflective. It was the same 20 years ago. It is the same today.

So, we're saying this is not reflective, all right? It needs to change. That is one on how and what is reimbursed. But number two, if you have insurance, look at it. What is the wording in the insurance. Actually, the insurance policy says as charged. This is the big challenged to us.

So, two concepts to remember. Cashless is not a policy benefit. That means they can pull out cashless or they can say that cashless benefit is not applicable for certain hospitals or tomorrow they can say across the whole country no more cashless, everybody pay and claim. That is the benefit. But the policy wording is as charged.

Now what is as charged mean? Actually, what it means is whatever the hospital charges as long as it's fair and valid, the insurance has to pay. What's the challenge with this? An educated policyholder can push back if the hospital or the doctor says we should use generic and the patient says I don't want generic. I want original drugs.

There is no wording in the insurance policy that says generic first. If I can give you examples where a patient very recently had a knee surgery and demanded that they have ceramic implants. As a responsible hospital we told the patient at your age you do not need ceramic implants. But the patient said okay no, I want— never mind I will pay

for it. You charge the normal implant and I will pay the excess for the ceramic implant. However, because the patient enquired from the insurance directly, and I am not saying the insurance is wrong, unfortunately this is how the product design is the policy wording is they cover all implants. Polymer, metal, ceramic all is covered.

In the end, the insurance covered. So it's not because the hospital did not provide the right implant or wanted to provide the right implant but because the policy wording is as charged. Now what is the challenge with that? I'll give you another example. A patient who buys only a RM50,000 policy and who then has let's say an injury early in the year and has damaged his knee and decides he wanted robotic. The insurance now some of them also covers robotic surgery. But there could mean that almost RM50,000 of his coverage is already taken up by March of this year.

Then when he comes in September he has another medical episode, his coverage is gone. So, what we're saying in terms of doing a tiered product is when you sell the product you must say generic first. When you sell the product, you must say that it is for the appropriate implant and we are willing to sit down with the insurance. We've been telling Bank Negara we are willing to sit down, we want to sit down and design those products. And example is for…

Tuan Sim Tze Tzin [Ahli PAC]: *Is there a mechanism for hospitals to sit down with insurance companies? Is there a committee or is there a mechanism for now?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Product design YB Sim this is something that we proposed to Bank Negara in October when we met them. We talked about doing this tiered product. BNM has said that they will form a working group for us to sit down.*

BNM, the Governor or BNM to be fair to them has said that they will take the lead, they will form the working group for us to sit together and design products where we say generic first, we talked about appropriate use of implant— if you buy and what we're saying is that the patient of the policyholder must have an option. I want to buy a million-dollar policy then maybe I can access robotic and everything else. But if I can only afford a hundred-thousand-dollar policy, my coverage is RM100,000 where I only pay RM200 or RM50 a month or whatever it is then my policy must be different. Then in that policy, I should not have access to robotics.

If I still want it maybe it is out of pocket. But at least then the hospital, the doctor can say I am sorry for your insurance product we do not cover some of the things. We

do not cover some of the more advance's stuff. You want to pay out of pocket, can. Does that mean it's less safe for the patient, no.

But I think like Datuk Kuljit has recently said medical advances happen every year. Does that mean that everybody must get the most advanced treatment? Not necessary. But the product must support the fact that we can insist to the patient that for your product what we can offer you is the basic standard of care. The current product does not support that.

So, the last item and I think this is where we said together with the insurance we need to sit down and with the insurance and other policyholders and stakeholders, we need to come out to educate policyholders. We also have a big issue YBs in a sense that when products are sold and again, we are not pointing fingers at anyone, right? We understand. When agents sell insurance product, they want to keep their customers happy. Because of that sometimes when a patient requires, they are not sure do I need the MRI, I've got pain, right? But sometimes agents may then encourage the patient to say ask the doctor for admission, tell the doctor please admit the patient so that he can coverage and so on so forth.

Policy holders also encourage patients sometimes not to declare their pre-existing conditions. Currently in Malaysia when you buy an insurance you do a self-declaration. Honestly ask yourself how many policyholders are 100 percent truth?

Again, this puts hospitals and doctors in a very difficult situation. Patient actually has comorbidities, has got hypertension. But when they buy the insurance, everything is a no. When they come to the hospital, blood test is done, the patient is assessed, they have hypertension.

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Now, the policyholder tells the doctor, "Doctor, jangan declare, jangan beritahu. Kalau tidak saya tidak dapat coverage." This puts doctors in a lot of— doctors will do the right thing actually face a lot of scrutiny. The patient is upset with them; the agents get upset with them. We do not want to face this situation. That is why we say we need to educate policyholders that when they declare, when they buy insurance, they must be truthful.

Do we need to move towards having some basic assessment before you buy insurance? Maybe, because the honest truth is, a lot of patients underdeclared. Do not declare what they have and they buy insurance but then they get rejected when they go to the hospital. Then, they get upset. That creates the whole other cycle that's negative.

So, all these we need to do together. We need to do this together with the insurers, with the agents who are involved, with Bank Negara and others. Otherwise, this will continue. So, this raising public awareness on insurance policy and claims and something that we must do together with all parties.

So, these are really what we feel need to be done soon in the next three years, so that we can try and contain inflation. It is impossible to reduce healthcare costs. I think some of the product designs, like we said that can help in terms of the per claim cost if you can design it properly. But otherwise, overall, what we can do is try to reduce the inflation rate.

If I can then go on to my last slide which is really the long-term measures for a sustainable healthcare ecosystem. One thing that I think we need to do in Malaysia, especially as we have an ageing society and we've mentioned earlier about noncommunicable diseases increasing in Malaysia, hypertension, diabetes. Unfortunately, we are number one in all of these which we do not want to be number one, right.

But an issue we have in Malaysia today for access to private hospitals, access to specialists is if I have insurance, I can go straight to Dr. Kuljit. I do not have to go through a GP even if it is a simple matter of something being stuck and the GP could do. Doctor Kuljit should be doing the more complex work. It is boring for him to take you know a very simple piece of mini something that lodges in your nose, you know. Budak main *something* masuk guli dekat— *If a GP can do it, the GP should do it. Datuk Kuljit should be doing more complex work.*

So, we need to bring primary healthcare or primary care into the quotation. We need to come in and be the doorkeeper so that at the hospital level, we do what is needed at the hospital level. Otherwise, you go to the GP. So, the product again. The product design needs to support this. Our national healthcare system needs to support this.

I do not like to quote some of our neighbouring countries but let me give you an example down south. 80 percent of their primary care is private. It is not by the government, it is private, 80 percent. Yet, that is part of their healthier nation program where the GPs look after the patient. If you need admission to a government hospital, they go through the GP. The same should have happened for us. We need to strengthen primary care so that patients are better managed, they are monitored, their compliance is monitored so they get less sick. If they are less sick and they are less NCDs, the claims rate will reduce. If the claims rate is reduced, it will cause more viable for the insurers.

Because I sell the insurance and less people are sick, I don't have to raise my premiums so much. So, all this has a cascading effect, right? So that is the first part.

Number two, in terms of value-based healthcare, like we mentioned, we do need to adopt a new reimbursement model but this must be aligned to the national healthcare scheme. Unless we want to be the first country in the world where we adopt a [Tidak jelas] model like DRG but it is not for national healthcare. What do we mean by that? In our neighbouring countries like Indonesia, Thailand, Philippines, the adoption of our model like DRG, is where the government pays for the treatment in a private healthcare based on an agreed reimbursement model. It is not for private insurance or self-pay patients. Now we say— we do not say it cannot happen but what we do in Malaysia is for the insurance to pay the hospitals based on DRG, will be the one and only country in the world that has done that. There must be reasons why other countries have not done it, right. So, it must be together with the national healthcare scheme. Only then its viable.

Lastly, we do…

Tuan Sim Tze Tzin [Ahli PAC]: *On this point, can you explain to us what's the potential pitfall or negative is if we have a private insurance paying for DRG?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, I think the challenge YB Sim is who will determine the price, right? For national healthcare schemes, the government collect data. Like I mentioned earlier just now, what needs to happen is the government need to collect data. Right now, the government is collecting data for diagnosis only. So, private hospitals, we submit data to the MOH, to My Health Data Warehouse, based on ICD-9. What we submitting is a diagnosis. That means a patient comes, they are diagnosed with a certain ailment and we report to MOH. We are not reporting the procedure. So, if you speak to HTO to Dr. Yap, really the data that the government needs to start collecting is procedure. Even to the insurer, the data that they collect is still a diagnosis. Procedure is part of the claim but the complexity of procedure etcetera it is not there because our coding system is on ICD-9.*

So, the first pitfall is that we need an aggregator. We need a neutral party to actually understand the cost. If you leave it to the insurer, who's going to determine the cost? We thought data, who is able to advise on the cost? Will the insurer, both of us are private entities. The insurer will drive it to the lowest margin. So, if I give you now an example of a neighbouring country, I don't want to name it, the issue we said DRG is a good tool. But the issue is that the price is set wrongly, okay.

So, in this neighbouring country, the price for stenting is set at one particular price. It is expecting or whether it is one, two, three stents, it doesn't matter. But the price that was set is only variable to insert one stent. So, we take an example now, a patient who comes to see a cardiologist, he got multiple blockages, clinically requiring three stents but the price that was set is only for one stent. Only viable for one stent. And this is what is happening in that country. The patient comes has one stent inserted. Three months later, readmitted again for another stent to be inserted. Three months later, come in again and have a third stent inserted. Of course, the cause per admission now looks low, RM20,000 versus let's say RM40,000 for three stents but it is RM20,000 plus RM20,000 plus RM20,000, RM60,000. Somebody thinks they are very happy because they only paid RM20,000 per admission but the total cost is RM60,000 versus RM40,000 if all three were inserted together.

Now, why has it happened? It is because the price was wrongly set. It is no longer viable for the hospitals and the doctors to do it. Is it ideal? It's not. This is partly the reason why a lot of them come to our country. It's because that is not the ideal way of doing it. It's not because the doctor wants to do that. It is not because the hospital wants to do it. It's because the price is set wrongly. But somebody thinks that that is the right thing to do because per admission cost has come down and they have met their KPI. So, this is our concern.

But if you do it as the national healthcare scheme, we will have enough data. The insurance data pool is still small and it is also a certain pool of patients. The moment I have cardiac— I have some heart ailment, I buy insurance, I'm already excluded. So, a patient whose got cardiac, who got comorbidities will be excluded already but if you have a national healthcare scheme, then all patients are covered, the data set will be correct. If you only go through a small insurance data set, we are concerned that the data will not be correct and because of that, prices will be set wrongly.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi*, on this point, actually the government has a very huge data set ya. Private hospitals also have a very huge data set and they actually benefit you more if you share the data set to the government, right? So, I think then we can combine a private and a government hospital and then we have a good data set. Am I right? In terms of procedures.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Agree YB, agree YB. I think, like I said, our discussion— APHM discussion with the Health Transformation Office of MOH that's indicates we want to move towards that. Traditionally, what we have been collecting*

is only diagnosis. Yes, we are supportive, we want effort to be put in, we want processors to be put in so that we share the right amount of detail and data so that analysis can be done and the right things can be set forward for Malaysia.

Dr. Kamal Amzan [APHM]: *Anwar, would you mind if I say a few words? YB Sim, Madam Chair, Dr. Kamal again. I think we are aligned. We have the national interest at the heart and we want to collaborate. We will share our data with you. But allow me to paint another colour so that you understand the complexity of the DRG's spectrum. I go back to pneumonia. So, from a diagnostic purpose, from a diagnostic perspective, it is just pneumonia but there are many categories of pneumonia. Some that can be treated as outpatients, some need ICU, some normal stay. So, there are many variations, there are many permutations to every diagnosis. From a procedure-related perspective, let's take appendectomy for instance. An appendectomy is something that is quite common.*

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So, appendectomy in most patients is just appendectomy. But there are appendicitis that have perforated. You've got adhesion that the doctor would have to release. There are many permutations, there are many variations to every diagnosis related group that is purposed but I agree and I think we are aligned to have a national service scheme that where we share data and we can work collaboratively to come out with the scheme that works for.

Datuk Dr. Kuljit Singh [APHM]: *Just to add on, so, what it means is DRG if it's going to be useful enough, it needs a lot of time. It cannot be rushed in a couple of months and with the idea of having it this year for example it will be a disaster, so you need to have time to get the data both public, private with all the cost put into. It takes couple of years and many countries in the world took take years to come out with a proper DRG and even then, some of the DRGs were not that successful despite of all the effort. So, I think we need time, it cannot be rushed.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *First, I'd just like to mention my observations from your presentation. Your very first two slides trying to impress us that this industry is not making a lot of money. Slide three and four, you're giving the impression that this industry is not making money and your profit is reasonable and that is the thing that we are stressing from the very beginning.*

Okay, with that observation, I am just wondering whether you have comparative data for private hospitals in terms of the breakdown of cost to run the hospital. If you

have, could you share with us? Otherwise, we will ask from the KKM on that ground. Okay, that is my first observation and question.

Second is, I think your slide nine, when you give a picture of the cost for the nursing care services, I think that slide gives us a skewed situation whereby you put in your slide is RM18,000 per bed by three nurses. In reality, that three nurses are not servicing only single bed, they are servicing the whole ward maybe. So, you are not that three nurses, are not servicing one bed but it's actually a number of beds in that ward. To me, it's a little bit skewed in terms of the information that you shared with us. That is the second question.

Third question, just like to have your comment on the fact that it has been mentioned that private hospitals going to the Bursa, going for listing. That again, has in a way put the private hospitals, putting in the commercial consideration at a higher priority rather than servicing and give medical services. And we also know that there are colleges and hospitals, twin together. People opening medical colleges and hospitals, private hospitals and it is a known fact that the ROI for private hospitals are much-much shorter period as compared with medical colleges. In other words, business in private hospitals is much more lucrative than medical colleges. Just to get your comment on that. So, that is so far. I'll just reserve a few of my questions later. Thank you.

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay, thank you YB for your questions. Maybe I take the second one first, on the nursing course. Maybe I have to apologies in a sense that perhaps I didn't do well enough, a good enough job in explaining earlier. So, we go back to the slide, number nine. I really appreciate the opportunity to clarify this.*

Please feel free to verify this with the MOH. The example we are taking here is nursing in ICUs, intensive care. It is a stated requirement that is one-to-one nursing. Otherwise, we will not get licence. So, in ICU, it is one nurse to one bed, not including other supporting staff. So, one bed, it is three shifts, it is three nurses. Without taking into account yet, days off, sick leave, going on training and so on. In the ICU, literally, one patient, one nurse.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *In reality it happens?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *No, no.*

Datuk Dr. Kuljit Singh [APHM]: *In reality, you go against the law.*

Encik Chin Keat Chyuan [KPJ]: *Madam Chair, 100 percent, if anyone of us dare to say in reality it is not, our licence will revoked by CKAPS, 100 percent*. ICU mesti kena satu dengan satu.

Tuan Sim Tze Tzin [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] Do you think CKAPS will change…*

Puan Erica Lam [APHM]: *No, it's not excessing.*

Datuk Dr. Kuljit Singh [APHM]: *There's not a question that is excessive here, we follow the law. The law dictates it very clear when you run an ICU, it has to should be one nurse, to a patient.*

Tuan Sim Tze Tzin [Ahli PAC]: *No, I think regardless of the law, from your perspective, from the hospital experience, does it necessary to have one-to-one?*

Datuk Dr. Kuljit Singh [APHM]: *It is very necessary. If you land in an ICU, you will know what I mean because the criticality of treating a patient in an ICU it is of that depth and KKM can actually well verify that because KKM is the one who put this ruling because if you give private hospital because private hospital do it their own. This KKM's ruling because KKM knows that in an ICU, even in their setting it's same, KKM can verify. The rule comes from them. The law has been enacted by them because of the intensity of treatment in an ICU. So, it's not excessive.* Kadangkala *I can tell you that there are certain very critical patients, we also put two to that one patient if that patient is very critical, at times.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *On that— I've not gone to the ICU that often to visit people.*

Datuk Dr. Kuljit Singh [APHM]: *Ya, please don't go.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *I hope I don't have to go to the ICU but never at one time I see— if I got, I've seen that ICU that 10 beds, I don't see 10 nurses there. I mean, that is the reality. I mean that's my observation. My observation should be shortcoming there etc.*

Datuk Dr. Kuljit Singh [APHM]: *So, that's the observations but the reality is not true.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Okay.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *YB, if I can just clarify, like I said when I started just now. KKM and CKAPS very strict in terms of how many beds we can licence because they will come and visit, they will put in in our licence, it stated in our licence and there's amount of bed we can open and operate. Irrespective of whether you*

see 10 nurses or not, the fact is, we have to hire if it is 10 beds, 10 times three, 30 nurses with an additional times factor of 25 percent. For operational purposes, we have to factor another 25 because somebody may be on sick leave, somebody may be on training and all that. If we do not show, CKAPS that we have 30 staff nurses on our payroll, we cannot operate 10 beds.

Now, on that day when you come, if a nurse is assisting a doctor somewhere else or doing something else, you may not see all 10 sitting there at the same time but the reality is, we will not even get a licence of operate. So, like I said, maybe I did a poor job at explaining the slide, this is for critical care and what we are saying is because we have to do this. It is a right standard, this is a global standard. For ICUs, it should be one-to-one. But because we have to do it— we are not saying it's wrong, what we are saying is because we cannot charge the actual charge for this, it's why we have cross-subsidise.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Okay, thank you for the clarifications. My next question, follow-up question is what about for the other ward outside the ICU? What is the requirement like? That is my follow-up question. I am just reflection it in my mind, there are cases— I am not talking about the medical industry; I am talking about JPJ. People— industrial commercial vehicles when they go to PUSPAKOM, they change their wheels, the tyres. After getting the PUSPAKOM checked, the moment they turn around the corner, they change back to them*

Seorang Ahli*: [Bercakap tanpa menggunakan pembesar suara]*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *…Original tyres, worn out original tyre. I mean that is the industry, I am not talking about medical industry here. But it could be the case as well. I am pinpointing to any private hospitals but that could be the case but I'd just like to follow-up on my follow-up question, what are the other requirements for the other ward besides ICU?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think YB, for most of us who operate private hospitals, our family members also get admitted to our hospital. I think none of us want to go back at home at night thinking that we doing something unsafe. I think our conscious needs to be clear, our doctors by and large are not our employees, they are not. Doctors are independent contractors in the hospital.*

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They are also a third party that watches over us. If in a hospital and the doctor admits the patient into ICU and he feels that the ICU which is supposed to have one to one does not have enough nurses, they will give us hell because it is also their reputation.

It is also their patients; everything is to them. If the hospital did not provide the right nursing care and something happens to that patient, the doctor will also be answerable.

I give you assurance YB that we are not like some other those industries. We cannot. Here we are, we are providing life saving procedures and helping patients. Our doctor's reputation and everything else is also contingent on that. Like I said they are not our employees. If they are unhappy with the hospital, they will make it known to us very clearly if the hospitals are not complying.

So, besides CKAPS, besides party like MSQH will give us accreditation. CKAPS licensing every two years YB, they will come and check. It is not one license and that's it. Every two years when they come, they will look at historical data. "Okay, you have been admitting patients, you been operating 10 ICU beds, show me your roster." They will randomly pick. "Show me your roster from six month ago. I want to see whether you had 10 nurses on the roaster. Who are their names? Check with the HR files."

So, YB I think to— give credit to CKAPS actually we hope that Act 586 should also be used in KKM hospitals. Because it is a very stringent act. It is good. But it will also then indicate what is the cost of care that we provide. It is expensive in terms of providing the nursing care. But what we asking for is fairness in terms of where charge it, YB.

So, if I come back to your first— on the listing one as well right. Maybe Chin can help me. But in terms of ROI YB, we're happy to come to you and show you the data. Hospitals only recover their investment eight to 10 years. Maybe Chin you want to add?

Encik Chin Keat Chyuan [KPJ]: *Okay, thanks Anwar. YB thank you so much for the questions. I'm sure among us today we have to— at least IHH and KPJ we are both listed company. So, when YB you asked your question is about cost. I think the cost is all publicly available right. Today if you are looking at here who we are and all these and you asking about the profit margin and all maybe I can just quote one quick example about KPJ if I'm allowed.*

If we are looking at 2023, when we are looking at margin— just now Encik Anwar already shared right plus minus where I think the profit after tax plus minus about nine to eleven percent. KPJ if you were to check back the record and all these, 2023 our profit margin after tax (PATMI) is only register as 7.7 percent. The next question must be why 7.7 and you are even lower than the industry right. Because KPJ we are very proud of ourself. We have 29 hospitals across all the states. We are not like only appeared in a top tier city like KL, Damansara, kan? Dekat *Penang and all known. We have it in Perlis,*

we have Miri, we have Sibu, we have Pasir Gudang, we have in Batu Pahat, we have it. Every single small city. You know because of the variant, because of bed occupancy and all these.

So, we have been very-very low in terms of the margin 7.7 percent. Imagine 7.7 percent versus EPF who is also one of our major shareholders right. EPF can pay dividend up to 6.3 percent. I'm talking about KPJ at that time 2023, it's only 7.7 percent. It's all available. So, YB feel free to look at all these and then you will realize what is actually the cost.

I quote another example. When 7.7 per se and we are only looking at profit after tax and also PATMI right, it is only registered close about RM216 million. That year itself we invested more than RM240 million back into our CapEx. Because of why— the buildings, because of all the machine after 10, 15 years. All the important PET/CT, MRI, CT scan. All these need money and it's all ranging from RM4 million to RM40 million. We spend back RM215 million CapEx out of our profit close about RM216 million.

So, this is how capital heavy industry for a healthcare, YB. So, it's all publicly available. So, please feel free to check. So, if you are saying that, "Chin, is this really industry where you guys have so much profit and all these?" My answer to you, I better save money more in the EPF then doing a healing business you know, YB. Thank you.

Dr. Hajah Halimah Ali [Ahli PAC]: Datuk Wira.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kejap.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Terima kasih Datuk Wira Pengerusi. Saya *refer* untuk *insurance versus cash payment* ini*. Page 17.* Dalam tuntutan oleh pihak hospital kepada syarikat insurans, berapa tempoh pembayaran itu dapat dibayar oleh pihak insurans kepada hospital ya? Itu satu.

Dalam *table* ini yang kedua itu nampak agak pelik— minta maaf agak pelik sebab dari segi prinsip ekonominya dan *business operational* ini sudah pastilah bayaran *cash* itu lebih murah. Jadi, ini *first time* saya tengok bayaran *cash* itu lebih mahal daripada bayaran tertangguh. Ini saya tak pasti logik di mana.

Yang ketiganya, adakah ini menunjukkan bahawa syarikat insurans ini dia ada kuasa tawar menawar kerana dia beli *company*, dia ada *deal direct* dengan hospital, dia ada tawar menawar hingga dia dapat kurangkan kos yang sebenarnya daripada berbanding dengan *cash*. Jadi kalau ada kuasa tawar menawar, bagaimana struktur ataupun SOP tawar menawar itu yang digariskan oleh pihak hospital?

Yang keempat, nampak kedua-dua *table* ini, nampak data ini nampak agak *difference* ya. Tahunnya juga berbeza dan yang *table* kedua itu, itu disebut kalau dia di-*warded* tiga hingga lima hari ya. Tetapi yang sebelah itu kita tidak pasti itu adakah sama ataupun tidak. Itu kena sepatutnya saya lihat perlu jadual itu tadi disebut *apple to apple*. Jadi sepatutnya begitu juga dalam *table* ini. *Thank you.*

Encik Anwar Anis bin Anis Ahmad [APHM]: Terima kasih YB untuk soalan-soalan itu. Mungkin soalan yang terakhir tadi ya, memang kami minta supaya perbandingan ini dibuat secara telus dan *apple to apple* kerana perbandingan yang sudah menjadi agak viral ini memang memudaratkan kepada kami. Doktor kami dipersoal, kami dipersoal. Memang kami minta supaya perbandingan ini dibuat dengan secara telus dan pada basis yang sama kerana ini data kami. Kami bersedia. Kami sudah mengatakan bahawa kami bersedia memberikan bil-bil kami kepada pihak seperti BNM untuk memeriksa dan memastikan bahawa apa yang kami katakan adalah yang kami *present*. *We are prepared*.

Pada masa yang sama kami juga minta yang data di sebelah kiri juga dikongsi dengan kami kerana kami nak tahu kalau ada pihak hospital kami— kami tidak tahu ya*, in any industry there are bad apples.* Kalau memang adalah segelintir yang membuat perkara-perkara yang tidak benar, kami nak tahu sebagai persatuan. Kami tidak boleh mengambil tindakan tapi kami boleh sekurang-kurangnya menasihati dan sebagainya. Pada pendapat kami itu bukan sebab kenapa data itu berbeza. Memang basis dia tidak sama pada pendapat kami lah. Tapi *that can only verified like you said YB by having somebody look at it in a transparent manner.*

Mungkin soalan pertama YB bayaran daripada insurans kepada kami *on average* is *about 45 to 60 days*. Ini tidak termasuk *deferment* ya. Maksudnya dalam kontrak kami dia akan kata 45 hari ataupun 60 hari daripada tarikh semuanya sudah *confirm, final GL*. Nak dapat *final GL* ini kadang-kadang juga mengambil masa kerana ada soal, ada *clarification*.

Untuk pengetahuan YB semua ya, insurans sebenarnya bukannya dia kita bagi bil dia bayar, bukan begitu. Kita kena *submit*. Bila *patient* itu masuk ke hospital *if you are insurance patient upfront because of PDPA and everything else we will get permission in our documents to say that we will have to share your data with the insurer.*

If we did blood test, we did CT, we did x-ray, all those reports must be provided to the insurer. They will then look at those data. Dia akan meneliti semua kemudian kalau dia rasa ada benda yang tidak patut dibuat, dia akan kata saya takkan bayar. *So, that*

process is actually atau dia minta doktor *justify* kenapa doktor minta *blood test* ini, kenapa doktor minta x-ray ini dan doktor kena jawab. Selagi tak jawab bil itu tidak *finalise*. Selagi tidak *finalise*, 60 hari atau 45 hari itu belum bermula lagi ya.

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So, that soalan pertama. Jadi adakah insurans ada kuasa tawar-menawar? *The reality is* memang *I mean— so, okay, why,* kenapa pihak yang bayar kemudian *instead cash* dapat diskaun? *So, I supposed it's also the function of the volume.* Jadi insurans ini seperti yang saya kata tadi bila beli insurans ini *cashless* ini bukan *stated policy* yang harus diberikan.

Jadi untuk hospital, masuk ke dalam panel insurans untuk jadi *cashless* memang ada perbincangan. Jadi insurans akan kata*, "Saya insurans besar, saya memerlukan diskaun yang lebih dan sebagainya". So,* memang ada kuasa tawar menawar.

Jadi itu tidak dapati dinafikan. *So,* mungkin berbeza dengan industri lain. *Yes, cash is sometimes is paying higher not all the time, right.? Sometimes paying higher, sometimes paying lower but the insurance because of the volume and the relationship as a commercial entity, certainly it has the ability to negotiate and get into an agreement with the hospital which very often, almost all the time. Results in some form of discount.*

Saya harap menjawab soalan YB ya?

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Saya tak dapat terima lagi.

Encik Anwar Anis bin Anis Ahmad [APHM]: *So,* ini saya rasa— saya tak tahulah kalau PAC ada bidang kuasa nak minta *agreement* daripada kami kah apa? Kami telus. Memang dalam *agreement* dan sebagainya akan tertera.

Dalam bil sebenarnya kami sudah memberikan beberapa contoh kepada Bank Negara. Maknanya bil— dan bil yang kami beri penting untuk diingatkan. Maknanya hospital sama, doktor sama, pesakit dengan kondisi yang serupa. Maknanya kalau *patient* itu datang untuk denggi, dia tak ada *comorbidity* atau *comorbidity* yang sama dan sebagainya dan *length of stay* yang sama.

Kita berikan maknanya dari hospital yang sama, doktor merawat yang sama, menginap untuk kita tiga malam di hospital *three days of treatment, side by side the bil…*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Okey, *clear.* Cuma yang tadi *different* antara *by insurance* dan *cash* itu. Jadi saya nak bagi logik, *economically,* kenapa *cash* itu lebih mahal? Itu yang saya belum faham lagi.

Encik Stanley Lam Kean Fatt [Ahli Lembaga APHM]: *Sorry...*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Go ahead.*

Encik Stanley Lam Kean Fatt [APHM]: *Sorry, I'm Stanley, I'm APHM board member. I just want to point out to the PAC members. I mean even now right, if the situation become more critical in the sense that because of the Bank Negara regulations, all the insurance can only increase their premium by 10 percent by the next three years. So, what they did is that come to private hospital, they demand for more discount.*

So, such a scenario would be more visible moving forwards. In which, in order to stay between the panel, the insurance company are asking for more discount. Much more than what we are providing to them at the moment.

Because they're very straightforward. They come to you they say taken up balance that they book, right? So, you have to either give them more discount in order to stay between the panel or else you be not given any panelship. Okay?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Before,* saya bagi kepada Bayan Baru. Saya nak tanya *since* YB Sik tidak puas hati. Saya cuma nak tanya *survey* ataupun kajian dibuat ini melibatkan beberapa hospital ataupun dibuatkan oleh *your* persatuan?

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, YB Chair, as stated on the table itself. The sample size is 10,000. This were from…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *From the whole presentation the survey you did?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, for the data YB?*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ya.

Encik Anwar Anis bin Anis Ahmad [APHM]: *Correct, so,* daripada hospital di bawah *group IHH...*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *No,* daripada awal *this presentation.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *This presentation.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Yes, that means survey that you did.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *There are very difference studies that we are quoting inside there, YB. So, if you look at* kalau kita pergi ke slaid nombor tiga. *[Merujuk pada pembentangan slaid] So, if you look at it on the profitability study and the breakdown. We put there the participating hospitals,* maksudnya *basket of participating hospitals* dalam *our study actually we do indicate transparently which are the hospitals that are participating.*

So, there are two studies that we are quoting in our presentation today. One, is on profitability. So, this profitability study, it was member hospital of APHM that participated. But to be transparent YB what we did and that is why in case the question came up.

If you look at this chart on the righthand side. Ada dua. *Participating hospital* dengan *footnote* nombor satu. Dengan nombor dua, *private hospital group.* Maknanya hospital yang *either public listed but the data is available.*

The reason we put both side by side kerana nak *correlate* kita punya data, nak *verify* data kita. Maknanya data di mana pihak yang kita minta buat *study* ini dengan *publicly available data for listed companies* sama ada *there is consistency. And what we can see is it's almost consistent. The PAT for the participating hospital between nine to 11and private hospital group between at 12 percent.*

So, these are available YB, right. So, I think our financial statements you can even almost you can Google it actually, you'll find it.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih YB Wira Pengerusi. *I have three questions. First question is about transparency on the bill. Okay, I think— a lot of insurance, sorry, the patient who pay with GL letters, they requested bills from the hospital and they were not provided, okay. Then, I mean that is what some of the complaints are.*

Secondly, now we found that the change of way of billing now. I received the latest complaints dated 28th of February from KPJ. The patients were given one page. Last time, they were given— if you're really push for it, you can get the full 19 pages, 20 pages of itemised bill. But now it's only one page and one is, one portion is hospitals and second portion is consultant. Consultant you know regulated under the 13 schedules.

But the hospital is only— this one is for— I just give the example. This case is about— what is the case, let me see. Okay, I think— okay, I don't want to go details but the cost of medical bill is about RM40,000. RM7,000 are the doctor's procedures. RM32,000 is hospital bills, [Tidak jelas] hospital, consumables, various kind of things.

When the patient wants, request detail, the hospital refused to give, okay, refused to give. So, the issue now is transparency. So, what we need is transparency-lah. *You know, when people request you have to give. I think that's where issue number one.*

Number two adalah tentang *tier pricing. This third-party administrator (TPA), informed is that, there are five tiers of pricing. First tier of pricing is medical tourist.*

They're charged usually higher. The agents are given about 25 percent commission to bring in the medical tourist.

The second tier is the full paying fees, full paying people, GL. So, they have this guarantee letter. So, definitely it would be higher. The third one is the pay and claim. They have— they can pay, all right? And then, they claim insurance later. Then fourth one is this self-paying. Self-paying is another tier of pricing. The last one is the one who are really like begging to get the discount. So, these are TPA told us, these five tiers of pricing. So, can you comment on that?

The third question is about, I want to go back to your first and second— sorry, your third slide. I find it very interesting because for your breakdown of RM100,000 revenue. The consultant fees are only RM155. That is above RM1,000, that is beyond your RM1,000.

Okay, to make it simple. So, it's about 15 percent of your what do you call the total cost, cost of medical bill, 15 percent. However, there's another one direct cost. So, what is that one direct cost that is about 32 percent?

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And then the staff cost of 31.2 percent, all right? Can you explain to us what is that the direct cost and staff cost? Because you see, when we go to the hospital, the most important thing— I think-lah *is seeing the doctors with the procedures and the operation, you know, the procedures. That is only about 15 percent, 15.5 percent. But the other things of direct cost, staff cost, is— I cannot understand why the staff cost is so much higher, double the doctors' cost? Because doctors' costs and procedures must be the most expensive ones. But, like that— it's like that. And then, some of the what you call* saksi *also told us that in the hospital, 40 percent of your staff are not directly in the nursing or healthcare, it's about billing. You know, you try to— 40 percent of your staff is to do the administrative work, to claim, to verify, da, da, da. Those are the things that I think should be, you know, it's a bit too much of a cost to a hospital. It should be reduced. Because with AI or with better coordination, better understanding between the hospitals and the insurance company, I think this cost can be reduced, you see.*

All right. So, please explain to us. Please, ya.

Encik Stanley Lam Kean Fatt [APHM]: *Sorry, maybe in terms of cost, I want to address that* lah.

Datuk Dr. Kuljit Singh [APHM]: *Let me just answer the first question.*

Tuan Sim Tze Tzin [Ahli PAC]: Ya, *sure.*

Datuk Dr. Kuljit Singh [APHM]: *The question about the hospital not giving detailed billing. The patient can actually report to CKAPS. CKAPS will know what to do with that hospital. They have to give detailed billing. I mean, they are always with these isolated examples and then that is used as a big story. But what I always tell is that if there is, the law is there. You go and complain to CKAPS and CKAPS will know exactly what to do. The hospital is by compulsion have to give detailed billings. That is one more...*

Tuan Sim Tze Tzin [Ahli PAC]: *But the insurance company also got a complaint about that?*

Datuk Dr. Kuljit Singh [APHM]: Ya, *they can...*

Tuan Sim Tze Tzin [Ahli PAC]: *The insurance company also say that, "Eh, hospital. They couldn't get the detailed billing from the hospital", why is that so?*

Datuk Dr. Kuljit Singh [APHM]: *So, they can complaint to CKAPS. CKAPS will know what to do with that hospital, it's in the law. I'll answer the first part of it. So, if you have that complaint, you know what to tell them. Complaint to CKAPS, they will make sure the hospital gives detailed billing. Second question, maybe the rest can answer.* Siapa nak ambil? *Who are...*

Encik Stanley Lam Kean Fatt [APHM]: *Maybe I just answer in terms of cost* lah*. I mean, just for YB's understanding, right? I mean, first of all, you asked about what's the direct cost is? I mean, direct cost is its cost whereby you use for the treatments, you know, including all those medical supplies, pharmacy cost, even some of the lab, the antigen cost, you know. All those— cost is needed for you to procure before you provide that treatment to the patient. And just mind you right, just for your information, a lot of those costs is— let's say for some of the pharma in that sense right, we have no control about the prices. It is all— many of them are original drives, right, I speak made by the big pharma companies, right...*

Tuan Sim Tze Tzin [Ahli PAC]: *On pharma cost to— they testified to us it's about 16 percent.*

Encik Stanley Lam Kean Fatt [APHM]: *Now, just try to understand. I'm just— let me explain right. I mean, I'm apart from pharma, as the same medical supply, the catheter that you are using, right? The sutures that you are using. All this part and parcel of the direct cost, right? So, just want to explain for that. Circling is about the staff cost, right? I mean, just for your information, staff cost in Malaysia is already considered very low. If let's say you compare it to the U.S, the staff cost alone is more than 50 to 60 percent, right? And this is one of our concerns as well, right? Malaysian, those I*

understand, we have always been quoted, we have been underpaid right? We have been underpaid and that's why we are losing our staff, right?

One of the reasons that we are not able to pay higher because we have to control the staff cost in order to charge lower. Otherwise, I can tell you the staff cost with the— If let's say we want to pay as high as our neighbouring countries, our staff— our billing will increase a fill full. That's a reality, right? Just to put you an example, my hospital in Malacca alone, we employed about a thousand staff, just one hospital employed a thousand staff. Can you imagine that? And I can quote that more than 50 percent of our staff are clinical staff. They are high-paying staff, we cannot underpay them. So, we have to have a lot of staff in order to comply with the regulations and requirements.

And just to tell you another one, we are considered a medical tourism hospital because more than 30 percent of our patients are coming from overseas. But I just want to assure you, we never pay a single cent to anybody who brings in a local patient to the hospitals, not even one cent. Because this is not the practice of our hospitals...

Tuan Sim Tze Tzin [Ahli PAC]: *No, you are not paying a single cent to local...*

Encik Stanley Lam Kean Fatt [APHM]: *I mean, I just want— Sorry, just what YB talk about, you know, bring in patients to get 25 percent commissions, that's totally not true. In our practice, we never pay a single cent. Okay.*

Puan Erica Lam [The Association of Private Hospitals of Malaysia (APHM)]: YB, *this is Erica. I am from the APHM Board as well, I am also the Honorary Treasurer for APHM. Allow me to clarify one more point about the staff. The number of staff, why do you need so many number of staff? Apart from the international standard, KKM standard, actually it's in the law. It's in the Private Healthcare Act that we must provide. Let's say, for example, if you have 10 staff, 10 staff in the ward, you must have another almost 10 staff, there's known nursing to support the nurses to deliver the care. So, in the private hospital setting, it is just not one doctor deliver the care, it is the whole team who is delivering the care that is involves nurses, pharmacist, radiographers, medical technologist which is the laboratory people, they have even pharmacist assistant, dispenser, they even have a cook and a server if they even have to do the clinical janitors, cleaning company. All this is part and parcel of the hospital, plus security, who look after patient safety.*

So, our staff force is big. Like what Stanley mentioned, a typical 300 bed hospital, you have a minimum of 1,500 staff, minimum. So, for Sunway, for example, I believe almost nearly 700 to 800. I believe they reaching about 3,000 staff already. So, this 3,000

not even including doctors yet, just pure— more than half of them are professionals. They are not what you say the billing staff. Billing staff in our hospital system I think less than five percent. Ya, *very, very small. Just the nursing itself, nursing itself, let's say my hospital, now Pantai Hospital Kuala Lumpur, my staff trained is about 1,500, about 700 to 800 staff are all pure professionals. Meaning they are minimum either registered with Nursing Act or either in the alike health act or either they are other semi-skilled staff to support the care to a patient.*

So, whereas the direct cost— Just want to add on, clarified for Stanley. The direct cost means that the direct cost that you have to purchase in order for you to deliver the care to the patient. That is the drugs, the laboratory antigens, even implants, surgical tools, all that is essential to deliver care. So, it's not about one doctor delivered the whole care, it's a whole team. Ya, *thanks.*

Dr. Hajah Halimah Ali [Ahli PAC]: Datuk Wira, *can I refer to page five? Page five is about billing and constructure. Where is the medical legal issue as part of your costing? Is that important to you? Is it a big factor contributing to the costing and do the escalation of medical healthcare costs or what is the percentage? As far as a private hospital is concerned, this medical legal factor, how does it contribute to this escalation of cost?*

Datuk Dr. Kuljit Singh [APHM]: *I think— Thank you very much, YB. We didn't put that in. That was one of escalating the cost of hospital billing in recent times. We have got payouts about RM4 million, RM8 million, RM10 million and I think the government even had a debt of RM15 million payout, it's in the court.* Ya, *it is not listed in the patient bill. In many parts of the world, medical legal costing is also put into the patient's bill and we don't do that, we don't do that. So, we get hit at any given time with that kind of bill to pay the indemnity or sometimes it's not even covered by the insurance and we have to actually pay out of our pocket to the court or to the plaintiff.*

That's a good point that they raise. I think— You want to add on? I think if you want, add in that.

Puan Erica Lam [APHM]: YB, *this is Erica again. Allowed me to mention, we didn't specify the word "medical legal" because it is a practice. What does it mean the practice?*

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Actually, the word is called redundancy and preparedness. If you are not prepared enough, we are not doing enough to safeguard the infection control that where

it leads to patient's injury. If you do not have a qualified staff to deliver care, that's where you have injury, unintended consequences to the patient. If you are not buying a registered, approved drug or by the Medical Device Authority which means you are applying dangerous practice onto the patients or sometimes it's all these will lead to medical legal.

So, preparedness and redundancy are a huge chunk of cores that are in a private hospital. We can't say like we learned a lot during COVID-19 time. So, all the hospitals in over the— less than one month where they prepared ourselves how to deal with COVID-19? All these costs are actually we talking about redundancy and preparedness. So, you will just have to put all these up together to serve a patient, even though it means only one patient.

Tuan Sim Tze Tzin [Ahli PAC]: *Can you please answer my five-tier pricing by TPA?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Can, YB Sim. I think on the five tiers, I think like our colleagues had mentioned. Again, we are more than happy to produce bills for you so you can look at it. But in the hospitals, what we keep stressing is, there is only one charge or one price per item to the patient. In the bill, it could be lower because there is a five percent or 10 percent discount to the insurer.*

Okay, that means it's RM10 and it will be transparent in the bill. You will see RM10 discount, RM1 because it is 10 percent, final price RM9. If it's a patient who really cannot afford, et cetera if 20 percent discount is given, RM10, RM2 discount, RM8. Transparent in the bill. You will always see what is the actual, the full price and if any discount is given.

So, we actually don't know where or how these five tiers come about. For medical tourists, in the Act 586, the government allows the doctors to charge an additional 25 percent. That, yes, it is the doctor's fees which is allowed under Act 586. The doctors can charge an additional.

Now, whether that happens or not, actually most hospitals and most doctors do not charge but the government allows it. So, yes for medical tourists, the professional fees by the doctor, he can charge an additional. But again, if you look at the hospital, if it was RM10 to the insured patient, it will be RM10 to the self-pay, RM10 to the pay and claim, the discount is transparent if there's any given.

So, we only have one tier of pricing. We cannot stress this enough that we only practice one tier. Does that mean we cannot give discount? Does that mean we cannot help a patient who cannot afford to give him a bit more discount? I think we have to

recognise that's allowed in any industry. But we do not have RM10 to this class of patients, RM12 to another class of patients. So, that one we have to make it clear.

Maybe YB if I can also take us back to— maybe to YB Halimah's question first. This billing and cost structure, we've not captured everything YB. If we put everything, then you will say, "Saja, make it looks very this one". So, suddenly medicolegal cost is not there. We've not put the cost of regulation in here, for example. We've not put the cost of accreditation in here. We've not put let's say, audit cost.

I mean all these are compliance costs. So, this is non-exhaustive. We just wanted to give you an example of what appears in the bill. What appears in the bill but it's not the full cost and the fact there are a lot of things that do not appear on the bill.

We can expand this list maybe by double. It's not a problem. What is not in the patient's bill can really double because there is so much that we obviously cannot charge. I mean it is not right. We cannot be charging cybersecurity, medicolegal but these are obviously costs which are not inside there. If I can take us back to slide number three.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Yes, YB.*

Dr. Hajah Halimah Ali [Ahli PAC]: *So, how many percent of your— it's not itemised in the patient's bill and you have to cover that? That's part of the cost or operational cost. So, where do you get the money from? From your profits? What percentage are you putting there because it is more than your— the other two columns? Your items in the patient's bill and items appearing in the patient's bill. So, it's even more because it is not exhaustive as you said.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *But I think YB firstly, maybe after the PAC* saya kena marah dengan yang lain dululah. *I didn't do a good job on explaining slide three and four first*. *So,* bulan puasa ini mungkin *a bit* lembablah.

So, we go back to slide number three, if you don't mind. Okay, so maybe I have to clarify perhaps maybe sometimes when we present, we think that it is clearly understood. But maybe it's not. So, I think what we are trying to say here is for that 1,000 unit, these are— what are the breakdown of the various costs in the hospital before we arrived at the operating profit dan sebagainya.

In terms of what we don't charge— so what we charge to the patient? Obviously, in the bill is a direct cost. So, if I can give you categories. If you look at hospital bill, normally you will find— maybe like I said in the first line is admin charges. Okay, we charged some small amount for admin. We will charge equipment. Equipment that is

used, you will find it in the bill. Laboratory, because again all of that, you will find it in the bill. So, there will be a category of that.

You will get a category of medical supplies. So, these are ward supply, OT supply. And then you will find nursing charges. So, we do charge some. What we are saying is we do charge in the bill but often it is not the full amount that we need to charge. And then, we will charge pharmacy. Now, pharmacy, we admit not only do we charge. This is where YB for the things that we don't charge. We have to recover some of it. And that's why you will think that why is a medicine that is RM1 being charged RM3? Is that reasonable?

It is because for all those things that we don't bill, we have to recover it somewhere and unfortunately, the way the industry has developed, the way the payment structure developed, that's where we are charging it. And then YB, so that— let's say pharmacy. Medical consumables, sama. *Unfortunately, what is RM0.50 maybe we charged RM2.50 because all those things we cannot charge are being recovered in those line items.*

Because if we were to charge, again already we are— there are so many questions in our transparency of the bill. If we were to charge for our redundancy and preparedness, if we were to charge for finance stuff, security stuff, lagilah *patient* akan tanya, *"I tak guna pun finance ini. Kenapa you caj kepada saya?". So, we admit that in our billing structure, that is how it has developed over many years.*

Ultimately YB, if you go back to slide number three. What we are trying to explain in this slide is— and YB Sim to your question just now is the example you give, a bill of RM40,000, RM7,000 doctor's fees. It's very much aligned to what we're showing here. So out of that RM40,000, RM7,000 is about 17 percent. So, the 15 percent is an average. So, what we are saying is out of that RM40,000, let's take away the RM7,000 which is the doctor's fees. Let's take that away. So, that was 17 percent. In our study, average is 15.5. So, that leaves us with RM33,000.

So, what we are saying is that RM33,000, these are our costs. Out of that RM33,000, almost 30 percent is our staff cost.

Tuan Sim Tze Tzin [Ahli PAC]: *Is it possible to reorganise your billing? Because this creates a lot of uneasiness among the public. Because they see that the glove is RM20, they look at the Pampers RM50.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, YB...*

Tuan Sim Tze Tzin [Ahli PAC]: *I mean you should do a better job at explaining and put the cost structure differently.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Agree, YB. Agreed. If you are…*

Tuan Sim Tze Tzin [Ahli PAC]: *RM200, RM300 per bed, per night is already obsolete. That has to be revised and talked to the insurance because the insurance now is only RM300 per month— per day, per night which we all know about it.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Agreed, YB. I think as an industry, we hope to get support so that we can restructure our bills and present it in a way that perhaps is more reflective of our cost. We— I think this may be an opportunity. I think certainly with PAC and all the discussions that are happening, it is an opportunity for at least one stakeholder in the government to take the lead and bring us together and say, "Okay, we need to re-look at how the bill is structured".*

If we were today, as I said YB, if today one of the hospitals or even as an industry, we start saying that we are going to charge the room and board at RM800 per night, the impact is to the patient, YB. Because of the product structure, the impact is to the patient. Because then, because the patient policy, room and board RM300, now charged at RM800. The patient will be imposed a co-payment. Most policies now will say, "If you exceed your room and board entitlement, there is a co-payment".

So, if we do it YB without an understanding, without government assistance to change the current model of payment, there will be a lot of different impacts. One, like I said, direct impact to the patients.

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Then you start saving co-payment, then the patient has to pay out of pocket for that co-payment and certainly they will not be happy. But there is also other implication, YB. When we talk about nursing just now, and like we said we are not saying it is wrong, but the insurer will come every year to do an audit to say, "Why is your hospital charging ICU nursing at RM600 when everybody else is charging RM300? You cannot charge RM600. If you continue to charge, we may have to remove you from the panel."

So, it is because— is become part of what the understanding is. So, we do need the PAC, we do need the government to help bring all the parties together and transform how we do certain things. We agree, YB. We are aligned to you.

Encik Stanley Lam Kean Fatt [APHM]: *Maybe— Stanley here just want to…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Bayan Baru minta laluan *since same subject?*

Encik Stanley Lam Kean Fatt [APHM]: *Sorry. It's me Stanley here. I just want to explain and what Anwar has said. When we said co-payment right, I mean just give an example. If let's say a patient the bill is RM10,000, let say for instance, right and he chose to stay in a single room and by right he can only stay in double-bedded room. Let say for example, the difference of the bill the double-bedded and single room is just RM100. He stays for three days. So, even say he's entitled to double-bedded room but now he wants to stay in single room. By right the difference three days is only RM300 but when we talk about co-payment is the total bill by itself.*

Let say the bill now is RM10,000, let say for example. He needs to pay a co-payment of 20 percent. That means he had to shoulder RM2,000 of the bills instead of the RM300 on the room difference. That is what we meant, the co-payment that we meant just now. So, the implication to the patient it is very big. That's why if let's say we want to restructure the bill, it's not just the hospital side, but the insurance side also must accept and design their products appropriately. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okay. Kubang Pasu. *[Berucap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Sambung sekali lah ya. *First, on the related subject on this histogram. D&A is what? Drugs?* Ubat *na?* D&A?

Encik Anwar Anis bin Anis Ahmad [APHM]: *Depreciation and amortisation.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, sorry. So, like drugs you* masuk dalam *which cost?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Under direct cost, YB.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You* masuk dalam *direct cost* lah?

Encik Anwar Anis bin Anis Ahmad [APHM]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, all together 318. Besides that, what are other the direct cost? Besides drugs?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, in direct cost is drugs, medical consumables, anything like Stanley said, anything where we have to acquire and we have to pay the vendor.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Roughly,* ubat *or drugs* ini *how many percent of total if you breakdown from that 318* kan? *Your direct cost 318* kan? *How much is the drug cost?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, I think actually…*

Encik Stanley Lam Kean Fatt [APHM]: *Usually, the drug cost in the range of 15 to 20 percent.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *15 to 20 percent?*

Encik Stanley Lam Kean Fatt [APHM]: *Yup.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think YB if I can clarify. I mean the reason why…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *…About half of this direct cost 318. About half.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So maybe YB if I can clarify. The reason why is sometimes a bit— it can be misleading to give you a specific number is because it really depends on the kind of hospital and what they do.*

Women and children hospital, let say a rumah bersalin – *who's mainly doing deliveries that drug cost may not be very high but it is more of their procedure fee, OT fee, the medical consumables in the OT* dan sebagainya. *So, percentages can really vary. I think what we are saying is within the bill, if it's a hospital that does more surgeries actually that direct cost will be a lot more surgical item.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okay.

Encik Anwar Anis bin Anis Ahmad [APHM]: *If it is hospital that's doing— doesn't do a lot of surgery is mostly medical…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But 318* ini *you total up* semua sekali lah?

Encik Anwar Anis bin Anis Ahmad [APHM]: *318 total up* semua sekali.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Sometimes surgery must more…*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Correct.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Sometimes drugs more* lah.

Encik Anwar Anis bin Anis Ahmad [APHM]: *Correct YB. So, I think maybe a bit dangerous and misleading to breakdown that, it really depends on the kind of hospital and the kind of service they provide, YB.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: YB Pengerusi, *you see* kita dah dengar daripada banyak pihak *stakeholders, this private hospital maybe the last* lah kot. Ada lagi kah?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tak ada dah. *[Berucap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Tak da dah?* Kita dengar daripada MMA, *University Hospital* dan sebagainya. Dan, *insurance company of course they came, many of them. The issue is insurance company* kata dia tak buat untung *on the medical insurance. Even though yang total insurance* itu dia untung banyak, lepas itu bangunan dia pun hebat-hebat. Dia kata *medical insurance* dia tak buat banyak. *Okay? Little profit. You all remember?*

And private hospital also say they don't make much profit. In the end, premium insurance dia meningkat tinggi. Jadi, *sebenaq*-nya apa yang terjadi *pasai betui* kah? *[Ketawa]* Saja, saya naik *heran*. *So, they must be somewhere that you all have to sit down what is exactly happen. Of course, the government have to play the role* lah *because* kita dekat sini ini kita dengar macam-macam *all sides can be confusing to us.*

But not that we don't believe what you all said. Encik Anwar punya *presentation to me very comprehensive, very convincing, right?* Pihak *insurance pun very convincing* juga. *[Ketawa]* Yang kita *clear* ialah *from University Hospital. Very clear,* kita tak *confuse.* Tapi *mai* sini *confuse* balik. *[Ketawa] So, I think there must be a certain thing that they have to sit down together.*

The other thing is that I want to mention Datuk Wira Pengerusi, is a question of addressing long term demands supply mismatch. Now it's mismatch. Demand is getting higher and higher. You go by economic theory, supply is less. You have to pay higher. Not because dia punya *cost higher. Not because the cost of private hospital, insurance higher but because the demand. Mismatch ya? Mismatch.*

In the last five years actually, I've read some article that's not much expansion on number of hospital public and also private. I think there is must be some concrete plan to match between the demand and the supply. Therefore, maybe ada *competition,* kan? *Competition normally good but sometimes competition* pun boleh tak bagus *juga. So, in this case I think it should be good.*

And the other thing I would like to ask is public hospital some of them big hospitals are listed including KPJ, Mr. Chin. Okay Mr. Chin, kan? *They are public listed. Public listed* ini maknanya apa? Kita ambil duit orang *as capital but you have to pay, give them dividend. You are under pressure every year, every month to think of how to make profit. So, there are two parts,* kan? *Social and commercial profit and social part, welfare part but for private hospital which are listed I think* dia punya *weightage* dia *is more towards*

the commercial. How much dividend that shareholders are expected from you, kan? *I am sure there is that element,* kan? *Maybe okay, those big one listed. Macam IHH PJ, KPJ, TMCL all these are listed. Then we cannot,* nak *privatised* pula macam MAHB pula. Jadi isu balik pula. Jadi macam MAHB.

So, that one okay but I think the future I think government must have, must come in to see whether is the right thing to do for the private hospital to go for listing. Because you under pressure all the time to make profit. Dulu *I think— I don't know Gleneagles was not listed,* kan? *And now they* masuk dalam IHH *now,* kan? *So, they are listed. They are pressured to make as much profit to make the shareholders happy with their investment. That is what is expected.*

The other thing, what do you think of this issue of DRG's. You all mentioned many times and previously also we heard about this DRG issue many times. I want to ask from private hospital here in terms of implementing DRG. It can standardise the pricing. The pricing and also which give more transparency in terms of costing and charges. That is all for the time being, Datuk Wira Pengerusi. Nanti panjang sangat pula. Terima kasih. *Any response from your side? Thank you.*

Datuk Dr. Kuljit Singh [APHM]: *Maybe I will do the DRG part first. As we explained just now, that the DRG is a good tool. We are not saying that DRG is a bad thing to do.*

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But there's nowhere in the world that they used DRG as we mentioned earlier that they using it just for private. It's always use by the government.

So, our stand is we can use DRG but not at very short-term. Let the government together with private sit down together and formulate the DRG. In fact, the government needs to do one first. So that when they do budgeting on their side, they can also get the feel on how much amount they need to get from the Ministry of Finance. Together once they come out with DRG which is strong enough, then we can put a costing into the DRG for private. Then, definitely we will get a good tool that can be used for our purpose.

As we said earlier that we can't do this in just a couple of months. It will take a few years before this DRG can be used as a proper tool for both public and private. It's just cannot be sake of the private tapi *public* tak apa*. Can do how whatever costing—no. We also want to make sure our* rakyat *it goes to the public also get the best treatment with the best amount of budget.*

Is the budget enough or not at this point of time. Is it enough? Probably they need more budget. If you want to have more budget, you need to have a tool and the tool would be probably in my viewing is DRG.

So, if the government uses the DRG for their purposes it's very easy for the private then to use their DRG concept to put in our cost and then DRG becomes useful. So, that's our stand on DRG.

So, I want the message to be very clear from us that we are not against it. We are only against it if you do it in a hurry. That's wrong. It has to be done in a proper method. Let the government do it first. We are able to assist.

Then as we go along, we can use it. Like as I said, no example in the world where they are only purely used for private. I can answer on DRG because I repeat it this so many times. So, I can answer that.

The other question was on public listing versus not public listing. There are answer to that because it can become worse. Both answer. Anwar? Public listing versus…

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think Dato' YB Kubang Pasu your comments and your questions are very valid. I mean if I was not— we are not in healthcare I think we will have the sentiments and same questions.*

For most of us, YB I think we've worked in whether public listed, non-public listed entities and hospitals, YB. I think the fact is there are two parts I think to this question. Again YB, for most of you, you can access information. I'm sure you can get even your Parliamentary assistance to look at it. The fact is healthcare— firstly for public listed one, actually it's not a dividend stock, frankly.

So, then the question is why do the people want to invest into it? I mean if you say your profit is like this, your dividend tak banyak, buat apa orang nak *invest?* Pelik juga. *So, I supposed the answer to that is healthcare as an industry is whether you like it or it's quite a not, it's quite a robust industry. Irrespective of what happens, healthcare remain. During COVID-19, healthcare is still— hotels maybe suffering, theme parks will be closed but healthcare irrespective always remain quite relative.*

So, I think for investors, they will always invest in some steady investments with lower returns but they are willing to do it and some high-risk investment with high returns. So, healthcare I think meets— for most investors, there is that middle ground where what they want is…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *When you said return* itu *what kind of return?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay, so, maybe YB if I can explain. So, it's not so much about annual dividends. It's not so much about the profit. But because healthcare is such a long-term industry with growth prospect. So, I think if you think about it for Malaysia itself and you talk about supply and demand, YB, you are very correct, right?*

So, in Malaysia we're aging society. If you are investors, you think that hospitals will become more relevant. The demand for hospitals will increase, as you rightly said, YB. So, the value of a healthcare—so, today I invested RM10 million but that value in five years maybe RM15 million not because the profit or dividend annually is a lot. But because this is an industry that continuous to grow. So, the value—so, I invest RM10 million in five years maybe it's RM15 million, I have RM5 million of capital appreciation.

I think that's the reason. It's not because they feel that hospital can make a lot.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That one for the big investors, big shareholder.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Correct. That's right.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Less small one* yang beli tiap-tiap hari, jual tiap-tiap hari, tak ada apa.

Encik Anwar Anis bin Anis Ahmad [APHM]: Itu pun *I think for them what they see is healthcare…*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]* Dividen.

Encik Anwar Anis bin Anis Ahmad [APHM]: *It's not for dividend. But because of the appreciation of the share price if you talk about public listed. It's not because how much dividend you get.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Unless one day you sell. You don't sell you don't see the money.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Correct. Absolutely right, YB. I think we want to explain that—I think some of the YBs just now,* semua datang kata tak buat duit. *The difference for hospital is we are not saying we are not profitable. We are profitable. Our evidence is there. You can look at public listed, non-public listed. We are after tax, nine to 12 percent profitable.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Very good.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *What we also want to say is we are very capital intensive. A lot of reinvestment has to happen. So, of course you can argue whether nine to 12 is it reasonable? But the reality is even for government and YB you are correct, in the last five years the number of new government hospitals has not been very dramatic. But the government budget for MOH has increase on an average rate of 12 percent per year.*

So, where has that 12 percent gone? It is because the cost to operate healthcare is indeed increasing at that rate of six to seven percent and if you increase your claims rate is that 12 percent. So, in fact the government budget reflects what we are also going through. So, that's number one.

So, the fact is despite the fact that the supply has not increased, the fact that the demand is increased is because of the claim rate. So, for us YB that profitability we are saying we are profitable but we need to reinvest a lot of it. If there is change, there's a problem. It could mean that if there's a dramatic change and we cannot even generate 10 to 12 so that we can reinvest at least, eight, nine, 10 percent, that means we stop investing. If you stop investing, we might go back to what Malaysia was 30 years ago.

30 years ago, my own father who unfortunately passed away from cancer. When he needed a PET scan, when I was maybe— this is 1995. There was no PET scan in Malaysia. He had to travel either to Philippines or Hong Kong, the closest for a PET scan.

Today we have PET scans. But if we stop reinvestments, in the next five years, it will again come back to mean that Malaysians may have to travel to other countries to receive advance care and treatment. Is that what we want? I'm sure that's not what all of us want, YB.

So, we hope that I think our presentation today is part of it is to make everybody understand that we are not saying we are not profitable. We are profitable but our profit margins are what we have stated here. Which we believe is fair given the reinvestment.

Number two YB, the point I want to make on profit is for hospital operators, this is all that we do. Our business is only hospital, by and large. Now, as you said insurance says they are not profitable for the healthcare's segment but as a company they are certainly profitable.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But they don't want to share profit of…*

Encik Anwar Anis bin Anis Ahmad [APHM]: *We cannot comment.*

Encik Chin Keat Chyuan [KPJ]: *Maybe allow me Anwar. So, I think before I start let me start the* pepatah. Tapi pepatah ini bukan pepatah Melayu, pepatah Inggeris. *First of all,* maklum balas adalah sarapan untuk juara.

So, thank you so much YB Sim for highlighting the complaint from a patient to talk about the RM40,000 bill only have RM7,000 and RM32,000. Immediately when I heard about that, I immediately text my team.

Now, my entire 29 hospitals everybody panic because I said, "If I find out which hospital has this, I would not accept it." Because as Datuk Radzi said, "Feel free to get the patient to complaint to CKAPS". Because silap yang buat itu kena bayar, kan? *We have to pay for the mistake.*

This is a big mistake. You cannot be giving a RM40,000 bill to a patient with a single page saying that this RM40,000, hospital RM32,000, doctor RM7,000. Ini memang *to my standard is not acceptable. So, thank you so much YB Sim.*

I think after offline maybe what I will do, I will reach out to you, please show me that and I will make sure we will pay for the price. That means we will apologise to the patient, we will make sure we print out and we allow the patient to make any complaint which he or she deemed right. So, I think that first.

Datuk Dr. Kuljit Singh [APHM]: Okey, mencelah. *I just* mencelah *a little bit. That doesn't mean that one example is across industry.*

Encik Chin Keat Chyuan [KPJ]: *Correct.*

Datuk Dr. Kuljit Singh [APHM]: *There's a very wrong kind of way sometimes go to the* rakyat *that all the hospitals are doing it, that's right. Sorry,* mencelah. *I learnt from the Parliamentarian. [Ketawa]*

Encik Chin Keat Chyuan [KPJ]: *I think that's first, right? Now, second, I like the question of YB asking about if insurance is not making money, hospital is not making money, who is making the money? Please, allow me to share this.*

I came from the industry where we have a lot of conversations but never once we talk about it.

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What happens to vendors where they are offering drugs and also medical consumables and medical devices? When we look at the right-hand side of med-tech and pharmaceutical, and let me tell you, I used to be a former company where they are the world's largest healthcare company in the world. We know how much we are making and not for any reason because we need to reinvest back for R&D. For example, any

devices— let's say a medical implant that we actually put it to the market, the R&D cost is a billion of US Dollar.

Let me give you one example of any drug, a blockbuster drug. We are talking about today, we have a lot of drugs which is actually cost us hundreds of thousands, it's not a million. How much is actually the investment behind? Usually for active ingredients that we need to discover, we will usually have a pool of more than thousands of potential candidates before they are being stream down, all the way until the final 10. We would have spent more than USD1 billion.

Before we can actually come out to the final stage, right, it would be another half of billion. So, any blockbuster drug needs to be out, we need to spend USD1 to USD1.5 billion. Today, you're talking about some of the diseases like [Tidak jelas] per patient, you are talking about at least RM1 to RM1.5 million. There is a potential cure to patients and that again it's a cost that you are talking about pharmaceutical and medical device company, they are trying to recover from their R&D.

Now we talk about generic, but a generic is only available after 12, 15 years, whether exclusive period is actually been over.

Seorang Ahli: Ya.

Encik Chin Keat Chyuan [KPJ]: *Today, you are looking at many drugs* kan, baru sahaja keluar dekat *market. We can't ask our doctor to say that use a generic. Because there's no generic available in the market. The drug is actually getting more and more advanced, better and much more targeted, right? Whether you talk about radiotherapy, talk about [Tidak jelas] and all this. They are very, very expensive. And if take times you know. Always talking about better drugs today, cheaper drugs tomorrow.*

You need to have the R&D in order for us to come out with that. This is actually where the price is actually being paid. Of course, not talking about our currency depreciated and all this adds up to the cost. So, that cost inflates the majority of it, a big part of it, since doctor fees cannot go up because of the Schedule 13. Hospital, we can't do much because we are also very much actually being scrutinised by payor, where payor today controls 70 percent of our total volume and that's the reason YB to your question, right.

Mengapa insurans boleh *bargain with us? Because they control 70 percent of the volume to outpatients. If you are not giving a discount, today they are asking for 40 percent discount. Even now as we speak, I just agreed to give a discount to the insurance company, they're asking me 25 percent discount and you know my profit, as I mentioned*

just now, my [Tidak jelas] only 7.7. How to give all these? After giving all this, you still expect to make a profit, you know, because every quota you still need to deliver is up.

This is where I want to make it very, very clear. I can't represent everyone. At least from the KPJ standpoint, we're trying to make a decent profit improvement through our internal process efficiency. Through procurement, which I think is one of the potential proposals for us is you need to exercise your economies of scale, right? KPJ I ada 29 hospital. *But, before that, what happened is that 29 hospitals they go and buy all this equipment and devices and drugs on their own. Crazy, I came from the industry, I used to love KPJ so much.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Small volume, volume. [Mencelah]*

Encik Chin Keat Chyuan [KPJ]: *Because I have different pricing for different hospitals. But now, when I'm in there, I don't allow. I saved millions within the past 18 months and that translates…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That saving Mr. Chin, it helps you to reduce the charges, maybe.*

Encik Chin Keat Chyuan [KPJ]: *Reduce and make it more compatible to my friendliest industry player in the market. So that my outpatient, my inpatient, increases. Patient is happier, my shareholders are also happier. But it doesn't mean I increase the price for my patients. It's because I recover back those leakages that I have and I am only speaking on behalf of KPJ here, right? So, I think that is actually where we are going through right? Yes, listed company, you need to show profit. But the profit doesn't mean you have to immediately pass on to the patient.*

Thank you, YB.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay. The other thing, short one.* Dalam *you* punya *profitability of private hospitals, under investment, you make public profit after tax 108. That means 10.8 percent and then reinvestment is 95, that means you minus that, you punya profit* tinggal *1.3 percent* kan. *Why did you put too much money for reinvestment? You can always take a loan from the bank. I am sure you have your reason.*

Encik Chin Keat Chyuan [KPJ]: Ya. *So, I think this actually something that I always— when I was in that industry, I never understand, right. But running a private hospital is almost crazy, especially when you have 29 hospitals. We have gone through the era where we had close about 43 years history. All the machines that we buy, all the*

lifts, all the buildings that we have, already into— now over 40 years. So, semua kena tukar. *I admire some hospitals where they are only five years old, 10 years old, right, most of their machine are the latest cutting edge and they have not faced that, you know.*

For me, my doctors pun kena tukar, *because my doctors, from the time when they joined me, until now, they are 80 years old, they are 76 years old. So, I am actually facing those phases, we allow my doctors, they are slowly scaling down, they are very, very good until today.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *How many percent of your specialists are employed by you?*

Encik Chin Keat Chyuan [KPJ]: *Oh, employed very, very little. Only MO is actually employed. All specialists are not employed, except maybe emergency physicians; they are being employed. All doctors they are on contract. They are on a contract basis.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Why is that so? Why? Why not on full pay like other employees?*

Encik Chin Keat Chyuan [KPJ]: *Because we can't afford to hire all, you know.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Ketawa]*

Encik Chin Keat Chyuan [KPJ]: *They are too expensive, YB.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But— and the doctor they don't mind? The specialist, they don't mind?*

Encik Chin Keat Chyuan [KPJ]: *No, for sure. They are on their own. They only renting the facilities from us.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, they can go to any other hospital as well* lah?

Encik Chin Keat Chyuan [KPJ]: *They can do a visiting, especially on certain specialities where it is very far and fuel, they will be visiting others to provide the service.*

Datuk Dr. Kuljit Singh [APHM]: *I just again*, mencelah. *It is better for the doctors to be on contract so that they have nothing to do with the hospital.* Kalau dia *salaried, then there will be KPI on them. So, it's best to leave the specialist independent with the hospital.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This is my last question*-lah. *I think my last question. Just another one. Are you KPJ in particular, are you leveraging on the using AI data analytics to cut costs?*

Encik Chin Keat Chyuan [KPJ]: *We are heading towards that. AI innovations data-driven organisation, that is actually where we believe you invest and it's a huge investment. Let me just quote one example of what Encik Anwar has actually talked about. The EMR System Guard, Electronic Medical Record. That investment for us is a few hundred million. Only for my hospital size of close to 4,000 beds, it will require a few hundred million for me.*

I want to invest. Because why? It enhances efficiency and at the same time also my patient experience. But it will certainly it take cost but in the long run, it will help me to save. So that— ya. It will be a saving in the long run. But as of now, it is a CAPEX investment.

Puan Erica Lam [APHM]: YB, *this is Erica again. Allow me to explain. Any investment into technology, whether it's AI, a high-end IT system or cybersecurity. It does not mean that we can have— we have hired lesser people, but actually our duty is to upskill them to do something more value added instead of a manual job. So, indirectly, it is to make a system more efficient, deliver better care but does not mean you hire lesser people.*

So just want to give this kind of perspective. In fact, the IT cost is going up tremendously, even way beyond what we could imagine at this age. Like what Chin said, KPJ spent a few hundred million, I do not think I can check spend less than a few hundred billion, so even close to a billion, just to equip the system itself to make it safer for us to operate and even safe for the patient. Thanks.

Datuk Dr. Kuljit Singh [APHM]: *Chairman, I just have one more slide. We want to show you what solutions we have. We are not here just to be defensive, just to show us— show you all what our data is. We also want to proactively show you all what other solutions that we are working on. So, doctor—* doktor pula, *he is going to be a doctor soon. Anwar will present, very short, what is our solution that we are working on.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Thank you* Datuk. *So, I think we did mention the five steps…*

Tuan Sim Tze Tzin [Ahli PAC]: *But before that, because I have a related question. So maybe, let me interject first.* Mencelah dulu, *then* barulah Dr. Anwar, *future* Dr. Anwar *respond. Okey. I think one of the issues is that a lot of people talk about, especially also raised in the Edge by* Tan Sri Tong, *about the valuation of the hospital. We know that from the presentation, you're to build a new hospital, your new— your bed is about 1.5 per bed – RM1.5 million per bed*.

But once you start buying, buying an existing hospital, it goes up to RM5 million per bed.

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Recently and I want to get Dr. Kamal Amzan punya respons*, you bought Penang Island Hospital at the average RM8.5 million per bed. This valuation is astronomical. They actually put pressure to you to get more profits because you need to pay those kinds of investments. That's where a lot of the public is not happy because of that kind of exuberance of going, getting market share, buying new hospitals. And that kind of investment actually put pressure to yourself these unintended consequences to actually to raise your profits to pay for those. Maybe can you respond to us, Dr. Kamal? Why do you buy Island Hospital at that kind of valuation?*

Dr. Kamal Amzan [APHM]: *Thank you, YB Sim. I think before we buy a hospital perhaps let me qualify what I am about to say by saying that that purchase did not need an increase in price to the patients in Island Hospital. The prices remain. That valuation has taken a lot of factors into consideration. You are right including market share, strategic investments and for strategic reasons for the acquisition. That valuation is a commercial decision taking into consideration. The returns it will bring over the next decade also. It is not done in a way that we are looking for a short-term gain. This is mini long-term and on strategic grounds.*

The purchase price I think in a capitalist market Malaysia has, the price on Island Hospital isn't based on the RM1.5 million bed. We also take into consideration the value it has to the state's economy. Island Hospital is known for medical tourists. There are many other reasons why we would like to acquire to learn from one of the best hospitals in terms of medical tourism in the country. It could start off with RM1.5 million but over decades, over years that RM1.5 million shouldn't be so. I am sure you will agree that it will increase in value given the multiple investments the hospital has made. It has a new block now. It has a cancer centre, a heart centre and a multitude of facilities and specialities that did not exist during its inception. Whilst we may start off with RM1.5 million but as the hospital grows over decades with additional facilities and services it cannot remain at RM1.5 million per bed.

Tuan Sim Tze Tzin [Ahli PAC]: *That's the problem because you have a capital investment. You have CapEx that you need to recover. That's why when I look at your slide three, your utilities, rent and maintenance I think that will be going there that you or finance cost will go up. That put pressure to the hospitals to charge more to the patients.*

I am a Penangite also. I feel that I am being short-changed because of your I don't know whether it's a wise investment or not. You put RM4.6 million there, you want to recoup it. I will try to avoid Island Hospital next time. Although I love that hospital, right. My friends are working there.

Dr. Kamal Amzan [APHM]: *YB Sim. With due respect, I am also a Penangite. [Bercakap dalam bahasa Cina]* dengan izin*. So, when we bought the hospital, we worked the hospital, we also looked at the income it could generate for the group. Obviously, we will not buy something that we cannot afford to keep or we cannot get returns from it, YB.*

The price tag would have taken into account. The amount that the hospital could generate in terms of returns for the group. If you go to Island Hospital today, you will realise that there's no price increase and we have maintained the price point that Island Hospital has since prior to the purchase. When we bought a hospital, yes there is a price tag to it but whether we can afford it or not and the returns of investment would depend on how healthy their PNL is year on year. It doesn't mean that when we buy, we increase the prices to remain profitable. No. We would not be acquiring the hospital if it's not profitable and would not return us the return of investments that we would like.

Encik Anwar Anis bin Anis Ahmad [APHM]: *YB, if you allow me.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Before we continue, I think we will finish by 1.30. alright.*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Datuk Wira Pengerusi. Sikit sahaja. Untuk tambahan data kami punya analisa ya. Mungkin kalau ada jumlah *nurse* yang ada *Post Basic Intensive Care* ini berapa orang yang *permanent staff* dan berapa yang *locum*? Kalau ada. Kalau tak adapun mungkin selepas ini dapat diberi kepada sekretariat.

Tadi juga tanya ini yang melibatkan kita punya kita punya *presentation* ini. Dari segi gaji. Gaji *nurse* ini mungkin ada dia punya *rate* dia yang ada *Post Basic Intensive* ini dengan yang biasa. Ketiga, 68eraj dalam prosedurnya itu apabila ada pesakit yang tak dapat insurans tak boleh *cover* dia punya rawatan, kos rawatan, bagaimana proses yang dibuat oleh hospital ini sama ada ada *negotiation* untuk dia mungkin boleh bayar berapa *percent* dulu sebagainya ataupun terus dia perlu di-*refer* ke hospital kerajaan. Jadi, bagaimana prosedur itu dilihat?

Encik Anwar Anis bin Anis Ahmad [APHM]: Okey terima kasih YB untuk soalan. Jadi, *post basic nursing* di ICU ini YB. Sebenarnya 68alua ikut akta *to the letter*

of the akta *itself actually all.* Kalau hospital baru *all nurses in the ICU, must be post basic trained*. Tetapi KKM sendiri faham bahawa di Malaysia tidak ada *nurses* dengan *post basic* yang mencukupi. *The number is very small. Most post basic courses are actually done in KKM and KKM itself cannot help the country produce enough*.

Officially from CKAPS, there are guidelines. Maksudnya *it is one-to-one nursing but in ICU for example, what they allow minimum is either 50 percent of the staff must have post basic. If there are certain hospitals who face challenges, KKM may allow after looking at the data the experience of the nurses they may say that okay minimum you must have is one post basic staff per shift. On the question of post basic CKAPS and KKM understand that we have a big challenge in the whole country including for KKM to produce enough post basic staff whether in private or public hospitals.*

Although there is a requirement in the act, they do say, "Okay, minimum 50 percent must be post basic trained in the ICU". Which means if there are 10 nurses in the ICU, at least five must have post basic. That's number one, YB. YB asked about the salary. For most hospitals for staffs who got post basic is an additional allowance. A few reasons. We also want to encourage the staff to go for post basic. Hospitals are always willing to sponsor staff. But sometimes staff you know because to go for post basic is minimum six months to 12 months depending on what post basic it is. Then the staff has to go.

You have to understand YB for a staff to then leave the hospital and go, when they still have their basics salary. But when they are no longer in the hospital, they don't get their overtime, they don't get certain shift allowance, night allowance. So sometimes staff pun dia tak nak*. They don't want to leave their job for six months to go and do post basic. Because of that, we put it as an additional allowance to encourage them so that they know when they come back the post basic allowance can be RM800, RM1,000 on top of their basic salaries. So, maybe before the ICU staff the salary was RM6,000 after getting the post basic and coming back they get an additional allowance of RM800, RM1,000 depending on the hospital. It is not standard. All that like I've said we've not calculated inside here. We try to keep it as simple as possible.*

Your third question, YB, on patients who are under insurance and then other the coverage is so katakan bil itu RM50,000 tapi dia punya *limit* RM30,000*.* RM20,000 itu insurans dah tak *cover. Actually, hospitals always try to do what they can in a sense that— that's why we talked about financial counselling. The hospital will say okay have you got EPF that you'd like to withdraw and we can help you. That's one. Do you have—*

some patients will may have credit cards. Hospitals actually absorb the cost to provide instalments free. Interest-free instalment. But that is through banks and through credit cards. If patients also don't have that— if patient really is and hospital asks for documentation. Okay. Please provide us your salary slip and this and that, memang *patient* ini nampak okey memang ada masalah. Sukar nak membayar*. Most hospitals will also allow payment by instalment. So, that the patient can settle the bill overdue cost of time.*

There are now also new products in the market where patients can get financing for health of care. Again, with the enough documents and all that, there are parties out there who will then provide them some financing to settle their healthcare bills.

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What I'm trying to say is hospitals will try by enlarge to see how can we help the patients to settle the bill that is not under the insurance. So, we do try. But of course, I think one of the slides what we say is we have not included the write-offs. Actually, every year hospitals will write-off hundreds of thousands ringgit unpaid bills. Of course, we will try and recover but we will also have to write-off.

Dr. Hajah Halimah Ali [Ahli PAC]: *Encik Anwar, can I interject there. So, how many percent of your* itu kalau *if everything goes well, I mean the best scenario* lah kan itu*. Tapi* kalau ada keadaan di mana *you will private hospitals do send patients which are not covered to the government hospitals. So, how many percent of that kind of issues do you have?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think percentage wise YB, is actually not very big, right. Because one is even to transfer, the patient has to be stabilized. So, it does happen, you're very right especially if you know it's an unexpected cause, there are clinical complications. So, like I've said early on some financial counselling is done.*

But now doing the procedure, the patient develops some complication and so on and so forth and the bill is now unexpected. Yes, for those patients we will also discuss with the patients what are your options. The doctor will always discuss, the hospital will discuss what are the options for the patients. The patients feel that they cannot anymore sustain be in a private hospital and they want to be transferred to a government hospital, the private hospital will do so. Our responsibility is to transfer and to make sure the patient is stable before a transfer happened because any accepting hospital will also want the patient to be stable. They do not want to take in a patient and then the patient

has further complication or you know has a— you know we hope doesn't happened but mortality and so and so. It…

Dr. Hajah Halimah Ali [Ahli PAC]: *About five percent something like that, no?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *No, much smaller than that.*

Puan Erica Lam [APHM]: *YB, much smaller, much smaller. If you are talking about patients already admitted to the hospital and due to the financial constraint, they cannot continue, actually numbers pretty small. It's less than five percent definitely. But those who came for outpatient consultation then after that understood that, "Oh, the financial planning is a bit too taxing", they probably already go to a government hospital. Will not get admitted also.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So YB, like I said— sorry, any other question?*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Thank you, Datuk YB Chairman. A few question. Number one is the you mentioned about the decrease in the number of nurses and if I'm not mistaken you mentioned about doctors as well. No?*

Seorang Ahli: *They also trying to take Malaysian doctors as well already. [Berucap tanpa menggunakan pembesar suara]*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Okay. Thank you. I think on the nurses. I mean it's very clear it has been mentioned many times the concern from MOH. But, the doctors two years ago, I think 2022 there was a statement by MMA they said there was about 22,000 surpluses of doctors right. Then recently the Minister mentioned about the worrying trend that there will be less houseman in the field and also there is less intake of medical doctors. So, there will be a downward trend of you know medical graduates in the coming years.*

Now, I don't know whether that is the effect of wrong perception. There was a surplus of doctors that make the less interest in a student pursuing the medical course or what I don't know that's the— but if there is a less interest of students going to that maybe you could share some thought of it why that happened. Number one. Notwithstanding that you know doctors and especially specialists make handsome income in general compare to other profession.

Number two is on the threshold for referral to public hospital. There are cases where patients who are undergoing some maybe treatment or operation and then they were referred to a public hospital. But you mentioned just now there are consideration for I would say compassionate treatment, negotiation, things like that. So, in the case of

referral to public hospital, what are the major concern, is there a threshold or something like that?

Number three, you did not mention anywhere— I don't know whether it's coming about the national health scheme that would probably help the ecosystem— coming.

Datuk Dr. Kuljit Singh [APHM]: *Okay.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Then I wait first. The other one, the last one I think it is very important thing, we miss the medical inflation as a whole in your presentation. I mean you did mention about segment I mean the fraction of the cost to your overall cost, right. But where in those segment that contribute to a higher inflation of the overall medical cost?*

The drugs for example I mean the PhAMA has been said they don't have high inflation you know. They are the among the lower part of the inflation in this value chain of the medical industry. So, can you comment on that?

Datuk Dr. Kuljit Singh [APHM]: *Maybe I'll answer the doctor part.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Yeah.*

Datuk Dr. Kuljit Singh [APHM]: *Yeah, I mean there are a lot of doctors that as qualified in Malaysia because we got close to 42 medical schools in Malaysia for 32 million population which is huge. But having said that whether there is a decrease in the interest to take medicine, to some extend that might be because of the younger people don't look at medicine as a field that it is attractive enough because today they have got so many other fields which are probably less stressful, early way of making better money than becoming a doctor. My own family like both me and my wife are doctors and my whole uncle, aunties all are doctors but my children did not take medicine for the same reason they don't see quality of life being a doctor. The quality of life is better in other disciplines.*

So, there might be a bit of decrease with the younger group. And same goes with nursing because nursing you know there are a lot other things they can do you know. Why should they want to take up nursing as a job. We always tell them the medicine; nursing is actually a very stable job. Even during the pandemic no healthcare worker was retrenched by private hospitals. Every other industry there were retrenchment, they were asked to go. In the private hospitals we kept them even though the private hospitals did not have patients at that point of time but we utilised them to help the government in many areas which is always not taken account that how much private hospitals assisted

during the pandemic. They only focused on the negative part and then we go on different area.

So, that is why as human resource is concerned. I can't go more in detail because I don't have the exact data how many medical doctors are there in the country waiting to be registered because they are all medical officers. They may not be specialist. So, that's on the doctor's part. And then the rest.

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, YB maybe just to add I think for Datuk Kuljit answer for the doctors. For nurses what we seen YB is there always this I don't know whether it's 10 years but there is a cycle, there is a cycle. So maybe about 10 years ago, 12 years ago there was this cycle where we have too many nurses and the reason was many private colleges the entry requirements were lowered and we have excess of nurses. In fact, the government have the scheme that we have to take nurses.*

Although because the entry requirement was lowered the quality of nurses was a big concern for us. Again, we supported the governments' call, we hired those nurses whom many— even for six months were not allowed to touch patients. They were to observe, they were to be trained. I think in the government scheme it was minimum we keep them for a year. If we feel after one year, they still not suitable carrying on with nursing, then we were allowed to let them go. But that was when it was too many.

Then the entry requirements were tighten again because there was a huge concerned doctors were very concerned the quality of nursing was poor. The entry requirement from three credits was brought back up to five credits for example. The number of colleges then shrank. So now we come to a situation where we don't have enough nurses, right.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Should it be three credits now again?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So now it's three again YB. Okay. [Ketawa] Although as hospitals we actually have concerns. So, maybe but this time we believe that KKM and the nursing board has taken some input into consideration.*

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Previously, when it was five brought down to three, was just three credits, of course compulsory BM. This time, it's three credits but it's compulsory to have math and science. To pass math and science in part of the three. So hopefully, we don't have the same situation where the nurses' quality drop again but I think these are— unfortunately that's how it has been. It's almost like a 10 years cycle. Too many, too little, too many.

To address this YB, if I can share very quickly is again there are efforts with MPC, with KKM, funded by the World Bank, we've done 15-year study to look at supply and demand of nurses and specialist to include for the first time. All these while KKM had their own study or private did their own but this time include the KKM, non-KKM hospitals as in universities, Ministry of Defense and private hospitals.

We hope that this study will form the right policies moving forward because we can then predict for the next 15, 20 years, how many nurses, how many doctors that we need and then, we put in the right incentives and tools to do so. So, I just want to just add to that answer.

Number two, in terms of your question on threshold of transfer to public hospitals. What I want to also share is, actually we probably take in a lot more from government, as in transfer from public hospital to private, is a lot higher than the other way around. I would probably say it's a ratio of 5:1. So, these are patients who go to government hospitals but because they have insurance or they feel that they can afford treatment and they don't want to wait, they actually get transferred even especially for trauma and others get transferred to private.

The other way around YB, really most of the time is because of financial but I think our responsibility as I mentioned, our doctors' responsibility is when anytime a transfer happens is they have to be stable. So, even if the patient already said I cannot afford, our duty is to stabilise the patient and make sure that during the transfer, the patient isn't put any additional risk and the patient can continue their treatment in the government facility.

National healthcare like I say, we'll come to that YB, but on your question about inflation. So, maybe I go back to slide number 15 here. [Merujuk pada pembentangan slaid] This are the four top drivers that we said for inflation. And again, I want to clarify, when we say Pharma it's not because the same item price increases a lot because there are a lot of innovator drugs, a lot a new drug coming in, a lot are new studies and so on that show that these are better drugs, less side effect and so on so forth. But this certainly are the driver in term of increase the cost to the patient.

Secondly, like we said is also increase in import and value for medical consumables and drugs as well because of I think in the last few years, you know whether it's the exchange rate and so on so forth, all had an impact where it drove up one of four main pillars of increase.

Then we said it was medical staff and we've elaborate why we need to retain staff and we have been increasing salaries and not just of nurses, we also have to increase salary of others. And we made indirect impact and we support it.

No, please don't get me wrong, we support increase in minimum wage. Where you may be thinking, "You mean hospital ada bayar staff nurse and staf lain yang gaji kurang RM1,700?" No, it's not for medical staff. But we still have to employ a lot of security guards. We still have to employ housekeeping and all this.

Most of the time, these are from outsource and they are foreign workers. But every time there is an increase in minimum wage, all that costs need to be pass through to us as well. So, but like I said we do support it. We support the increase in minimum wage but it also adds a lot of pressure in terms of our operating cost and finally, we said it was regulatory delays.

But if I can again take you to slide 16 very quickly. If you talk about what were those components. I didn't spend too much time going through one by one, but in this slide, it really shows you what is the increase in various component.

You can see from our study it's not everything, like for example diagnostic and lab. Actually the contribution of increase was very small, right? But if you look at facility charges. Actually, the contributions to the increase is big. Although it's a small component of the— it's five percent but the increase was 20 percent for facility charges, why?

Actually, the increase in utilities has been quite dramatic for us. For hospitals that used to pay maybe RM500,000 to RM600,000 per month for utilities. I would say in the last five years it has gone to almost RM1 million. There is no separate tariff for hospitals.

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara] Per month?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Per month yes, RM1 million per month, sorry. So, the facility charges what has increased is the increase in minimum wages because your security, your housekeeping, your everything else, your utilities, all this.*

So, if you look at the increase, it is very different for different components. But these are the main components in this slide that has contributed to the increase. But I just want to emphasise again, if we pass through all this increase, it would have been a 15 percent per annum inflation, if we pass through. But through the efforts like Chin mentioned in terms of negotiating.

So even for the security guard for example, we used to have 20 security guards, then we look at some of the systems, how do we reduce from 20 to maybe 17 or 18. Try

and reduce it by allowing some system, putting in CCTVs, doing other investments so that I can try and reduce the headcount cost.

If it's electricity, a lot of us have gone into various modes of changing all of bulbs into LEDs. Looking at changing our chillers to oil-free chillers and magnetic chillers. So, these are the efforts that we've done, so that we don't pass that cost on.

But again, if you change from oil-based chiller to magnetic oil-free chiller, it's a few million ringgit still, right? But those are the reinvestments that we are doing so that we don't pass on operating cost.

So, I'm mindful of time, YB…

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *I got three questions but the answers are very short answer. First question is about this APHM, can you just— I would like to put it on record in Hansard, how many members that you have and who are your members? One.*

Second question is I did one question just know but it's not answered yet. What is the requirement for nurses in other wards besides the ICU?

The thirds question is, okay this is a little bit of what has gone through my personal experience when my wife goes to a private hospital and it was mentioned to her, to us that, okay you got to stay overnight for you to claim. Is that a normal scenario with regards to going to admitted to the private hospital? Thank you.

Datuk Dr. Kuljit Singh [APHM]: *Yes, I'll answer the first administrative answer. APHM has got 165 members and you can only be a member of APHM if you have a hospital license. That means I cannot become a member of APHM. I am here because I am delegate of my hospital.*

So, the hospital becomes a member. 165, number one. Number two, we are the only association representing hospitals in the country. Total registration with the government maybe about 200 plus, we are not sure about that figure with the government. But we cover all the known big hospital and reputable ones are all with us.

But I cannot tell you the other balance, we don't have the data of the registered hospitals with KKM, that we don't have the data.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: Okey, soalan susulan. *The 165 for example KPJ is conceded 39 inside here or…*

Datuk Dr. Kuljit Singh [APHM]: *Not yet 39 yet, about 30.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *30. So…*

Datuk Dr. Kuljit Singh [APHM]: *30,* kan?

Encik Chin Keat Chyuan [KPJ]: *[Bercakap tanpa menggunakan pembesar suara] By middle of this month is 30.*

Datuk Dr. Kuljit Singh [APHM]: *30*

Encik Chin Keat Chyuan [KPJ]: *Now it's 29.*

Datuk Dr. Kuljit Singh [APHM]: *30*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *That means 165, 30 of the 165 are KPJ?*

Datuk Dr. Kuljit Singh [APHM]: *Yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *All right, okay thank you. Second and third question please.*

Datuk Dr. Kuljit Singh [APHM]: *The second and third question.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay, maybe just to add to Datuk Kuljit. According to the KKM data for 2022, Health Facts 2023, number of private hospitals is 207. That's Health Fact 2023.*

For ward nurses I think Mrs. Erica did tried to answer that. Ward nurses, KKM requirement is a bit different. The require 55 percent PCA, right? Which is patient care assistant and 45 percent are nurses, right? Which is to the question earlier just now, I mean why we have a lot of other assistants, right? So, in the ward, what MOH requires is for every bed is 45 percent is nurses, 55 percent is patient care assistant. Anything you want add Erica?

Puan Erica Lam [APHM]: *No. January, the ratio— the ratio for January ward, we are talking about according to CKAPS they expect, every one— every six patients you have one nurse, registered nurse. But in private setting, because of the demand, because of dedicated care requires by patient and majority are private rooms, single room. So, the ratio has come down to every four patients is attended by one nurse.*

Datuk Dr. Kuljit Singh [APHM]: *We missed your third question. We answered two of three. Which is your third question?*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *My third question is my own experience.*

Datuk Dr. Kuljit Singh [APHM]: *That one.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Yes. Regarding that…*

Datuk Dr. Kuljit Singh [APHM]: *Is it a prerequisite that you must— short answer is no. That's not a prerequisite. I mean when you said that whether you must admit only then you can claim? Short answer is no.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think that's a correct short answer. It's more complicated than that right, YB. In a sense that if you buy insurance product, it's for admission. If you are under let's say a company benefit it covers inpatient and outpatient, right?*

So, it really depends on what coverage you have. Is it a coverage under a company which allows you for outpatient treatment including specialists or is it you own personal health insurance which is for admission. But of course, insurance also encourage— to be fair to them, encourage daycare procedure.

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Because they realised that for daycare, the cost is to be lower. So, the insurance does encourage for daycare procedures. So, it is not true that you must be admitted to claim but it has to be either daycare or admission because the insurance product that you buy is for hospitalisation… [Dicelah] It's not for an outpatient.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So that means the company insurance policy that you have taken, that you got to be admission?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Ya. So, that depends on— self insurance product it was for hospitalisation.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Thank you.*

Datuk Dr. Kuljit Singh [APHM]: *Do you have time to present that one slide? We do it very quickly.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I will try. Okay. So really, YB's and members of the PAC, you know, we wanted to outline the potential timeline and pathway to propose the initiative. We shared with you the five initiatives in a three-long-term initiative. But we felt it maybe helpful for all of us if we outline what we can do in the short term and what we can do in the medium term and some of the steps that I need, so that we can also, you know, mind frame the timelines.*

So, if you look at the short term, I mean we said that we— APHM will be talking to MoF, Bank Negara, MOH to look at some sort of initiative that we can announce hopefully soon or we meet, I think another week's time with MoF. But also, drug price … we've committed to it, we have always told Bank Negara that we are agreeable to have— to be on the joint taskforce to study and design the tiered value-driven insurance product we talk about, where whether generic first, appropriate use of implant and so on. We are committed to that and we hope that is something that will start. We cannot initiate but we hope Bank Negara will initiate this by the third quarter of this year.

We also would like to suggest that there is a study on reducing regulatory on operating costs, we gave you the example just now. The amount of just on manpower cost alone before we start operating and after we start operating. We hope that the study can be done in Q4 for with MOH so that we can look at how we can reduce this cost, right.

All this is in addition to the premium caps that insurance is doing and also just like Mr. Chin mentioned, that additional discount that we are already been asked to provide, right, in addition to what was before, around 10 percent on average. That we think is something that we can do in 2025. In 2026, we hope that we can launch the new insurance products, hopefully early next year, once we sort out everything with KKM, we hope we can move towards drug price display for inpatients. If we can sort out a lot of issues that we mentioned and then in Q2, we hope that we also can table the result of the study that we undertake…

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry, you say VDP. What is that?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, if you look at 2025, that's why we're saying the value-driven high tune product YB Sim. So, if I go back to 2026, we hope to be able to table the findings on regulatory and operating cost containment and hopefully that will result in some changes and regulations. And then in towards later part of the year, then we should start the taskforce and reducing the medicolegal burden. To YB Mas has a point. Medicolegal cost is something that increasing dramatically, insurance for doctors, insurance for hospital is increasing because of the payout and all access of RM10 million.*

It is not just by private hospital, this will benefit even KKM. The amount of money spent by KKM to settle medicolegal is also increasing very dramatically. So, we would like to participate and have a taskforce to do that. Then in 2027, we can take on those recommendations for medicolegal changes and whether it goes to the AG or whoever it is that we need to, so that those recommendations can be taken. So that for medium and short term, very quickly, then on the long-term initiative.

What we can start doing this year is obviously to have a formal work group to explore the alternative payment model, whether there is DRG or anything else. So, we should start that as soon as we can. Somewhere in the second quarter as well, we should set the parameters. YB Sim, you rightly said we should submit those data to MOH but we need to decide what data, how do we submit it, who receives it, MOH. So those data perimeter settings should happen soon.

In Q3, we hope that we have can have an alignment of timelines to National Healthcare Scheme, right to YB Haji Azli has just questioned just now. We need to have alignment between what we do in terms of reimbursement model as well as the National Healthcare Scheme because this needs to work hand and hand and so we need to start the discussion soon. And then later part of this year as well, we should start a training and roadshow on the data submission to MOH so that our hospitals are prepared and then rolled out the data template.

Then we move to 2026, we should have a report after we do the work group, we should have a report on what is direction we are taking. Is it DRG? Is it something else? Because we need to decide what it is, then we can start looking at the data. The data should start been submitted by early next year and once we know which direction we going in, we need to start training people. DRG needs to happen with codes. People in the hospitals, we need staff who understand how to code the DRGs and without that manpower, without training them, it will take six months maybe to train them. We need to start a program to start training codes, especially the DRG.

We need to then have a joint system for evaluation of all this as well, right? In Q3 launch the pilot payment model, maybe someone in 2026. Launch it with maybe selected hospitals that are willing to participate. We need the pilot because in contingency, what are the pitfalls, what are the issues? So, we should start that by late 2026. We should also, in 2026, look at a primary care pathway. We spoke just now that the primary care network in Malaysia is not playing you know the critical role it could play. And because of that, they are also under pressure. They feel they are on the sidelines. Patients are going directly to the hospital and so on. So, the primary care pathway needs to re-explored by somewhere in the next year or towards the end of next year.

Then in 2027, we should analyse the data that we have. We need to expand the data because initially, the pilot data maybe for maybe like 20 different procedures or something. We need to expand the data. We need to review the pilot program, then we need to have a national recommendation on the payment model to adopt, we need to align it again to the National Healthcare Scheme and its activation. Towards the end of the year, activate the use of the primary caps network into the pathway because if we going towards National Healthcare, primary care is actually steps in.

Only then perhaps after three years, then we can assume that if we can keep to all this quarter one, quarter two, quarter three, quarter four, we can do all this works group in meetings assuming we can keep to that aggressive timeline, we can launch a

new payment model aligning to the National Healthcare Scheme with the face rollout as part of transformation and the next stage of Malaysian Healthcare.

Datuk Dr. Kuljit Singh [APHM]: *So, this is what we are already working on. Let's say we are proactive in this, despite of all the challenges we have but we as a group, we are quite serious about this and we think that this is important. So, just to conclude quickly that private hospital makes an integral part of the healthcare system, 30 to 40 percent. We showed, as I mentioned to you during the pandemic they will be significantly working with the government. The government acknowledge that you know the private hospitals a lot of what was done during the pandemic wouldn't have been solved.*

So, I think it is important that we have to have this work together the assumption, presumption that you have it out there sometimes needs to be narrated in a correct manner and not just on small examples. We sometimes tarnish our we are working, which is not the adject picture. So, I hope this discussion today has been fruitful. There is a lot that we are doing together so that we become more resilient and we become partners. You can imagine if there are no private hospitals at all in Malaysia, or you remove all the private hospitals and let the government take over healthcare 100 percent. Nationalise every private hospital, can government do that or not?

While they believe be the same way we are today. So, I'm just not asking a question to get an answer but just imagine if that is the situation. I'm just— my concluding points together with what we are working towards, a proposed initiative and we working closely with the Ministry of Health, the Ministry of Finance with Bank Negara, all the related parties including the insurer.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *One more question from Bayan Baru, still have a question.*

Tuan Sim Tze Tzin [Ahli PAC]: *Quite a few questions, okay. I think to give justice to these complex issues, we should— you know, to have this kind of you know, because this is a platform for you to bring your answers. You know we are not like trying to— if you don't give us the testimony, then there's going to be a problem because your voices are not heard when we are doing our report. I think more of us here want to have a long-term solution to this and I think you all Malaysians, we are Malaysians, we are all into this, you can make a profit but I think it's not excessive profiteering.*

That's what the majority of the consensus of the lawmakers as well as the government. I think when I look at your profit and loss, you know, your profit PAT and the profit before tax. I forgot, is IHH or KPJ, your profit before tax was about 30 to 40 percent.

Okay, one of the reports, I'm not too sure. Okay and then can you first, you please explain to me how your profit before tax is 30 percent and then profit after tax becomes 10 percent? I think maybe gross profit lah*, gross profit* ya*, okay.*

The second thing is that we compare your full-fledged hospital. Some other smaller hospitals, okay. So, for example, a nonprofit one like Lam Wah Ee is quite a big one. They manage to contain their price; they contain their what do we call the cost, Tung Shin Hospital, okay.

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We ask them to come and present themselves. They managed to what do you call maintain— not profit but breakeven. Some of the smaller hospitals such as this Chinese Maternity Hospital (CMH) in Seremban. They make a profit, decent profit and they still provide very good healthcare.

So, I'm looking at you know, is our hospitals like some of other hospitals are too luxurious, okay, because you invested the top-notch. I'm not saying that we don't need that. Just one percent or two percent of the top-paying patients need that but if you build that kind of hospital and all the costs would be unaffordable for the majority.

So, is the APHM or your KPJ, IHH. Are you thinking of doing a smaller community-based hospital? Maybe not the kind of JCI standard. Maybe what do you call a lower standard. Meaning, three-star. We are talking about; you don't have a six-star hospital. You get a three-star hospital to provide for basic care. I think that is where Malaysians need and we are not like one thing that luxury kind of thing.

So, my third question is because we look at everyone will come in. Everyone will call in. They blame other people. Insurance blames the hospital. Pharmaceutical blames other things. Say that, Ringgit. The doctor blames insurance. Hospital now blames insurance. How are you going to do yourselves? You cannot be blaming other people only, right?

You know, when we say you tunjuk *someone, the four fingers point to you. So, what we are talking about? Of course, we, as a government were try to have a laissez-faire, so that you grow. We understand the market economy. We understand demand and supply. But when there's a problem with what do you call excessive and escalating out-of-control price. Then, the government must come to regulate.*

But, for me I'm a pro-market, although I'm in Parliament I speak against, I said it should be delisted. But I'm a pro-market guy. I'm asking whether APHM as an industry can self-regulate or not? What are the things that you do for yourselves to reduce the

cost? What are you going to contribute to reduce the cost? Can you do, can you propose something to self-regulate rather than the government comes in to regulate? Thank you.

Datuk Dr. Kuljit Singh [APHM]: *So, thank you YB.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Datuk Pengerusi *can I just add one final question to Bayan Baru? As mentioned earlier proceedings also we involved non-profit hospitals, like their Board of Directors not being paid any cent. Even where they procured material overseas also they used their own personal money.*

I'm looking at your slide number three. Out of your 1,000 points of your revenue, 1,040 is your PBT. I just seek further clarification out of that how many point goes to the board members? Thank you.

Encik Stanley Lam Kean Fatt [APHM]: *Maybe in terms of profit I'll try to explain.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Maybe just the last question because it just a quick answer, actually we are transparent. In the slide, slide 14, you can see directors' remuneration is only one percent. That's not to us. That's director. We are very transparent. It is there. Slide number four, director remuneration is one unit out of the 1,000. That means 0.1 percent.*

Encik Stanley Lam Kean Fatt [APHM]: *So, I'll just to try explain in the account presentation. There are many types of profit that we are referring to. We have gross profit. We have operating profit. We have profit before tax. Then, we have profit after tax.*

Right, I just try to answer that. I mean how do derive your gross profit? Your revenue minus the cost of sales. Then you have gross profit. How do you derive operating profit? After you minus your overhead cost, you arrive operating profit. How do you derive to profit before tax? It involves depreciation, amortization, forex, impairment of assets before you arrive to profit before tax. Profit after tax is after you pay the tax and the tax also no so straightforward, sometimes it involves before tax.

So, what I'm trying to explain here is that, when we look at certain accounts right, sometimes look the profit before tax is very high, doesn't mean that the hospital is operating in a very high profitability level. Sometimes involve all these assets restructuring. Sometimes involve buying and selling business. Sometimes involve foreign exchange. Sometimes involve it involves other causes which is part and partial in order to you to derive profit before tax.

So, it is not tax straightforward. So, our advice if let's say if you want to look at the profitability of the hospitals is better to focus on operating itself in order to understand whether the hospital makes a lot of margins out of the operation or not, okay.

Puan Erica Lam [APHM]: *Maybe just add on this, Erica. When you say gross profit margin when Stanley mentioned about it is the revenue minus your direct cost. It is exactly the line of 1,000 minus 318. That is what you saw the 30 percent or 40 percent profit but that profit is only gross profit. You have to minus all the costs incurred to run the business. That's where you add it up with the second line that we call operating profit which is 130.*

After that, you pay all the taxes and whatsoever. Then you finally derive the profit after tax, thank you.

Encik Chin Keat Chyuan [KPJ]: *So, YB, just a quick one. I so happened also know the Tung Shin Board of Directors. So, we're all in industry, we talk to each other. I hope we can also get that kind of treatment where Tung Shin Hospital upon the passed away of Tan Sri Teh Hong Piow, they've gotten RM145 million in donations.*

Listed company don't get donations you know. So, that is big, from RM145 million allowed them to buy a lot of equipment and really provide subsidised kind of treatment to the patients. And for us we have to borrow money up to our nose level for us to actually keep up.

So, I think that is actually a huge difference from non-profit or missionary hospitals versus where we are actually— we are profit-oriented. That's for sure. But we are not actually passing on everything to the patients. That is actually also a fact. Thank you.

Dr. Tan Hui Ling [The Association of Private Hospitals of Malaysia (APHM)]: *Maybe I can add a little bit on the smaller hospital or the non-profit. I'm Dr. Tan Hui Ling, I'm from APHM Board Member. Also, a bit about my background I'm from Bagan Specialist Centre and we are very close with the Lam Wah Ee Hospital which is an NGO.*

So, we know that the vendors do sell their products at different prices for different types of hospitals. So, I grew up working around Lam Wah Ee, almost every day and with my dad. When I took over and ran the Bagan Specialist Centre, I realised that the prices that they quoted us are different from Lam Wah Ee.

The vendors came back us and told us Lam Wah Ee is a charity hospital. So, they are priced the items to them very differently from so-called for-profit hospitals. Which that explains why partially non-profit hospitals can run and break even, I won't say they're making a profit, okay but they can break even because they buy and purchase equipment and pharmaceutical products at a lower price compared to for-profit hospitals.

That explains part of it, of course, some of them also have a subsidy from donations from the public. So, I hope that will help demyth a bit.

Tuan Sim Tze Tzin [Ahli PAC]: *Yeah, so, my two questions are does the regulation— do you— like three-star hospital. Do you think that you want to work with KKM to have the lowest standard, the MHQL right? Is that MHQL?*

Seorang Ahli: MSQH.

Tuan Sim Tze Tzin [Ahli PAC]: *MSQH, whether you can relax a bit on the MSQH but at the same time consideration of the litigation and all this the standard of care. But better way to save costs because we want a hospital that's functioning but not too excessive, too much regulations. That's the question and self-regulation among the industries. How do you play your part to bring down the cost?*

Datuk Dr. Kuljit Singh [APHM]: *Okay, how do we bring down the cost, there's one whole slide, that's our actions that we are going to take.*

■1350

Then, in healthcare there's no such thing as bringing down standard. Whether it's a small hospital or a very big five-star hospital, the standard of care of the patient has to be the same. So, the cost of keeping the standard of the care has to be the same. You cannot say that you know we will try to cut corners, tell MSQH that we will give poor quality...

Tuan Sim Tze Tzin [Ahli PAC]: *No. What I mean is that you can follow— okay, JKR standard or you want to follow British standard. You know? That kind...*

Datuk Dr. Kuljit Singh [APHM]: *No. So, in medical care there is only one standard. Because I can't have a patient in front of me and say, "Oh, because of you now— never mind, I give you something very shoddy, maybe not complete so that you pay less", cannot. Because you can go to any hospital whichever level because depending on the treatment that you have undergone. Some treatment may be not available in a smaller hospital. So, then you wish to...*

Tuan Sim Tze Tzin [Ahli PAC]: *My question arise because one of— in one session, one of the complaint is that it used to be a hospital. But, after they moved out from that hospital, the old— the existing hospital nobody wants to buy because it's no longer meet the standard. Okay, but it used to be a functional hospital as well. You see?*

Datuk Dr. Kuljit Singh [APHM]: *Because CKAPS is very strict. So, which is good.*

Tuan Sim Tze Tzin [Ahli PAC]: Ya, *that's why my question is CKAPS is it too strict that actually we are actually causing the rise of the cost?*

Datuk Dr. Kuljit Singh [APHM]: *I think I will agree with CKAPS strictness because I don't think so we want to compromise anything when it comes to patient safety. I always tell my hospital workers and my people that don't take CKAPS as a challenger. Actually, CKAPS is doing something good for you. So, the hospital whichever you mentioned may deem not to be safe. What it means that is probably CKAPS is not allowing to be registered anymore because it doesn't meet any standard. So, for that fact I think for our benefit of our patient, I think that's the most important thing. Forget about your profits, forget about everything but the patient steadily— if I am a patient, I don't want to go to a hospital where's the standards are not met. Definitely no. I would not work in the hospital where the standards are not up to their mark because it is dangerous for our patient.*

There's ethical consideration looking after the patient is the most important thing for us. End of the day, it is not a restaurant or other kind of product that— even restaurant is also very important. The standard must be there. But some product you buy it doesn't work; you can just throw it out. You cannot throw your health out of the window. So, I think for that...

Dr. Tan Hui Ling [APHM]: *Maybe I add a bit on that. I think the standards are important and the regulations are also important. But the execution can be improved to make us more cost efficient. So, for example in Singapore, MOH comes out with this standard of items that any new set up needs to have. Okay, whether you need an exchange of 12 times, humidity of certain level, temperature of certain level in your OT. All this are very clear cut stated out and they leave it to the private hospitals to set it up and run it. When it starts running it, only then they come and inspect that you meet the standard being set.*

Whereas our side is we have a pre-establishment approval. We submit a borang *to say we want to build this hospital according to this standard, MOH check from engineering, doctors, every single type of professional involved, they check. Then, they approved. Only then we can start building. After we built, we have a second round of submission again for MOH to say, "Okay, what you have built is according to the original plan and you have enough staffing and equipment's to make sure that you are fit to run the hospital". Only then we get the license and we start running. So, that is a very long*

and tedious process. Both for the private hospitals as well as MOH. Used up a lot of time and a lot of man power.

So, if we can make this whole thing more efficient— for example, earlier on Anwar cited, "Six months of waiting for the license to get the license to operate but we have to pay guarantee income to the doctors and salaries to all the staff". If we can eliminate that and as you said, self-regulate. Private hospitals self-regulate, they making sure that we need all the fixed requirement for a safe hospital. We set it up, we are ready to run it. Once so-called physical complexion, CPC, all there, we run it then MOH come and check. If we do not meet a requirement then yes you penalise us. I think that part of self-regulation will help us a lot whether it's ministry or private sector. In terms of manpower cost, instead of so-called lost opportunity or time cost.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Last one question.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, one of the biggest debate— even Bank Negara, even KKM, they are unhappy about the hospital supply and services (HSS), the cost of it. So, it's about 70 percent of your— on the medical bill. So, what we are asking is that how do you bring down that cost? The HSS?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think YB...*

Tuan Sim Tze Tzin [Ahli PAC]: *And— and if, because the government is thinking of regulating already. If let say you guys are able to bring that cost down then there's a way that self-regulating rather than the government regulate for you. Because under the KPDN, Act 736, what you call Anti-Profiteering Act. They can go in and audit and regulate. So, what is your respond to this? Thank you.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I think YB, we certainly would like to be able to engage all the way further. Because I think what we try to explain today was the reason why the costs are parked in those areas was because we are not charging for this other things and that's why we need your help. We need the PAC's assistance so that for us to reflect the actual cost for hospital surgical supply right, HSS, or even pharma and all that is for us to charge the actual cost for other thing which are incurred. So, that one we need to change the systemic approach and I think we want to clarify. APHM is not here to blame anyone. I think we are saying that there are systemic issues because of how things are developed in the last few years. We are not blaming insurance; we are not blaming anyone else.*

So, even KKM right? So, we are saying yes. If you allow us to self-regulate, we believe there will be some savings because of the things that we mentioned. But the standards must be maintained. Like Datuk Kuljit said, "We cannot have two standards. That will be difficult". But, in terms of how we charge and for the surgical supply for it to be not appear as if you overcharging is we have to really change the bill structure and that's what we try to present today. So, what we need is really PAC's assistance to have somebody neutral whether this is the PAC, whether this is special committee, whether it's MoF. We need somebody to bring together to understand to say, "Okay, we want hospitals to reflect the actual cost". So, insurance and payers you must accept that now nursing charge, NICU will be a minimum at least over RM1,000. Right?

So, we need somebody to be able to do that. If we do that, yes, we can bring down the mark ups on HSS, on surgical supplies. We've always said that cross subsidisation exist in our structure, we acknowledge it exists and we need to solve that. But we need a third party to come and help us to solve it.

Encik Stanley Lam Kean Fatt [APHM]: Ya, *maybe I will add on to what Anwar said. I mean, in order to control the output cost rise— Stanley here. You need to control the input cost. We are at the end of the funnel to deliver the care. So, a lot of input cost, we need the government's help to work together with relevant agency to control the input cost. I mean, one of the things YB Sim, just for your information, recently with the expansion scope of SST, there are many services whereby last time they charged six percent, now they charged eight percent. This is exactly what we are referring to, right? The increase of input cost has resulted in the increase of the output cost. So, we wish the PAC and the respective authority can sit down together, let's brainstorm and find solution to this, right?*

It is very difficult and I would say that it is quite unreasonable when you asked the hospital to control the surgical cost and medical supply cost when we have no control at all about the input cost. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih. Suara pun tak ada dah. *[Ketawa]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Berucap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Itulah. Terima kasih atas jawapan yang dibagi. Bulan puasa, suara pun tak ada. *So,* Bayan Baru *satisfied?* Okey. *So, this is our 11th proceeding. So, I think we had a very long proceeding*

for this issue. Of course, kita semua nak yang terbaik dan untuk rakyat Malaysia dan banyak— saya rasa yang ini yang paling lama kot. Lama kah? Ini paling lama? Ada lagi lama. Okey, *so* yang ini bukan paling lama lah. *So,* terima kasih saya ucapkan pada Datuk Dr. Kuljit, Encik Chin *and also* Encik Anwar *and also your team and also your colleague* yang hadir datang memberikan penjelasan kepada PAC dan saya tangguhkan pada pukul 1.59. Terima kasih.

Datuk Dr. Kuljit Singh [APHM]: Terima kasih.

[Mesyuarat ditangguhkan pada pukul 1.59 tengah hari]



MALAYSIA

LAPORAN PROSIDING (HANSARD)

Khamis, 6 Mac 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Pharmaceutical Association of Malaysia
Puan Kam Ai Teng
Presiden

(ii) Persatuan Farmasi Malaysia
Puan Harpeet Kaur
Pengarah Eksekutif

(iii) Malaysian Organisation of Pharmaceutical Industries
Encik Ch'ng Kien Peng
Presiden

(iv) Malaysian Association of Pharmaceutical Suppliers
Encik Lim Teng Chyuan
Presiden

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 6 MAC 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Datuk Ali anak Biju [Saratok]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Puan Vivian Wong Shir Yee [Sandakan]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Zulfa Amirah binti Jubri @ Mohd Zufri [Pegawai Tadbir (Seksyen Sinergi dan Kolaborasi Strategik) Parlimen Malaysia]
Cik Jackie Mary Fernandis [Penasihat Undang-undang II (Pejabat Penasihat Undang-undang) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam
Encik Aznirul Fariz Bin Alwi [Ketua Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
PKPj Suzana binti Alias [Ketua Cawangan (Bahagian Penyiasatan Tata kelola)]
Encik Mohd Nadzri bin Ibrahim [PKPj]

Kementerian Ekonomi
Puan Noor Diana binti Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K), Bahagian Perkhidmatan Sosial (Bahagian Infrastruktur dan Kemudahan Awam)]

Jabatan Akauntan Negara (JANM)
Puan Noor Azira binti Abd Rashid [Akauntan]

SAKSI-SAKSI

Pharmaceutical Association of Malaysia (PhAMA)
Puan Kam Ai Teng [Presiden]
Puan Deepti Saraf [Naib Presiden]
Puan Chan Li Jin [Pengarah Eksekutif]

Malaysian Organisation of Pharmaceutical Industries (MOPI)
Encik Ch'ng Kien Peng [Presiden]
Encik Sharvin A. Subramaniam [Pengurus Kanan Polisi]
Encik Wan Amir-Jeffery Bin Wan Abdul Majid [Ahli EXCO]
Puan Grace Yap [Ahli EXCO]

Malaysian Association of Pharmaceutical Suppliers (MAPS)
Encik Lim Teng Chyuan [Presiden]

Persatuan Farmasi Malaysia
Puan Harpreet Kaur a/p Darshan Singh [Pengarah Eksekutif]
Puan Nur Zulaika Binti Roslan [Setiausaha Eksekutif]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

KHAMIS, 6 MAC 2025

Mesyuarat dimulakan pada pukul 11.33 pagi

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
mempengerusikan Mesyuarat]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh*. Selamat pagi. Salam sejahtera saya ucapkan kepada semua Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas, semua ahli ex-officio ada pada hari ini Jabatan Perkhidmatan Awam, kuning hari ini ya. Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga penasihat Undang-undang Parlimen selaku wakil daripada Pejabat AGC. Yang Berhormat, ahli mesyuarat sekalian hari ini kita akan teruskan prosiding ke-10 bagi isu peningkatan bayaran premium insurans kesihatan caj hospital swasta dan juga impak kepada kesihatan awam di bawah MoF, Kementerian Kesihatan Malaysia dan juga Bank Negara Malaysia.

Sebagaimana semua sedia maklum, ini bagi kita dapatkan penjelasan berkenaan faktor-faktor yang menyumbang terhadap peningkatan premium insurans dan juga caj hospital termasuk kos rawatan perubatan, kemajuan teknologi, kos operasi hospital, inflasi dan faktor-faktor luar seperti pandemik. Dalam usaha untuk kita mencari jalan mengurangkan impak peningkatan premium insurans kesihatan dan juga kos perubatan, adalah adil untuk kita dapatkan— dan juga wajar untuk kita dapatkan pandangan dan juga penjelasan daripada semua pemegang taruh dalam industri kesihatan negara.

Hadir di hadapan kita, di hadapan PAC pada hari ini yang pertamanya adalah Yang Berusaha Puan Kam Ai Teng, Presiden Persatuan Farmaseutikal Malaysia (PhAMA); Yang Berusaha Deepti Saraf, Naib Presiden Persatuan Farmaseutikal Malaysia (PhAMA); yang ketiga Yang Berusaha Encik Ch'g Kien Peng, orang Melaka, Presiden Pertubuhan Industri Farmaseutikal Malaysia (MOPI); Yang Berusaha Encik Lim Teng Chyuan, Presiden Persatuan Pembekal Farmaseutikal Malaysia (MAPS) dan seterusnya Yang Berusaha Puan Hapreet Kaur a/p Darshan Singh, Pengarah Eksekutif Persatuan Farmasi Malaysia. Jadi, saya ucapkan ribuan

terima kasih di atas kehadiran semua bagi memberikan penjelasan dan juga penerangan di hadapan PAC pada hari ini.

Sebelum saya menjemput saksi itu memberikan penjelasan pada hari ini, ingin saya maklumkan dan juga saya ingatkan bahawa prosiding PAC ini adalah tertakluk di bawah Peraturan Mesyuarat 85. Peraturan Majlis Mesyuarat Dewan Rakyat dan juga Akta Rahsia Rasmi 1972 iaitu Akta 88 sehinggalah prosiding ini selesai dan sehinggalah laporan PAC dibentangkan di Dewan Rakyat. Saya difahamkan bahawa semua saksi akan memberikan pembentangan. Ada lebih kurang berapa ya? Di hadapan saya ada MAPS punya pembentangan, PhAMA dan juga MOPI. Ada tigalah, betul ya? Jadi memandangkan saya menjangkakan untuk kita habis— selesai kita punya persidangan ini dalam pukul 1.30. Jadi, saya harap dapat memberikan pembentangan dengan...

Seorang Ahli: *Concise*. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]:...Tepat dan jitu. Sekiranya kalau ada persoalan dan saya minta Ahli-ahli PAC boleh bertanyakan terus sebab kita tak nak kita patah-patah balik ya. Kita mulakan dengan MOPI dulu. Jadi saya persilakan—Mana dulu? Sebab tadi kita dah ada— yang mana dulu?

Beberapa Ahli: PhAMA, PhAMA. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: PhAMA? Okey. Sebab dia nombor satu. Jadi saya persilakan Yang Berusaha Puan Kam Ai Teng, Presiden Persatuan Farmaseutikal Malaysia (PhAMA) untuk mulakan pembentangan. Terima kasih.

Puan Kam Ai Teng [Pharmaceutical Association of Malaysia (PhAMA)]: Ya selamat pagi dan salam Malaysia Madani. Terima kasih kerana memberi peluang kepada PhAMA untuk menghadiri sesi pada pagi ini. Nama saya Kam Ai Teng, Presiden Persatuan Farmaseutikal Malaysia. Bersama dengan saya hari ini Puan Chan Li Jin, Pengarah Eksekutif PhAMA; Puan Deepti Saraf, Timbalan Presiden PhAMA; Puan Jessie Leow, Pengurus PhAMA.

Izinkan saya berkongsi ringkasan sejarah PhAMA. PhAMA telah ditubuhkan pada tahun 1972 pada mulanya sebagai Persatuan Perdagangan dan Pengilang Farmaseutikal Malaysia. Nama semasa kami PhAMA telah diterima pakai pada tahun 1999 apabila persatuan memutuskan untuk meningkatkan tumpuan kepada ubat-ubatan inovatif dan membenarkan pengeluar ubat generik melakar laluan baru mereka.

Tiga tahun yang lepas, kami menjalani penjenamaan semula yang besar dalam melancarkan logo baru untuk melambangkan pendekatan yang lebih dinamik dan kontemporari. Walaupun asas kami kekal tidak berubah iaitu untuk meningkatkan akses kepada ubat-ubatan inovatif kepada rakyat Malaysia, kami sememangnya ingin memperkukuhkan *public-private partnership* yang sedia ada dan komitmen untuk meluaskan jangkauan kami melangkaui industri penjagaan kesihatan ke arah pendekatan ke seluruh masyarakat yang disyorkan oleh Pertubuhan Kesihatan Sedunia dan Menteri Kesihatan.

Kita mempunyai 45 ahli dan kebanyakan ahli-ahli kami terdiri daripada ahli-ahli syarikat inovatif antarabangsa yang juga mempunyai operasi di Malaysia. Semenjak kita bermula dari tahun 1972, PhAMA memang dikenali sebagai tulang belakang kepada industri inovatif, ubatan inovatif di negara ini.

Dari segi sumbangan pembinaan negara ahli-ahli kami sememangnya bertungkus-lumus untuk memastikan pelaburan langsung asing ke negara Malaysia.

■1140

Pertamanya, RM720 juta pelaburan sebagai jumlah pelaburan langsung. Nombor dua, kita sentiasa memacu pelancongan perubatan melalui rawatan berkualiti dan paling penting akses kepada ubat-ubatan inovatif.

Keduanya, keluaran dalam kasar negara. Sumbangan ahli-ahli kami, RM6.8 bilion disumbangkan dalam tahun 2020 dan diunjurkan bertambah kepada RM9.8 bilion, 2024 kepada RM13.4 bilion, 2027 dengan pertumbuhan kira-kira sebanyak tujuh peratus. Keduanya, RM40 juta pelaburan tahunan setiap tahun oleh ahli kami untuk profesional perubatan untuk memastikan terdapat *continuous medical education* di kalangan ahli profesional perubatan.

Ketiganya, memastikan peluang pekerjaan. Menjana peluang pekerjaan untuk lebih 15,000 individu dengan sifar pemberhentian semasa pandemik COVID-19. Sebanyak 80,000 individu lagi bekerja secara tidak langsung dengan industri ini sebagai perkhidmatan sokongan. Paling yang kita juga sentiasa memastikan kemajuan penjagaan kesihatan. Ahli PhaMA menyumbang dengan ketara kepada landskap, percubaan klinikal. *Clinical trial* di Malaysia dan menyumbang 80 peratus pada jumlah pelaburan dalam sektor ini. Dari tahun 2020 ke 2024, pelaburan sebanyak RM700 juta dalam ujian klinikal yang dijalankan di Malaysia sememangnya didorong oleh AMC Pharmaceutical.

So, dalam menyokong Kementerian Kesihatan dalam penyampaian penjagaan kesihatan, memang tidak dinafikan semasa pengurusan COVID-19, *I think,* rata-rata masyarakat mengenali PhaMA. Pengurusan COVID-19 yang

berkesan dalam akses tepat pada masanya dan memastikan bekalan vaksin mencukupi untuk semua rakyat Malaysia, dengan itu berupaya menyelamatkan nyawa dan paling penting membendung penularan COVID-19. Masa itu juga, ahli-ahli kami pastikan bekalan ubat-ubatan secara berterusan, secara mampan sepanjang perintah kawalan pergerakan.

Keduanya, ahli-ahli kita juga sentiasa menyokong pencegahan kanser. Kita tahu kadar kanser di negara semakin menaik. Ahli kami seperti AstraZeneca bekerjasama dengan rangkaian Kanser Paru-paru Malaysia (LCNM) untuk melancarkan kempen saringan kanser paru-paru percuma untuk meluaskan akses untuk diagnosis kanser paru-paru menggunakan teknologi AI pada September 2022. Ini akan membantu menurunkan kadar kanser di negara kita.

Nombor dua, MSD menyumbangkan vaksin HPV bernilai RM90 juta kepada Persatuan Kanser Kebangsaan Malaysia (NCSM) untuk memastikan vaksinasi HPV percuma kepada kanak-kanak perempuan dalam komuniti yang terdedah pada risiko tinggi demi membasmikan kanser serviks di Malaysia.

Ketiganya, skim akses perubatan *(medicine access schemes).* Bilangan pesakit yang menerima *patient access programme. So,* ahli-ahli kita sentiasa cuba membantu pesakit-pesakit untuk menerima ubat-ubat inovasi di kedua-dua sektor sebagaimana yang terpapar di skrin. Nombor atau bilangan pesakit yang menerima bantuan ini semakin meningkat dari tahun ke tahun.

Ketiganya, seperti mana yang saya telah maklumkan, melabur dalam percubaan klinikal. Ini amat penting kerana dengan pertama kalinya kita berjaya melancarkan tiga ujian klinikal. *First-in-human* di Sarawak dari tahun 2022 ke 2024 dengan AstraZeneca dan Roche. MoU juga ditandatangani dengan Clinical Research Malaysia dengan objektif yang untuk menyokong pembangunan bakat dan mengembangkan minat dalam kajian saintifik. *So,* dengan itu saya akan *hand over my presentation to Deepti.*

Puan Deepti Saraf [Pharmaceutical Association of Malaysia (PhAMA)]: *Thank you.* Selamat pagi. Selamat Malaysia Madani. Izinkan saya *present* dalam bahasa Inggeris. *I promise to be slow and please stop me if you have any questions in the way. My name is Deepti. I'm the Vice President of PhaMA and also the General Manager of Roche Malaysia.*

So, at first sort of— we are trying to understand how the medicine cost placed out in the entire treatment of a patient. These are the reports from the Malaysia National Health Accounts 2021 where you can see on the left-hand side chart, that medicines out of the entire treatment cost only account for about roughly 16 percent.

It's actually less than 16 percent of the total cost of the treatment in the out-of-pocket segment.

On the right-hand side, you will see an example, recently presented to the ministry and some other officials from Taiwan. This is a private hospital in Taiwan and they have looked at all the costs that they incurred as expenses. You will again see that medicine only accounts for 12 percent of the entire cost of the entire hospital structure. So, what we are trying to say is that medicine only contributes to a fraction of the entire cost of treatment. If you go to the next slide, you will also see that over the years, the cost of the expenditure from the Ministry of Health has been relatively flat, as can be seen in that orange line on the graph. Of course, that has been some increments in the private sector but largely in the public sector, expenditure has been quite flat when it comes to medicine.

Not just that, you will also see, this is a 2022 report from the ministry and from Malaysia's statistics on medicine. It again says that only 10 percent of the MOH's expenditure was allocated to pharmaceuticals as such. So, with these two slides, what I'm trying to summarise is that medicine is just a fraction of the entire treatment cost and only solving for medicine price, will not solve for the entire inflation challenges that we see in Malaysia today.

There are many reasons why we see inflation in prices and overall healthcare costs. We, of course see that on the left-hand side in my chart you can see that we have a social demographic of the country where we see more aging people, which of course need much more care and treatment as aging brings a lot of chronic diseases with it, the lifestyle of the population which also contribute to metabolic disorders such as diabetes as well as cardio metabolic problems. We there, foresee a rising prevalence of these conditions in the population as a whole that NCDs.

We also know that, in addition to this as science is advancing across the world and new innovative medicine are getting launched. This, of course, brings with it better care, better outcomes but with the R&D costs, it also brings some more expensive medicine into the population but it helps the population to be more productive to become better faster. Some of the other reasons also include the weakening of the Ringgit Malaysia and the reason past. Of course, there are lots of rising costs in doing business as well as in production.

As you can see on the right-hand side, with all the micro indicators, energy and utilities, transportation and logistics, commodities. All these costs and the recent past have increased within the range of one and a half to three percent. If you put all that together, it adds to the cost of medicines and the cost of manufacturing products.

If you go to the next slide, you will also see that not just all these inflations parameters, the social economic parameter but we also in Malaysia and in the pharmaceutical industry have a complex supply chain and there are multiple partners and agents from the pharmaceutical industry who manufactures by the time it reaches the patients. There are multiple layers in the middle, which we have to ensure that this enables the patients to have access to the medicine with the large geography.

From the suppliers, both the MNC as well as the generic manufactures, we have distributors at one level which then goes to the hospitals, sometimes directly. When it goes to the public sector, we also have agents and suppliers who then further supply to hospitals and clinics. So, there's a complex supply chain which is needed in this industry but it also adds to the cost of the medicine. But having said that, despite all these inflations of producing medicines of the weakening RM of the population, we see that in the recent past and I'm talking from 2022 to 2023 and also from 2023 to 2024, we have used IQVIA data and we have looked at the top PhaMA members. So, the MNC companies and their products and we have seen that our price increases have been quite reasonable in line of the inflation, in facts sometimes even lower than the inflation.

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So, you will see from 2022 to 2023, there was a price increase overall of about 3.5 percent and from 2023 to 2024, a price increase 4.7 percent.

I hope the room feels this has been a reasonable price increase given all the inflation cost. This also includes launches of new innovative product that already been incorporated in that price increase 3.5 and 4.7. In addition to this, Malaysia has a lot of laws that makes sure that no company make unreasonable profit. So, under the Malaysia Price Control and Antiprofiteering Act 2011 under KPDN, there are laws in place to ensure that companies such as ours do not make unreasonable profits. So, I hope this also tell the room that you know there has been a reasonable price increase at least from PhAMA's member in the recent past.

In addition to that, innovator companies and innovator product also added lots of societal benefits to the patient. As you can see from the left-hand side chart of the blue graph, you will see that almost RM9 billion we were able to save with innovator launches. This is actually added to the quality of life of patients worth RM9 billion. You will also seen some of the launches in the recent past and again you will see that actually with the addition of these new products, while they bring some— you know, you make all of them expensive but they are actually extend the quality of life of

diabetes patient almost three percent. Another product here which extends the quality of life by almost 18 percent. Again, while the price increase has been quite reasonable, we are also adding more people in the society to be more productive over the years.

In line with our Prime Minister's vision and also our policies in place, generics first policy. You will see from both these graphs that not only in terms of doctor's prescriptions where over the recent years, it has largely gone to generic drugs—almost about 55 percent of the prescriptions were actually given to generic drugs. As you can see in this graph and this is the latest data from 2023 and 2024. All the volumes even on the private channels, 66 percent actually is contributed by generics. So, this is in line with our vision that generics are actually taking the main prescriptions, the main volumes when it comes to private hospitals too.

Having say that, this graph is also shows us that there is a challenge in terms of the median markups that are happening at different levels. So, once we as a manufacturer sell to the hospital or sell to the distributor, there are markups that are put at the hospital level. You would see that in the first block, innovators versus generic, you will see the markups that have been implied or have been put by the inpatient setting in the private setting. You will say that the markups has been quite high. Both the innovator and generics but even more in generics than the innovators. This trend is consistent through different channel. So, whether it is a private hospital, private clinic, community pharmacies, you will see that sometimes margins and markups have gone up 300 percent by these providers. I'm sure for good reasons but this of course adds to the cost of the patients pricing and then the inflation cost that we see in Malaysia.

In summary, what I would like to end with saying is that overall medicine does not contribute to the major amount. We are in the range of 12 to 16 percent of the total cost. There are multiple factors that have increased the production cost in the recent past. However, PhAMA members price increased has been in line with that inflation or even lower with that inflation considering all the new products that we have launched in Malaysia.

There are multiple other factors such as markups that have been adding to the inflation in Malaysia and we are committed to work with the government and the Ministry of Health to come out with solutions that enable all of us to reduce the cost for patient. With this I hand over to Li Jin to come and suggest some solutions from our side.

Tuan Sim Tze Tzin [Ahli PAC]: *Before that,* YB Pengerusi.

Puan Deepti Saraf [PhAMA]: *Yes, sure.*

Tuan Sim Tze Tzin [Ahli PAC]: *I want to ask a few questions. Number one is how do you price your product? Meaning, let say one medicine. Let say Panadol, easy* ya. *So how do you price it? Is there a price in Malaysia different from price in Singapore, different from price in Indonesia?*

Puan Kam Ai Teng [PhAMA]: *Yes. So at least from our member perspective— because we are a global MNC, so there is a standard way to price the product. Coming back to you, it depends on the GDP of the country. So therefore, for example Malaysia versus Singapore for example, Malaysia price for same drug would be technically lower compared to Singapore. Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, meaning you price based on the country GDP* lah. *So, meaning…*

Puan Kam Ai Teng [PhAMA]: *In general,* ya. *So, every company there will have slightly different policy but in general, we will look into the affordability of the country. Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. So just now you were saying that when you sell to the hospital, it was— some goes up almost to 300 percent, the markups. So, you sell to hospital, they mark up another 300 percent to be sold to the patient. Am I right?*

Puan Kam Ai Teng [PhAMA]: *So, basically from this data it shows the different range, yes. When we sell to the hospital with X price then it is up to the provider, example the hospital to determine what they want to markup. So, we don't…*

Tuan Sim Tze Tzin [Ahli PAC]: *So, this is where you survey the hospital prices and then you find out that actually…*

Puan Kam Ai Teng [PhAMA]: *This is from…*

Puan Deepti Saraf [PhAMA]: *Medicine price monitoring report from Ministry of Health.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, okay.*

Puan Kam Ai Teng [PhAMA]: *So, this is available…*

Tuan Sim Tze Tzin [Ahli PAC]: *So, after selling at this price, the total cost of the hospital bill is only 16 percent. Meaning with this markups.*

Puan Kam Ai Teng [PhAMA]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, meaning actually if we don't have this markup, it would be maybe lower. Maybe eight percent, nine percent. Am I right?*

Puan Kam Ai Teng [PhAMA]: *Technically, yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Technically, yes.*

Puan Kam Ai Teng [PhAMA]: *So yes, medicine contribute not more than 16 percent based on just now what are my colleague have shared to total cost of the bill, the healthcare bill.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. In many, many countries, a lot of people are— sorry to say* lah, *they are condemning pharmaceutical companies because a lot of consider very expensive* lah. *So what is your— let say, in Malaysia. What is your margin like for a typical, normal product medicine? What is the margin?*

Puan Kam Ai Teng [PhAMA]: *So, I'm—* ya.

Puan Deepti Saraf [PhAMA]: *So, our margins are quite— we have a transfer pricing system from our global headquarters. Most of the general managers locally not even have an idea of our existing margins. But these margins like I said, the price of the drug in Malaysia is really depending on the overall incidents in this country, the current competition. Competition plays a huge role because we control each other prices by being competitive to each other. We also have— like I said we have always looked at offering additional rebates to our patient directly.*

For most of the chronic diseases, we have also seen such as in cancer where the innovative product can be very expensive. You will always find a patient assistance scheme, usually given to people who cannot afford the medicine, so that they can get free drugs. We have also compassionate youth programmes where we have given free programmes, free drugs to our patients for life in many chronic diseases.

So, I think overall I would say that the PhAMA members have been quite considerate of the current situation. We also price differently when it comes to the government sector we give much lower prices.

Tuan Sim Tze Tzin [Ahli PAC]: *Never mind. You just tell me what is the typical margin? That is the question.*

Puan Kam Ai Teng [PhAMA]: *We cannot…*

Puan Deepti Saraf [PhAMA]: *I don't think we can share that information.*

Puan Kam Ai Teng [PhAMA]: *I apologise. We are unable to disclose. Because every member has different range and it is actually for us also anti competition. So, we are not able— we are not allowed to talk about pricing.*

Puan Chan Li Jin [PhAMA]: *Perhaps* YB*— my name is Li Jin. I'm the Executive Director of PhAMA. Perhaps* kalau saya boleh jelaskan berkenaan dengan *the price increases. So, every company would have their own ratio.* Tetapi daripada slaid, *which was derived from IQVIA,* daripada *an average of 20 top pharmaceuticals companies in Malaysia, the average increase is between 3.5 to 4.7 percent.*

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So, that is the average increase across 20 top pharmaceutical companies di Malaysia.

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry, sorry. My question is your margin.*

Puan Chan Li Jin [PhAMA]: *The margin. Yes, so the margin, I apologise we are unable to…*

Tuan Sim Tze Tzin [Ahli PAC]: *How about give us a range?*

Puan Kam Ai Teng [PhAMA]: *No also. We are not allowed to disclose. Because different member to be frank even for us we are not allowed to talk about the pricing and we can't even…*

Seorang Ahli: *Rules and regulation? [Bercakap tanpa menggunakan pembesar suara]*

Puan Kam Ai Teng [PhAMA]: *Disclose. There is a regulation. That is why the regulation for the enforcer to check on the accounts and individual company.*

Tuan Sim Tze Tzin [Ahli PAC]: *We are in Parliament you know. [Bercakap tanpa menggunakan pembesar suara]*

Puan Chan Li Jin [PhAMA]: *Also.*

Tuan Sim Tze Tzin [Ahli PAC]: *We are in Parliament. You are supposed to tell us the truth.*

Puan Chan Li Jin [PhAMA]: *No, no, YB. It is no that we are not telling the truth but because every medicine is different. So, there are thousands of medicines so which medicine we are talking about specifically?*

Tuan Sim Tze Tzin [Ahli PAC]: *No, you give me a range typical usually. I'm not forcing you to disclose your profit or whatever but just give a range of the margin.*

Puan Kam Ai Teng [PhAMA]: *Understand, we are unable to. We can't.*

Puan Deepti Saraf [PhAMA]: *YB, the way it works here is that oil companies get a transfer price from the global counterparts and we then sell the product at that transfer price with additional whatever says in marketing cost that we have locally…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Yang itu kita semua faham *that scenario. But YB Bayan Baru asked for the margin.*

Puan Deepti Saraf [PhAMA]: *The margin that we sell to the hospital or the margin— there is no— the margin that we sell to the hospital, that's our pricing there is no specific like I said it depends really on the R&D, how innovative the product is and a lot of others factors that contribute to the margin.*

There is no standard margin that we can share a range because cancer product versus anti-infectives, whether they patented, whether they are not patented, there is a lot of complexity so there is no standard margin that you will see.

Tuan Sim Tze Tzin [Ahli PAC]: *Yes, it's okay. I understand there is no standard. But you tell me the range*-lah*. I mean like maybe…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Maybe three to 10 percent.*

Tuan Sim Tze Tzin [Ahli PAC]: *10 percent to 300 percent. Okay, you can tell me. Or 300 percent to 1,000 percent. It's fine.*

Puan Deepti Saraf [PhAMA]: *I don't think there is a range that we have ever come out with or asked our members to disclose. So, we will not be able to give accurate information today on this topic.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Hello Pengerusi. I think as manufacturer I mean being in the manufacturing industry the margin is— there is a margin and there is a gross margin and then there is a profit. And then at the end of the day people look at the book and okay this industry normally makes say five to 10 percent of their profit and the other range maybe much more localities and things like that.*

But the margin is there but I don't know. I mean I don't think it resemble the— because it will— you have to consider the— I mean I'm just not saying that I'm supporting them but it is difficult to tell.

Puan Chan Li Jin [PhAMA]: Ya, susah, lain-lain.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Because* memang *very difficult. Because a lot of factors built in, in the margin itself. So, if we talk, I can say my margin is let's say 300 percent but does it say it's high? No. I don't know. If you want to explain…*

Puan Kam Ai Teng [PhAMA]: *Yes, exactly very difficult. Every member also different, every drug also very different because of the different life cycle of the drug so that is why we are unable…*

Tuan Haji Azli bin Yusof [Ahli PAC]: *But if in a different way normally how much does the profit the pharmaceutical industry makes? If you can give a range?*

Puan Kam Ai Teng [PhAMA]: *Globally…*

Puan Deepti Saraf [PhAMA]: *Globally I think it would be in the range— very difficult in the range of 10 to 18 percent. Again, every company I'm sure you will find the company at 35 percent but I'm just trying to give you an average if you look at*

global books of all pharmaceutical R&D companies, it can range between 10 to 20 percent…

Puan Kam Ai Teng [PhAMA]: *Yes, 10 to 20.*

Puan Deepti Saraf [PhAMA]: *And each company depending on the products that they launch, R&D cycle you know if they have recently invested in R&D, it's depending on many factors but I'm giving you a very wide range because there is no again— you have to look into the books of every global company and their lifecycle.*

You have to— the main problem with the innovative PhAMA companies is the R&D costs and the clinical trial costs, and that changes every year depending on the what are they working with. So, the margin of the pharma companies globally in any country have never been disclosed.

Tuan Haji Azli bin Yusof [Ahli PAC]: *I just have some information that says generally the pharmaceutical companies are among the industry that have very high profit I would say. High profit. That mean if you have high profit definitely you put a lot of margins on it.*

Puan Kam Ai Teng [PhAMA]: *So, because like we have mentioned I think there is couple of conversation on this so that is why we fall back to the Malaysia's Price Control and Anti-Profiteering Act. So, that is why for our profit we have to make sure we comply to this. Even at global level we are very strict. We have to comply to the local law.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, thank you. I give it to Saratok, Wangsa Maju and Sandakan.*

Datuk Ali anak Biju [Ahli PAC]: Terima kasih Pengerusi*. Refer* pada muka surat nombor tiga, *page three. This is talking about the cost of drug is only 16 percent of the treatment cost.*

So, I would like to know what is the real cost or the estimated cost for cancer treatment, drug in the cancer treatment? Because the issue that we have now the treatment for cancer, the drug is very expensive. Maybe the whole medicine, maybe 16 percent but I think the percentage of drug cost in cancer maybe higher. Do we have the figure? Separate figure for it?

Puan Deepti Saraf [PhAMA]: *Maybe I can take that since Roche is in oncology company too. Maybe it would range a little bit higher. Maybe 20 percent to 25 percent.*

However, I would say that these are innovative products that bring life and quality of life to the patients and also this has traditionally always been expensive even the generic biosimilars that has come to the market have always been

expensive too because of the complexity of the production. These are biologics, they are not simple chemical compounds that can be manufactured in a simple plant.

Having said that, I think the main challenge has been the inflation and not the the basic cost. Even 50 years ago cancer drugs are always more expensive and you know even today also.

I'm saying in the last recent past years the inflation whether it has come from cancer or it has come from other diseases, we might have to look into that data. We have looked at accumulated data and actually it's not cancer that has increased cost in the recent past.

So, these are my two responses that recent inflation is not coming only from cancer. Cancer has been traditionally a very difficult to manufacture and produced. Lot of R&D has go into it. Multiple failures before one product is actually made available at the patient level.

Puan Kam Ai Teng [PhAMA]: *On the other hand, I think in terms of the percentage of drug cost for cancer patient. The patient— the good thing is with all the innovation they have a lot of options.*

So, for example in lung cancer they have option of a much cheaper innovative drug to a latest one which is maybe five or 10 times the cost. But all are innovative drug. So, that is the good thing with advancement in R&D. So, just to share.

So, they have option dari mungkin sebulan, mungkin untuk *lung cancer* mungkin lepas bagi *patient access program* mereka perlu bayar dalam RM2,000, RM3,000 *to* RM20,000 *so they have a lot of options.* Semua memang ubat yang terbaru.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Still in the…*

Puan Kam Ai Teng [PhAMA]: *So, that is the good thing about new innovative option.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay. [Bercakap tanpa menggunakan pembesar suara]*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *All right, I got three questions. First question just tries to understand or to know you better about PhAMA.*

Puan Kam Ai Teng [PhAMA]: *PhAMA , yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *You mentioned that your members are 45 member companies. In other word your membership is based on companies. Are all these 45 companies are MNC or they're 100 percent Malaysian companies in this membership of PhAMA.*

Puan Kam Ai Teng [PhAMA]: *So, majority to be upfront like what we have mentioned earlier there are actual MNC, majority are MNC.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Majority, how many of the 45 is MNC?*

Puan Kam Ai Teng [PhAMA]: *How many…*

Puan Chan Li Jin [PhAMA]: *Perhaps I can take this answer. So, out of the 45 MNCs, sorry out of 45 members of PhAMA, 39 are MNCs and the others are the local companies based in Malaysia who are not pharma producing companies, yes. Our associate members who do business with pharma companies. So, they maybe training companies, they maybe data companies like IQVIA is a data company. So, they are not pharmaceutical producers.*

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Tuan Ts. Zahir bin Hasan [Ahli PAC]: *That means, the six local companies are not pharmaceutical companies?*

Puan Chan Li Jin [PhAMA]: *Yes, they are not pharmaceutical companies. So, they do digitisation…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *And 39 MNCs are all pharmaceutical companies?*

Puan Chan Li Jin [PhAMA]: *Yes. They are pharmaceutical companies.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Technically*, *PhAMA is practically controlled by MNC*-lah*?*

Puan Chan Li Jin [PhAMA]: *Yes, I wouldn't say control…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *I mean control in the sense that— 35 out of it.*

Puan Chan Li Jin [PhAMA]: Sebab— *because the present has to be global.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: Ya, *because I got to understand. Because who you are to understand what is your background and to really understand what is your response like*-lah. *Okay. We established that first. Second question, is already answered by the first question because out of the 39 members, are they producing innovators drugs alone or they are also producing generics?*

Puan Kam Ai Teng [PhAMA]: *Only innovative drugs alone for all the members, yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *All the members are producing only innovative?*

Puan Kam Ai Teng [PhAMA]: *Ya, so that's why therefore doing the R&D—* untuk cari ubat baru *for the unmet need.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: Okey.

Puan Kam Ai Teng [PhAMA]*:* *That's why clinical trials are something that we focus on a lot.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *That means all the innovator drugs are controlled by this accession?*

Puan Kam Ai Teng [PhAMA]: *Not really, but they are the members of the association. Ya. So, they…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Are there any other pharmaceutical companies in the world that are not here in Malaysia?*

Puan Kam Ai Teng [PhAMA]: Ada. Memang ada.

Puan Chan Li Jin [PhAMA]: *Yes*. Ramai, ramai. *About 200 innovator companies in the world.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *In the world 200, only 39 in Malaysia?*

Puan Chan Li Jin [PhAMA]: Betul.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Okay. All right, that is to know you better. Now*…

Puan Chan Li Jin [PhAMA]: *A little bit YB*, nak tambah sedikit *je* berkenaan apa yang Puan Presiden cerita tadi berkenaan dengan R&D. *So, the PhAMA companies are the ones who is pouring in millions of FDI in clinical research in Malaysia. So, we are helping or we are working very closely* dengan *clinical research Malaysia* untuk membawa *clinical research* ke Malaysia dan *pharmaceutical companies who are members of PhAMA*, mereka melabur untuk menjalankan *clinical research* di Malaysia.

So, bukan sahaja *in terms of FDI*, tetapi kita meletakkan— kita mengharumkan nama Malaysia sebagai satu negara yang maju, yang *capable of* menjalankan *scientific examination* dengan jitu dan *we have the facilities, we have the infrastructure that is scientifically ready.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *At the same time, we hope…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Puan, sebelum Wangsa Maju tanya, saya nak tanya puan, nama? Boleh berikan nama? Sebab tak ada dalam rekod kita dan juga jawatan ya.

Puan Chan Li Jin [PhAMA]: Nama saya Chan Li Jin, saya Pengarah Eksekutif PhAMA.

Puan Kam Ai Teng [PhAMA]: Saya juga nak tambah tadi *the R&D,* bukan saja *the* pelaburan *but* paling penting, *access patient* yang mungkin yang tak mampu

untuk dapatkan ubat terbaru. Contohnya, mereka boleh masuk ke *clinical trial* untuk dapatkan ubat tersebut.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Okay*, *I hope at the same time not making Malaysian as guinea pigs or whatever.*

Puan Kam Ai Teng [PhAMA]: Tak. Tak.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: Okey. *My third question. In our earlier proceeding, it seems that— okay, normally in Malaysia, government procurement of the same item is more expensive than the private sector. Usually. In all other industries in Malaysia, government procurement tends to be more expensive. In this industry, buying drugs from our earlier proceeding, it seems government procurement is lower than private. Is that true? And if it is true, why is it true?*

Puan Kam Ai Teng [PhAMA]: *Yes, for innovative products, at least for our members' companies is true.* Sebab *the public patient* memang *at the pricing in government is lower.*

Puan Deepti Saraf [PhAMA]: *He's saying higher.*

Puan Kam Ai Teng [PhAMA]: Eh? *Is he saying lower or higher?*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Government procurement…*

Puan Kam Ai Teng [PhAMA]: *General is higher*, tapi *drug lower, is it?*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Yes. Yes.*

Puan Kam Ai Teng [PhAMA]: *Drug lower.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *All other industries are higher, but for the drug government procurement is lower.*

Puan Kam Ai Teng [PhAMA]: Ya. Ya. *So, correct* kan *the understanding?* Nanti terbalik bahaya juga. *So, the*— memang untuk ubat-ubat, kita memang *offer government lower*, betul. *That is the pricing policy to support broaden of access in terms of innovative drugs. So*, memang *members* kita, salah satu *pricing policy* untuk kita nak pastikan sebanyak rakyat yang boleh dapat akses *to innovative drugs. So, that is why the pricing* dekat *government, we actually price it much lower* sebab *government cannot effort.*

Sebab *we want the patient* yang pergi ke *government hospital* untuk dapat ubat yang terbaru juga. Contohnya, kanser. *Like breast cancer today,* memang banyak ubat *ready* yang baru, tapi memang murah. *And I think PSD and PRA* mereka memang pun *make sure*-lah *the price is actually lower than neighboring country. They will do a reference check*.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Roughly, how many percent lower than private?*

Puan Kam Ai Teng [PhAMA]: *Depends on* ubat. *Depends*…

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Roughly. Roughly.*

Puan Kam Ai Teng [PhAMA]: Tak boleh juga sebab *different* ubat, memang *different. Depending on the company.* Tapi memang *much, much lower. It can be 30 percent of private for example or 40. But it's because of the need of the* tolong *the patient* dekat *government*.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *That means, innovative drugs there is no generic yet, you're giving a lesser. I mean, a lesser discount to the government as compared with innovative drugs that are already a generic drug? You got what I mean?*

Puan Kam Ai Teng [PhAMA]: *If the— if the…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *That means, for example, your innovator drugs as not generic yet, you might give a government ya— lower, five percent for example. If there's no innovative drug but at the same time there's a generic that you might give a much lower discount or— to the government.*

Puan Kam Ai Teng [PhAMA]: Ya. *Because like I think details mentioned the force of the market to determine one of the factors is also the force of the market and competition. So, because of if there's a…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Can we conclude that, so far your pricing is a concern, if purely on a commercial basis. Can we conclude that?*

Puan Deepti Saraf [PhAMA]: *No, I do not agree.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *It is so difficult for us to understand, to get the answer in terms of percentages. Your conservation is more on commercial terms. You, although you say, okay, annularity because— yes if you got innovative drugs, there's not generic. Of course, we have no choice. If I am sick, I need that innovative drug. Whatever price you give, I'll take. But, in another scenario, where you have innovative drugs, at the same time you have generic. So, you will definitely will price your…*

Puan Kam Ai Teng [PhAMA]: *It's not true. Because when we price the drug, we really think about the access.* Sebab kalau *we put it, for example, to be frank like cancer drugs. If the price that has been launched* kan, *for example, if we go to Singapore or Hong Kong, or even you know, Australia whatever in the private market, it could be like* dua, tiga kali lebih mahal. *Two, three times more.*

So, that is— but when reach Malaysia, what we do actually is to make sure we price it sebanyak *patient yang can afford within what we can accept in terms of like you say, the margin. So, it's like a different case from one drug to another. So,*

we don't actually bawa *the* ubat baru *and then* terus biarkan *the* ubat *so high. So, if you check in the past, especially* ubat *like cancer* kah, *the unmet need product*-kan, memang *the price* bawah *versus the other country*-lah. *For example*, *Singapore.*

Puan Vivian Wong Shir Yee [Ahli PAC]: Okey.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Last. Last. Sorry. Sorry,* Sandakan. *That means now, for example, Panadol*-lah. Okey. *Panadol is an innovative drug, correct? No? I mean, then you get 1001 generic of Panadol, Paracetamol etcetera. Okey. Because of that, ya, you push down the price…*

Puan Kam Ai Teng [PhAMA]: Ya. *Because of the competition. So…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Correct, because of the competition.*

Puan Kam Ai Teng [PhAMA]: *Yes. Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, that scenario, give us the fact that if there is a generic drug, that definitely the innovative drug price is going down.*

Puan Kam Ai Teng [PhAMA]: *So, I would think…*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *It's more to*— ya lah, *what you mentioned is a market…*

Puan Kam Ai Teng [PhAMA]: *Yes, market force. So, whether its generic or other competition.* Sebab, *because sometimes a lot of drugs, same class,* kita ada beberapa ubat. *Like from different companies, they will produce slightly different.* Tapi untuk penyakit yang sama*, for example. So then, that is also competition. Therefore, the pricing is determined by the market forces.*

Puan Chan Li Jin [PhAMA]: YB, izinkan saya tambah sedikit lagi. *So, I think with regards to* yang tadi YB sebutkan, *so*, kita pembuatan ubat ini hanya untuk *commercial purposes. I think probably that is* sangat-sangat *mistaken*. Sebab kalau kita nak fikirkan 20 tahun dulu, *if you have cancer, your survival rates are so low.* Tapi disebabkan R&D *and the continuous innovation into the drugs that come in, so that's why today, cancer patient still have a good chance of surviving.*

One more thing also, I need it to be make known is that because of the pattern, so, walaupun *the pattern periods are for medicine* adalah 20 tahun kan, tetapi 20 tahun sahaja *in which we have the pattern. I believe medicines are one of the very few commodities in the world that pattern* dia adalah dikontrol dekat 20 tahun sahaja. Lepas 20 tahun kita punya *pattern* habis. *So, generic* boleh masuk, harga boleh turun. Betul. Tetapi, apabila ubat itu didaftarkan di Malaysia, *they go through a lot* of processes nak daftarkan ubat, nak daftarkan untuk *marketing etcetera.*

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So, the time to market satu ubat *usually* dalam lapan ke 10 tahun sahaja. *So,* lapan ke 10 tahun mereka jual, lepas itu paten dah habis dah. Lepas itu, *generic* baru masuk. *So,* paling-paling pun 10 tahun.

Satu lagi, ubat ini adalah satu produk yang sangat *unusual* sebab tak ada lagi produk lain apabila kita jual produk itu, habislah. Habis jual, halal kita jual. Ubat itu adalah satu produk di mana kita ada *clinical trial* satu, dua, tiga, empat. Lepas *clinical trial* keempat, kita ada lagi satu yang kelima, namanya *pharmacovigilance. Pharmacovigilance* adalah kita akan *monitor* pemakanan ubat itu seumur hidup, selama ubat itu ada di *market*. *So,* kita sentiasa, selama ubat itu dijual di *market*, kita akan pastikan bahawa ubat itu selamat. *So*, kita akan *continue to monitor*.

Kalau *let's say* dalam 10 tahun tiba-tiba dia punya *monitoring* itu menunjukkan, *"Oh, ubat ini menyebabkan orang yang obese itu menyebabkan mereka ada sakit jantung"*, kita akan tarik balik. Satu dunia akan tarik balik ubat itu daripada *market because* ubat adalah satu-satunya produk yang *we have continuously pharmacovigilance*. Selama 100 tahun pun, kita akan *monitor* keselamatan ubat itu. *Efficacy, and safety of the medicine.*

So, the patent period is only for 20 years. Terima kasih, YB.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Sandakan, lepas itu Kubang Pasu ya.

Puan Vivian Wong Shir Yee [Ahli PAC]: *Okay, thank you so much,* Timbalan *Chair.* Soalan saya adalah— *because we focused a lot on* ubat *which is I think your main. But I want to ask what do you cover other than* ubat *because I have friends that work in pharmaceutical companies, they push sales for like* susu tepung kah, *baby paediatric* kah, *like pampers* kah.

So, I want to know, what do you merangkumi? *Do you* merangkumi *like, for example, old age special products like for their supplements, vitamins and all? Does it include inside or is it just extra work for them? So, can you just explain more on that?*

Puan Kam Ai Teng [PhAMA]: Ubat sahaja. *So, that's why for our member company* memang ubat sahaja. Ya. Tetapi, merangkumi ubat inovatif. *That means* ubat yang baru.

Puan Vivian Wong Shir Yee [Ahli PAC]: *Okay. So, no those test kits,* apa-apa langsung? *No?*

Puan Kam Ai Teng [PhAMA]: Tak ada. Cuma ubat. Ubat untuk penyakit.

Puan Chan Li Jin [PhAMA]: Ubat adalah di golong di bawah dua jenis. Satu adalah ubat *ethical*. *So*, ubat yang perlukan doktor atau farmasi. Itu adalah ubat yang

kita sebut hari ini. Ada satu lagi kategori ubat yang dinamakan *over the counter medicine*. *Over the counter medicine* adalah macam Panadol. Panadol kita tak perlu doktor. Kita pergi ke farmasi, terus boleh beli tanpa *prescription* daripada doktor. *So,* berlainanlah ubat OTC dengan ubat *ethical*. *So,* ubat *ethical* ini memang perlukan *prescription* daripada doktor ataupun *pharmacists.* OTC tak perlu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dah? Sudah habis?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Kubang Pasu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih, Yang Berhormat Pengerusi. Saya ada beberapa perkara saya nak tanya. Pertamanya, *on page* tiga, *page three. Chairman* pun pandai cakap bahasa Melayu, *so, I* boleh cakap bahasa Melayu ya... *[Ketawa] Very fluent.*

Saya tengok *under page three* itu, *medicine only contributes to a fraction of the entire cost of treatment. That title, and table* sebelah kanan, *cost structure of Linkou Chang Gung Hospital*. *I have been to that hospital before when I was in Taiwan. Big hospital.* Taiwan ini dia punya *percentage of* ubat punya kos *towards, total cost is only 12 percent and* kita punya *about 16 percent. So, why the difference between Malaysia and Taiwan? It's 30 percent more?*

Puan Deepti Saraf [PhAMA]: *I think result* itu *firstly I must say that this is the source from the Ministry Malaysia National Health Accounts and it's 2021. I think we have all the data but I think the reports have not been published. Taiwan collects all the data and has it. So, I would say this is the range YB that we should consider.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Don't you have the same data like Taiwan in Malaysia?*

Puan Deepti Saraf [PhAMA]: *We do not. We have— I have not seen it. Maybe we have.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You should have.*

Puan Deepti Saraf [PhAMA]: *Maybe it will be made available to the Parliament.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I don't believe only Taiwan have. All the country will have.*

Puan Deepti Saraf [PhAMA]: *I hope we have. But we have not seen it ourself.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But you are trying not to be transparent, I think. You want to hide the cost. You show only the Taiwan one…[Ketawa]*

Puan Chan Li Jin [PhAMA]: *No, no, YB. Maybe we can put in listing. So, in perspective, what we tried to show today is whatever data* yang kita boleh cari daripada Malaysia. *So,* Malaysia ini kita dah tahu dah susah nak dapat *the data*. *So*, apa-apa data yang kita boleh dapatkan, kita *try to* tunjukkan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *We have few companies here. Can any company volunteer to tell us what is the percentage of your variable cost, fixed cost and the...*

Puan Chan Li Jin [PhAMA]: Sebab yang *the Linkuo Hospital is the cost of the hospital. So, it's not the cost of manufacturing*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Yes. But I'm talking about medicine.*

Puan Chan Li Jin [PhAMA]: *Yes. Talking about medicine.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But it's the same thing. You can translate hospital into your own drugs you make in your company, your factory.*

Puan Chan Li Jin [PhAMA]: *Cannot because how do we calculate the cost of R&D? Because, for example, for R&D…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *R&D, you can calculate what. How much you spend a year, then put in the cost. It's not difficult to put R&D cost.*

Puan Chan Li Jin [PhAMA]: Ya, sebab contohnya kan untuk mendapatkan…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Maybe you all* tak mahu ceritalah *I* ingat.

Puan Chan Li Jin [PhAMA]: Untuk mendapatkan satu molekul, kita kena *test* 10,000 molekul. Kadang-kadang daripada 10,000 molekul itu, hanya dua sahaja yang didapati sesuai untuk dijadikan ubat. Yang lain itu semuanya *fail.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *At the end of the day, that is your total cost.* Kos R&D, *you* masukkan dalam itu. *It's okay*. *But surely you know how much the amount is.*

Puan Chan Li Jin [PhAMA]: *You mean to come out with the same graph, what is the variable cost, fixed cost?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I think you should have. You should have. So that we can see the right amount you spend to produce one drug. The other thing I want to check, ask you is okay, innovator is like the original drug and they are patented. And then, up to 10 years,* dia punya paten habis. *Then generic comes in*. *You* pakai *free* lah. *You* kena buat itu ubat *free* lah, tak payah pakai

bayar dia orang punya inilah, kan. Kalau dia *still patented, you have to pay a certain amount of money to the original company who makes this drug.*

So, that means ubat *generic* dengan *innovator* ini *the same* lah? *Your molecule* semua sama, *your chemical* semua sama, *exactly? Is it the same? Effectiveness is also the same?*

Puan Deepti Saraf [PhAMA]: *If their chemical, I would say they are largely the same Dato'. In biologics, the manufacturing process, et cetera, can be different. So, they are called— they are biosimilars and they are also generics. So, there are multiple categories in the biologic side. But biologic side typically used for very unmet needs in high-burden disease areas such as cancer, rheumatology. So, if they are biologics, the manufacturing process can be different even in the biosimilars or generic versions.*

But if they are chemical entities, I would say that sometimes they use different kinds of binding agents but mostly, the chemical ingredient is almost the same. But of course, I'm sure, I have friends from MOPI can handle that question much better than I can.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Who is the scientist here? [Ketawa] Who is going to— somebody want to say something or what?*

Puan Chan Li Jin [PhAMA]: *Our friends will be able to describe what is the manufacturing process like. It is exactly like what Deepti has described. So, the active ingredient, the API, is the same. So, what happens in the generics is that they will take the API and* mereka akan jadikan *generic* daripada *the API* itu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, generic and innovator is the same* lah?

Puan Deepti Saraf [PhAMA]: *If they are chemical entities, yes. If they are biologics, no.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But we were told by other group some other days, that for cancer treatment especially, you* tak boleh pakai *generic*, *you* kena pakai *the original or innovator. Is it correct?*

Puan Chan Li Jin [PhAMA]: *No. The active ingredient is the* ubat yang— adalah dia punya *compounds* yang sama untuk digunakan dalam *innovator and also generic*. Tetapi, *the fillers and the binders are different. So*, pembuatan ubat itu dia bukan hanya gunakan *active ingredient*. Dia akan gunakan benda-benda lain. Tepung, benda-benda lain untuk menjadikan satu ubat.

So, dalam kanser, mereka menggunakan *biologic products. So, biologics* itu adalah satu *life compound. So, life compound* itu memang susah untuk dijadikan *biogeneric* ataupun *biosimilar* sebab dia memerlukan dia punya R&D *and also the manufacturing process* itu sangat rumit. *So, even* sekarang ini walaupun kita katakan ubat kanser sangat mahal, ubat *biologic* sangat mahal, satu dunia ini *actually* sebenarnya kekurangan ubat-ubat seperti itu.

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That's the reason why the cost susah sangat nak turunkan sebab satu dunia pun berebut ubat itu. *So,* apabila ubat itu nak dibawa ke Malaysia...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, this is the last question. Do you have in Malaysia we make our own drug from day one patented become innovator like from your company?*

Puan Chan Li Jin [PhAMA]: *I believe that one later our friends from MOPI will be able to answer. I believe is also yes or no, I* tak tau lah. Nanti MOPI akan jawab lah. *So, I will pass it over to our friends later.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak ada?

Beberapa Ahli: *[Berbincang tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay. Alright.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Can we let them finish the presentation because we have two more.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You finish first ah?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *We have two more papers.* Boleh? *I think you all go straight to— I mean the* lain-lain Ahli-ahli PAC kita tak mahu balik lambat. Nanti nak balik ke Dewan. *So, can you please just continue?*

Puan Chan Li Jin [PhAMA]: *Sorry.* Saya akan *present* secara ringkas sahaja. *So, the way forward* yang kita nak unjurkan adalah kita mesti fokus *more on preventive health. So,* sekarang ini kebanyakan kos terlalu tinggi sebab ramai *patient* yang datang ke hospital pada peringkat yang sangat lewat. Mereka keadaan yang sangat sakit, sangat teruk baru datang ke hospital. Sebab itu lah ubat dengan harga rawatan sangat tinggi.

Kalau mereka boleh menangkap ataupun boleh mendapati penyakit mereka pada peringkat yang awal seperti kanser *especially*. Kalau mereka boleh *detect* pada tahap yang awal, apabila mereka pergi ke hospital, rawatannya akan sangat lebih murah daripada apabila rawatan sudah *stage 3, stage 4*. Rawatan akan sangat tinggi.

So, the second one is innovative healthcare financing. Kita syorkan supaya— *for example,* insurans sekarang ini kan. *So,* insurans itu dia punya *formatting* itu, dia tidak berapa *friendly* sebab dia dipecahkan kepada banyak-banyak lagi sektor-sektor lain. Contohnya dalam satu insurans itu, satu sahaja bahagian adalah untuk perubatan. Yang lainnya untuk *investment link,* untuk *live coverage. So*, dia menjadikan *the medical* punya aspek itu sangat rendah. *So,* kita kena fikir balik macam mana kita boleh *expand innovative healthcare financing* supaya *healthcare* punya *cost inflation* boleh diturunkan.

Last sekali itu, kita rasa *and* kita berharap lah Dewan ini boleh membantu untuk meningkatkan lagi *investment* dalam kesihatan. Setiap tahun pada pembentangan bajet, kita selalu syorkan supaya lebih *allocation is given to* kesihatan. Sekarang ini *every year* pun kita tengok bahawa *the* alokasi untuk kesihatan itu masih lagi tidak mencukupi. Itu sahaja syor daripada kita. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sila Bayan Baru. *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *back to the previous slide.* Okey, saya nampak bahawa *you are asking us to do more on preventive care and then, insurance must do something. And then, government must do something. How about PhAMA? Pharmaceutical companies? Can you do something to help lower down the cost? What can you do?*

Puan Chan Li Jin [PhAMA]: *We have been investing heavily in patient access schemes. So,* dalam *patient access schemes* itu selama banyak tahun dah. *So, it is like for cancer treatment and* untuk ramai banyak-banyak rawatan yang sangat kronik, kita memang ada macam beli dua, dapat satu *treatment free.* Beli satu, dapat satu *treatment free.*

So, ini adalah data daripada tahun-tahun yang lepas. *So,* setiap tahun itu— *actually this is a bit outdated.* Ini daripada tahun lepas apabila kita *present* kepada Menteri Kesihatan tapi keseluruhannya, *we have given out the value of treatment* yang lebih daripada— sekarang ini saya rasa dah menjangkaui 100,000 pesakit yang mendapatkan *patient access schemes* daripada kami. *So, that is our contribution back to the country.*

Puan Kam Ai Teng [PhAMA]: *Yes. So, in terms of the cost I think we have mentioned this I think for private and government in various scenario, we really try to make sure as many patients in government that can access to our product. So, either true like you said, lower down the cost especially whenever we can that in the government sector. We offer actually reasonable price. That is why especially in*

terms of cancer. More and more innovative drug is made available in the government sector. More patient can access different kinds of new product and patient access schemes.

Memang *over the years we have been— all companies have been trying various design. Some even like buy two, free for life. Many, many kinds. Just to make sure the Malaysian patient have good access to innovative medicines.*

Tuan Sim Tze Tzin [Ahli PAC]: *I think this is okay* lah, *this is one of your effort* lah *I would say. But this is not all encompassing. It is targeted certain groups. What we are looking at is the national level of price going down, okay. And I think as a Malaysian, we must work together* lah. *You know, that's the whole purpose the PAC is calling everyone to find out what you can do, okay. Of course, everyone will say the government must do this, okay. Government must increase in the spending. Everyone told us the same thing but we have to throw back this question to you. What can you do? So, it is possible because big pharmas, like it or not, you know about it. They make big money, okay. Alright. You can disagree, it's okay. We all agree to disagree.*

But however, the issue is that your transfer pricing. Can you work on it to reduce the transfer pricing so that Malaysia can enjoy a cheaper selling price lah.

Puan Kam Ai Teng [PhAMA]: *The increase.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yeah. How about that? Can you work on that?*

Puan Kam Ai Teng [PhAMA]: *So, in fact I think in the recent years if you look at the price increase, those are the things we have been working to be frank, YB. So, that is why in terms of the price for Malaysian market right, despite all the inflation we haven't been increasing. Probably what we see here right maybe the entrance of a new innovative product. So, even then is only four percent. That is why we have been actually working very hard especially many of us in the MNC are Malaysian. So, we also want the price to be affordable for Malaysian. Yeah.*

So, we have been doing that. You have to trust that we have been doing that. That is why you see is apparent in terms of the price increase, actually most company flat. A lot of product we don't increase price for many years. I can attest to at least the organization that I am with. Many products for 10 years, never increase. Never increase price, yeah.

Puan Deepti Saraf [PhAMA]: *I can mainly add to that Roche as a cancer company, for example breast cancer standard of care. Gold standard for breast*

cancer is cheaper in Malaysia by 15 percent versus Indonesia, versus Indonesia which is a much lower GDP market.

Second example in spinal muscular atrophy which a rare disease, we have given RM35 million worth of free products to our patients, to our children so that they can have access for life to these drugs. This is just example of one small indication, one small product. We have multiple such example. I have around 3,000 Malaysian patients on patient assistance schemes where all cancer products, all my products are given with one plus one free, one plus two free. All these things to make sure that patients have accesses to the best care in Malaysia.

Tuan Sim Tze Tzin [Ahli PAC]: *I understand. I just want that the effort to reduce the cost because whatever your buy one, free one whatever, it's not everything, you see. The problem is we have overall medical inflation is that running out of control.*

Puan Deepti Saraf [PhAMA]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Everyone must do something to control it, you know.*

Puan Deepti Saraf [PhAMA]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Or else we will get it spiraled out of control, nobody can buy the drugs, you see.*

Puan Deepti Saraf [PhAMA]: *I understand.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, we are asking whether PhAMA can work out a plan to reduce the cost of medicine. That's my question.*

Puan Kam Ai Teng [PhAMA]: *We will bring it back to the board, like I mentioned actually the members have been consistently ensuring the price, there is no increase in most of the product. But I hear you YB, we will bring it back to the board and try to work on this or even more or maybe at least share something with you all if needed. But be rest assured, we have been putting a lot of effort like to ensure the price of innovative drug doesn't increase more than the inflation. That we can attest to that. Most members are doing that.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, last question from* Kubang Pasu. *Before that ah, how many presentations, can I know? MOPI will present right? Okay, then we have MAPS? M-A-P-S? M-A-P-S will present. Then, we have this what* Puan Harpreet Kaur *from* Persatuan Farmasi Malaysia*. Are you going to present anything?*

Puan Harpreet Kaur a/p Darshan Singh [Pengarah Eksekutif, Persatuan Farmasi Malaysia]: *We don't have slides but we will reading out our statement.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, okay. Good, thanks. Okay,* Kubang Pasu *last one.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, just to extend to what Bayan Baru said. Now, contribution about 16 percent, total cost. You can reduce further* lah. *That is what he means. Okay the other question is, is there any difference of price? Price of sale for government, private hospital, private pharmacy, private GP? Do you have any price differential between when you sell to these entities?*

■1240

Puan Kam Ai Teng [PhAMA]: *So, technically the government and the private— I mean government and private there'll be a difference but between the private channel we have there is anti-competition act, right? So, we have to offer the same unless there is a volume difference.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, generally the same price?*

Puan Kam Ai Teng [PhAMA]: *For private, yes. But private and government is difference.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Government less?*

Puan Kam Ai Teng [PhAMA]: *Government is much lesser. So, that is known.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, if you can do government less why can't you do private less also?*

Puan Kam Ai Teng [PhAMA]: *Because…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Why more for private? The cost is the same.*

Puan Kam Ai Teng [PhAMA]: *Subsidised. So, to be frank…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, subsidised.*

Puan Kam Ai Teng [PhAMA]: *So, to be frank…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Subsidised* tak boleh buat apa. *Subsidised*.

Puan Kam Ai Teng [PhAMA]: *Yes.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay. Landing? [Ketawa]*

Puan Kam Ai Teng [PhAMA]: *Ya. Thank you.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, saya nak terima kasih kepada Yang Berusaha Puan Kam Ai Teng, Presiden *from* Persatuan Farmasi

Farmaseutikal Malaysia (PhAMA) dan juga rakan-rakan dia. *So,* seterusnya saya ingin menjemput Yang Berusaha Encik Ch'ng Kien Peng, Presiden Pertubuhan Industri Farmaseutikal Malaysia (MOPI). Dipersilakan.

Encik Ch'ng Kien Peng [Presiden, Malaysian Organisation of Pharmaceutical Industries (MOPI)]: Yang Berhormat Berbahagia Puan Pengerusi, Ahli-ahli Jawatankuasa PAC, tetamu kehormat, rakan-rakan industri serta hadiran yang dihormati sekalian. Selamat petang dan terima kasih atas peluang ini untuk kami Malaysia Organisation of Pharmaceutical Industries (MOPI) berkongsi pandangan kita.

Kami ingin menegaskan bahawa kos ubat bukanlah faktor utama dalam peningkatan premium insurans kesihatan dan caj perubatan. Sebaliknya, industri pengeluar farmaseutikal tempatan telah memainkan peranan dalam memastikan akses kepada ubat melalui persaingan dalam pasaran generik dan mengukuhkan kapasiti pengelolaan tempatan demi kepentingan rakyat Malaysia.

Slaid kedua. Industri pengeluar farmaseutikal tempatan diiktirafkan sebagai industri strategik dan kritikal untuk negara kita. Sebab-sebab, diberikutnya. Satu daripada dua rakyat Malaysia mengambil ubat yang dikeluarkan oleh pengeluar tempatan. 64 peratus daripada jumlah ubat generik di pasaran Malaysia dihasilkan oleh syarikat tempatan. 47 peratus ubat daripada senarai Ubat-ubat Penting Kebangsaan (NEML) hasil daripada industri tempatan. Industri ini melaburkan RM623 juta pada tahun 2023 dan menyediakan lebih daripada 15,500 pekerjaan di Malaysia.

Tentang MOPI sedikit sebanyak. MOPI kini mempunyai 52 ahli mewakili semua pengeluar utama farmaseutikal tempatan. Ahli MOPI mempunyai keupayaan menghasilkan pelbagai produk berkualiti tinggi yang mengikut piawaian antarabangsa, PIC/S, EU; TGA daripada Australia; US, FDA.

MOPI bukan sahaja mewakili pengeluaran ubat tetapi juga pembekal bahan aktif farmaseutikal API, syarikat pembungkusan dan pencetakan untuk ubat. MOPI memainkan peranan penting sebagai jambatan di antara industri dan penggubal dasar termasuklah dalam penyediaan latihan GMP dan pematuhi *regulatory*. 50 peratus daripada ubat preskripsi di Malaysia dibekalkan oleh ahli MOPI. Industri ini bukan juga turut meneroka teknologi tinggi termasuk vaksin, *biosimilar* dan ubat rawatan kanser.

Persatuan-persatuan industri farmaseutikal di Malaysia PhAMA mewakili syarikat inovator, MOPI pengeluar generik tempatan dan *biosimilar* tempatan, MAPS mewakili pengimport ubat generik.

Di sini menunjukkan ahli-ahli di MOPI. Kebanyakan ahli-ahli MOPI menubuhkan syarikat di Malaysia lebih daripada lima tahun. Contohnya, Xepa yang saya mewakili, 58 tahun di Malaysia. Saya punya rakan-rakan daripada Duopharma, sudah 40 tahun, tujuh tahun menubuhkan syarikat di Malaysia. Saya punya rakan Y.S.P *investment from* Taiwan dia sudah juga 35 tahun di Malaysia.

Industri mengeluarkan farmaseutikal tempatan terus melabur dalam R&D dengan jumlah 1.16 bilion daripada 2019 sampai 2023 dan dijangka 1.56 bilion, 2024 sehingga 2027. Pelaburan *CapEx* 2019 sehingga 2023 lebih kurang 1.79 bilion. Pelaburan *CapEx* untuk *next* tiga tahun dan 2024 sampai 2027, 2.32 bilion.

Rantaian bekalan industri pengeluaran farmaseutikal Malaysia terdiri daripada tiga tahap yang dia boleh nampak di slaid yang kanan. Industri terdiri daripada pengeluar API, pengeluar generik, pengimport, pembekal dan sampai ke tahap dua ialah pengedar dan kemudian ubat sampai ke pesakit melalui hospital, klinik, farmasi, doktor perubatan. Rantaian perubatan yang kukuh memastikan ubat berkualiti dan selamat sampai kepada pengguna-pengguna.

Pecahan daripada pasaran sektor kerajaan dan swasta 2024. Ini data yang *latest* sekali. Slaid ini menunjukkan pecahan pasaran sektor kerajaan dan swasta. Pada tahun 2024 berdasarkan kepada nilai dan kuantiti keseluruhannya sebanyak 12.81 bilion dari segi *value* atau nilai sektor swasta menguasai 73 peratus, RM9.36 bilion manakala sektor kerajaan menyumbangkan 27 peratus, RM3.45 bilion.

Dari segi kuantiti volum, sektor kerajaan membekalkan 57 peratus. Manakala, sektor swasta menyumbangkan 43 peratus. Walaupun sektor swasta mendominasi dari segi nilai tetapi sektor kerajaan masih merupakan penyumbang utama dalam jumlah unit yang dibekalkan. Saya meneruskan kepada slaid yang *next*.

Pecahan pasaran sektor swasta pada tahun 2024, 9.36 bilion dibahagikan kepada *pharmacy sector*, hospital dan klinik. Hospital lebih kurang 29 peratus. Saya *narrow*-kan lagi *next slide*.

Sumbangan ahli MOPI nilai dan kuantiti bekalan ubat generik kepada hospital swasta hanya enam peratus daripada jumlah nilai pasaran hospital swasta datang daripada ubat generik yang dihasilkan oleh ahli MOPI dengan nilai 1.75 juta. Sebaliknya, 94 peratus daripada nilai pasaran hospital swasta masih dikuasai oleh ubat import dengan jumlah keseluruhan 2.54 bilion.

Dari segi kuantiti, 81 peratus daripada jumlah unit ubat yang dibekalkan ke hospital swasta adalah ubat generik keluaran ahli MOPI bersama dengan nilai yang 4.84 juta. *Next slide*.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Can I ask when you say unit mean?*

Encik Ch'ng Kien Peng [MOPI]: Unit maksudnya *counting unit,* maksudnya ubat-ubat katakan tablet, satu tablet sebiji, sebiji. *Sorry*.

Slaid yang seterusnya menunjukkan pembahagian daripada segi ubat kanser, ubat antibiotik suntikan dan *also* contoh-contoh seperti ubat antibiotik *tablet*. Slaid ini menunjukkan lebih kurang empat peratus *(percent)* harga kenaikan bagi ahli MOPI dan ubat antibiotik suntikan yang biasa digunakan di hospital, MOPI ahli kebanyakannya mengurangkan ubat.

Contohnya, katakan ubat daripada rakan saya daripada Duopharma dia punya *gentamicin* untuk suntikan. Dia turunkan dua sen per suntikan. Sebagai contohnyalah.

Punca-punca peningkatan harga di Malaysia kebanyakannya adalah contoh-contoh seperti yang berikut. Deflasi daripada ringgit, kadar inflasi, kos bahan mentah, kenaikan harga siling, kerja lebih masa untuk pekerja di kilang, kenaikan tarif elektrik─ kebanyakannya.

■1250

Sebagai kesimpulan apa yang saya nak menegaskan di sini ialah kos ubat bukan faktor dalam peningkatan premium insurans kesihatan atau caj hospital swasta sebagai faktor yang saya tunjukkan. Pengilangan tempatan penting untuk keselamatan bekalan ubat dalam jangka panjang. Industri pengeluar farmaseutikal tempatan komited untuk mengkaji bagaimana keupayaan pengilang ubat-ubat yang penting kini 100 peratus diimport boleh dikeluarkan atau dihasilkan daripada di Malaysia. Sebagai peranan yang strategi untuk meningkatkan sistem kesihatan Malaysia.

Kami berharap sesi ini dapat membuka ruang perbincangan yang lanjut untuk menyokong dasar yang memastikan akses kepada ubat berkualiti dengan harga berpatutan untuk semua rakyat Malaysia*. This is my end of speech. Thank you*. Saya boleh ambil soalan ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Terima kasih. Saya nak tanya satu soalan yang kita tahu Pharmaniaga adalah pengedar ubat di Malaysia yang terbesar kan. *So, what is the relationship Pharmaniaga and all these drug producers*?

Encik Ch'ng Kien Peng [MOPI]: *Go back to the slide* yang lantai bekalan itu. Pharmaniaga ada dua syarikat. Sebenarnya dia ada syarikat yang *manufacturing*. Dia pengeluaran. Juga ada syarikat yang pengedaran. Tapi dia syarikat yang pengeluaran itu adalah ahli MOPI.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Oh. Bukan ahli yang PhAMA?

Encik Ch'ng Kien Peng [MOPI]: PhAMA itu *association*. Dia mengandungi *company* daripada Sanofi, Brexo, Pfizer. *Company* yang besar-besar tapi Pharmaniaga itu dia syarikat Malaysia.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tapi bukan *member* kepada PhAMA?

Encik Ch'ng Kien Peng [MOPI]: Bukan, bukan. Pharmaniaga bukan *member* kepada *PhAMA Association.* Bukan.

Puan Kam Ai Teng [PhAMA]: *Because of Pharmaniaga there are two parts*. Satu *part* itu memang pengilang. Satu *part* lagi pengedar. *So, the relationship with us is when they are* pengedar *for some of the members for some drugs. Like government tender. So, they have different role in the ecosystem*. Tapi bahagian *the* kilang *one*, *the* pembuatan, memang mereka ahli MOPI.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi. Samalah saya nak tanya tentang MOPI. *You are actually a generic producer*-lah kebanyakan?

Encik Ch'ng Kien Peng [MOPI]: *Yes, yes. I am a generic producer.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, kita *look at the bigger system now* dengan *distribution,* dengan Pharmaniaga*,* dengan ekosistem ini. Bagaimana kita boleh mengurangkan kos kepada ubat-ubatan generik di Malaysia ini?

Encik Ch'ng Kien Peng [MOPI]: Ini soalan yang bukan senang nak jawab. *I would say that you see the price of the local,* tempatan kebanyakan ialah ubat yang *primary care* yang macam *hypertension*. Macam ubat-ubatan selesema. Kebanyakan kita punya ubat untuk jenis yang *primary care*. Hospital swasta ini memang *percentage very low*, okey. Kita punya ubat daripada segi harga sebenarnya kalau *polycule to molecule* harganya memang sudah kurang.

Kalau YB, *you are asking about the margin*, kita punya *margin some of the member* kita memang *public listed companies* juga. Kita pun ada *annual report. You* boleh nampak kita lebih kurang 10 persen sahaja. Lebih kurang. Macam mana nak kurangkan lagi harga? Satu *suggestion* ialah meningkatkan kita punya *economy scale*. Kalau *economy scale* boleh meningkatkan katakan *volume is* besarkan, dia memang boleh menurunkan kita punya kos.

Tapi kita perlukan sokongan daripada katakan *channel-channel* yang—*private hospital* yang *also* membeli ubat-ubat daripada generik. Tengok kita punya *market share is very small* ini. *Six percent*. Kalau dia *increase our market share of course, our member can assist how to reduce price. I hope I answer your question.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry. How about you, yourself, your companies how do you reduce the cost and then* boleh jual murah lagi?

Encik Ch'ng Kien Peng [MOPI]: *As I mentioned, if I wish that if my capacity can be fully utilised better. If my capacity is— let's say 100 indexes. I am using say 60 percent index of my capacity, if I can increase the volume, you have more demand. I can more order. Then my capacity is better utilised. Of course, I can look into better overhead then I can reduce my cost. And I can be better pricing. I hope I answer your question.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. During the Parliament, the Prime Minister has said that there's a cartel in the industry. Monopoly, cartel and etcetera. What do you suggest to the government to break this kind of monopoly and cartel?*

Encik Ch'ng Kien Peng [MOPI]: *YB, can you be more specific in what way you are saying there's a cartel?*

Tuan Sim Tze Tzin [Ahli PAC]: *I am just quoting the Prime Minister when he speaks in the Dewan.*

Encik Ch'ng Kien Peng [MOPI]: *I cannot cite any reason because I am not sure in what angle because not that I know off there's a cartel. Maybe he referred to something I may not know. Can you elaborate?*

Tuan Haji Azli bin Yusof [Ahli PAC]: Tambah sikit soalan.

Encik Ch'ng Kien Peng [MOPI]: *Because of the sign the anti-competition* tak ada kartel, kita ada *problem. But don't think there is no off*-lah*. Yes, sorry YB.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *To say about the cartel. Continue.*

Encik Ch'ng Kien Peng [MOPI]: *No, no, no. I cannot say anything. I don't know what cartel. Thank you.*

Tuan Haji Azli bin Yusof [Ahli PAC]: Tadi tuan ada sebut tentang *increase volume* kan? *But your volume is already 80 percent. [Dicelah] 81 percent. So, how do you think you can increase more volume because…*

Encik Ch'ng Kien Peng [MOPI]: *You see the pie chart they illustrate—* yang tunjuk ialah *pie chart* ini *volume* kita memang besar daripada segi *volume in terms of number in table.* Tapi kita punya nilai memang *very small. YB, of course, asking what can we do more, right?* Katakan kita sudah— *I mean we—* Nak *take out the skin again to go to the next level* apa yang kita boleh buat ialah *one of the possibilities is have a big economy of scale*.

Tuan Haji Azli bin Yusof [Ahli PAC]: Adakah anda juga mengeksport?

Encik Ch'ng Kien Peng [MOPI]: *Yes, economy of scale is including the export*. Saya punya *member* banyak yang juga buat *export*.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Percentage-wise? Because this can increase your volume.*

Encik Ch'ng Kien Peng [MOPI]: *Yes, they are working very hard to increase the volume by export. Some of the members have about 50 percent of the business as export. Some of the members are as small as 10 percent. Different companies have different strategies. Like my company, I am 25 percent is export. So, we are working hard to increase the exports. Of course, that is to improve our technology, our GMP standard. We are working very hard to improve our CapEx in investment to make sure we have a better standard. So,* kalau boleh bersaing dengan luar negeri. Tetapi kalau nak *increase the standard,* memang nak tambahkan kos yang nak melabur, *of course, it is also a chicken and egg situation.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Because* kerajaan ada bagi insentif kan untuk LMW yang eksport, *then you have certain*...

Encik Ch'ng Kien Peng [MOPI]: Sebenarnya Yang Berhormat, bukan semua syarikat daripada MOPI boleh memanfaatkan daripada ini sebab yang SME, saya kata ada *members* yang SME. Saya juga ada *members* yang *public listed company*. Ada kecil, ada yang besar. Kalau dia punya polisi untuk syarikat yang kecil— tapi syarikat kecil itu memang kadang dia fokus dengan Malaysia. Tapi syarikat yang besar memang boleh eksport, ada potensi nak eksport.

Kalau *government* punya polisi yang boleh lebih selaras dari segi *based on potential*. Kalau ubat— katakan syarikat yang kuat, yang boleh eksport juga memberikan geran, yang boleh— sebagai memajukan daya tenaga untuk eksport, ini amat dihargailah.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Encik Ch'ng saya nak tanya, *when you say export*, boleh bagi sedikit contohkah kerana kami bukan dalam bidang ini? Contoh jenis ubat apa dan adakah ia adalah *supplement* ataupun ia adalah ubat?

Encik Ch'ng Kien Peng [MOPI]: Kebanyakan kita punya *members,* sebenarnya buat kebanyakannya ubat. Majoriti yang buat ubat. Ada sedikit yang buat *supplement*. Katakan sebagai Xepa kita punya standard *company,* kebanyakan ialah ubat yang kita eksport bukan *supplement*.

■1300

Bukan Vitamin C macam itu. Kebanyakan yang kita buat itu *prescription drugs* untuk *hypertension* dan *diabetic.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Can give example?*

Encik Ch'ng Kien Peng [MOPI]: *Okay, for example, it can be antibiotic drugs that we export. It can be drugs for low lipid, lowering drug for hypertension that we export. For example, some of our members export until to the South East Asia, of course, to Africa, the Middle East. Some of the members also export to the US, one or two members export to the US. Some of those also export to Australia. So, it's a quite wide spread in the export.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Antibiotic also we export?*

Encik Ch'ng Kien Peng [MOPI]: *Antibiotics also, hypertension drugs, diabetic drugs all kind.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sila, Wangsa Maju.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Just to very clear, MOPI are all the pharmaceutical companies in Malaysia members of MOPI or there are some not members of MOPI?*

Encik Ch'ng Kien Peng [MOPI]: *We only accept member* yang menubuhkan kilang di Malaysia. Kalau dia ada kilang dia baru boleh jadi MOPI *members.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *That means….*

Encik Ch'ng Kien Peng [MOPI]: Kalau dia *trading* saja, buat satu *office* yang lima, empat orang saja tak bolehlah. Tak boleh jadi *member.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *That means all pharmaceutical* kilang *are members of MOPI?*

Encik Ch'ng Kien Peng [MOPI]: Ada lagi satu yang *some of the members yang traditional medicine*, dia bukan MOPI. Kita *membership* punya *open* dia mahu *join* kah ataupun tak nak *join,it's a….*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *So, that means your members all pharmaceutical allopathic medicine are all members of MOPI?*

Encik Ch'ng Kien Peng [MOPI]: *Majority, I would say 91 percent is member.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Okay, thank you. Now, my next question is you produce only generic?.*

Encik Ch'ng Kien Peng [MOPI]: *Yes*.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *What stops you from producing innovative medicine or drugs? What stops you? Are the pharmaceutical MNC stopping you or there's not enough fund from the government or what?*

Encik Ch'ng Kien Peng [MOPI]: *You are asking— okay, I think there two questions. You are saying what stops us from innovation? I think the majority of our members, they started small in Malaysia, 50 over years ago. Until established slowly*

until today. But the majority of them are from SMEs background. They also come out with their own capital. They are very careful as well and when you want to go for an innovation drug, yang ubat-ubat yang sebagai *pharma* yang dia *share, it's all the very high-end cancer drugs, biologic drugs. Those require billions of dollars of investment which is beyond MOPI members can afford. Because when we produced, we also got to worry about a couple of factors. For example, can we sell? Can we sell that Malaysia market could be small, too small for us.*

So, then we do have the ability to export.? If we invest and they take 10 years by the time we can go through all clinical studies yang *Puan Li Jin just now shared. By the time it happens, it maybe 10 years after that. But the 10 years after that, maybe drug investment, billions of dollars, the disease punya pattern may change. So, I can't be sure that I may have the ROI, right? So, that you have to be very careful. So, this is the one true fact that we have. But of course, it doesn't say that it cannot be done if you have the vision on the* wawasan yang boleh sampai itu tahap. *A couple of things we can do.*

In case YB you are asking what kerajaan *can do? What* kerajaan *can do is that perhaps in order to support local manufacturing industry, number one we need consistent policy.* Polisi yang konsisten. Sebab polisi yang konsisten maksudnya, *if you are committed to develop the industry all the way* boleh jadi. *But you have to be consistent* tak boleh ubah-ubah. Sebab *you invest. Invest,* jadi *cannot get back the return. Then,* rugi punya itu syarikat-syarikat punya, *all the* syarikatlah.

The second reason, I can see that the policy also must beside support pelabuhan, *also support generic* lah. Sebab kebanyakan kita mesti ada *generic business* yang boleh kita punya *base* yang kita *how we make the living. So, we that we have the base that we can earn the income. Then, we can invest. If you don't have the base, we don't have more money to invest. So, I mean these two is a one.*

Of course, individual syarikat *we have to find our own way if we want to find technical partners or whatever in order to speed up the development rather than waiting for 10 years. I hope, YB, I have answered your question.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Still trying to find the answers—but, okay you have given the answers. I'm just wondering. You mentioned earlier, Madam about MNC's roles in terms of localising some of your services or your contribution. Do you contribute locally to develop even further local pharmaceutical companies?*

Puan Kam Ai Teng [PharMA]: *So, at this moment, in terms of that, we only invest in shared services for function but not the manufacturing side. So,* kita macam

ada yang— kat *Singapore* ada tapi kat sini tak ada sebab *the reason is I think incentive* kerajaan *is more than that. Also, the high skill worker*, yang itu paling penting. *So, that is why MNC for now,* memang tak ada yang beroperasi *the manufacturing* dekat Malaysia. Tapi untuk *shared service* yang *finance,* IT memang ada. Kita bawa ke sini *and then* untuk jalankan operasi untuk seluruh pelusuk dunia.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Kubang Pasu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya mahu tanya sikit fasal ini *pie chart. Trying to understand. Both of these pie charts* ini *are* pasaran hospital swasta bukan kerajaan? Kerajaan tak masuk dalam ini?

Encik Ch'ng Kien Peng [MOPI]: Ini hospital swasta sahaja.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, Mr. Ch'ng, thank you. Company you* buat apa Mr. Ch'ng di Melaka?

Encik Ch'ng Kien Peng [MOPI]: Saya buat ubat macam *cough and cold* punya *medicine.* Ada *hypertension drugs*, ada ubat yang mata punya, *generic.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *All generic?*

Encik Ch'ng Kien Peng [MOPI]: Semua *generic*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *All generic.* Ya, *Mr. Ch'ng,* di sini kita tengok nilai dia punya *value of money, imported very high, 94 percent, correct?*

Encik Ch'ng Kien Peng [MOPI]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ertinya hospital swasta ini dia pakai banyak *drug imported*, kan?

Encik Ch'ng Kien Peng [MOPI]: Daripada segi nilai…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Nilailah, nilai.

Encik Ch'ng Kien Peng [MOPI]: Tapi daripada segi kuantiti memang *generic* jugalah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Cakap fasal nilai dulu. Nilai dulu.

Encik Ch'ng Kien Peng [MOPI]: Nilai, nilai.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Nilai dulu. Nilai *only the six percent.*

Encik Ch'ng Kien Peng [MOPI]: Ya, *six percent.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey, kalau *pie chart* ini, kerajaan dia jadi macam mana? Berapa peratus?

Encik Ch'ng Kien Peng [MOPI]: Tapi kerajaan tak ada di dalam sini. Kerajaan dia ….

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You* tahu tak? Kerajaan dia *imported* berapa?

Encik Ch'ng Kien Peng [MOPI]: Ya, ya. Katakan saya dari segi— kerajaan, *you can see this slide,* dari segi seluruh Malaysia punya market, 12.8 bilion. Kerajaan (*government*), 27 peratus daripada segi nilai.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That one okay. I'm talking about imported and domestic local companies.* Itu *I* tahu *but how much imported* yang kerajaan punya?

Encik Ch'ng Kien Peng [MOPI]: *How much imported?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You* punya sini *six percent* saja, yang *local*, kan?

Encik Ch'ng Kien Peng [MOPI]: YB *you* tanya tentang....

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Imported drugs.*

Encik Ch'ng Kien Peng [MOPI]:...*generic* saja kah?

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Generic* saja.

Encik Ch'ng Kien Peng [MOPI]: *Generic* saja. Okey, *generic* saja saya punya data yang saya ada sampai 2023 saja, *a year before this.* Kalau *generic, imported* 36 persen. *Local, 64 percent.* Ini boleh nampak daripada slaid yang kedua, 64 persen.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That one* keseluruhan lah?

Encik Ch'ng Kien Peng [MOPI]: Keseluruhan Malaysia.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *66 percent imported?* 64 persen *locak?*

Encik Ch'ng Kien Peng [MOPI]: *Yes*, 2023 data.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Kalau *innovator*?

Encik Ch'ng Kien Peng [MOPI]: *Innovator* lain daripada *generic*. Sebab seluruh Malaysia sebenarnya *innovator* dari segi nilai 2023, 53 persen daripada *innovator. Generic,* 25 persen. Tapi daripada 25 persen ini kalau kita bahagikan daripada 25 persen itu *generic* itu 64 persen *local*. 36 peratus *imported*, okey? Boleh....

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So,* majoriti *local* lah?

Encik Ch'ng Kien Peng [MOPI]: *Majority local* daripada 25 persen itu saja.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *25 percent* itulah.

Encik Ch'ng Kien Peng [MOPI]: *25 percent* itu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey, yang belah kanan itu, *Mr. Ch'ng,* kuantiti. *What are you trying to explain because* kita tengok dia punya itu kalau dalam itu warna yang gelap itu, ubat *generic* daripada pengeluar tempatan, *so,* tempatanlah? *81 percent* ini unit.

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Encik Ch'ng Kien Peng [MOPI]: Ya, itu daripada segi kuantiti. Ini menunjukkan dua faktor lah. Satu ialah memang ubat di dalam kerajaan ini, dia tak mahal.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tapi ini pun hospital swasta juga.

Encik Ch'ng Kien Peng [MOPI]: Ubat daripada kerajaan walaupun dia kuantiti besar tapi dia tak mahal.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ini pun hospital swasta juga?

Encik Ch'ng Kien Peng [MOPI]: Tak, tak. Ini kerajaan dan swasta. Perbezaan jumlah sekali.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ini jumlah kuantiti pasaran hospital swasta. Dua-dua swasta. Saya *refer to this one. Not this one.*

Encik Ch'ng Kien Peng [MOPI]: *Not this one* ya. Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Ketawa] You* tengok lain.

Encik Ch'ng Kien Peng [MOPI]: Okey, okey. *Sorry.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dua-dua swasta,

Encik Ch'ng Kien Peng [MOPI]: Ini ya dua-dua swasta. Inilah menunjukkan kita ubat ini daripada buatan tempatan ini, memang tak mahal.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya tengok— kalau tengok ini yang belah kanan, import hanya *90 percent,* yang *local 81 percent.* Betul?

Encik Ch'ng Kien Peng [MOPI]: Kuantiti? Maksudnya, saya punya...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *When it comes to value, it is different.*

Encik Ch'ng Kien Peng [MOPI]: Ya. Maksudnya kita punya ubat buatan tempatan tak mahal.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ya. *That is why value is less* tapi efektif.

Encik Ch'ng Kien Peng [MOPI]: Efektif.

[Ketawa]

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I* takut juga nanti *you* cakap ini makan ubat sebab itu dia murah sikit...

Encik Ch'ng Kien Peng [MOPI]: *No, no, no. I mean* jika kita buatan tempatan kita punya— sebab katakan yang Puan Li Jin dan Miss Kam tadi *whatever they explained,* maksudnya dia punya ubat itu adalah ubat yang tahap yang lebih tinggi lah, dia punya ubat kanser, ubat *biologic* yang dia punya *disease,* bukan benda lain.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Bukan biasa macam Panadol lah?

Encik Ch'ng Kien Peng [MOPI]: Kita punya ubat memang kebanyakan...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Panadol kita buat di Malaysia kah?

Encik Ch'ng Kien Peng [MOPI]: Buat Malaysia ya. Buat di Malaysia.

Tuan Haji Azli bin Yusof [Ahli PAC]: *I try to* tambah sikit boleh ya. Boleh mencelah?

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Boleh, boleh mencelah *[Ketawa].*

Tuan Haji Azli bin Yusof [Ahli PAC]: Saya cuba *compare value* dengan *volume* itu. Bila *you* buat perbandingan ini adalah *you* buat perbandingan untuk aplikasi yang sama kah ataupun *different?*

Encik Ch'ng Kien Peng [MOPI]: Tak. Itu aplikasi, dia ada banyak-banyak...

Tuan Haji Azli bin Yusof [Ahli PAC]: *No. Within the range* maksud saya itu. *Let say you* masuk Panadol, masuk *this one,* paracetamol lah *let say. Paracetamol is common name* lah untuk aplikasi demam contoh kan. *Then* tapi ada yang *local generic* dan ada yang import. *So are you referring within the same scope?*

Encik Ch'ng Kien Peng [MOPI]: *Yes, yes. But this slide is talking about usage,* nilai *and the…*

Tuan Haji Azli bin Yusof [Ahli PAC]: *No, no, no. So because I compare* ini kalau harga ubat yang import ini, satu tablet lah RM2.30. Yang *local* punya baru empat sen saja. *I used your...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The volume when the price* ya?

Tuan Haji Azli bin Yusof [Ahli PAC]: Ya. *Because of the value. So* memang...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Very cheap* lah.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Too cheap* lah. *So* kita *worry* juga tadi macam *you* cakap.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Worry* juga.

Encik Ch'ng Kien Peng [MOPI]: *Thank you for...*

Tuan Haji Azli bin Yusof [Ahli PAC]: *But we use generic.*

Encik Ch'ng Kien Peng [MOPI]: *But* ini yang kita katakan ialah banyak ubat yang katakan yang RM1 sampai ubat yang RM10 itu ada *more than* 1,000 ubat tahu*.* Sebab ini *general* punya slaid lah.

Tuan Haji Azli bin Yusof [Ahli PAC]: Satu lagi *I* nak tanya. Dalam sini, berapa SKU *approximately?*

Encik Ch'ng Kien Peng [MOPI]: SKU, *offhand* saya tak ada data sini.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Roughly* lah.

Encik Ch'ng Kien Peng [MOPI]: Saya tak pasti. *More than 1,000.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Pharmaniaga dia masuk dalam ini kah?

Encik Ch'ng Kien Peng [MOPI]: Pharmaniaga ubat yang keluar daripada Pharmaniaga masuk ini.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Masuk sini ya?

Encik Ch'ng Kien Peng [MOPI]: Yang menghasilkan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Pharmaniaga dia tak eksport?

Encik Ch'ng Kien Peng [MOPI]: Dia ada juga— berapa persen saya tak pasti tapi dia ada eksport juga.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Last* sekali Mr. Ch'ng, tadi ada YB dah tanya fasal *what is stopping you from producing your own drugs? After all generic* dah *copy* dah pun, *pattern* tak *dak. Why can't we do our own drugs here compared to you* ambil dari luar dan teknologi? Kalau *you* nak *start* dari awal nak buat *pattern,* itu lain. Jadi inovator. Saya pernah pergi US, saya ada tengok satu *lab* dia orang buat. *It takes five six years.* Dia *test* dekat itu tikuslah apa lah kemudian baru *to human being. What is stopping you? You can give cheaper.*

Encik Ch'ng Kien Peng [MOPI]: Ya. *As I explained just now, all those are require billion of dollars investment.* Dia punya *starting from the phase 1* study, *phase 2, phase 3, all the studies and the tests— is a take time.* Kalau kita buat itu *investment*, yang *any* syarikat yang buat itu *decision to invest, they were taking a risk. So that risk, is that I explained just now,* tak pasti adakah ada *return on investment.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You* kena macam *ini get government support* tapi kena serius lah. *Government will support this kind of thing. R&D very expensive before you get...*

Encik Ch'ng Kien Peng [MOPI]: Ya, betul tetapi ubat yang— ya, R&D memang *very expensive.* Tetapi katakan kanser punya ubat, lebih daripada 100 jenis *tahu*. Tapi mana *tahu* katakan satu syarikat yang nak ..

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak apalah *you* jangan buat kanser lagi. Buat lain dulu lah.

Encik Ch'ng Kien Peng [MOPI]: Ya, ya. Kalau kita hendak pilih satu ubat, macam mana kita tahu satu ubat yang sesuai yang kita menerokakan teknikal R&D itu dia akan popular, yang boleh digunakan daripada masyarakat, kita tak pasti lagi. 10 tahun tahu sebab dari sekarang tahu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey Mr. Ch'ng, *thank you, all the best.*

Encik Ch'ng Kien Peng [MOPI]: Ya, ya. *Thank you, thank you.* Terima kasih.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Tuan Pengerusi, Datuk Wira Pengerusi, soalan.

Pertama yang saya merujuk kepada slaid ini, *the slides in front of us. Just want to get the further clarification. This is one is for the* hospital swasta yang ubat import itu *can I say does that include the patented or drug that account for the higher value?*

Encik Ch'ng Kien Peng [MOPI]: *Yes. The* ubat yang import itu, mengandungi ubat generik kah, ubat original— semua masuk.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *All sort drugs* lah.

Encik Ch'ng Kien Peng [MOPI]: *All sort, all sort.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Patented and generic. Then number two, I would like to find out— okay now, generic drug, just now you mentioned 36 percent versus 64 percent. 36 is…*

Encik Ch'ng Kien Peng [MOPI]: *36, 36.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Imported. 64 is locally manufactured. Now, similar active ingredient for example medication for allergic, active ingredient A,* dia punya *producer that particular in the drug. One is imported, one is locally produced. What is the price differential for that particular medication? Local cheaper or local more expensive or various among different…*

Encik Ch'ng Kien Peng [MOPI]: *I feel that— ya, because there is different many, many brands* yang *imported* jenis sebab Malaysia kita memang *free market,*

kan? *So* dia kalau kan ubat-ubat yang dia import, katakan alergik punya *drug,* dia ada dia punya *pricing strategy* lah.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Set for example one particular drug* lah. *Drug A*…

Encik Ch'ng Kien Peng [MOPI]: Alergik punya ubat, saya tak…

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Antihistamine* lah *for example.*

Encik Ch'ng Kien Peng [MOPI]: *Antihistamine* ya. Okey katakan *antihistamine* untuk alergik yang biasa kita guna katakan...

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *They are imported...*

Encik Ch'ng Kien Peng [MOPI]: Selesema punya lah, selesema. Ubat yang biasa kita semua— katakan Zyrtec daripada Glaxo. Dulu sebelum saya kerja di Xepa di Malaysia, saya memang kerja di Glaxo. *So* Glaxo kalau dulu— kalau sekarang dia punya Zyrtec, ubatnya lebih kurang RM5.00 katakan, Malaysia *local* punya lebih kurang lima kali daripada...

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Five times cheaper?*

Encik Ch'ng Kien Peng [MOPI]: *Five times cheaper.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Locally produced* lah. *Across the board, it is more than the same* lah *for the drugs.*

Encik Ch'ng Kien Peng [MOPI]: Tetapi Zyrtec memang dia *branded. Reputation very high. So, you know it is— there's reasons for their price is higher.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *So, my third question is okay, you are locally produced or manufactured drugs, how many percent of the raw material are being imported?*

Encik Ch'ng Kien Peng [MOPI]: *I would say 90 percent more than the API is raw material. The raw material* ada dua jenis lah. Ada katakan *packaging material* itu dia memang kebanyakan *local.* Tapi kalau kata API yang *active pharmaceutical ingredient,* ubat-ubat itu yang *all the effluence,* dia kebanyakan import dari India kah, China, *European,* kebanyakan.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Okay. If you look for the past five years, pre and post COVID because there is a lot of issue of logistics, during those time, how far does it affect the pricing, the price of your locally product drugs?*

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Encik Ch'ng Kien Peng [MOPI]: *I think* kalau *raw material* bila masa COVID-19 itu dia punya memang *spike* sangat tinggi. Tetapi sekarang dia sudah *normalised* sikitlah dia *normalised*. Tetapi dia *normalised* dia masih tinggi sikit daripada yang sebelum COVId-19 itu. Walaupun dia tak setinggi *peak* bila COVID-19 punya masa. Tapi walau dia *normalised* tadi tapi dia masih tinggi sikit.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *So, now its normal-*lah?

Encik Ch'ng Kien Peng [MOPI]: Normal tapi dia masih tinggi daripada lain-lain punya segi. Kadang— walaupun dia taka ada logistik punya isu, tapi kita ada isu lain sebagai USD, *currency exchange and* lain-lain punya *factor*.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *So, my last question is on this generic drug. How far is it true that the absorption of that particular drug compared to the patented one and similar drug, one is patented, the other one is you know are generic. Is there any variation in terms of the absorption?*

Encik Ch'ng Kien Peng [MOPI]: *Okay, Malaysia MPIA is quite effective— very effective regulatory agency. If whatever we want to register, we need to pass through the biologic, bioequivalent study.* Kalau *bioequivalent study passed and we register in Malaysia, the efficacy is as good as the original.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Encik Ch'ng Kien Peng [MOPI]: *Again? Sorry.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara] How many years does it take for you to get it being a certified by that certification body just now?*

Encik Ch'ng Kien Peng [MOPI]: Katakan *we have formulation, we file in— let's say we develop, it takes two years to develop and then we file in. File in normally we have 18 months and the MPIA will approve.*

Dr. Hajah Halimah Ali [Ahli PAC]: Datuk Wira nak tanya*. So, this all* bekalan ubat *including injectables?*

Encik Ch'ng Kien Peng [MOPI]: *Yes.*

Dr. Hajah Halimah Ali [Ahli PAC]: *And traditional?*

Encik Ch'ng Kien Peng [MOPI]: Tak.

Dr. Hajah Halimah Ali [Ahli PAC]: *All western medicine?*

Encik Ch'ng Kien Peng [MOPI]: *Western medicine.*

Dr. Hajah Halimah Ali [Ahli PAC]: *That volume is very glaringly very— it's just* terbalik *all the* nilai*. Do you have new, new drugs? How much of these are new drugs?*

Encik Ch'ng Kien Peng [MOPI]: *Like we say, new drug* yang *NCE* itu *new entity* kebanyakan yang *patented* dia memang *imported.*

Dr. Hajah Halimah Ali [Ahli PAC]: *It's all imported.*

Encik Ch'ng Kien Peng [MOPI]: *Yes, imported.*

Dr. Hajah Halimah Ali [Ahli PAC]: *You don't have any in Malaysia?*

Encik Ch'ng Kien Peng [MOPI]: *So,* sebagai yang *PhAMA Association explained of course they invested in R&D. Invested so much in R&D billions dollar and so many years so they are normally priced on the high side in order to get like the return.*

So, because there is a lot of investment upfront, they have spent. You can see the quantity is small for special disease tapi dia punya ubat memang mahal sikit sebab dia punya *quantity for that kind of disease* untuk *smaller population of people.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Or do we have advancement like nanotechnology, you increase in bioavailability, use the skin absorption thing, do you have— how much is spent on improving a little bit higher-end kind of medicine?*

Because you said the raw materials are imported so actually the final product it can actually improve it a lot and actually export it somewhere else who can pay more like Singapore or something. We are still— we just doing what we need right?

Encik Ch'ng Kien Peng [MOPI]: *Yes okay. Maybe it's twofold to explain. YB, you are asking about the innovative drugs, right? Are talking about innovative drug or you talking about local generic?*

Dr. Hajah Halimah Ali [Ahli PAC]: *Well, it's kind an irony. Thing like your malaria treatment, the actual product is from here tropical areas* tapi yang *patent is in US,* kan? *They making tonnes of money from there,* kan?

Encik Ch'ng Kien Peng [MOPI]: *Malaria drugs I don't…*

Dr. Hajah Halimah Ali [Ahli PAC]: *Chloroquine.*

Encik Ch'ng Kien Peng [MOPI]: *Hydroxychloroquine…*

Dr. Hajah Halimah Ali [Ahli PAC]: *Initially it's all from this tropical forest.*

Encik Ch'ng Kien Peng [MOPI]: *The biggest hydroxychloroquine producer is in China. One of the companies produce about 70 percent…*

Dr. Hajah Halimah Ali [Ahli PAC]: *Where do you get the raw material?*

Encik Ch'ng Kien Peng [MOPI]: *Yes, but they actually have to process, they still have to chemically process. It's not just raw material straight where you can use.*

So, when they process, it includes a chemical plant and that plant is the biggest producer of hydroxychloroquine if I know it's from China. Of course, Sanofi

also have a drug for that kind of treatment. In case if you want to say it more about from Sanofi you want to say anything, yes.

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Use your microphone.*

Puan Deepti Saraf [PhAMA]: *No, I'm trying to understand like the question is about what….*

Puan Kam Ai Teng [PhAMA]: *I mean to produce higher-end generic, I think. [Bercakap tanpa menggunakan pembesar suara]*

Puan Deepti Saraf [PhAMA]: *Correct. I think it's more about how do you innovate to produce higher-end generics which I cannot answer.*

Puan Kam Ai Teng [PhAMA]: *Higher-end generics...*

Encik Ch'ng Kien Peng [MOPI]: *Okay. YB your question is how generic can innovate is it?*

Dr. Hajah Halimah Ali [Ahli PAC]: *Yes. We are kind of the same level what last 10 years, 20 years?*

Encik Ch'ng Kien Peng [MOPI]: *No, you see current local so* kita punya syarikat *yang MOPI members for us is we are focusing at this moment our business as well on patented of patent drug [Tidak jelas] when you come to generic. So, patent when they are off from the dead period and we want to replicate and develop it is also not easy.*

Some of the generic if you want to mimic the original drug is also a lot of investment in order to come to study and to improve the bioequivalent. Of course, that we have invested. As you can see the slide just now with our members spend billions of ringgit in the investment R&D, you know. In the slide I just show you just now.

Dr. Hajah Halimah Ali [Ahli PAC]: *Are you involving the higher education centres, universities and all that or is purely by the company. Drug company?*

Encik Ch'ng Kien Peng [MOPI]: *Some of our members are also involve* kerjasama*, collaboration with the university for the sole development like…*

Dr. Hajah Halimah Ali [Ahli PAC]: *Clinical trial, you said about clinical trial as well.*

Encik Ch'ng Kien Peng [MOPI]: *Clinical trial, the latest end or also sometimes in the earlier stage of the formulation. Some of the members do work closely with the university.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Yes, yes*. Kalau tak ada saya ucapkan terima kasih kepada pihak MOPI di atas pembentangan itu tadi.

Encik Ch'ng Kien Peng [MOPI]: Terima kasih.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kita akan pergi kepada pembentangan ketiga, MAPS ya. Saya harap kita boleh habiskan pembentangan MAPS ini pada jam dua.

Encik Lim Teng Chyuan [Malaysian Association of Pharmaceutical Suppliers (MAPS)]: Terima kasih. Nama saya…

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kalau nak bertukar tempat pun boleh supaya nampak ya. Boleh duduk di depan, tepi ini pun okey. Ini apa? Persatuan Farmasi Malaysia. MAPS.

Encik Lim Teng Chyuan [MAPS]: Selamat tengah hari. Nama saya Lim Teng Chyuan. Dengan izin saya akan menggunakan kedua-dua bahasa Malaysia dan Inggeris untuk persembahan ini sebab ada rujukan-rujukan yang dalam bahasa Inggeris.

Pengalaman saya dalam industri farmaseutikal hampir 36 tahun. Saya bermula sebagai ahli farmasi komuniti lepas itu— yang itu untuk dua tahun. Lepas itu syarikat MNC sembilan tahun. Bekerja di luar negeri di Myanmar, tiga tahun. Lepas itu industri generik sehingga sekarang. Kami tunggu slaid ya.

I have included references listed in the slides. If you see a sub superscript with a number, it refers to the last page of the presentation which are the references and the page number is stated together with the reference.

So, I hope to be quick because most of the point has been raised and there is actually not much more that I can add to what has been discussed. Is it okay? The slide ready? Okay.

Saya mewakili Malaysian Association of Pharmaceutical Suppliers (MAPS). Ada 37 ahli biasa iaitu syarikat-syarikat yang terlibat dalam urusan penjualan, pemasaran dan pengedaran farmaseutikal di Malaysia.

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Produk kami kebanyakannya generik yang diimport dan harga kami ini murah dan sumber import kami ini mesti menepati standard yang diset oleh Agensi Regulatori Farmasi Negara (ARFAN). Antara syarat-syarat termasuk GMP yang setaraf dengan PICS dan kajian *bioequivalence*. Komponen-komponen *healthcare* ada banyak. Fokus kepada kiri iaitu antara caj-caj atau komponen yang terlibat. Tapi, saya nak fokuskan kepada yang kanan. Menurut *MH8 Reference* yang sama dengan

PhAMA, 15 peratus dia— dia kata 16 peratus *but yet* 15.7, okey. *15.7 percent to total healthcare cost in the private market.*

Because today's proceeding is on private, so I am not going to touch on the public and also the impact on the insurance. So, I am only going to limit it to this. I am not going to talk about investment or anything else. So, what is defined by medical goods? It's not just pharmaceuticals, if you go to the reference it says, pharmaceuticals appliances as well as Western medicine, TCM etcetera. So, it's not fit— not limited.

So, 15 percent is already an overrepresentation of pharmaceuticals. This percentage is measured at the healthcare provider level. Meaning it was so dark…

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Sorry, can I interject?*

Encik Lim Teng Chyuan [MAPS]: *Yes, please.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *What do you mean by Western medicines? Allopathic medicine?*

Encik Lim Teng Chyuan [MAPS]: *Ya. Allopathic medicine. Ya. If I may continue. Okay. This percentage is measured at the healthcare provider level. Because when we talk about private healthcare, they come in the form of hospitals, private hospitals, clinics as well as pharmacies. Even sometimes department stores even the mamak stalls can sell you paracetamol. Okay. So, this is— private sector actually is very old and composing. You can go to KK Mart and still some cough mixtures as long as not under the Poison Act.*

Markups range from 24 percent to 402 percent, depending on outlets, this study is done by Nur Sufiza who is right now with a pharmacy program, pharmacy services program. The markup of medicine prices was genuinely higher in private hospitals and community pharmacies. The markup for generics genuinely is higher, generic medicine was markup at 31 percent to 402 percent and innovated drugs were markup from 24 to 86 percent.

I am going to take a bit of time here because there's some confusion in the house when we talk about markup and margins, they are not the same. All right?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Can you please share with us, I mean the 402 percent itu?*

Encik Lim Teng Chyuan [MAPS]: *Ya. It's in the study reference number two. I don't bring the study here because that will be a lot of 20 handouts will be a lot. All right. But you can download it actually if you just Google it, you can download it. So, this is a study done by the Ministry of Health itself. I just want to make a bit of*

correction here, on the talk about margin and markup which are very different. Because when you talking about margin, you are not talking about markup.

But we are here we are talking specifically about markups for the benefit of the house. Margin is when you take the price differential and divide it over your selling cost. Where markup is you take the price differential and divide it over your purchase cost. So, generally, margin and markup are not the same. But the same markup can be different from the margin. For example, 25 percent is actually a 35 percent markup, all right? I hope you follow me.

Let's look at the theoretical— next slide, please. Oh sorry— back to the slide before. The reason why generics are markup at 402 percent or even higher. There's a reason for it. Take for example, a strip of doxycycline, 10 tablets are five days of treatment and our cost to the healthcare provider is probably only RM1. So, if they are going to markup 30 percent, it's not even worth the time of the doctor to go and dispense it. So, it's justifiable sometimes, if they markup 402 percent for generic. Just to cover their cost.

Next slide, please. So, I am going to give you the theoretical impact of medicine price and I am using this very loosely based on the previous definition that is pharmaceutical appliances etcetera. So, if we take a theoretical total do of RM10,000 from the hospital and the medicine component is RM1,500. So, the non-medicine cost is RM8,500.

Looking at the before and after, the scenario of— if at all, pharmaceutical suppliers like MOPI, PhAMA and MAPS members increase by 10 percent. The medicine component goes up to RM1,650. So, in fact, a 10 percent rise in our cost gives only a 1.5 percent rise in total healthcare cost holding all costs or other costs are the same. Next slide, please. So, I worked out a chart here on theoretical on the lower axis it the price increases by the pharmaceutical company and the vertical axis will show the— its impact if we hold all other prices. Even if we have a 100 percent price increase in pharmaceuticals, the total healthcare cost does not even go up to 20 percent. Next slide, please.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry.*

Encik Lim Teng Chyuan [MAPS]: *Okay. Sorry*.

Dr. Hajah Halimah Ali [Ahli PAC]: *That's the theoretical*-lah.

Encik Lim Teng Chyuan [MAPS]: *No, I am just saying that the component by pharmaceutical companies does not move the needle when it comes to the cost of healthcare.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Okay. I will be the devil's advocate*-lah.

Encik Lim Teng Chyuan [MAPS]: *Okay, please.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Okey. Because you are not here. What about twisting it the other way round? Don't worry. I am a doctor, so I am with you okay? Medical doctor. Okay. So, what— when you say that if the others do not increase in price or the other healthcare thing, only the medicine increases a little bit? What about the other way round? If the medicine doesn't increase and the other say they have got to increase. Because this [Tidak jelas] whatever electricity bill* naiklah *whatever. So, what's your comment?*

Encik Lim Teng Chyuan [MAPS]: *Thank you, Dr. Halimah. I am representing the pharmaceutical industry. I can only speak on the knowledge that I have within the pharmaceutical industry. As for the hospitals, whatever the cost, they want to increase, I have no credibility to justify it. I hope you accept my answer because I am not in that industry. [Dicelah]*

Okay. When healthcare professionals are paid by insurance, it can be from personal as well as from employer. Personally, it impacts patients directly as patients pay out of pocket for the premium themselves. From the employers, even the public is affected because when the employer pays the premium, it comes out of profit.

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So, either way, the rakyat *suffers when the insurance premium increases. I won't read the caveat but let's move on to the next slide.*

Another way we can pay our healthcare professionals is paying directly out-of-pocket from the patients. This has big issue when it comes to catastrophic events like cancer or you can have a rare disease like a metabolic disease. So, this can go up to hundreds of thousands in cost. Malaysia has a high rate of out-of-pocket expenses at 35 percent compared to Thailand, which is nine percent and Brunei. Sometimes, rarely, I'm considering it because of the healthcare insurance increases are to cancel all my insurance and pay directly from the company.

So, impacts of rising premiums. The next slide, please. I can talk a bit more on insurance because I'm married to a person who used to work for ING benefits, if you know what that means. But she has taken VSS seven years ago. The impact of rising premiums are out-of-pocket people will go, will cut back and they become underinsured. Some may even go to the extent of canceling their coverage and others will be diverting to public healthcare which offers RM1 for general and RM5 for specialist treatment. This will lead to an increase in government expenses and it could also be leading to some optimum intervention in private healthcare intervention if, let's say, they opt to cover less.

As for employers, the same thing where we can be underinsured. We can underinsure our staff, cancellation and also, we can resort to the reimbursement model. Lately, even YB Bayan Baru has mentioned about hospitals charging more for insurance patient. So, if I were a company, I would rather pay out-of-pocket than to pay through insurance. Next, please. Role of insurance.

Sorry. Now, all of them are there. But I'd like to focus on two things. One is the pooling resources. That means anybody who buys an insurance is spreading the risk. The other thing which is not talked about is an insurance company is supposed to invest and they should have investment income. So, this extra income should also be used for the benefit of the payers rather than the benefit of the company.

If I may move on to the next slide. So, this is the question that I'm posing not just to the PAC but to the country. What is a reasonable premium? Based on the MNHA report, the per capita expenditure on health was RM1,974 in 2019. So, how much higher than RM1,974 per year is a reasonable premium?

Now, on the claim ratio, which was brought up in the previous session here at the dewan bankuet. I'm giving this case here from a schoolmate of mine. I'm privileged in that because of my wife's uncovered. So, I don't— even though she has taken the VSS, so I don't really know the problem that the normal rakyat faces. But I got this from a schoolmate. I have chosen to redact the name in this case because it contains some medical conditions that are listed there. So, for the privacy of the patient, I'm just not showing the name.

But if we were to look at it, assuming there is no increase in premium from 2018 to 2023, he paid for RM42,000 in premiums. He only totally claimed RM23,000 between 2023 and 2024. The claim ratio is 47 percent, ignoring premiums paid thereafter. So, I don't see the justification for the increments for 2024 onwards.

Now, this is his wife. I don't redact the name because there is no medical information. So, she has paid RM21,000 in premiums until 2024 with no claims and her premium jumps to 47 percent and another 47 percent. So, I don't see a rationale for this kind of increase. She cannot— the insurance company cannot say, "Because she claimed and therefore, we have to cover".

So, this next slide is for my company. There are two periods there, but in essence, what you see that we paid premiums and we had claims. We have overpaid between RM63,000 to RM96,000 based on the period. So, every time we make a claim, they will increase their premiums. Okay. Now, I just want to show to you that as generics, we are not very profitable.

The reason why I can show this next slide is because it's my company. I can't divulge information from other companies. So, medicals profits were RM456,000 on RM17 million of sales in 2017. You can get it from the MyCC report. So, medical profits dropped to RM225,000 on RM22.5 million in sales in 2023. Our profits are almost half despite a 32 percent increase in sales and the 2023 report is actually you can get it from the CSMM.

My last slide, the concluding slide. It may seem like the insurance pays but finally we pay. Either out-of-pocket or via employers to the insurance companies. Insurance companies gain very much via annual hikes like the case of my schoolmate's wife and claims-based history which is in the case of my company. So, what I'm concluding is that BNM needs to regulate such hikes so that it is reasonable. With this, I conclude my presentation. Thank you. I'm ready to take any question.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya bukakan *to* soalan.

Dr. Hajah Halimah Ali [Ahli PAC]: *Okay. Why was your profit reduced even though your sales increased in 2023?*

Encik Lim Teng Chyuan [MAPS]: *Thank you Dr. Halimah. I was hoping someone would ask that. Basically, we are very careful with price increases. Since 2017 until last year, we have maybe increased prices twice over a period of seven years despite the US Dollar strengthening because MAPS is, our members are fully 100 percent based on imports. Whether you like or not, the imports are denominated in US Dollars. I've spoken to my Japanese supplier, 10 years ago to pay them in Yen. They say they will think about it. They are still thinking about it. I have a supplier from Europe and they want US Dollars.*

So, among all my suppliers, I have only one accepted Euro, but recently they decided to go with another company. So, I don't represent them anymore.

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Tuan Sim Tze Tzin [Ahli PAC]: *Thank you so much, Mr. Lim. Okay, for pharmaceuticals, there are a lot of suppliers. Some of the local suppliers are equally good. So, for example in Bayan Baru, there are about 30 companies supplying medical— pharmaceuticals, stringers, all kinds of pharmaceuticals.*

But they used to be the manufacturer— the machine manufacturer for B. Braun. So, they master the skill of doing this high-end very sophisticated, very precise medical or what they call pharmaceutical products. So, after many years of supplying to B. Braun, they still do, the machine for them but they also do their own these pharmaceutical products.

But what they found is that a lot of local companies are still comfortable to buy import, you know B. Braun products whatsoever and not choosing Malaysian made in Malaysia. Whereas they themselves has already sold their products to Europe. That means they are actually equally good and they have all these MDA certification. So, my question is can we try out locally made products, okay.

So, maybe you can get more margin and it is cheaper, alright. And then supply to our market. So, that actually we all win lah *in terms of Malaysian. Malaysia's company can survive, the hospital can lower the cost, and actually you know, economy of scale for Malaysian companies as well. What do you think?*

Encik Lim Teng Chyuan [MAPS]: *Thank you YB. Okay, I need to make a bit of clarification on what you have just said. There are two things involved here in your question. One, is we are talking about medical devices. Today we are basically talking about pharmaceuticals. So, they are regulated differently. I think that Malaysia is one of the top actually producers of medical devices. A lot of medical devices are rubber products. Take for example. Many years ago, we used to— it's a very strange arrangement. We used to represent a company called Bard in the area of urology, okay.*

And you have these catheters which you insert into the urinary system for various reasons. Sometimes it could be due to a prostate cancer. They have done something called a turb procedure and you need the catheter to stop the bleeding. A lot of the products— There's actually a factory in Kulim, Bard factory in Kulim and they produce a lot of Bard products. But the strange thing is that policy of the company is that even though is made in Kulim, it has to be sent back to US and US will bill us.

So, it's the policy of the companies that are the owners— they make such policy and there's nothing we can do about it.

Tuan Sim Tze Tzin [Ahli PAC]: *But these are MNC.*

Encik Lim Teng Chyuan [MAPS]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *We are talking about locally— local branded products.*

Encik Lim Teng Chyuan [MAPS]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, so there's a lot of supplies in this company.*

Encik Lim Teng Chyuan [MAPS]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *But I think it is not known and sometimes we have a tendency to look up B. Braun, everything B. Braun is good, you know. It may*

not be because at the end of the day, who master the skill to produce it is more important. The rest is just branding lah.

Encik Lim Teng Chyuan [MAPS]: *Exactly. Again, we are diverting but I will answer your question because I also deal with the MDA. Bard basically is governed but except for their drips, most of their products will be under the MDA. So, yeah, there are good local producers. The problem like you have mentioned is marketing. It's that the usually MNC's would have— they would pay a highest salary to get people who are more 'suited' to that kind of a job.*

Whereas the local ones are more focused on the basic getting the things done rather than marketing. I hope I have given you an implication to think about.

[Pembesar suara dimatikan]

Dr. Hajah Halimah Ali [Ahli PAC]: *Last* lah kot. Nak tanya lah mungkin *open to* apa kan. *Not just their— you also in charge of this imported original medicines from the West. No? No? Yeah, okay.*

Encik Lim Teng Chyuan [MAPS]: *Let me, okay if you back to my number two slides, number two, I said mainly, mainly…*

Dr. Hajah Halimah Ali [Ahli PAC]: Tak apa lah. *On this time* lah.

Encik Lim Teng Chyuan [MAPS]: *But like over 90 percent of our products are generics.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Okay.*

Encik Lim Teng Chyuan [MAPS]: *There will be some small companies. Take for example the company that I represent from Japan is called Meiji. It is actually an MNC but we started in 1951. Although the company I had in Malaysia is 1967, but 1951 we actually dealt with Meiji. At that time, the big drugs then were kanamycin, streptomycin and it's very important for TB. But these products have fallen out of favour. So, although I represent an MNC among my companies but we don't have any more innovator products from the company. So, that's why I'm saying we are generally mainly generics.*

Dr. Hajah Halimah Ali [Ahli PAC]: *In that case, I transfer my questions to the relevant* ini lah. *Right now, you got— I'm not sure, I already too much in politics I suppose. The importers of supplies medicines and all that were generally Apex, Zuellig and all that* kan? *What a monopoly of all the imported medicines and as the whole medical supplies. Is that right? No? Are we having diverse now?*

Encik Lim Teng Chyuan [MAPS]: *No. Can I clarify it? Actually it is very hard to get a monopoly in pharmaceuticals because there are so many drugs in so many therapeutic categories, alright. If you follow the IMS therapeutic class, there are a few*

hundred therapeutic class. Within the same therapeutic class, there can be 10 different products. When I was studying pharmacy, for oral antibiotics there are only two classes which is Biguanides and Sulfonylureas. Now you have help me with it. 10 different classes. Within the class itself, there could be another 10.

So, there is no actual monopoly or cartel but the problem is when it comes to distribution. But then again, it's a question who you prefer to work with when it comes to distribution. Zueligg itself is not really an importer although it does import but many products almost everybody on this table, on that side of the table uses Zueligg for distribution. But the policies of what is still them. Nothing to do with Zueligg.

Dr. Hajah Halimah Ali [Ahli PAC]: *So, there is healthy competition of the suppliers. Not just monopoly. We are talking about cost here, you see. Okay. Thank you.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Boleh tanya sikit tak Datuk Wira *Chairman*?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Silakan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Page 3* ya. *Healthcare cost components versus medicine cost ya. Your slide, page 3. This layman we are not in this industry.*

Encik Lim Teng Chyuan [MAPS]: *Okay.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, when we see something which is quite odd, then we have to ask. Markup range from 24 to 402 percent. What is the reason? One, the big range. Number two why* sampai *402 percent?*

Encik Lim Teng Chyuan [MAPS]: *Okay. For this you have to go to into the paper but I can summarise this for you because this is based on the study done by Nor Safiza. The study done is based on generics as well as innovator products.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This is for both?*

Encik Lim Teng Chyuan [MAPS]: *Sorry?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This is for both generic and innovators?*

Encik Lim Teng Chyuan [MAPS]: *Please say it again. I didn't quite…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This is for both generic and for also innovators.*

Encik Lim Teng Chyuan [MAPS]: *Well, the range starts from 31 percent for generics to 402 percent and for innovators is 24 percent to 86 percent.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Yang bawah itu *24 to 86 percent.*

Encik Lim Teng Chyuan [MAPS]: *It is for innovators.*

■1400

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But is still high. Why generics is much higher?*

Encik Lim Teng Chyuan [MAPS]: *Generics is much higher because of base cost is very low. So, like I've mentioned before, one strip…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, one strip the percentage amount is small?*

Encik Lim Teng Chyuan [MAPS]: *One strip of doxycycline which is equal to— Dr. Halimah you should, you can agree with me one strip of 10 tablets of doxycycline is good enough for one cause of antibiotic. So, it is one full course is only RM1. So, if they are going to charge it at RM1.30…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *30 percent.*

Encik Lim Teng Chyuan [MAPS]: *That would be, it wouldn't even pay for his time to dispense. So, sometimes when we charged RM5, RM4 for him to…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, 400 percent?*

Encik Lim Teng Chyuan [MAPS]: *400 percent is a markup.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *400 percent*-lah.

Encik Lim Teng Chyuan [MAPS]: *400 percent is a markup.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, the amount is small, but the percentage is big. Markup*-lah*. Markup* ini *normally* kalau *private clinic* dia *mark up that much?*

Encik Lim Teng Chyuan [MAPS]: *Depends. Depends on…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Macam Dr. Halimah last time she charged more I* dengar*. [Ketawa]*

Dr. Hajah Halimah Ali [Ahli PAC]: *This is a charitable clinic* tahu*. [Ketawa]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Berapa *percent*? 500, 1,000?

Puan Harpreet Kaur a/p Darshan Singh [Persatuan Farmasi Malaysia (MPS)]: *May I assist to give an answer on that? I'm from the Malaysian Pharmacists Society. So, we represent the pharmacies, similar to Malaysia Medical Association they represent the doctors. So, the markup for generics is always higher and the markup for…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Because lower based.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Because the cost is lower. So, the mark up is higher and for patents is normally a lower mark up. The reason being I think every one of them have explained it's to cover operational cost. I believe you all have met MMA on the fourth and probably they have given you a similar answer.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *…take care electricity, take care of everything*-lah.

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Yes. The thing is no one can do the same markup range for everything because then it will not cover your operational cost.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The hire your mark up, the hire your margin would be.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Actually, the margin is higher, I agree. But then it covers the cost. At the end of the day, you have to look at the whole income and expenses statement.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not necessary. Not necessary.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Not, necessary for all but there is a difference in practice. So, for example private hospitals' practice is very different. For general practitioners practice is very different. For community pharmacies' practice is very different.*

So, the best way to is actually ascertain how much they've earn from their total business is to look at their profit rather than, you know if you drill down to this level because there are many reasons or justification as to why markups are different. Thank you.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, I want to ask here the gentleman again. I didn't get your name.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Mr. Lim.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Mr. Lim. You don't look like Mr. Lim. [Ketawa]*

Encik Lim Teng Chyuan [MAPS]: *Yes. You can call me Salim. [Bercakap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, Mr. Lim are you, you have been in this business for many years?*

Encik Lim Teng Chyuan [MAPS]: *36.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Figures. Is it a good business? Is it good profit?*

Encik Lim Teng Chyuan [MAPS]: *Lately, no.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Only lately, how many years lately?*

Encik Lim Teng Chyuan [MAPS]: *20 something years.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not late*-lah*. 20 something years is not lately. There is a lot of time many years. [Ketawa]*

Encik Lim Teng Chyuan [MAPS]: *Let me just say this. Apologies to PhAMA. When I was in MNC company, I was paid better.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Paid better. Can I, I want to ask…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, please.* Tak payah laluan.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Almost the same. Not same, similar. We know— Mr. Lim you agree with me that pharmaceutical industry is one of the most I would say profitable industry. Do you agree?*

Encik Lim Teng Chyuan [MAPS]: *In term of generic, no.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Not generic. Okay.*

Puan Kam Ai Teng [PhAMA]: *I think getting tougher. Used to be. Getting tougher.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Because our colleagues from the innovator says, they still make profits of say 10 to 20 percent. Which is very rare now in many industries. And you are coming from pharmaceutical. But yours is basically maybe warehousing and distribution, right? So, do you enjoy the same profitable as the other…*

Encik Lim Teng Chyuan [MAPS]: *The reason why I'm doing this job as twofold. One is it is fulfilling because I am bringing in products, cheap. Because I'm firstly a pharmacist so I want access to healthcare. So, it is very fulfilling to me although I don't get paid as much.*

Secondly is that because I don't work with an MMC anymore. I have a better quality of life because I don't get— I don't have to report very quarter on you know my performance.

They have all sorts of reports that needs to be submitted and they will never look at the good things. They look at the bad things and press you there. So, my

quality of life although I'm paid less is way better, I'd rather have quality adjusted life years. [Ketawa]

Tuan Haji Azli bin Yusof [Ahli PAC]: *The reason I ask is because we are all looking at the cost here and then we try to find out where we can reduce the price. So, whether from the manufacturers, innovators or from the other I mean segment of the supply chain. And you are in the distribution of it, right? And I know, cause I'm coming from the warehousing and distribution industry and their profit is very minimum.*

Encik Lim Teng Chyuan [MAPS]: *You be lucky if you get one percent.*

Puan Kam Ai Teng [PhAMA]: *YB, just to correct just now, 10 to 20 is actually global. So, doesn't apply to local. So, yes. Based on what we read on that is published globally. But at local is not. We didn't declare anything because we don't know. It's a big revision between the members.*

Dr. Hajah Halimah Ali [Ahli PAC]: *What about Donald Trump tariff and all that? Is there any influence in the local market and all that?*

Encik Lim Teng Chyuan [MAPS]: *Okay, the Trump's tariff is for imports into US. So, for exports I don't see there's the problem. Unless, you do a reversal. You want to tariff them.*

But the WHO has a paper that says that and in fact the Dasar Ubat Nasional *(DUNas) says that there should be no tariff on drugs into Malaysia.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay. Last one* ya.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, Yang Berhormat Wangsa Maju *last one.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. I want to check with you, apple to apple. Generic drugs is how much— let's say generics drug is RM1 and how much is innovators drug? On average. I'm not asking for details.*

Encik Lim Teng Chyuan [MAPS]: *Sorry, you asking who? Me?*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, the difference between the generic drug and innovators drug. I'm open to everyone who knows the answer.*

Puan Deepti Saraf [PhAMA]: *You speak for generics.*

Encik Lim Teng Chyuan [MAPS]: *Okay, how much is vibramycin?*

Seorang Ahli: *I don't know.[Bercakap tanpa menggunakan pembesar suara]*

Encik Lim Teng Chyuan [MAPS]: *You don't know. Okay. Vibramycin is doxycycline. Where are selling RM1 per strip. You think you can match that?*

Tuan Sim Tze Tzin [Ahli PAC]: *No, no. I want to know how much is innovator. Apple to apple. So, we want to get the sense of what is the difference in pricing.*

Puan Kam Ai Teng [PhAMA]: *I think depending there's like 30 to 70 percent. At least of my three years, I'm in pharma for 20 years in Malaysia market. So, I think 30 to 70 percent price difference depending on what type, what class. So it's a big range.*

Puan Deepti Saraf [PhAMA]: *I agree because if you are an innovator typically if you are in patent you won't have a generic. So is difficult to tell you what is the pricing difference. Once you are off patent and there are many generics and biosimilars in the market you also — there is a price difference for the decreases, right? Obviously. So, the lifecycle has changed and so the price difference becomes very minimal. Sometimes in cancer, I have seen price difference just 10 to 15 percent also. Even in cancer.*

The innovator is 15 percent higher than the generic and the generic is only 15 percent lower. So, it depends on the lifecycle of the product if you are still in patent, if you are still or you have the generic or biosimilar.

Again, it depends. All of this depends on the deceases area, the manufacturing, where you getting the drugs from. The efficacy, safety and so many aspects to be considered. But mostly, I would say I have seen differences very minimal also and I have seen differences very big as well. Yes, so I think in cancer the difference once you start to get generics and biosimilars, starting to reduce dramatically and maybe about 15 percent.

■1410

Encik Lim Teng Chyuan [MAPS]: *If I may just offer. There is a concept of first generic, second generic, third generic and thereafter. The rule of thumb that I observe is that usually the first generic comes in at 30 percent lower. Second generic maybe at 50 percent. The point is that if you have competition then it drives the product down. I just give you an example relating to the saliva test kit for COVID-19. When I was offered the product, my cost price was USD4. When the competition went up to 50 test kits the retail price is RM4.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, my last question. We are talking about industry. Cut across generic innovators. Everyone wants to make the system efficient and bring down the cost if possible. For example, you guys are in the part of this Pharmaniaga into hospitals in general hospitals. Number one want to ask you, whether the Pharmaniaga business model works to bring down the cost or not?*

Second is that do you think that we should be dismantling— let's say you have access to hospitals faster and cheaper that way, let's say to general hospitals? Then the third one, is there a rule that PhAMA— your company the PhAMA, the innovators or generics, you must have a local partner to access to government contract? Is that the rule? [Dicelah] Does it put to extra cost for supplying to medicine? Thank you.

Puan Kam Ai Teng [PhAMA]: PhAMA?

Seorang Ahli: *He said, innovator. [Bercakap tanpa menggunakan pembesar suara]*

Puan Kam Ai Teng [PhAMA]: *Innovator?*

Tuan Sim Tze Tzin [Ahli PAC]: *All* lah*, you can comment.*

Puan Kam Ai Teng [PhAMA]: *All. Same. Because the majority of the government purchase is generic. Maybe generic can answer first. But in general, clearly yes. I think that is the rule, right? To supply to government hospitals is a known fact. Like we have to go through an agent, tender. Tendering agent or* bumi *agent. So that is ongoing.*

So, given if you go through a tendering agent, for sure we will supply to the tendering agent then it is up to the tendering agent to do the markup to the hospital. So, that is how it is working now.

Tuan Sim Tze Tzin [Ahli PAC]: *How about whether Pharmaniaga is the right vehicle to send drugs efficiently to the general hospital or is it better that you guys go straight when hospital no— I mean whether this model is it efficient whether it is better cost-benefit wise. Is it better to dismantle this vehicle? What do you think?*

Puan Kam Ai Teng [PhAMA]: *I have very limited experience with Pharmaniaga, so maybe Mr. Ch'ng.*

Encik Ch'ng Kien Peng [MOPI]: *Thank you for the question. I cannot answer directly maybe I just explain from Pharmaniaga business what they face. I am talking about the distribution side of the business, right? They have two manufacturing and also with distribution. Distribution for Pharmaniaga to my view, there are a critical part of the supply chain in Malaysia. It is all ready for so many years. They are partly also a national service. Now, anyone of the company if you want to distribute our drugs means with the small volume to cover until East Malaysia is not something that we can afford to.*

Pharmaniaga to be fair they also— although I am just speaking on their behalf, they are not present here today. They also find it very difficult to get the profit

back for the distribution to Sarawak and Sabah. Frankly speaking that part is losing business badly.

Now Peninsular Malaysia they are using that to cover up. Now, what else they have done good deed for the government is that they have stalled the medicine to a certain degree of buffering for about two months in their warehouse. All the medicine, they delivered to the Pharmaniaga and then they stall in their warehouse and before distributed it to all the government hospitals. So, they are being an important part of the supply chain in Malaysia. If we want to dismantle that we have to be careful about to make sure the ecosystem of the whole of Malaysia is not jeopardized. So, there is a lot of thought to be think about.

Then we ask the next question YB, I am sure all of us are businessmen, we also think about. Can we invest to compete with Pharmaniaga? Then we ask ourselves, how are we going to price if we want to go to East Malaysia. Then we got the price very high on that side. But then it will not be in the interest of the government to take care of the East Malaysia citizens. So, I don't have the numbers here. Just in my thoughts. So, I wouldn't want to abruptly dismantle— we ought a better thought of the whole ecosystem. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Thank you Mr. You have last word from you?*

Encik Lim Teng Chyuan [MAPS]: *Again, when we talk about government procurement we are talking about different levels where Pharmaniaga is concerned based on the Approved Product List (APPL) which has a certain number. Then there is national tender which may not be in the Pharmaniaga. For this, we can use others. We may still use Pharmaniaga we can use Primabumi, we can use some other* bumi *agents. There could also be a hospital tender or it could be a local purchase order. It really depends on which level. So, when it comes to Pharmaniaga, basically they have the whole thing for APPL because of their distribution services. But some of our members are actually* bumi *companies.*

Take for example our roles— If they are approved by the Ministry of Finance then it can go direct. They don't need to go through bumi *company.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih Mr. Lim dari... *[Dicelah]* MAPS di atas penjelasan itu tadi. *I think we go for the last presentation*. Saya persilakan Yang Berusaha Puan Hapreet Kaur a/p Darshan Singh, Pengarah Eksekutif Persatuan Farmasi Malaysia.

Puan Harpreet Kaur a/p Darshan Singh [MPS]: Terima kasih. Salam sejahtera *and* salam Malaysia Madani kepada Puan Pengerusi Majlis dan semua

hadirin. Secara rasminya, Persatuan Farmasi Malaysia merupakan satu pertubuhan profesional yang mewakili ahli farmasi dari sektor awam dan sektor swasta dan tidak terlibat dalam sebarang aktiviti penghasilan atau perdagangan.

Oleh itu, kami dengan penuh rasa hormat memohon agar Jawatankuasa Kira-kira Wang Negara dapat mengadakan sesi bersama dengan profesional farmasi sama seperti yang telah dijalankan bersama Persatuan Perubatan Malaysia. Persatuan Farmasi Malaysia boleh memberi pandangan lebih terperinci tentang kos penjagaan kesihatan dari setiap aspek *supply chain*. Izinkan saya untuk meneruskan *presentation* saya dalam bahasa Inggeris.

The Malaysian Pharmacy Society is the national association for pharmacists formed in 1967. Our motto is service towards a healthy society. MPS plays an important role to further the development of pharmacy and pharmaceutical education and to foster interprofessional relationships among members.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *How many members that you have?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *We have 5,000 over members. The majority of them are from the private sector. However, in Malaysia, there are 20,000 over pharmacists and the larger number is in the government sector.*

When MPS first started, we represented mostly private sector pharmacists. But now MPS is in involved almost every level of jawatankuasa *meetings at the KKM level because there is a push after the Health White Paper to move towards public-private partnership. So, our government sector pharmacist numbers have gone up but we have representation in the* Majlis Bersama Kebangsaan *where we advocate for government sector pharmacist rights especially when it comes to their contract issues, when it comes to their PRP issues.*

MPS has a member and has members representing the society in the National Anti-Microbial Resistance Committee, Malaysian National Medicine Policy Working Committee, Traditional and Complimentary Medicine Committee, National Committee on Clinical Research means Pharmacy Editorial Board, Technical Committee for Halal Pharmaceuticals and Halal Medical Device Standards and Quick Services Committee, Malaysian Council for Tobacco Control, Malaysian Professional Care, MSQH and MEDREC.

I won't go into too much detail about society because I believe everybody is tired. So, we have shared our public statement on the 21st of February. I think we've sent out 20 copies to whoever is here. I will just go through the main points. So, the

rising cause of private healthcare has placed a significant burden on the rakyat*. I think every here agrees with that.*

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I probably believe that the PAC has done their homework and what you have realised is that the sharp increases in insurance premiums and private hospital charges are probably where most of the blame is going to rest. So, this is further compounded by the spillover effect on public healthcare facilities, leading to congestion and longer waiting times in the government hospitals as key healthcare providers, pharmacies are deeply concerned about this financial strain placed on Malaysians.

So, we have some points that we have to share out. Number one, there should be transparency and fairness in healthcare pricing and number two, strengthening public-private healthcare synergy. This is, I think, one of the points that we would like to highlight more which is increasing cost of private healthcare resulted in higher dependency on public hospitals. To alleviate this pressure, MPS strongly support the implementation of a National Health Insurance that integrates public and private healthcare services.

A well-structured NIH will ensure financial protection for Malaysians and ensure accessible and affordable care. Expand the role of community pharmacies and the general practitioner clinics to reduce congestion at the government healthcare sectors. Improve collaboration between public hospitals, private hospitals, general practitioners and of course, reduce the out-of-pocket expenses,

Our third point is strengthening the role of pharmacists in disease prevention, rational medicine use and cost reduction. The government, in our opinion, must act swiftly and decisively to address systemic inefficiencies and prevent further financial strain on the rakyat. MPS firmly believes that pharmacists, alongside other healthcare providers, must be actively involved in shaping national health financing reforms and ensure a cost-effective, patient-centred healthcare system.

Pharmacists remain committed to working with policymakers, insurers, healthcare providers, and patient groups to establish a transparent, sustainable, and equitable healthcare ecosystem. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: Datuk Wira Pengerusi, *I want to ask the pharmacist because we see that pharmacy is booming. Everywhere there are, every shopping mall, every corner, every shop lot have pharma— every community. So, I think it's making quite good money, is it? Why is that so?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Okay, the why is that so maybe a bit difficult for me to answer because I'm representing the Malaysian Pharmacists Society. But the chain pharmacies, they do have expansion power because they are chain pharmacies. So, if you look at the expansion that is happening it's mostly with chain pharmacies.*

We don't see this with independent pharmacies so much because independent pharmacies they probably started off in one community. They have been there like 20, 30 years and then a chain pharmacy is coming up and opening beside them. So, MPS did notice this issue happening and we have highlighted many times that there should be zoning done. So, that there is a gap in how many pharmacies are open in one place.

However, the feedback that we got back from the government is that competition is good and it reduces the prices. So, that is why independent pharmacies have no choice but to accept when chain pharmacies open beside them. So, on one side, yes it looks like the business is booming but on the other side, the prices of the drug go down. So, that benefits the community. So, it is a like Catch-22 situation you— you are stuck in a worst side. I don't know how to give a fairer answer than that.

Tuan Sim Tze Tzin [Ahli PAC]: *So, I want to ask about cost again. Let's say use pharma innovator of generic sold to private hospital, they got a markup of 300 percent. How about pharmacy, the chain pharmacist or local pharmacies, what is the markup like?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *The markup is definitely lower and the reason it is lower is because they have lower overhead. So, for example, if we just look at one independent pharmacy, you would have the pharmacists' working there and the other cost that they would have to cover if they don't own the building is rental and of course, utilities and they would have their staff which is a smaller number. So, I believe that markup— markup is always related to operational cost. So, if their operational cost is lower than the markup is lower.*

However, MPS, I do think— we do agree that they need to be some transparency when it comes to private hospital charges because they are moving towards wanting to be profitable because they are, I guess, listed companies and they have to show that they are making the profit. So, I believe what the PAC is doing in the right direction. It is just now matter of getting how we are going to reduce the cost.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Your members are pharmacists? All pharmacists?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *All pharmacists.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Is there any pharmacy owner?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *No. We do not accept pharmacy owners as members.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *They are governed under any….*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *To my knowledge, they are not governed because most of the pharmacists who work in pharmacies are already our members. There is a smaller society but I'm not sure how many members they have and I'm not sure how much representation they have in terms of owners.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Supposedly they have.*

Tuan Sim Tze Tzin [Ahli PAC]: *Is there a professional board governing pharmacy?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Yes, the Lembaga Farmasi Malaysia. So, our members have to be registered with the Lembaga Farmasi Malaysia.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya tak tahulah saya nak tanya pada Puan Harpreet ataupun sesiapa. *Because* contoh Masjid Tanah, ada dua farmasi yang lama, *more than 25 years old* beroperasi. *Then, suddenly* sekarang ini ada dalam lebih kurang lapan farmasi dalam Parlimen Masjid Tanah. *Ada yang big name which they compete one and another and the big one of course, they sell much cheaper compared to* yang kecil ini.

So, how you…

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Why is their price cheaper?*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]:….*monitor. No, how you monitor, so, that* macam yang lama dan yang kecil ini *can survive?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Okay, there's a very good question. Thank you for that question because we do have a lot independent pharmacies as members of MPS and they are struggling because they are not able— they do not have the purchasing power.*

So, purchasing is done at— I mean, correct me if I'm wrong, my colleague from the industry's side. But the cost that is sold to government or to the private

hospital or chain pharmacy or to GP they tend to be different. So, there are different prices that are given to different healthcare providers. I believe this affects the cost to some level. There's also a requirement— I mean there's also a need to have if you are able to purchase a larger lot then you get it at a lower price. But independent pharmacies don't have that type of purchasing power.

So, when you don't have purchasing power, you are not able to compete in terms of pricing and when you are not able to compete in terms of pricing, you cannot lower your price. So, what MPS has advocated for our independent pharmacies to focus on is services. Meaning, retain your customers by providing very professional services in terms of the counseling and the dispensing. It is not an ideal situation but when we went up to propose for zoning, if you give the answer that zoning cannot be done because competition is healthy for the public, then one side of the party has to suffer. Unfortunately, it happens to be the independent pharmacies which I believe is the same problem general practitioners who are sole owners are facing.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk Wira, boleh?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Okey, Kubang Pasu, *then* Wangsa Maju.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Betul, banyak macam *pharmacies being opened.* Ada Watsons pun, Caring dan lain-lain lagilah. Tapi, *based on my observation, they are selling more non-drugs than drugs.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: Yes.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *They are selling shampoo, they are selling cream. I think that's how— I think that's their major business. Their major business is actually the non-drugs. That's why* dia buka banyak. *The funny thing is, even though* dia kata *pharmacy,* kadang-kadang kita pergi farmasi tak ada.

Puan Harpreet Kaur a/p Darshan Singh [Persatuan Farmasi Malaysia]: Ya, betul.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, you* kena beli ubat yang kena *subscribe. So,* nampak macam farmasilah, *everywhere. Compared to certain countries, Australia, England,* dia mesti ada farmasi dia *all the time.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Yes. Actually…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, this is not good for the patients actually.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *There's a reason that is happening. That's because in Malaysia there is no dispensing separation in the private primary care. So, for example, if you go to a government hospital, you see the doctor, you can only get your medication at the pharmacy. If you go to a private hospital, you see a doctor, doctor in the office will not give the medication. You still have to go to the pharmacy to pick up your medication.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Or private hospital?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *The private hospital is the same. You have to go…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But I have a doctor at Assunta, he told me, "You go and buy from that shop".*

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Puan Harpreet Kaur a/p Darshan Singh [MPS]: Ya. *So, they do give you that…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *[Ketawa] The same medicine.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: Ya. *They do give you that choice because the private hospital issues you a prescription.*

However, in the private primary care which is where we have a general practitioners and community's pharmacies, that is no dispensing separation. So, when there is no dispensing separation, pharmacists who have been trained to dispensed medication cannot practice what they have learned in their studies. So, majority of them ended up expanding their pharmacy from just having that pharmacy counter to have a shop front. So, when you have a shop front, you do put in things.

I think based on what the market wants and what people— at one point, there is a big thing about selling goods like all these herbal foods and all that. But then after COVID I believe a lot of people prefer one stop centre. You just enter one place and you are able to buy everything at the same place. So, some of these things are happening because of what is the requirement of the people who are coming to that pharmacy.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *How to confirm? Your name is Amrahi Buang* ya?

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *No. Amrahi Buang is our president. My name is Harpreet Kaur.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *No wonder. He is Honorary Professor of Pharmacy Practice.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Yes. This statement is from our president. His name is Amrahi Buang. He is Honorary Professor.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *First time* saya tengok ini. *[Ketawa]* Tapi *first time.* Sungguh pun *you* kata tadi, *competition reduce the price of drugs but it is not really true because* dia masing-masing semua naik.

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Well, if your cost price* naik *then your sales price will* naik.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I give you one good example. I'll give you one— I'm sure all the medicine* pun naik harga. *There are competition,* masing-masing *compete* naik harga.

I always have Zyrtec. I always keep Zyrtec. Whenever I buy, I buy dulu *maybe five years ago* RM10, *la* sekarang RM20. *So,* mana-mana *you* pergi *you'll surprise this is not reducing the price actually. They competing to increase the price.* Betul kah?

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *No. I don't agree with that. I don't think they competing to increase the price because like our pharmacies, the complaints that we received from them is that there is a lot of price-throwing by bigger pharmacies. So, the independent cannot survive because they cannot reduce the price by that much because the cost price that they are getting…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So very competitive* lah.

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *It is competitive. I have to admit, it is competitive.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Wangsa Maju, *last question* ya.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Before my question, just like to give a good new to this industry. One, Malaysia has got the highest percentage of obesity in ASEAN countries. 15.3 percent adults got diabetes. By the time we reach 2030, we got 15.3 percent of Malaysian aged society. So, these are potential clients or customers to this industry.*

Putting that news aside, I would like to check— coming back to PhAMA. That means you have factories here in Malaysia that is you produce your innovative drugs?

Puan Kam Ai Teng [PhAMA]: *No. At this moment actually none.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *None, okay. Next question is, you've been saying that to produce innovative drugs, it is very expensive. Amongst the biggest cost centre is on the research. Am I right?*

Puan Kam Ai Teng [PhAMA]: *Yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *What are the components of the research that make it so much expensive? Besides the researcher maybe, what else? What are the components of the research that make it cost so much? Sorry. What are the components? What are the perimeters?*

Puan Kam Ai Teng [PhAMA]: *So, because the failure rate is so very high to be fair. Very, very high* sebab *it is an experiment,* kan? *So* bila— *and then like what they have— for example the Alzheimer disease,* untuk *20 years, all the big pharma is being investing to try to find a solution and after 20 years, I think only one drug is — one or two drugs is successful. Most of it, all failed.*

So since I've graduated, I joined PhAMA until today, memang *all failed. So that is why the R&D cost can be very, very high. So of course, when R&D cost when you try the active ingredient itself and then the trial different phase, the researcher, so everything is so expensive and yet, after the investment failed, many, many time before you get a success. So that is why the cost of R&D is actually very high.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *So, the failure rate is high?*

Puan Kam Ai Teng [PhAMA]: *Very high,* ya. *To get a new finding, to solve unmet problem, disease* yang memang tak ada penyelesaian, kan? *So a lot of failure, very difficult.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *All right. Thank you.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Saya rasa itu sahaja...

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Can I just make a statement on the obesity and diabetes? Malaysian Obesity Society actually has taken note of this and we would like to share with you that pharmacies are involved in the government sector in medication therapy adherence clinics. Because there were not enough healthcare providers to manage diabetes. So now pharmacies are involved and they manage the patient diabetes.*

We are now working very hard to get this type of pharmacies into the private sector so that a person can go either to the public or private sector and they will get like a comprehensive diabetes management. We are also working with PhAMA companies who have recognized that there is something call pre diabetes. So, there

are many of the MNC companies that are working with MPS and pushing this agenda forward, training people, educating because health literacy very important for Malaysians. Once we increase that, we will definitely see the reduction in some of these NCDs.

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Personally, I would request and encourage whether it is from the PhAMA, from MOPI, from the Pharmacies Society as well. Please engage yourself or your members, encourage your members to engage in preventive medicine.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Yes, we are.*

Puan Kam Ai Teng [PhAMA]: *Yes, yes.*

Tuan Ir. Ts. Zahir bin Hasan [Ahli PAC]: *Because that is— your core business is selling medicine but please also involve in the preventive measures.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *I can definitely say that you know like I've— because MPS is a NGOs. So, we are quite neutral. I would say that I've been invited many times with PhAMA companies to come in to their events and talks about preventive care. So, I would say that they are very serious whether when I say PhAMA I mean local and non-locals. Because sometimes PhAMA is the name of the society but I'm seen pharma. P-H-A-R-M-A. So, both MOPI, MAPS and everyone. The agenda is there. To go towards the preventive care. Right now, I think the challenge is getting the health literacy up so that people understand what preventive care is. We have gotten push back like if we have to do all this then what is the point of having a doctor and pharmacies. So sometimes the understanding needs to be improved but there is definitely we have a framework and we are working towards that.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Datuk Wira Pengerusi, *I want to ask the last question [Dicelah]. But before…*

Puan Deepti Saraf [PhAMA]: Ya, *okey, sorry, sorry. I would just saying on behalf of PhAMA what we've— what we can assure you many companies are doing already and we'll continue doing and even for the amplify is not just health literacies, screening, earlier diagnosis. So that when patient comes early, the cost goes down and the system. So, we have been doing this, multiple people have been screen through PhAMA programmes and events and we'll continue to amplify. This is something we are committed to doing, to further the improve the healthcare status in the country.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Datuk Wira Pengerusi, *before I ask my last question, I think everyone of us are in the same Malaysia which is facing serious*

problem of rising cost in medical. So, I hope that PhAMA, MOPI, whoever that is here, must find a solution for this country because eventually we are all aging and we are going to see hospital and all this.

Okay, my last question. I want to ask is a very— it is good news maybe it is for me because I'm a bit overweight already. This Ozempic kind of things, it is coming to Malaysia or not? [Dicelah] Maybe Wangsa Maju no need but definitely…

Puan Kam Ai Teng [PhAMA]: *Ozempic is already in Malaysia.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *It is in Malaysia. My husband used it.*

Tuan Sim Tze Tzin [Ahli PAC]: *These are – just explain what is Ozempic to everyone of us* ya. *We guys many still don't know.*

Puan Chan Li Jin [PhAMA]: *Maybe just allow me to take this. Ozempic is available in Malaysia but only in the private sector. So that is why when we say that when a drug arrives in Malaysia, there are two layers to go through.*

The first one is the drug has to be registered in Malaysia. That means ubat itu boleh dijual di Malaysia. *So Ozempic* adalah satu contoh lah. Selepas ubat itu sudah boleh dijual di Malaysia, *you've to go to the second level where you've to get that registered into the national drug formulary. We called it the Blue Book* supaya ubat itu boleh dijual di *government hospital. So* kalau ubat itu hanya dijual di *private hospital, private clinic* sahaja, *the majority of people would not have access to it.*

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So, dia mesti ada melalui *this two process. The first process* pendaftaran untuk menjual sesuatu ubat di Malaysia. *Second one,* pendaftaran untuk meng-*list*-kan, senaraikan ubat itu ke dalam *National Drug Formulary* supaya semua orang boleh dapat di *government hospital.* Sebab kalau tidak dia akan *only available in the private sector and I would say 80 percent of people will not be able to afford it.*

Tuan Sim Tze Tzin [Ahli PAC]: *Presently... [Bercakap tanpa menggunakan pembesar suara]*

Puan Chan Li Jin [PhAMA]: *Presently not in the blue book. Only in the private sector. But I have to warn you all because we have noticed a very alarming trend that some clinics are illegally importing it. We call this parallel import. They are selling it via WhatsApp.*

So, PhAMA is working very closely with the Pharmacy Services Programme (PSP) under MOH to make sure that people are not buying them illegally melalui *WhatsApp.* Mereka hantar *WhatsApp to say you just* hantar kita mesej kita akan jual kepada *you. Actually cannot.*

Ozempic is a prescribed medicine. Hanya kalau dapat *prescription* daripada doktor. *So*, kalau mereka beli melalui WhatsApp itu sangat berbahaya. Kena *check* dulu jantung semua sebelum boleh ambil ubat itu.

Puan Kam Ai Teng [PhAMA]: Kena jumpa doktor *first* sebelum...

Puan Harpreet Kaur a/p Darshan Singh [MPS]: YB, YB as *a pharmacist I'd like to advice you that you are not overweight. So, you don't actually need Ozempic but this is normally— they keep it aside for patient who are diabetic but extremely overweight because they are not able to control their meals.*

So, it works but it should not be recommended for people who do not require it. So, you definitely need to see your doctor before you are prescribing it. If the clinic doesn't have stock, then you can request for your prescription to purchase it from a pharmacy.

Tuan Sim Tze Tzin [Ahli PAC]: *It is a fun, it's a joke question.*

Encik Ch'ng Kien Peng [MOPI]: *YB, YB the more important thing is that YB how much you ready to pay for Ozempic? [Ketawa]*

Tuan Sim Tze Tzin [Ahli PAC]: *How much is it now? Malaysian price.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *RM600— I mean mu husband uses it. So, we pay about RM600 something per month because it's one injection per week.*

Tuan Sim Tze Tzin [Ahli PAC]: *Is it effective?*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Very effective. He has lost about 15 kgs and he's way much healthier and his diabetes is so very well-controlled.*

Tuan Sim Tze Tzin [Ahli PAC]: *See, see.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *So, it is very effective but it was suitable for him because he was extremely overweight yeah.*

Puan Chan Li Jin [PhAMA]: *But you cannot stop, YB. Ozempic is a drug you cannot stop. Once you start you have to continue. Once you stop you will become* lagi besar*. So,* bahaya itu ya.

Puan Kam Ai Teng [PhAMA]: *No, it's not true. Wrong, YB. Wrong info. No, no. You can stop.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *That is not true, that is not true. You need to have a good lifestyle and you have to make sure you exercise and meals have to be controlled. He has reduced his dosage. As in not weekly anymore and he's weight is still well maintained.*

Puan Kam Ai Teng [PhAMA]: *So, lifestyle plus the drug.*

Puan Harpreet Kaur a/p Darshan Singh [MPS]: *Yes, lifestyle is a big part of it.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Siapa nak *order Ozempic after this, go and see them. All right. So,* terima kasih saya ucapkan kepada semua yang hadir pada hari ini dan juga memberikan penjelasan.

Terima kasih Puan Kam Ai Teng daripada PhAMA, Puan Kam Ai Teng; Puan Deepti Saraf daripada PhAMA, Encik Ch'ng Kien Peng daripada MOPI; Encik Lim Teng Chyuan daripada MAPS dan juga Puan Harpreet Kaur daripada Pengarah Eksekutif Persatuan Farmasi Malaysia di atas kehadiran dan juga penjelasan yang diberikan kepada PAC.

Kita tangguh pada jam 2.23 petang. Terima kasih. Saya suka nak mengingatkan kepada semua Ahli Parlimen dan juga semua ahli ex-officio, hari Isnin kita ada satu lagi prosiding…

Encik Ahmad Johan bin Mohd Affandi [Parlimen Malaysia]: APHM. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: APHM. *All right*. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 2.43 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Isnin, 3 Mac 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Malaysian Medical Association
Dato Dr Kalwinder Singh Khaira
President

PENGGAL KEEMPAT
PARLIMEN KELIMA BELA

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

ISNIN, 03 MAC 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Puan Vivian Wong Shir Yee [Sandakan]

Tidak Hadir *[Dengan Maaf]*

YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Syahredzan bin Johan [Bangi]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Cik Jackie Mary Fernandis [Penasihat Undang-undang II, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

EX OFFICIO

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Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)

PKPj Suzana binti Alias [Ketua Cawangan (Bahagian Penyiasatan Tatakelola)]
P/TPj Mohd Anuar bin Ismail [Timbalan Pengarah Kanan]

(samb/-)

Kementerian Ekonomi (KE)

Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) Bahagian Perkhidmatan Sosial (Bhg. Infrastruktur Dan Kemudahan Awam, Kementerian Ekonomi)]

Jabatan Akauntan Negara (JANM)
Puan Noor Azira binti Abd Rashid [Akauntan (BPOPA)]

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Malaysian Medical Association
Dato Dr Kalwinder Singh Khaira [President]
Datuk Dr Thirunavukarasu Rajoo [President Elect]
Dr Mohamed Namazie Ibrahim [MMA Past President]
Dr Vasu Pillai Letchumanan [Honorary General Secretary]
Dr Liew Shan Fap [MMA Member]
Dr Sivanaesan Letchumanan [Honorary Deputy Secretary]
Dr Mastura Md Yusof [MMA Member]
Dr Timothy Cheng Tsin Jien [Chairman, SCHOMOS MMA]
Dato' Dr Venugopal Balchand [MMA Member]
Dr Gunalan@Arumugam Palari [Member of MMA Insurance Committee/Private Specialist Committee]
Pn Syaza Nur Nadrah Bt Alias [MMA Secretariat]
Dr. Kuharaj Balasubramaniam [LIFE Member]
Prof Dr Nur Aishah Mohd Taib [Pensyarah Perubatan, Jabatan Surgeri, Fakulti Perubatan, Universiti Malaya]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

ISNIN, 3 MAC 2025

Mesyuarat dimulakan pada pukul 2.32 petang

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin ***mempengerusikan Mesyuarat****]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh* dan selamat petang, salam sejahtera Yang Berhormat Naib Pengerusi PAC; Yang Berhormat Puan Teresa Kok, Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas, Ahli-ahli ex-officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang wakil AGC.

Yang Berhormat Ahli Mesyuarat sekalian, petang ini PAC Parlimen akan mendengar keterangan dan juga penjelasan berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan Malaysia dan juga Bank Negara Malaysia.

Sebagaimana semua sedia maklum, prosiding ini diadakan bagi mendapatkan penjelasan berkenaan dengan faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan juga caj hospital swasta dan ini termasuklah kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan juga faktor luar sebagaimana yang telah berlaku sebelum ini iaitu pandemik.

Jadi dalam usaha untuk mencari jalan mengurangkan impak peningkatan premium insurans kesihatan dan juga kos perubatan serta memastikan akses kepada penjagaan kesihatan yang berkualiti, adil dan juga mampan bagi semua lapisan masyarakat, PAC berpendapatan adalah wajar untuk mendengar penjelasan daripada pelbagai pihak yang terlibat dalam isu ini.

Yang Berhormat Ahli Mesyuarat sekalian, hari ini yang hadir di hadapan PAC dalam prosiding pada kali ini adalah yang pertama Yang Berbahagia Dato Kalwinder Singh Khaira, Presiden Persatuan Perubatan Malaysia (MMA); Yang Berusaha Dr

Vasu Pillai Letchumanan, Setiausaha Agung Kehormat MMA dan yang seterusnya Yang Berusaha Dr Gunalan@Arugumam Palari, Ahli Jawatankuasa MMA. Terima kasih saya dan juga PAC ucapkan kepada semua kerana sudi memberikan komitmen untuk hadir pada petang ini.

Sebelum saya menjemput saksi untuk memulakan pembentangan, saya nak maklumkan pada semua Ahli Mesyuarat, bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 iaitu [*Akta 88*] dan juga Peraturan Mesyuarat 85 Peraturan Majlis Mesyuarat Dewan Rakyat sampailah prosiding ini selesai dan juga laporan dibentangkan di Dewan Rakyat.

Jadi tanpa membuang masa, saya dengan ini menjemput Yang Berbahagia Dato Dr. Kalwinder Singh Khaira untuk memulakan pembentangan. Dipersilakan Dato.

Dato Dr Kalwinder Singh Khaira [Malaysian Medical Association (MMA)]: Terima kasih Puan Pengerusi, Yang Berhormat-Yang Berhormat. Kami hendak mengucapkan terima kasih kepada *Public Accounts Committee* kerana menjemput MMA untuk datang hari ini dan untuk membentangkan apa yang— pendapat-pendapat dari segi kefikiran doktor. Seperti semua tahu *all the problems* dengan izin, *all the problems that we have is a triparty of the insurance companies, you have the hospitals and you have the doctors.*

We are here today to represent the doctors and amongst us today we have got members and the doctor, pakar-pakar daripada hospital swasta*, from the university and also, we have some from the government. If I'm given the time* mungkin saya *introduce because* nanti mereka pun akan bincang ya. So, dari segi pakar-pakar *we have Dr Gunalan is an anesthetist; Dr Namazie is an anesthetist from private practice; Dr Mastura Md Yusof, our oncologist; Dr Venugopal, cardiothoracic surgeon; Dr Kuharaj, O&G specialist; Dr Liew Shan Fap, gastroenterologist; Dr Timothy, orthopedic surgeon; Dr Vasu is a hepatobiliary surgeon. I am a physician but in government*-lah.

We also have got two general practitioners who are among us Dr Thiru, is also here and also Dr Sivanesan also here. And also, we also Prof. Nur Aishah, a breast surgeon. So, we have a lot of doctors here today from different fields…

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *We are very lucky, you are very lucky. [Ketawa]*

Dato Dr Kalwinder Singh Khaira [MMA]: *No. When we say that we have a chance to present to your committee madam, everybody wants to give their views. So, they think that this is one of the ways that's we can get our views across. It is not easy sometimes we do try to get our views across, doctors views across, sometimes*

threw statement, sometimes threw press but I think this is the best opportunity we have to put our view. Then, so I think that is why we thank you for taking the time. I don't know how long we will take, I hope we have the patience.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Actually, we have until I mean before four because we have another proceeding— okay.*

Dato Dr Kalwinder Singh Khaira [MMA]: *We try our— hopefully.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay. I think we can go after four also, can. No, problem.*

Dato' Dr Kalwinder Singh Khaira [MMA]: *[Ketawa] Thank you, thank you, thank you. So, I think as we mentioned, what are we going to do today, so we going to talk about the reasons of what we think is the cause of the rise in the premium price and also our proposal and what we think will be the challenges that we are arise, if we implement it.*

So, we have prepared a slide, but I think the slide is more of a framework. We are here to engage. So, you know we will engage and any questions we will answer so hopefully at the end of the day there will be a better view on this.

So, without further ado, I will pass over to Dr Gunalan to start with the presentation. Thank you very much.

Dr Gunalan@Arumugam Palari [Malaysian Medical Association (MMA)]: *Yes. Okay, thank you Dr. Khaira. Thank you very much* YB-YB yang terhormat sekalian. Izinkan saya berucap *mixture of English and Malay as well*-lah *for the purpose of the some of the terms, terminologies used might be a little bit easier to be precise in English.*

So, I was actually part of the first initial representative for the Malaysian Medical Association when we had the first public proceeding last week and I think I met YB Sim as well as YB Teresa at that meeting.

And I think it was actually very good opportunity to hear first-hand what are the public views on some of the issues. I think we are here today not so much in times of trying to find faults or try to menyalahkan sesiapa pihak *but we are aware of the issues surrounding it. Using a forum to pick up on who is at fault is not main agenda here.*

I think what we are trying to do is actually we want to try and put across the views from doctors especially yang berkhidmat di hospital-hospital swasta *where we are actually seeing first-hand some of the issues that are faced. And to be honest with you, Dato Khaira mentioned three parties here. The most important party I think is actually the public because we are first time experiencing directly the impact of*

what the struggles are being put across and how it is actually impacts it the public, all right?

■1440

We talk about some of the solutions that have been proposed— I mean there's a lot of words are been brandished about. The current arrangement that we have is fee for service, we provide a service, there's a fee for it. But what's been proposed is actually diagnosis-related group which I think something that we are have researched and we actually would like to share our views on that. The only thing is whatever actions that we want to take we are just very cognizant and mindful that we do not— we want it— want to solve the problem but we should not actually create or make the problem worse. That is one of the things that we all worry about. But whatever solutions that we are trying to get from all the parties, we are very concerned about this particular aspect of it as well. All right.

Now, a bit of a background. Now, the insurance industry and the doctors in private hospitals we have actually— we consider each other's as partners. We actually have no major issues with them directly. Over the years, we have actually worked very well. Both sides understand each other's function. The product is there to be sold to the consumer. The consumer utilizes the product and has access to healthcare in our private sector. That symbiotic relationship has actually worked very well over the years.

However, during COVID-19 and subsequently, the after-effects of COVID-19 as well as the rise in medical inflation have actually made the relationship somewhat strained. I used the word strain because it is not beyond repair. The relationship is still very cordial when we speak to each other is quite good. But what is the problem is you hear a lot of statements are all being released without actually being taking into account some of the pinpoints. So, people are getting very emotional. People are actually just sidestepping some issues and probably may not be directly focused on what is the actual impact on the ground.

Having said that our belief is that we need to make the ecosystem work. We need to correct some of the misconceptions of private healthcare. I think why we are very concerned about this is the public has for the last couple of months assumed that a lot of doctors in private healthcare are actually the culprits behind the reason why the premiums are going up. During the last PAC meeting, I was actually sitting next to a retired gentleman, introduced myself as a doctor, pointblank he said that you guys are the reason why we are here in this hall in the first place. So, it does a bit of a stunning thing lah *for me basically.*

I'm used to have people looking up to doctors. Now, the last couple of months is basically we are under the firing line of a lot of things. That misconception is basically because the public has been fed a narrative that is completely different from what is actually on the ground. So, we are here now to actually correct some of the things because I think it's very important that we set the tone right for the discussion. We also must actually be very clear about what we as doctors are facing and we actually the patient's advocate. None of us are actually out here to actually talk about profit and whatnot. At the end of the day, we doctors have an oath and we need to fulfill that oath and we are delivering healthcare service to patients that come and seek our services.

Now, some of the anecdotal views that have been put up in public which I think I would like to take this opportunity to actually correct it. This thing about cash patients paying more and sometimes more than the insurance and whatnot because sometimes insurance companies have certain arrangements with the hospitals where we are supposed to give a 10 to 20 percent discount. Whereas this particular extension is not actually given to the cash patients. So, at times there are sometimes the same surgeries the patients may actually end up paying more compared to what is insured.

There are also times when certain procedures are done as a package so where the package was concerned certain discounts but this is at the goodwill of the doctor and the hospital. There is a certain cost element to the procedure but doctors take it upon themselves to set the look this particular patient may not afford it, we give a substantial discount of the fees. That is actually purely a volunteering thing. So, sometimes again, why certain patients are paying cash and why certain insurance procedures are charged more, these are some of the reasons behind it. But again, I think to break it down in detail I think these are things that we actually have to highlight and move forward.

The second thing is in any department we do not actually ask for your card before starting treatment. That's actually a very wrong thing to actually assume. A lot of times people come in a collapse state or a near cardiac arrest state kind of thing, treatment in a private hospital is always treated first, ask about the money later. Only the yellow and the green zone type of cases where the patients come in with cold or fever and cough that potentially where they are actually waiting to be seen by the doctor is when the finance team will ask what is the method of your payment. Would you like to pay using cash or with the— That is purely an administrative question. Not because we are going to stop treating you because of whether you have a card or not.

For all red zone cases where the patient comes in collapse, we are mandated by the Private Healthcare Act to actually proceed to start the treatment first. Once we stabilise and the patient is back to some form of stability, that is when we actually ask the question. This is more of a financial discussion and not so much of medical treatment. Treatment is still going on. We will ask the patient, "Do you want to continue care here and this is the estimate or do you want to continue your care at the public hospital if you find that you do not have the means to kind like pay for this treatment."

Most of the time, doctors are still involved in the care of the patient. Just because they cannot pay, it doesn't mean that we have signed off. We will still continue managing the patient until the care of the patient is handed over to a team that is willing to take over. Like most of the time, the private hospital in Klang Valley, we'll actually call our colleagues from HKL or Serdang or Ampang or even UMMC, UKM to actually see whether they are willing to take over the hand management of the patient. But, while the patient is still housed in the hospital, they will care— it's not to say you are stopping the care, the medications are stopped, the ventilators are stopped. Nothing of that stop. The typical thing that you see in a Hindi movie and Tamil movie, it doesn't happen in Malaysia. We are all bound by the laws of the government. So, we need to actually clearly emphasize that fact lah.

Now, this discussion with the insurance industry honestly speaking is something that has not been overnight, today only we decided to talk about it. We in MMA in 2020 itself, this engagement in the industry has been going on for a very long time. But, in 2020 we felt that— look, it's about time that all of the players, stakeholders need to come on the table and have an open clear dialogue about some of the issues in private healthcare because we know as doctors this is not sustainable. Why we know? It's because we are asking for approval for a procedure. We get a lot of kick pushbacks from the insurance companies to say look this is not covered, this will not be covered, this is not covered and why? Because the terms and conditions and policy will not be right.

So, we knew that this is going to be a problem arising in the next five to 10 years if this continues to go like this, especially as medical technology devices, equipment, medications are all exponentially getting expensive but they are all needed. Because these are cutting-edge technology that is there to make a difference in the patient's life. To a cancer patient, what we are going to treat or use on him will decide whether he lives another five years or ten years. So, this is all very important discussion that we actually started with the industry itself.

The only thing that stopped it is COVID-19, number one. The second thing was there's a lot of discussion about some of this whether are running foul of the Competition Act or whatnot. So, we have actually had a discussion with the insurance industry and we are actually more or less on the same page. It just that we needed a lot more push and I think the push now is more valid and significant because as parliamentarians representing the voice of the population, you see the problem now. Previously the problem was only seen by the doctors and people who are directly involved in it. But now it's come in the open, which is now a good thing for us because we now have a platform to actually say the look, this is no longer a joking matter, it is a serious matter. We need to have more focus on this.

Now, this is not a slide that I cooked up. I actually pulled this out from the Life Insurance Association of Malaysia 2023 Annual Report. Now, we already know that this particular survey was actually done by the industry and compound annualised growth rate yes, all of us agree. It has been growing steadily to five to 10 percent. Over the period of the last— in fact the last year itself I think quoted about 12 percent. We all agree this is actually a fact. It is going up and up but there are various reasons for this. Cost of the equipment, cost of medications. Wages, wages in private hospitals are going up tremendously after COVID-19. We are losing our good nursing team to overseas countries so we have to make the wages competitive.

Utility bills. We are now considered the industrial rate as well. So, for private hospitals, some— my private hospital has suddenly seen an increase of half a million ringgit monthly bill alone to actually cater to the sudden rise in the electricity tariff. So, these are all things that in order— you can't run a hospital without having 24 hour electricity, an uninterrupted power supply, the blood bank, the medications, the OR, everything actually needing power and all of those things. So, these things are all impacted the operational cost and I think our colleague in APHM will probably be able to elaborate that more in detail. But the next slide is something that I actually would like to share again.

Tuan Sim Tze Tzin [Ahli PAC]: Datuk Wira Pengerusi, *before you go to the next slide, can I ask a question?*

Dr. Gunalan @ Arumugam Palari [MMA]: *Sure, can.*

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Tuan Sim Tze Tzin [Ahli PAC]: *Dr, you are talking about number seven on the page I think four. You said anecdotal experiences are not necessarily representative of the overall picture. Cash pay more versus cash pay less versus insurance.*

Dr Gunalan@Arumugam Palari [MMA]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Can you tell me more about this?*

Dr Gunalan@Arumugam Palari [MMA]: *Also, like what I mentioned earlier, sometimes certain insurance companies they actually have an agreement with the hospital per say. So, for example if you are going to do this particular procedure, your fees, say for example, if a cash patient is RM30,000— he's the same procedures same our fees are the same everything else is the same. But it is actually a contract that is signed between the hospital and the insurance company to give certain discounts. This discount can be ranging within anywhere between 10 to 20 percent and I think of late you would have seen some announcement or public statement by APHM herself. There's some hospitals are asking some insurance companies are asking up to 30 to 40 percent discount.*

So, when those discounts are given, what happens is the fee overall for that particular procedure will be lesser. The patient who is paying cash may pay, say, RM10,000 for the procedure, by the patient because he's insured and we have given that contracted discount. So, he may end up paying, say, RM8,000 for the same procedure.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, you are talking about the specialist fee* lah? *Not the hospital?*

Dr Gunalan@Arumugam Palari [MMA]: *No. No. The hospital. The overall hospital.*

Tuan Sim Tze Tzin [Ahli PAC]: *The Bank Negara gave us different statistics because Bank Negara briefed us that for dengue cases. Pay and claim is RM1,200. But insurance, RM5,000.*

Dr Gunalan@Arumugam Palari [MMA]: *Okay.*

Tuan Sim Tze Tzin [Ahli PAC]: *Pneumonia, RM2,000 for pay and claim but for insurance is RM6,000. There's three times and four times difference. How do you comment on this?*

Dr Gunalan@Arumugam Palari [MMA]: *A lot of times actually we have to dig down deep inside in terms of what exactly to place behind the scene for that particular instance of invoice. Typically, for example, if you have a straightforward dengue patient who's actually coming in as an outpatient who's just being seen, taking some bloods, one or two tests and given some simple medications. He'd probably be discharged on the same day or even a day or two, monitored. But say, for example, the same patient that's actually coming in for stay in an ICU or frequent blood tests whatever, bill can potentially be a little bit of higher charges as well.*

Tuan Sim Tze Tzin [Ahli PAC]: *Just to correct you. It is not based on one or two cases. It is about 33,815 cases for dengue. Bank Negara's statistic. Then pneumonia, 53,888 cases. So, maybe— it's very widespread.*

Dr Gunalan@Arumugam Palari [MMA]: *But to be honest with you the doctor's fee in that particular instances has always been standard. Consultation fee.*

Tuan Sim Tze Tzin [Ahli PAC]: *No, no. we are not questioning the doctors. We are questioning the hospital. Doctor's fees controlled. We understand.*

Dr Gunalan@Arumugam Palari [MMA]: *Can I move on?*

Dr Vasu Pillai Letchumanan [Malaysian Medical Association (MMA)]: *Maybe to answer that, I think the comparison has to be apple to apple. There are many situations, not same scenarios. Even in dengue patient comes in. There is severity involved. There are many of the comorbidities involved. You want to compare the bill for cash patients to private patients. It should be the same scenario. That means all these factors must be taken into account. Whether in this report it has taken into account or not, we are not very sure.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yes, I think, if let's say the sample is 53,000, I think it is quite a representative of all. Let's say, if let's say, three cases, of course, I would say that each case is different. But 53,000 I think it is quite a complete statistic.*

Dr Gunalan@Arumugam Palari [MMA]: *Okay. We probably need to see that data as well.*

Dr Liew Shan Fap [Malaysian Medical Association (MMA)]: *Can I add something on this? Sorry.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Please mention your name and also your post.*

Dr Liew Shan Fap [MMA]: *I am Dr. Liew Shan Fap from Sarawak. I'm a gastroenterologist working in a private hospital. I think generally you would know the charges in private hospital in Sarawak is much lower than KL. I think we have looked at different things. Of course, you can compare from diagnosis very specific. A lot of times when we encounter a patient which is not affordable but they come to a private hospital, the doctors give a discounted rate. The hospital also charged lower. Sometimes, we have no choice we have to use generic drugs. But if a patient comes with insurance and they have the privilege to use a branded or patented drugs, if we give the generic drugs to the patient, they'll feel you are giving inferior and subquality care.*

I think, when we look at the money and amount of payment, we also need to look into the details what is— expectation from the patient. Whether we are providing

a quality care or we are providing a substandard care. Unfortunately, it is patient is still paying at the pressure of money to pay and say, doctor, I only have RM2,000. I cannot more than that. You have to find all sorts of ways to reduce the cost but is that the way that we need to go, are to reduce the cost of insurance cases.

So, you do not blame the doctor charge might higher or hospital because we actually—Actually, you look at that the doctor charges the same for both patients. But hospitals and we actually find ways to reduce the cost by including using generic medications. Some are shorter stay with the expectation of a higher rate of readmission. We have the pressure to discharge a patient. But I think eventually we need to equalise both. I think it's important to cross and gap in between. There is a win-win situation for all the parties. Thank you.

Dr Timothy Cheng Tsin Jien [Malaysian Medical Association (MMA)]: *Sorry. Just let me jump in, YB. Timothy here. Orthopaedic surgeon here from Sandakan. About 13 years in government service now and still in government service. There is no private hospital in Sandakan* kan, *YB Vivian? Just to add to your statistics, I know there is 53,000 but the problem is statistics is that especially if taken by non-medics, in that 53,000, we do not know how many were severe, how many not severe. Whether more of the severe were cash, more of the severe were insurance, less of the severe— you know what I mean? You can actually— I know it is statistics, but it can be also skewed. Depending on who collects it and how they collect it.*

So, it is actually it is different because I know if the person collecting just takes the word dengue and goes into the computer and abstract all the words dengue as a case, you may get very different results. Thanks.

Dato Dr Kalwinder Singh Khaira [MMA]: *If I may just add on one more point on that as a government doctor. From the private sector, we accept every case. We cannot say no. When we do have complicated cases coming in from the private to the government because unable to pay. Sometimes, some of the complicated cash-paying patients may be have been referred to the government for completion of care or because of complications rather than those who stay in the private sector until the end. The that also will be a screwing factor which I think that we need to say. Thank you.*

Dr Gunalan@Arumugam Palari [MMA]: *Alright. So, I think the next slide we all agree that the inflation has gone up. But the most important thing is that the 13 schedule that was started in 2014. Previously, the earliest schedule was 1998. There was no revision until 2014, where there was a 14.4 percent increase in our fees. There was an initial bump in the doctors' contribution to the fees from 2015 onwards.*

But from 2016, 2017 onwards, our fees are fixed all the way. Whatever contribution that you see for the total bill now is actually to be honest it is not a component because of the doctor fee.

Just for example, laparoscopic appendectomy, our fees are probably, say, RM4,000 for anesthetic and surgeon. Total hospital bill saying in 2015 was about RM20,000. The same RM4,000 we are still charging for patients but it is now RM30,000 for example because of the use of certain technologies and equipment and what not that has gone up. Our fee is still they are very similar. In fact, the percentage of the doctors' contribution to the overall bill is actually much lower. It used to be 30 percent. Now, I think most of the time we see at about 25 percent. At the rate the inflation is going, maybe by 2030 if it has no adjustment to our fees will probably around 20 percent. That's the likelihood that we are looking at the moment.

The amended fee schedule. This has been something that the doctors have actually sat together with the Ministry of Health officials. We have gone through from 2020 onwards. There are certain procedures that are not captured in the original 13 schedule that was released in 2013. This is because new procedures have come up. New technology has been used. For example, in robotics surgery, these are not captured in the fee schedule. We have sat together with the Ministry of Health Bahagian Amalan *and gave our reasons in terms of what is appropriate fee.*

At this present moment in time, these are still not gazetted as yet. We haven't gone into the details when it will be gazzeted or whatever but this is actually the amended schedule that is still being waiting for approval. That is still under the Bahagian Amalan *and Auditor-General Office.*

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Now, the other thing is that we talked about the insurance company always says about the buffet syndrome and the medical necessity— part of it. Now, for the insurance industry basically their feeling is that just because there is a medical card owned by a patient, doctors tend to overdo certain investigations and just since you are admitted, why not I just completely get you to do an echocardiogram and get you to do a stress test when it's not actually potentially warranted. I am not denying that it can happen, but the vast majority of the admissions in most of the hospitals are due to certain indications and we have to actually refer the patients if there is indication for referral.

For example, I give you an example, 40 years old lady comes in with abdominal pain on the right tummy, all right. It could be of many things. It could be a gynae problem, it could be a gastro problem, it could be a cardiac problem. So, the first physician that actually reviews the patient will need to decide what exactly is the

problem for this particular patient and you need to refer the patient accordingly to the speciality that is concerned. Nor, this is not a cartel behaviour. This is not about providing my friend and avenue of, "Eh, you also makan a bit lah, I also cari *makan a bit lah." No, it's not that. There are clear indications in terms of supporting the clinical decision making.*

From a medical legal point of view, this also— they have been concerned that we are indirectly rising the costs because we are moving towards a defensive medicine. Now, the problem with defensive medicine is the way litigation is playing out now in this country, many litigations are now being settled in the High Court at the costs of RM10 million, RM8 million and stuff like that. These are all astronomical figures that was unheard of just five, ten years ago. What's happening now is the lawyers are asking us, "Doctor, this particular patient had a cardiac problem. But you are not a cardiologist, you are gastroenterologist. Why wouldn't this patient referred to a cardiologist for you to rule out certain things?" This is in the case scenario where something goes wrong lah*. Then, we end up like, "Oh, I should have referred to the cardiologist to rule out all of this".*

So, this is why doctors are pushed into a situation where defensive medicine happens and in a facility or a hospital where there are all kind of specialties. We— it is incumbent on us as the doctors to actually make full use of the facility because it is different if you are in a district hospital where you are the physician who covers all the specialties. But when you are in the government, in a big center in Klang Valley for example, you have access to all these doctors. You need to actually do the right thing and refer them accordingly.

Now, whether it is warranted or not, its purely at discussion that this actually a patient-doctor confidential relationship. They need to actually figure it out. Now, if the patient feels that I don't feel I need a referral, it is strictly the autonomy of the patient to decide so and the doctors can only recommend and suggest. But if the doctors think that it is really necessarily and needed, he needs to refer the patient to the relevant specialty.

Now, that is about defensive medicine. I also talk about some of the impact of regulation. The Private Healthcare Act, this is more towards the hospital. But at the same time, some of the guidelines that are put in are actually making the doctors actually abide by these guidelines, abide by some of the standards like for example, Joint Commission of International Accreditation (JCI), MSQH. These are all standards that are put in place and needs doctors to comply with the standards.

For example, in the government side, single use disposable items are not actually things that we do in the government sector. I mean we use, reuse a lot of

equipment because they are sterilized and what not. But JCI does not encourage use of items to be recycled and reuse again. So, these are indirect reasons why some of the costs of delivery of this healthcare is actually going up compared to what it is in the government side. I am sure you know that in the government side, laparoscopic equipment for example, are reused about five to 10, to 15 times. The trocars cleaned up and all those things before they actually discarded. But it is not the same in private healthcare. Some of the trocars are single use trocars as well. So, these are indirectly reasons for the increased in the utilisation of some of the devices.

Now, for the insurance industry data again. Just purely focusing on the costs that was actually explained by the industry, how much they are paying for. Yes, rightfully 26.2 percent increased from 2023 compared to 2022. So, in 2023, RM7.7 billion was spent on medical services in the private hospital, all right. It's jumped from RM6.1 billion. Now, that is to include the workforce which is about 6,000 doctors, 100,000 staff nurses, physiotherapist, pharmacist— all that, they are delivering the efficient healthcare in private hospital which amounted to RM7.7 billion including the costs of the devices, equipment, medications and all those things. All that costs RM7.7 billion.

Now, I would like to just highlight a little bit of the same report. Now, in the same report, just down there, the insurance industry has actually highlighted the expenses that are actually involved in the insurance industry commonly. Now, just zooming in on one aspect, the agency remuneration. This is something that when I dig in, it's kind like shocked me because it is stated as RM5.3 billion. Remember the figures of RM7.7 billion that I said earlier. The RM7.7 billion was a total costs of healthcare delivery, but to remunerate the 80,000 licensed financial planners, it costs about RM5.3 billion. So, that's almost two third is actually be spent on licensed financial planners.

We are not in the business of telling insurance company how they do their work, this purely their prerogative. But to us relooking at it, it is quite a sizeable amount that can potentially be looked at in terms of why are we actually spending that much. On the same day that I get a letter from my insurer to say that your premiums are going up and I'm Facebook friends some of these agents, their showing their pictures in China of an incentive trips where they are actually going on a holiday, on a business class trip and what not. So, we doctors are being regulated, but are some of these practices indirectly increasing the amount of money spend to deliver the particular product? So, these are some of the questions I think is important that we are actually do not sidestep it. It's kind of like white elephant lah*, all right.*

The RM4.4 billion for the management expenses, again we are not telling the insurance companies how to do…

Dato Dr Kalwinder Singh Khaira [MMA]: *Want to ask the question.*

Dr Gunalan@Arumugam Palari [MMA]: *Yup, sorry.*

Tuan Sim Tze Tzin [Ahli PAC]: *Have you—* Pengerusi, *have you raise it up to Bank Negara? You have engagements with them?*

Dr Gunalan@Arumugam Palari [MMA]: *Okay. So, the 2020 meetings that we actually asked the— when we called the members, the stakeholders* lah*, when MMA called. Unfortunately, BNM did not sent any representative. So, we are only discussing about these issues with the insurance industry with the APHM, with the consumer association and the MMA. So, these are the parties— Bank Negara took a very behind the scene kind of approach. So, most of the time when we end up having these meetings, we highlighted some of these issues. We don't go deep into this kind of figures because at the end of the day, this is not MMA's concern. MMA's concern is basically how are your products delivery affecting the way we actually function at the hospital.*

Now for us, this is to be honest with you, indirect effect of us because agents are blaming us for declinature. Your doctor did not know how to write. That is why the insurance is decline. On the other hand, some of these patients were not told that they are not suppose to insured. Don't worry, as long as your doctors write this, you can actually get covered, all right. But when we actually submit the forms, we have to be very clear about what we write. When we state in the form that this patient has got diabetes or hypertension, whatever, this was not declared. Then, the impact is the client's insurance is decline because it was wrong disclosure. Why was wrong disclosure? The agent needed to make a sale.

So, this are some the other thing that have happening. The sales are being done, yes. We have highlighted it to the insurance industry as well. So, they are aware. We have actually told them that look, if we find across, come across, certain agents who were repeatedly doing this in our hospital. We will send you their names for your action and they actually welcome that. But that is actually to be honest with you, again not under our purview. It's not for us to actually give those names. They need actually look at that.

Dato Dr Kalwinder Singh Khaira [MMA]: Ya. *I just want to add on to the writing, even though Dr. Gunalan mentioned it's not under our purview, but it is the elephant in the room. It is a big contributor of the costs and maybe you know, of course it is a very tough call because it employs so many people. But then again,*

again as I mentioned, it is an elephant in the room that also hopefully PAC will look into it. Thank you.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry* Pengerusi, *when you said 'it', what exactly do you mean? Because you want to record it in our…*

Dato Dr Kalwinder Singh Khaira [MMA]: *I am talking about the percentage of the remuneration of the two third of the medical claims which is for medical going…*

Dr. Hajah Halimah Ali [Ahli PAC]: *An insurance ITOs?*

Dato Dr Kalwinder Singh Khaira [MMA]: *Yes, to the agents.*

Dr Gunalan@Arumugam Palari [MMA]: *To the ITOs. Yup, to the agents.*

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Dr. Hajah Halimah Ali [Ahli PAC]: *Just to record here. For your information, we had quite a few proceedings already with BNM and all that, insurance and all that. I have already mentioned my friends here that doctors are being blamed by the people outside there whereas their fees are regulated. So, the PACs understand that.*

Dr. Gunalan@Arumugam Palari [MMA]: *Thank you.*

Dato' Dr. Kalwinder Singh Khaira [MMA]: *Thank you very much.*

Dr. Gunalan@Arumugam Palari [MMA]: *Thank you very much for your support. Because I think the right term, the elephant in the room here is ours are regulated. The industry is regulating all this on us. Because for example, a couple a year ago, doctors when we are talking about our relationship with the pharmaceutical industry, they only said, look, doctors are being sponsored to go overseas. They go and attend a meeting for example. That particular company the sponsors, you only come back and you are supposed to use their equipment and whatnot.*

That relationship is now being scrutinised to the dot. I mean there have to be clear declaration. Doctors have to sign. It is a legal things and they have to make sure that they don't actually sanction those equipment and whatnot. They can—whether the company cannot force them to use that equipment. They can use it as part of the equipment. But just because you sponsoring me, I'm not supposed to be using your equipment.

So that relationship is very clearly defined and we doctors are also very careful and mindful. In fact, the pharmaceutical industry is also very careful. Every time for their compliance purposes, they make sure that this are all cleared out well before we sent doctors oversea for training and whatnot. So, I guess probably this might be something that potentially we can look that.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *I think you guys raised a very important and pertinent issues. Just want to get some clarification. Number one is that RM7.7 billion is a total medical insurance payout for patient*-lah. *Am I correct?*

Dr. Gunalan@Arumugam Palari [MMA]: *Yes, correct.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, covers all…*

Dr. Gunalan@Arumugam Palari [MMA]: *Contribution by the ITOs. There is still a portion that is actually being paid by cash patient out-of-pocket. There is also a portion that is actually self-insured corporation like the likes of TNB and whatnot.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, meaning everything add up is RM7.7 billion?*

Dr. Gunalan@Arumugam Palari [MMA]: *No. The contribution from the ITOs is RM7.7 billion.*

Tuan Sim Tze Tzin [Ahli PAC]: *RM7.7 billion. Then, on your next slide is that you are saying that agency remuneration for the agents is about RM5.3 billion. Then management expenses is another RM4.4 billion. What is that management expenses?*

Dr. Gunalan@Arumugam Palari [MMA]: *This is my assumption. I am thinking that this is basically the cost of hiring the employees, the cost of their operations, the CEO's salary, the board and managements' salary, all those buildings, properties and whatnot. So, this is prior to their operational expenses.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. Then, loss on disposal of assets and other out go. What is it doesn't mean?*

Dr. Gunalan@Arumugam Palari [MMA]: *That one I am not too sure, not too sure.*

Tuan Sim Tze Tzin [Ahli PAC]: *Then the biggest chunk, net policy benefits. What does it mean?*

Dr. Gunalan@Arumugam Palari [MMA]: *So, these are actually basically when you go up the earlier slide where there was a payment on disability, death payment. Those are actually very big payout. So basically— for example if the client is insured for RM2 million or RM10 million for example, they happened to have debt or TPD benefits. So those benefits go to the next of kin. So that is actually the policy payout. But it has got nothing to do with the medical component of it.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, you are saying the medical payout is almost— is just slightly more than payout to the insurance agents?*

Dr. Gunalan@Arumugam Palari [MMA]: *Yes, correct.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, thank you.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tuan Pengerusi, *I want to ask a question. You see, you look at that day in Parliament, 500 people come and voice out their complaints, right? You find that the patients who is blaming— actually what I heard is that they blamed the hospital, private hospitals especially and not so*

much on the doctors. So, can you comment on private hospital chargers? One glove cost RM20 and things like that.

Dr. Gunalan@Arumugam Palari [MMA]: *So, it is really depending on what is exactly you talked about the glove. Now, give just an example assuming on the glove issue.*

Disposable gloves are different from sterile gloves. So, for example, a box of disposal glove where you used for just a single procedure and you throw away, definitely are going to be much cheaper compared to a glove that is sterile glove that is actually meant for surgery.

In a surgery, there are six or seven people who are actually sitting in and doing the surgery and in one surgery, sometimes may end up changing three or four times because you are actually need to make sure that sterility is maintained and whatnot.

So, these are all part of the cost of actually doing the particular surgery. But how much they are being marked up by the hospital, is not something we actually have control. What be use, we will use in order for us to make sure that at the end of the day when we are doing the knee replacement, the risk of infection is zero because I make sure that I used sterile gloves which are actually clean and does not cause infection to the joint. Because dealing with the joint infection will be much more compared to the actual cost of the gloves.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *How much of the sterile gloves?*

Dr. Gunalan@Arumugam Palari [MMA]: *It depends. It could be somewhere within RM5, RM7 to the high-end quality ones which it glides very well, could be about RM20. Any surgeons here who can comment, the gloves. [Dicelah] It ranges.*

There is even a radiation proof glove as well where when you are doing a procedure that you don't want any radiation, that is also is there. So that both are used by pain intervention specialist who do a lot of procedures under radiology guidance.

So, all those things are different, different. So, a glove is just not a glove. The ones that you see in the pharmacy, the disposable gloves, yes, that one kotak, *one box is probably about RM4 or RM5. But of course, the hospital marks up but those are actually single used, once you used then you throw away but there will be another hundred pieces inside there. You will be using it for procedures that are not meant to be sterile per se.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya nak tanya, di hospital swasta, ada tak KPI untuk mencapai sesuatu *target?* Contoh, bulan ini *you need to achieve okay RM500,000.*

Dr. Gunalan@Arumugam Palari [MMA]: *No. So how it works in the private hospital.* Memang kita tak ada KPI yang *dictated in the contract.*

But say for example, it is an equipment say robotics surgery for example. We have the da Vinci System right now. In the da Vinci System, the equipment investment is actually RM7 million for example.

So, the finance team of the hospital will do some projections. Okay, this particular equipment is not board. Do we have the numbers to actually support this? So that is when the department seats together. The department will sit together and say, "Look, we have potentially 30 or 40 patients that are being referred to Singapore, to other hospital because we don't have the equipment. But if we have this equipment here, we can potentially use it".

Then, it is up to the doctors to actually make sure when the patient— when the equipment is brought in, we are able to utilise it. What the hospital don't want is, the return on investment going to waste. You buy something with just a million dollar, two million dollar and it sits there because it is not being used.

A lot of time the equipment are— for example, my hospital. We have a cath lab which is very busy angiogram, cath lab kind of things. We have so much of work being done that we couldn't cope with the volume. So, we are now opening up the second lab and third lab. But these are all data that we collect over period of time. To say that look, do we have the capacity to open up another lab? So, then we go accordingly.

But the misconception is that, we doctors earn a cut of the commission from using that. That I think is not true. We need to actually be very clear on that. Some hospitals may have an arrangement with the doctor where the doctor owns a particular device or equipment. Because he feels that I'm going to bring this particular equipment. I would actually use it as long as it fits the criteria and indication that you want to use it, it's appropriate, the hospital would not stop it.

But again, this is where I need to reiterate and this is the message that we also give to insurance partners as well, where there are outliers who abused the system who buy an equipment and purposely find an indication to do a procedure just because he can make money, those are the people that you need to flag to us. We have told our industry partners many, many time as well. So that outliers, identify, tell them— tell us and we need to look. A couple of slides from now I'm actually going to touch about some of that as well.

Dr. Kuharaj Balasubramaniam [MMA]: *Dr. Kuharaj, O&G specialist private sector. There is one quoting. We are independent contractor most of the time, working in the private hospital.*

We do not have access to what the billing is finally given to the patient. Many of time I only know my chargers. So finally, the bill is given to the patient then the patient comes to me sometime and are like, "Doctor, what are these chargers? We are okay with your chargers because it has been fixed by the law for the last 10 years or more. What are these chargers?" To be honest, I also don't know because there are actually coded in certain ways.

Now, to the analogy of the glove, everybody keeps talking about this glove. It come in the newspaper as well. There are SOPs that required one patient has one box of disposal glove to themselves. We cannot take one patient's glove and go and use it in another.

In KKM we do it all the time because you know, we need to cut cost. The nurse will scold us and say "Look, you jangan buang, bazir". But their gloves are different quality as well. There are different ranking and certain times we use slightly more expensive gloves for certain procedure because the quality of the glove is important for the kind of procedure that we are doing including sometimes radiation blockage.

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But there is another essence of it is that we are only one part of the medical healthcare provision. Medical devices, drug prices all are different, disposable items. I give you an example of laparoscopic myomectomy where we actually do keyhole surgery, we take out a big fibroid, we have a machine that cuts it up. That machine alone is single-used. It used to be useable but SOP and regulations demand now and that is disposable. The use of that machine is double the cost of my surgical fees. Include my patient will tell me is double your charge, I said what to do, my charge is fixed by law, they can mark it up whatever they want.

So, I think looking at it as a whole is more important, the multiple regulations that actually involving the private healthcare but just private healthcare, Medical Devices Act now is coming into force but we have to have a local distributor. Previously, we can go to overseas and buy certain equipment and use it for a cheaper price. But when we have regulations that insist, that we have a local distributor there is markup there also. At every step, there's a markup, so it the supply chain is just not with us.

Dr Mohamed Namazie Ibrahim [MMA Past President]: Ya Puan Pengerusi, *I am Dr Mohamed Namazie from past President of MMA. I have been sitting on the APEC Panel for the business ethics of small and medium enterprises of the pharmacy legal industry and it was very— I was representing the MMA as healthcare providers in that panel which had members from all over the Asia Pacific region. We were asked*

to come up with an ethical code for the pharmaceutical industry. Now, during deliberations what was found was about as smart as 40 to 50 percent of the cost of a drug is spent on promotion of the drug. Promotion of the drug.

So now, what the ethical code was looking at was how to control the price of the drug but you know there was an incentive given to the various people, the doctors to prescribe the certain drug and all this was well addressed and that ethical code— I mean we sat through over three years including the COVID-19 when we had online conferences meeting to discuss and finally it was published. But the thing is this code must be adopted by each— what the APEC call the economies. Economy is a country basically and there must be adopted.

Now, there was some attempt before for our local industry to adopt this ethical code but I think that more needs to be done. So, these are the areas. Now, giving incentives to doctors has been tremendously cut from what used to happen. So, at least in our country that is not much incentive but it does happen in other countries.

So, what I would like to highlight here is that there are many factors, hidden factors that contributed to the for example the drug as well as the medical devices. Okay, it's just not because we are two panels, one was for the pharmaceutical industry and another panel was for the medical devices industry. So, these two panels came up with the ethical code for this. Thank you.

Dato Dr Kalwinder Singh Khaira [MMA]: *Dr. Venugopal?*

Dato' Dr Venugopal Balchand [MMA Member]: *I am Dr. Venu, a heart surgeon at Pantai Hospital Kuala Lumpur and Assunta Hospital, Petaling Jaya used to be a proud member of Institut Jantung Negara for 40 years before I left for the private sectors.*

I understood the PAC member's question on KPI. To me, whether the hospital dictates to the doctor how much revenue he or she must bring in. Is that what you mean?

Tuan Sim Tze Tzin [Ahli PAC]: *Yes, yes.*

Dato' Dr Venugopal Balchand [MMA Member]: *Yes, so I think the answer is categorical no. I have been a heart surgeon in various hospitals for the last 25 years, not one hospital has told me how many cases I should do a month or not. One hospital has told me, Dr. Venu you must make half a million dollars in terms of revenue this month. That doesn't happen and I think that another urban legend– meet that needs to be demystified. I don't think any hospital tells any doctor, how much money to generate. Thank you so much.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *we ask the question because it is not like what— we want to know because some people complain to us including some*

of the doctors go on YouTube and all the this to category say that their CEO asks him to make certain standard, the video that went viral, okay. So, the video…

Dr Gunalan@Arumugam Palari [MMA]: *Ya. YB, that was actually a very interesting point because I did actually see that particular video. Honestly speaking, you know controversy actually a crack viewership. So, sometimes certain things being said by certain individuals representing the medical fraternity were actually take it out of context. We know that particular individual is actually hungry for like and glamour whatnot. I've said that we know the outliers out there, so we also do know that there are some doctor incentives. But to paint 6,000 doctors to have the same issues were actually doing it on the basis of incentive and inducement, especially like fee splitting, I think that is not the right way to describe it. But where they are doctors were clearly in breach of ethics; we need to hold them. That one I think we are quite clear on that part.*

Dato Dr Kalwinder Singh Khaira [MMA]: *I think, I would like to put our stand here that MMA doesn't condone this and any doctor of this nature, please report to the MMC, MMA will not accept this kind of behaviour, thank you.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you for the clarification. Pengerusi*, saya nak tanya *about over test, over investigation and all this because some people say that a simple procedure, you go to the hospital this— you know, went through many, many checks, many, many tests and then some simple— for one example, one of the MP recently said that Tommy, he said that he went normal* demam saja, *suddenly go to* hospital kena masuk wad, okey. *After two days he charged RM6,000. say I have nothing; I don't think I have a problem.*

Dr Gunalan@Arumugam Palari [MMA]: *Again, it becomes like— you know when you go down to the details sometimes, the MP is also high risk for the doctors. You make a mistake; something happens to the MP and then the whole country will look at you and say this doctor doesn't do the right things to make sure he should do everything to make sure…*

Tuan Sim Tze Tzin [Ahli PAC]: *I mean, just compare general hospitals and private hospitals. General hospital you do test that it you know* cukup-cukuplah…

Dr Gunalan@Arumugam Palari [MMA]: *Correct, correct.*

Tuan Sim Tze Tzin [Ahli PAC]: *...But for private hospitals a lot of tests.*

Dr Gunalan@Arumugam Palari [MMA]: *Yes, yes. So, actually bounds back down to defensive medicine perse. Now, at the end of the day, the premise of whatever been doing in a private hospital is doctor-patient, all right. If the doctor has explained to the patient and the patient agrees that the rationale for all doing this test is I understand, then by all means proceed. But if at that point in time, the doctor*

says, "YB, we can just do this test, that test or whatnot, you as the patient have got the right to stop and ask, why are you doing this test? What is the basis of it? Of course, to the patient who is educated, they may stand their ground and say I don't think I need this or whatever, there is no rationale. But to a poor uncle or pakcik, *they are really dependent on the doctor actually to decide. So, where there are gaps in the delivery the healthcare, we should be criticising it but across to board, I think most of the time, they are clinical indications for us to test.*

Dato Dr Kalwinder Singh Khaira [MMA]: *Dr. Mastura.*

Dr Mastura Md Yusof [MMA Member]: *Ya, I think— I am Mastura, I am a clinic oncologist from Picasso Hospital and Pantai Hospital here. Just want to add to that with regard to doing a lot of tests. Because we oncology in cancer, we do a lot of tests because cancer is very sophisticated and articulate in that way. So, sometimes a lot of tests that we have to do, the payer, the insurer only pays if the patient is admitted because the policy is such. Doctor, I can only do this if I am admitted. So, we will explain to the patient, that if you are admitted the cost is going to be more because there is an inpatient fee to what we are doing. But because the patients are desperate and they go on that arcade insurance policy that states as such then that happens.*

Second thing is when somebody is in the ED of a private hospital right and they are in the emergency department with a fever and if they're going to be treated at the emergency department and they go back, the insurance usually does not pay. The insurance does not pay for that.

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I mean, I experienced that with my children, my three children. They usually not pay for that. So, a lot of people actually ask to be admitted so that they can use their insurance and then they may actually blame the cost to be high because they had been admitted because of that. So, these…

Dr. Gunalan@Arumugam Palari [MMA]: *Ya. Ya, I, I…*

Dr. Mastura Md Yusof [MMA]:*…are the common issue that we see.*

Dr. Gunalan@Arumugam Palari [MMA]: *Ya. To add on the Dr. Mastura's point, we are slowly seeing a shift from some of the insurance industry partners where actually noticing that look, there are some cases can actually be paid cashless and outpatient. So, the number of companies that are actually understanding this part is actually there. But it's not widespread. So, we, the medical doctors, are actually saying that look, this patient can actually be potentially be managed as an outpatient because they fit these particular criteria and please extend the cashless facility to them.*

Problem is most of time the extension of the cashless facility is only upon a patient becoming admitted and that is actually the challenge. But, if the industry understands that look, we are moving more and more towards a daycare and outpatient treatment or even referral to a GP colleague in the private space then inpatient care which is a bit chunk as well RM200 to RM300 per day for patient to be in the ward to be seen by a nurse that's another charge for that, vital sign monitoring another charge for that. All of that could be negated. No need to charge because they are now in the comfort of their home. The policy side…

Dr. Mastura Md Yusof [MMA]: *And every time…*

Dr. Gunalan@Arumugam Palari [MMA]:*…press the bell another charge here. So, these are the things that we can potentially avoid. So, I think the industry needs to be a bit proactive, listen to the doctors. The doctors are saying, "Look, they are ways to do it". Just as long as you understand how to make your products work for yourself. Alright.*

Dato Dr. Kalwinder Singh Khaira [MMA]: Dr. Kuharaj.

Dr. Kuharaj Balasubramaniam [MMA]: *Actually, YB you mentioned that in KKM they do* cukup, cukup punya *test. Actually, I very be honest with you, we want to do an MRI prior to surgery, we want to do a CT scan when I wax working in KKM but the waiting time is three, four months if it is an elective procedure, there is no chance and the patient will be looking at me, "Can we do a surgery?", "When can we do the surgery?".*

In the private sector, it done more quickly. So, we are actually doing what is recommended practice because as he said, defensive medicine is a thing. If you are going for the surgery by just palpating the abdomen without doing a CT scan or MRI and you find a negative finding or there is a complication, you are done for in court. They will ask, "Why didn't you do an MRI?", "Why didn't do a CT scan?". That are always the questions that they'll ask.

So, to protect ourselves and also patient's safety, it's two in one. We end up doing further testing and imaging prior to inflation and we would do in KKM also. But the thing is, sometimes it doesn't permit.

Dato Dr. Kalwinder Singh Khaira [MMA]: *If I may talk about KKM a bit in terms of the fever case, YB. Sometimes in hospitals we do— we have test what we call as first line, so, I'm a physician, so I fever cases. First line, second line, third line. So, ultimately, you know what every doctor wants in a private or government is you want a diagnosis. So, sometimes when you don't have diagnosis, you do more tests. The only thing is government sector sometimes we don't do that many tests while looking for a diagnosis, you know. We take a bit a slower.*

But having said that, there are cases nowadays we do get complaints in government hospitals from patients asking why such a test was not done. I had a case in [Tidak jelas] and I had to answer why this test was not done? I have to answer that. Luckily, that test was not available on hospital, we just said, "Test itu tak ada di hospital…". Otherwise, I think I'll be in trouble. [Ketawa] Thank you very much.

Dr. Vasu Pillai Letchumanan [MMA]: *[Tidak Jelas]*

Dr. Liew Shan Fap [MMA]: *Ya. Puan Pengerusi. I'm Dr. Liew again from Sarawak. Talking about the cost that MP claim that bill is very high. I think it comes to the patient's expectation, okey. Some people are being very demanding and some of the symptoms they complain, they continue, all sort of symptoms. I guess— I'm practicing as a gastroenterologist.*

For example, 40-year-old, a lady, complains to you she has a pain of abdomen for last three months and it turns she may be complain it because it's stress and all of the things but in this kind of cases, what do you do? Do you want to do a gastroscopy or just leave it, treat and watch and see for next three months? It's very difficult sometimes is at the end of the day, you come to the patient's expectation and the symptoms and the severity.

If the symptom is very severe, if you don't do anything and we miss a cancer, for example, and the patient presented three months later with stage four cancer, I think they estimate— medical legal cases. Doctors now practicing very defensive medicine because of very high pay up of the insurance— medical legal cases. I think, eventually if we want to bring down the costs of the medical care, I think we need to look into all these aspects.

I think integrity— you should give more integrity to the doctors and decision and do not blame the doctors all the time for simple cases which I think if it is minor mistake and et cetera and bring to the court and— so all these will increase the cost.

So, I think in this case, maybe if we don't do enough, then they complain at doctor again. So, I think to be careful, a lot of times when we do a medical care we discuss with the patient. What the patient's expectations? We give them the cost and give them the options. If they decline or reject whatever procedure, we will not proceed. So, at the end of the day, the doctor's integrity and professionalism come with the patient's expectations. Thank you.

Dr. Hajah Halimah Ali [Ahli PAC]: Datuk Wira, kalau boleh nak tanya yang Sarawak punya tadi. *Why is it lower than Klang Valley,* Semenanjung*. Why? It's supposed to be more expensive* sebab nak bawa barang sana, hantar ubat apa semua sana. *So...*

Dr. Liew Shan Fap [MMA]: *Exactly. I think I want to bring to your attention for the hospitals CapEx. In fact, most of the big hospitals go into very high ends, high five-star hotel type of a hospital.. The smallest hospital cannot survive and also CKAPS come in a rule now, all the new hospitals have to purposely build. I think, I give you an example and KPJ in Kuching move to a new hospital and all hospital building is left there empty for the last few years because no one wants to take. I asked CKAPS what a waste. This hospital previously, had been used as a hospital, functioning for 10 over years, should be used fully utilised.*

The answer from CKAPS is because now the rules have changed and the CKAPS only give a license to the new hospital if they're purposely built because the shop lot hospital will not get a license. So, I propose what happened in Sarawak previously all the hospital majority of them come from a shop houses hospital and then now they make money and they upgrade. In order to fully utilise it and also reduce the cost, we need to bridge the gap in between government and also the private hospitals.

I think a budget hospital be the—- a lower cost should be considered and this is the the good example to fully utilise it and of course, we do not compromise a safety issue. But the requirement for the Private Healthcare Facility and Services Act right, has given a lot of requirement and expectation and all those come with cost. So, at the end of the day, the medical cost in private hospitals have become so expensive because of so much regulations and expectations in the name of safety and quality.

I think in Malaysia, we need to relook into all these things and look at another category which can close the gap in between this and look at the budget. My majority our patients are in the sandwich group which I think they look for this category. They actually quite reluctant to or cannot get the expected care in the government but cannot afford to go the private. So, I think in order to close the gap…

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry Dr., who set this regulation for this IJICJ, what ya? Ya.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *JCI, MSQH.*

Dr. Liew Shan Fap [MMA]: *Oh, this is a group of professionalism including doctors, hospitals et cetera all the experts come to decide. I think, of course, they get the reference from JCI and also the other international. So, all these expectations in a name of patient safety and also a quality care. For example, I give you an example the measurement in a corridor of the private hospitals previously I think is lower but now for the GP clinic is 1.2 meter as small then adequate.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Same MMC isn't? You're asking,* tak boleh.

Dr. Liew Shan Fap [MMA]: *I'm not MMC.*

Dr. Hajah Halimah Ali [Ahli PAC]: *This MMC.*

Tuan Sim Tze Tzin [Ahli PAC]: *Who regulates this? This…*

Dr. Liew Shan Fap [MMA]: *CKAPS.*

Tuan Sim Tze Tzin [Ahli PAC]:*…because your impact of regulation, accreditation. CKAPS, who is CKAPS?*

Seorang Ahli: *CKAPS district…*

Dato Dr. Kalwinder Singh Khaira [MMA]: *CKAPS sir, if I may answer. All hospitals, private hospitals are under the control of* Bahagian Amalan *of the Health Ministry.* Bahagian Amalan, *so, they have a section called as CKAPS. CKAPS is a section that goes and seized both the clinics and hospitals and you know they those the issue about the private GPs. Your door must be this size. If you door must open outside all those things. All those come under CKAPS. So…*

Dr. Timothy Cheng Tsin Jien [MMA]: *It's* Cawangan Kawalan Amalan Perubatan Swasta.

Dato Dr. Kalwinder Singh Khaira [MMA]: Ya.

Dr. Timothy Cheng Tsin Jien [MMA]: CKAPS.

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Dato Dr. Kalwinder Singh Khaira [MMA]: *So, it takes care of the private sector. It's kind of CKAPS. So there's a correlation…*

Tuan Sim Tze Tzin [Ahli PAC]: CK apa? CK?

Dato Dr. Kalwinder Singh Khaira [MMA]: CKAPS.

Dr. Timothy Cheng Tsin Jien [MMA]: CKAPS. Cawangan Kawalan Amalan Perubatan Swasta.

Dato Dr. Kalwinder Singh Khaira [MMA]: *So, I think what we're trying to say is that the increasing cost even though we are talking about all the things, there's also has an issue based on regulation, based on litigation payouts, all these has got rundown effect on the costs.*

Dr. Mohamed Namazie Ibrahim [MMA]: *One more thing* Puan Pengerusi, *regarding the CKAPS. CKAPS is just a government body. But that is— that implements The Private Healthcare Facility and Services Act and regulation. So, all these things that we are talking about is in the act and the regulation. CKAPS implements it. So, but the thing is…*

Tuan Sim Tze Tzin [Ahli PAC]: *It's* Akta 586 *is it?*

Dato Dr. Kalwinder Singh Khaira [MMA]: *Yes,* Akta 586.

Dr. Mohamed Namazie Ibrahim [MMA]: *Yes,* Akta 586 *and then the regulations come under— it's a regulation for 586.*

Dato Dr. Kalwinder Singh Khaira [MMA]: *Implementation of 586 is under CKAPS.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *All right.*

Dr. Vasu Pillai Letchumanan [MMA]: YB.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Ya, because we have another 19 pages more. Now is 3.41 pm.*

Dr. Vasu Pillai Letchumanan [MMA]: *Just to— the private specialist doesn't get any cut for doing extra investigations. That I have to be very clear. There are many diseases nowadays doesn't present according to textbook. They are atypical presentations. We cannot just misdiagnosis based on typical presentation alone. Then, the other thing is many patients come to private after seeking treatment in many other facilities. So, there are many complex cases which requires additional investigations.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Thank you. I will give to Kubang Pasu to ask question then I want you Dr. Gunalan to proceed with the presentation* ya. *Thank you.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you Datuk Wira Chairman. Today we all very lucky to have all the medical specialist in this room. We cannot have this many medical specialists anywhere else. But you cannot get any consultation* lah.

I just would like to refer to our doctor from Sarawak, he said about this five-star thing that's why the cost is high. This is one— I think this very true. But, sometimes let say you want five star you have to pay five-star. So, that is correct also. The other thing why the cost is high because they going through so many expansion and there is CapEx. They have to pay more money. Where they are going to get this money is from medical charges for the future expansion ya.

I also was informed by somebody that one of the reasons why they charge unreasonable cost to certain material used like very famous one gloves and so on. Is it because insurance company there are certain thing that they don't want to pay, they don't want to pay. But…

Dr. Gunalan @ Arumugam Palari [MMA]: *There's— whenever there's a bill that is actually given at the end of the day, there will be some amount under clarification that will not be covered.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ya. *So, what they do to take care of the other costs? Miscellaneous costs? Uniform— all kind of thing* lah, jaga, *okay. They have to add up all those costs. So, those costs they cannot put to this insurance company. So, they have to put all this— jack up the price. Is it true?*

Dr. Gunalan @ Arumugam Palari [MMA]: *That is actually part of the financial of billing mechanism of the hospital for them to actually like make up for certain areas that they are not able to charge. So, I guess probably from the hospital point of view they probably be able to answer that. But the doctors per se, again we do not actually interfere on that part of it. If do you think there's an amount under clarification that is not going to be paid by the insurance companies, most of times that will be end up as a bad debt for both the doctors and the hospital. So, we end up actually losing money although the service has been rendered.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But, I'm very sure the reason for the rise of the chargers of hospital definitely not because of you all specialists. You get very little. One specialist hospital doctor my nephew, he showed me RM110,000 cost— he gets only RM10,000. So, definitely not because of you but because of other things. Okay, thank you.*

Dr. Gunalan @ Arumugam Palari [MMA]: *That's correct. So, in the gist of time I just move on and I actually just want to highlight just one particular thing about these discounts. We doctor in private hospital feel that insurance company has squeezing us in terms of both the asking for exorbitant discounts 40 percent, 30 percent and all which indirectly will affect the way the hospital's function because ultimately the end of the day they need to bring in those equipment and this not sustainable for us to give out those kind of discounts without actually rationales behind that.*

Again, this is under the regulation Akta 586 *where the licensing of the private hospital purely is actually the duty of the doctors is actually regulated by section 78. Anything to do with the healthcare or the patient is prerogative of the doctor per se and there were section 78b there is a medical dental advisory committee supposed to be formed every hospital in private hospital will have this particular committee as well.*

You cannot enter any kind of agreement with the private entity that diminishes your role as a doctor. So, this one thing that we want to highlight to industry partners as well— despite all the issues that they highlight to us and trying to tell us not to do certain things, our role is protected by this akta. *So, we cannot actually tell us that you cannot order this test, you cannot order that test because ultimately at the end of the day the* Akta 586 *under this section 78 protects us— it is between us and the*

patient. So, they cannot put in these rules and regulations that fits to their claims process.

So, that particular committee they talked about the medical dental advisor committee is very important because internally in the hospital this would be the committee that puts a stop and check and balance for the doctor's conduct. So, things like ethical conduct of doctors whether they are overdoing things, billing and coding practices, price of equipment and medication, all should be coming under the purview of this committee.

So, my message to the hospital group is basically this is already allowed by the law. Make sure that this particular committee is given much more wider powers to actually make sure that the doctors toe the line. Because sometimes the interests of keeping the doctors there you may not want to rock the boat, you want to just continue their practices, sometime you think that it is too difficult to terminate the doctor, all that should actually be discussed by this particular committee.

The MMC's position on the rule of TPA very clear. Anything to do with asking discount and minimising the choice of the doctor and choice of treatment is considered unethical. Second part they are talking about the pharmaceutical industry and doctors would may refer to get kickbacks also is unethical and this is actually covered under MMC code of conduct. Anybody found flouting this can be brought to task. So again, the rules and regulations are there. It's just a matter of just highlighting that, sending a complaint to the MMC and MMC PIC will actually investigate. Three things can happen to the doctor. Warning, suspension, strike-off. Once he's strike-off that's it, game over for you in Malaysia. So, most doctors will be abiding by these things.

Quickly about this, diagnosis related group. I know that Professor Emeritus Syed Aljunid he's very passionate and this is his pet topic. So, I'm not actually going to be tell— diving deep into the detailed aspects of it. But, just a couple of things that we noticed. In fact, we had a lot of conversations with our colleagues from overseas, Germany and Korea where they've actually implemented DRG over the last 20 years or so and gathered feedback from them as well. So, they have mentioned that look the most important thing that you must have to in order to have DRG is social healthcare insurance, number one. That is a must. You cannot have a hybrid way of doing it and then try to implement DRG.

Second thing is the DRG coding has to be uniformed. It is a national DRG coding. That means whether you are in private or public hospital, the same codes, the same charges should be applicable, then only it will work. If you have just focus on DRG, lets do it for private sector and this is the charges and DRG for the public

sector and this is the charges, it is going to be very messy and technically going to be challenged.

We know the advantages. Yes. Easy to reimburse. This is pro insurance. All right. But, let's look at disadvantage. Under provision of care, meaning that the insurance company will dictate what you can and cannot do within that said DRG. Again, like what we had mentioned earlier certain patients may not fall into that particular category. They will need extra work to be done. Some patients because the insurance company say you must discharged in three days may need extension of stay but because it is not paid for, you discharged the patient early. What happens then, the patient will end up readmitting with complications.

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So, this is another drawback of DRG system. In private hospital we may end up selecting our patients. Right now, private hospital in Malaysia are actually doing tertiary level work almost equivalent to a public hospital.

Every state you have one big hospital that functions almost like a GH. If DRG comes on board we may actually be underserving that particular population because DRG may not take into account the cost factor especially there is a high-risk patient. We may end up rejecting care for them and moving them back to when already over stretched public hospital. That's one part of it we have to…

And we also found out from out colleagues in Germany, for the purpose of DRG coding, some doctors may end up upcoding. Upcoding means that they put the patients on a higher risk factor, so that the cost actually will be upscale as well. So ended up maybe an appendix we would have charged RM30,000 now the same appendix because you have up coded for the purpose of payment may end up— the insurance company may end up paying RM50,000. These are some of the technical challenges that have been shared.

Number one, back to the same thing again. DRG has to be applicable to both public and private hospital and National Healthcare Financing insurance has to be there. Because that is the one single payer that is going to channel the fund to put public and private hospital because it is DRG.

Let's see how Australia works. Australia has a single-pay called Medicare. All the big hospitals are all public hospitals that are funded by Medicare. But if you say your total knee replacement is going to be done in six months and you choose not to wait. You have your private insurance.

You choose a private hospital that has got the surgical services and there's a quote for that. That quote you pass it on to your insurance company, insurance company will pay that quote, Medicare will pay the private hospital a portion of the

fund because the same amount of money would have been paid if you have done the surgery in public hospital as well. There is an allocation of funds from different, different payers, if you were to take on your surgery in a private hospital. This cannot be done in Malaysia at the moment because we don't have that number one, the National Healthcare Financing, a single payer.

Again, looking back at all the countries that has implemented DRG, the single most stand out feature is basically social healthcare insurance. That has to be there in the first place. What we have in Malaysia right now is a hybrid form of financing, works well so far but we know that we need to improve on it.

One thing that was highlighted by our colleagues from Germany is this. When they start DRG there might be potential increase in the administrative cost of implementing DRG. You will need to coders. You need to have technical people, IT specialists, all those additional administrative staff so much so that in his country he has noted that— this is the public health physician, out of 10 staffs hired in a hospital, seven are sitting in the admin and three are actually delivering the healthcare service.

You have to look at that and see whether by implementing a monstrosity called DRG, are you actually going to help the patient and reduce the cost or you may potentially flip it and add on more cost of the overall equation. That's something that we need to look at.

Dr Timothy Cheng Tsin Jien [MMA]: *WMA stands for World Medical Association.*

Dr Gunalan@Arumugam Palari [MMA]: *Yes. Sorry. The other thing that he noted for Germany as well, there are a lot of ambulatory centres. Meaning that ambulatory centres basically you are a step-down facility. You're done with your care, you move to a step-down facility so that you don't incur cost for in-patient care.*

This is the challenge that we are facing at the moment. In principle our view is we are not wholesale rejecting DRG. I know DRG has been mentioned many times. But there are certain limitations.

Number one the external factors for DRG for us is hard to control. Price of medications, currency, costly drugs and technology. If we fix to a particular cost for DRG, for particular procedure, the very next year because of inflation we may find that we may not able to pay the hospitals the amount of money because inflation has caught up.

You need to continuously revise you charges and charges so that you can keep up performing the particular operation. Internal factors you can control. Now doctors charges we can control it, no problem. Profit of the hospitals I think all of us are quite clear that the number that we are talking about for private hospitals is in

between five to 15 percent. We are not actually talking about private hospital earning 30 percent, 40 percent.

In fact, yesterday one big hospital group declared RM3.9 billion in revenue but RM3.9 billion, after tax profit RM350 million after tax profit. But it is from 29 hospitals. So, when you actually break it down to one individual hospital it is not a lot. It is probably talking about a profit of RM20 million, RM30 million.

The numbers look big and it is very exciting whenever you see The Edge report RM3 billion, RM4 billion. But when you break it down to the final details, it is actually not a lot. In fact, some of the new small private hospitals that are being built by this conglomerate are actually losing money, being subsidised by the bigger older established ones, while they are getting up to speed.

Most of the time it takes five to ten years to break even for the hospitals that are in the smaller areas. So, the perception that private hospitals are making tonnes of money just looking at billions in terms of the revenue is actually wrong. You need to go down to the microlevel and figure out what is actually happening there.

One thing that I want to highlight, earlier slide please— is basically this. One of the challenges that we want to actually highlight is litigation. In order to reduce cost of litigation and we support this particular endeavour that was announced by the government, the Madani Mediation Centre.

I think we are all in favour of the Madani Mediation Centre to make sure that the lawyers are not the beneficiary of payouts. Because we know that a lot of lawyers are actually dragging doctors and hospitals to the courts in the basis of treating the patients or trying to find justice for the patient but we know that they actually making a lot money from the portion of the payout. If mediation can be done, dispute can be brought and settle early. So that's the thing that we want to support.

Tuan Sim Tze Tzin [Ahli PAC]: *This is Pengerusi, is this Madani Mediation Centre initiated by MOH is it?*

Dr Gunalan@Arumugam Palari [MMA]: *No, no, no. It is under the Pakatan Harapan government. The Law Minister just announced about a month ago that they have formed the taskforce comprising four seniors from the AG Chambers to actually look at mediation as a— I mean not only about medical legal but everything in terms of dispute to be brought into this Madani Mediation Centre which we support wholeheartedly because if we can mediate issues, then you no longer going to see the RM10 million, RM20 million payout because it takes eight or 10 years to settle the case.*

We can actually potentially settle it early, give the patient what the need as compensation and then we can move on. All right?

Dato Dr Kalwinder Singh [MMA]: *If I may say that MMA had interaction the Bar Council and also with the other organisation on this because it has an effect on how doctors' function. It is also has an effect on the doctors taking insurance and all that. It is something that we feel that— and also drives as was mentioned towards doing more tests and defensives.*

So as I mentioned just now it is not only about regulation also have an effect. Hopefully our Parliament will also look into these aspects that can be controlled because otherwise it has a small bowling effect on everything down the road.

Dr Mohamed Namazie Ibrahim [MMA]: *Puan Pengerusi, I know there are several YBs here in this committee. I would like to highlight the necessity for a national health insurance. We have been talking about the national health insurance since 1985. I have been involved in these discussions because MMA was asked to come up with the fee schedule for the national health insurance.*

First edition was produced in 1997 and then after that every five years we have been revising it. Now if we have a national health insurance it can alleviate some of the problems that we are facing today. For example, Dr. Gunalan mentioned about the Australian system by the Medicare.

Yes, Medicare has its own schedule. The Australian Medical Association has its own schedule. And then there are the reimbursements from the private insurance. In Australia, it is incumbent, it is mandatory for the doctor to present a financial consent form. So he has to or his staff has to work out whether the patients has got an insurance and then look at the website and see how much it is going to be reimbursed and then the Medicare, how much it will be reimbursed and what the doctor is going to charge in addition to that. So, that is known as a gap.

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So, this is presented to the patient and the patient has to consent. If he does not agree, he can go to another doctor. But most often, the doctors also will adjust the gap. That is what they are going to charge in addition to what the Medicare and the private insurance are going to reimburse. This has been working very well so far. But for GPs, there is a different system where the Medicare will reimburse the fee at a certain amount of fee and many GPs will take what is known as bulk billing. That means they will accept whatever the Medicare gives but some will have non-bulk billing which is where GPs can add on.

There are many benefits to this national health insurance. I think it needs some support from all the YBs and the PAC can also look into this aspect for the national health financing system. Thank you.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, boleh tak saya tanya tadi, kita punya Presiden MMA? *So, you went to see the Bar Council to talk about these medical legal cases and all that? Because that's in a way it hindering the clinical equipment potential of the doctors. So, even though* dia kata ini tak perlu, ini tak perlu, tapi *at the end of the day, just in case you know, just in case patient* nanti *sue* dia *because suddenly you got a complication*, dia tak nampak pada ketika itu. *That's one of the things that cause the costs to escalate* kan*? So, what was the outcome of that meeting?*

Dr Gunalan@Arumugam Palari [MMA]: *Okay. So, I was actually in that particular meeting. We had three committee meetings so far. The biggest take home after the discussion was basically this, that the Bar Council have agreed to set up a committee involving all the relevant stakeholders including APHM; MMA; six or seven lawyers from the plaintiff— Plaintiff meaning the one who most of the time defend the patients and the family; and another three or four lawyers from this end who actually defend the doctors; the medical insurance companies the indemnity providers, MPS or what not; all of that together on the same table to actually come out with solutions to actually move some of these cases towards mediation. That is number one.*

Number two, using the existing Rules of Court 2012, there are some ways or mechanisms for payout with the judiciary that are actually not fully utilised at the moment. For example, when the court decides payment, it is one turn for all payments. Meaning, a child can actually be one year old at the time the incident happens or whatever, it is calculated for 55 years and the money is disbursed all the way up to the age of 55, calculated already. If the child succumbs at the age of 10 or 15, that money is already paid out. So, the beneficiary technically speaking is not the child, but it's a family member. There are many, many things that actually we highlighted to the Bar Council to look into because at the end of the day, concerned countries like the UK, they moving towards staggered payment. Meaning that you don't pay the full lump sum because at the end of the day, the hospital now has to take a bigger insurance. Doctors for example O&G specialists be used to take insurance of RM30,000 to RM40,000 per year. Now, the same insurance is RM150,000 in order for us to actually provide O&G services.

So much so that, O&G specialists retired 50 years because the Limitation Act by the Parliament is 18 years plus six years for private— for a patient from a private hospital. Public hospital is 18 plus three. So, upon the last delivery that you made, you still have to pay your insurance for a good 21 years before you finally say that I am fully provided. So, most of the doctors are actually move the way from O and just

stick to gynae. That also impacts because the costs of delivering the particular O&G services in that particular hospital now exponentially goes up. Yes, Dr. Aishah.

Prof Dr Nur Aishah Mohd Taib [Malaysian Medical Association]: *Thank you so much. I think this is the first time I am actually attending one of the PACs and to have so many YBs in the room and the wait of political will is actually in your hands. [Dicelah] Because you know, honestly as a practitioner right now, we see the impact of people insured but not covered. So that means the insurance that the patients have do not cover for what they need. So, the instrument that we have today does not cover.*

So, I am coming from a breast cancer perspective. So, some of our patients are not covered because they have preexisting illnesses. So, I would say that the current insurance that we have now is covering the healthy people. So, what are we going to do with the silver economy that has been to come up soon? So therefore, I think the support of a social sort of community risks-based insurance is extremely important at this point in our country's trajectory because we are going into the super-aged stage soon. So, I would— I think we are going to you know, cut through tiny little straws trying to find out why the private insurance is increasing their premiums, but that's not sustainable at all.

So, I think you really need to go back to see how we can go towards community risks-based health insurance. So, another example is if you are a breast cancer patient and you have a coverage of a million, but guess what? Your targeted therapies may not be covered by the insurance or the oncologist has to be very creative in ensuring that the patient gets admitted for the treatments. Because you know, if you having outpatient treatments, they are not covered. So even though they are insured, they are not covered. Thank you very much.

Dr Mastura Md Yusof [MMA]: *I think I can, I can…*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *you are just now you mentioned about community— sorry, community rated, is it? Sorry, what is that?*

Prof Dr Nur Aishah Mohd Taib [MMA]: *Ya, I mean I am not an insurance person, but I think at the moment, people are— the insurance is based on individual risks. So, if you have hypertension, guess what? You can't take travel insurance. They do not cover preexisting illnesses. If you have breast disease and you know, our private hospital can also be very creative, so they do screenings that there is not required. For example, ultrasound breast. Not required, but many young ladies in their 20s go for this checkup and they find a benign cyst.*

Benign cyst is a preexisting illness. So, they will not be covered for breast cancer and they have difficulty getting rejected. What do they do? They postponed.

Every year, the patient will come to get a new report from the doctors hoping that their ultrasound be perfectly normal. But unfortunately, benign disease is very prevalence. So, I would say that at the moment, we are not really covering even those who are insured.

Dr Mastura Md Yusof [MMA]: *I will echo that because in oncology that's our most problematic issue with the insurance coverage. Because for example as you are saying, breast cyst is completely benign and they choose not to cover or to exclude or to investigate. Now, we are getting fatty liver. They are excluding patients with liver cancer because the patient has had some ultrasound or CT scan that mentioned fatty liver. I suppose all over here have fatty liver because of our foods in Malaysia, right. So, they were excluded. But the moment you have cancer, they were excluded. Then, even though my patient took the insurance in the 80s when immunotherapy was not even— has not existed yet. Today when she wants to take immunotherapy, they said oh we not covering immunotherapy. How is that? Because when she took the policy, immunotherapy was not even existed yet.*

So, not just that, also when people are saying we here in the room today that our fees are regulated right, but actually no. The insurance actually really, really pressuring us oncologists to— like pull down our charges. So, let's say now I am charging RM860 for my immunotherapy or my targeted therapy procedure fees, they asked me to put it to RM380. That's their… [Dicelah] Their…

Dr Gunalan@Arumugam Palari [MMA]: *Their recommended fees.*

Dr Mastura Md Yusof [MMA]: *Ya, their recommended fees. The insurance recommended fees, not the regulated fee that our fee schedule is recommending to us. So, when we do not want to do that right, they delay, they delay, they delay the payment for the patient. So that the patient's subsequent treatment will be affected and the patient will be like complaining to us. You know, for a procedure that is so specific like what we are doing as an oncologist, we do brachytherapy that is so specific. You don't get brachytherapy being done in many hospitals in Malaysia. They are also saying, this is supposed to be coded as this when they are not the ones performing the brachytherapy procedure.*

So, we are actually being pushed by the insurance other than they keep on changing. You know, how they categorize procedures are also not uniform. So, some don't cover…

Tuan Sim Tze Tzin [Ahli PAC]: *I think when we met with the insurance company, they said that actually the doctor is dictated, they will pay. Okay. But today, I hear a different story already. So, who is telling…*

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Dr. Mastura Md Yusof [MMA]: *It is happening already now and it is increasing. It is increasing now.*

Dr. Liew Shan Fap [MMA]: *I add on this one. Definitely both of my colleagues— this is very rampant nowadays. The exclusion for the insurance coverage is huge. The impact is huge as well. I'll give you an example. I have a few young ladies who had a CT scan something or ultrasound scan they have a polyp in the cervix. Just a simple small polyp in the cervix. When they come in, they said I would not cover any polyp in the stomach, in a colon. There is nothing related actually but I think one is a polyp. They just use the polyp and exclude all the polyp in the body. So, I think you need to look into the…*

Tuan Sim Tze Tzin [Ahli PAC]: *Is there a settlement mechanism on this dispute?*

Dr. Gunalan@Arumugam Palari [MMA]: *Also, YB, so this is again, it goes back bound down to the committee that we talk about.*

So, we are actually proposed that every three months we, the insurance company, MMA, APHM meet together and see we bring, like for example, the doctors have mentioned. We bring it to the table and look, here we are not to tell you how to do but this is education. We want to educate you in terms of what exactly do we mean by a polyp, what exactly do we mean by it. The underwriting terms and definitions have to be much clearer than what they have at the moment. Because many of these likes, for example, the definition of pre-existing of pre-malignant cancer. It is outdated compared to what our oncology colleagues are doing. So, the insurance definition and the current medical understanding are so wide apart and the policy declines based on their definition and this is the insurance definition. Not a medical society definition.

So, what we are trying to do is we need to actually bring it together and say look, your definition is flawed. It is outdated. Bare in mind, the people who are sitting in and giving the advice in the insurance industry are medical officers. They are not actually specialist in that particular field and again we are not there to criticize or downplay their role but it is good to have feedback or information coming from the people who are actually doing it on a daily basis. I am anaesthetic but I for the life of me, I cannot tell what is the latest definition for the oncology side of things because it is completely different ball game altogether. So, what more a medical officer who has just finished housemanship, who has got— contract was not extended, who decided to join the insurance company and he is now dictating the policy based on what he understands.

Tuan Sim Tze Tzin [Ahli PAC]: *Is there a mechanism to settle this dispute now?*

Dr. Gunalan@Arumugam Palari [MMA]: *Yup. So, at this moment in time, what happen is the insurance would actually say, "No, I'm not paying". The doctor will then write a deferment letter, a letter to actually state down these are the reasons why we say, this should be covered or what not. It goes back to their committee and most of the time, when— it is going back forth and forth, back and forth to the point that the patient gets frustrated and the doctors ultimately this is how it ends. A letter will be sent to IKN* (Institut Kanser Nasional) *in Putrajaya. That letter they will bring— but first, they cannot see IKN directly. They have to go to a* klinik kesihatan *first, get a letter from the* klinik kesihatan *and then go to IKN. IKN will have a limited budget and say who are the patients…*

So, can you imagine the poor cancer patients at stage 4, stage 3 trying to fight for their life and they are being driven through all this merry-go-round just because the terms of conditions of the patients are not clear on the insurance part of it. The promise that the insurance company has given is this, you have an annual limit of RM200,000 or RM500,000. You have a lifetime limit of RM10 million. When you sell a policy, you don't actually break it down to the terms and conditions. He sells right. So, when it comes to the payment, then all of a sudden, "Sorry ya. This is not included because of this, this, this". "You don't define this". But who decides that? So, that is the decision made by them.

I understand when they come and say, look, it is not we don't dictate. Honestly speaking, they don't dictate medical management but they dictate payout. The payment is dictated by them based on the rules of their understanding of the claims and underwriting terms. So…

Dr. Timothy Cheng Tsin Jien [MMA]: *Dr. Gunalan, sorry. If you Google "CodeBlue AIA Limit Test", they are not just dictating payout* ya. *The response to be annum letter, they are telling doctors limit your tests, prescribe generic drugs. It is no longer just payout. They are actually telling the doctors what test not to do, not specifically the name of the test but if you go, it is online. You just Google "Code Blue AIA Limit Test" and the whole article is there. The letter from AIA, I mean by CodeBlue telling the doctors please don't do this…*

Dr. Mastura Md Yusof [MMA]: *So, it is going to be extremely difficult for oncologists because a lot of our newer drugs that give you a better survival are not in the generic form. So, if you are going to buy something, a targeted therapy or immunotherapy, you can't actually trust. [Ketawa] You can't trust generic drugs because of the quality, right. You are putting your life here.*

Dr. Gunalan@Arumugam Palari [MMA]: *One-point blank thing to ask is, if it is the wife of the CEO insurance company would the same rule applies? Seriously, I mean, if the same rule applies, I'm sure they will look at okay you are insured by this insurance company, don't tell me they will say, "Oh, my wife has got a pre-malignant cancer so it is actually not excluded. It is okay* lah *I would actually not be covered. I'll go to the government hospital". It doesn't happen that way. Most of the time, we know that rules are changed according to it.*

Dato' Dr. Kalwinder Singh Khaira [MMA]: Dr. Kuharaj.

Dr. Kuharaj Balasubramaniam [MMA]: *When the public goes and take a policy now, they say within six months anything was not pre-existing. However, in reality, in fact, within two years, anything is deemed pre-existing. Infection is declared as pre-existing, an infection. So, going to this dengue infection, they say— they will argue it is pre-existing condition, deny all claims. It has happened numerous times. It happened last week to me, twice.*

I asked the patient, when did you take the policy? August 2023. I said sorry. They will say pre-existing and they will shift blame to the doctor and say the doctor wrote something wrong and they will tell the patient it is pre-existing. Previously, when they took a medical card, it went through a health insurance. You will actually go through a health check-up, find out everything and going. Now, there is no requirement as such, why? Because they can blanket rule say, within two years, it is pre-existing. This is the insurance definition of pre-existing.

This denial is not made by medical officers also by the way. Their denials are made by non-medical claims managers who have no medical background, who have undergone training run by the insurance company. The medical officers are very, very actually involved and never a specialist involved.

So, I've had denials for cancer; what we called HPE-proven, histopathological proven cancer. By the claims manager, on their determination on their own, after Google search. [Ketawa] I've got it in black and white…

Tuan Sim Tze Tzin [Ahli PAC]: *I think that this…*

Dr. Kuharaj Balasubramaniam [MMA]: *And this is something that should really be looked at as well. Because there is no accountability, there is no committee that oversees directly involving doctors and everybody else with regard to health insurance in Malaysia. It all goes to Bank Negara.*

Tuan Sim Tze Tzin [Ahli PAC]: *That is why I'm asking MMA. Have you guys proposed something to MOH?*

Dr. Gunalan@Arumugam Palari [MMA]: *So, my final slide actually is that. In 2020, we've actually realised this is going to be a big problem. We call the two*

regulatory bodies; Bank Negara Malaysia and MOH to actually come to the table and say, look, listen to the doctors' problems, listen to the doctors who are representing the patients by sitting there. Because our interest is not earning the money. Our interest is patients' care. See what has been done by the insurance company to actually limit patients' care.

Now, the argument about inflation, medical cost and what not, that is a separate discussion or financial discussion between the hospital and the insurance payer. But then argument now, is like basically two elephants are fighting and the guys who are in the middle are the patients and the doctors. We are patients advocate. We want to help the patient get treatment but this back and forth, back and forth is what actually citing.

So, when we actually ask Bank Negara to come in and take part in this discussion, very muted. I mean they have acknowledged there was an email but until today, they were never been a representative sitting in that particular committee to work together with us. MOH has sent the representative and quite a number of times, MOH would actually contribute to the discussion. Say what can the hospital do. Under the Private Healthcare Act, you are not supposed to do this. They give the feedback. So, the private hospital says you, okay, fine.

Another thing that we proposed, doctor to doctor discussion, say, look, your insurance client has declining. What is the basis? Why not you pick up the phone and speak to Dr. Mastura and understand it better? So isn't it better to do two-way discussion rather than signing a letter and that letter has got no— it is only authorised signature ya*. There is no name, nobody owns up to who made the decision, just a blank standard template of a letter saying that, sorry, this is declined. Then, we are the ones who are supposed to explain to the patient. So, they need to own that particular relationship in terms of how it is actually going to be excluded.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *if I may, the Healthcare White Paper actually suggested healthcare commission. Will the healthcare commission settle this problem?*

Dr. Gunalan@Arumugam Palari [MMA]: *I think if you talk about one aspect of it, you potentially may be because if every particular stakeholder is brought into healthcare commission, representing all the different parties, I think we potentially can look at that being one of the objectives for the healthcare commission.*

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Talking about the human resources, talking about the finances, talking about the delivery— all that is okay. But when we have a platform where we can use the platform to actually bridge the gap. I think the main thing is we want to bridge the gap.

We know there's significant misunderstanding in terms of what we can deliver, what the policy is all about, what the current understanding is medical treatment and all about, these grievances and misunderstanding has to be bridged, and that platform will work, definitely. But it needs— why it has failed so far is insurance companies don't actually think that doctors have a say. You know when we come to the table, is like as long as it's not Bank Negara, I will actually tell you what we want to do.

I would actually tell you that I am moving business away to another hospital because that hospital give me a bigger discount. It is not about patient care anymore. What about the existing patient who are there who are actually on the follow up? If you just arbitrarily move a patient from one hospital to another? So, these are because they feel that they a upper hand, rightly so because a significant revenue is actually coming from the insured as well. So, we also don't want to lose that revenue because if would affect the delivery of our healthcare system. But it cannot be use to blackmail us, that's what we trying to get at.

Dr. Kuharaj Balasubramaniam [LIFE Member]: *Alright, we are actually told we have contract with the hospital not you and I've given my phone number many times and said to clarify, please contact me directly. I've never been called.*

Dr Gunalan@Arumugam Palari [MMA]: *Ya, so most of the time, one it because if it's a doctor to doctor engagement they know that they may not be able to justify because we have the knowledge. So, easy thing to do is don't do anything, so what we will do as doctors, we will council our patient and say, look in the process of sending you to government side, do two things. Go and get the treatment done in the government side, second thing is please lodge a complaint with the ombudsmen and BNM. Make sure that they are aware.*

So, the more things go down their way, the more people will actually realise that there is avenue to address it. But how many patients actually have the willpower especially when you are cancer patients? They almost at the end their life and they already tired, alright they exhausted and for them to actually take up the file and go foresee this in BNM is actually asking too much of them.

Dr Mastura Md Yusof [MMA]: *Ya beside MMA, the Malaysian Oncology Society has also put effort to actually meet with BNM as well as the LIAM and PIAM which is the insurance…*

Seorang Ahli: *Life insurance association. [Berucap tanpa menggunakan pembesar suara]*

Dr Mastura Md Yusof [MMA]: *Ya, correct. So, but the— as what Gunalan was saying, it has in very-very below lukewarm, the response is below lukewarm. It's like for me, cold response.*

Dr. Kuharaj Balasubramaniam [LIFE Member]: *Sorry, if I could share my personal experience dealing with the insurance and the Ombudsmen Financial Services, it was very poor when we had an issue was actually a claim for my worker. Basically, they denied the claim saying this is a— we went to UM, it's not a government hospital. It was a bit of a question mark there. Ombudsmen of Financial Services took nine months to give us feedback from the insurance point, but the moment they came to us, they wanted to reply within two weeks. As a customer, the consumer and experiences from others as well, that only outlet we have is OFS for with regards to any complain, with regards to insurance, I think there is a dire need for actually a proper committee that actually looks into these issues.*

Dr Mastura Md Yusof [MMA]: Ya.

Dr Gunalan@Arumugam Palari [MMA]: *So, just in the interest of time, we come back to one final— we address all the problems that we faced, but moving forward, I think when we talk about DRG, one of the things that we all are worried about, are we actually proposing something that may potentially makes thing worst. So, to be honest with you, I think we have come across with what is the typical bills size of a private hospital? And this one is actually across the board— it is not a study but it's just an anecdotal pull out from my finance team that I can actually tell you that, majority of bills almost 65 percent, is actually below RM10,000. This is what— just one, mainly medical bill.*

So, where the significant chunk which is the surgical bills, it's actually generally falls between RM10,000 to RM50,000. This is the simple straight forward uncomplicated kind of procedure-like appendix, lap coli and what not. So, if these particular procedures can be like fixed a certain amount, then I think we are more than happy to actually looking into it.

Because it is very predictable, but the minute you cross over to the more complex work like cardiac neuro surgery, patient with simple surgery but multiple medical problem, diabetes, blood pressure, IHD, ischemic heart or what not. Then it becomes too complicated for the first phase if at all you want to implement the DRG, the feedback from we get from the other country is basically it has to be a slow, steady, phased approach. It cannot be like tomorrow all 600, 700 DRG codes will be implemented and that's it, we go. We need to look at say what is the common procedures that have being done in the private hospital that are predictable and relatively easy to manage, that can be given say three to five days and they're out— knee replacement, hernia all these things are predictable.

So, if we start like how in Korea, Korea there's only seven categories of patient that they put under DRG. Cataract, appendix, haemorrhoids, Caesar, hernia and

tonsil. So, you defined that set criteria which probably will cover a fair bit of current diagnosis and whether you get it done in Subang Jaya kah, *Sunway* kah *or Prince Court* kah *whatever hospital, it should be the same because it's predictable. Now, if that helps our insurance industry colleague, I am sure as doctors, we are happy to assist because again all these surgeries, our fees are fixed. There is no surprises when it comes to end of the bills. The surprise is only the hospital portion.*

So, that is the part where the APHM guys can agree that— look, if you gonna be doing in knee replacement it's RM35,000 here and RM38,000 there and we agree to come, say okay lah *all together for the purpose of making sure our populations get access, we agree to RM35,000 and that's it. Let's all move on and get it done because that will be one single fee that will cover a major of it. You ask us whether we like this line-by-line lining? No, we don't. Because it creates a lot of confusion to the public because the public sees that why is my diaper charged at RM20? Why is a cup charged— 15 cent cup charged RM10? It doesn't make sense.*

But how we gonna tell the patient that electricity bill is this much, nursing wages is this much. So, those are the things— so if we can just have one fee, negotiated fee, this is the cost, all agree to with we move on. But if you want to do it, learn to do it step by step, phase one, phase two, phase three. If phase one we learn, we understand what are the pinpoint, we can make it better. Then we go to phase two, a lot more diagnosis, a lot more things. But if to begin with itself straight away say, Indonesia has got a very good DRG system, let's implement in Indonesia system, we gonna fail. Because we are hearing feedback from that a lot of things, why are they coming to Malaysia? Because there is not much investment in the hospitals. Because the hospital not getting money to invest in the equipment, so they are coming to Malaysia.

Again, the last point is we propose what we call a soft cap. Soft cap means that some flexibility. So, say for example RM35,000 what we agree for knee replacement and that one particular patient they develops a heart attack after the surgery and now requires admission for further management or whatnot. So, these are the potential patients that we may have to give more treatment per se and all. So, soft cap means that there's some flexibility, majority will fall into that fixed predictable outcome, one or two will have issues, alright.

I think we have touched pretty much a lot about cancer care, I think Prof Aishah and Dr. Mastura anything you want add from your side for cancer? Because one of things that we want actually say is, please do not include cancer care under DRG because if you do that it's going to be difficult because to the private hospital, private insurance company, today they would say I'll fix you cancer surgery. Say for

example breast cancer RM40,000 take it, fix already what. But the very next year, there will be a new third generations or targeted therapy that is more advanced. Patients will not be able to have access because we have a pre-negotiated list of things that cannot be done. So, Dr. Mastura what do you think?

Dr Mastura Md Yusof [MMA]: *Actually, I want to say that, that cancer should not be inside there because it's is just so …*

Dr Gunalan@Arumugam Palari [MMA]: *So, many variables.*

Dr Mastura Md Yusof [MMA]: *…Unique and ya, so many variables. But I'll just want to highlight something that for cancer care at least for our country, the private sector places a large role. A large-large role. We have about probably times more the number of centers that are managing cancer in our country compared to public sector. So, there like 36 almost 40 centers in private, while in public we still have 12 and it has not— I think it has only increase from nine to 12 the last 20 years for public. So, if let say if our patients are not supported by insurance, the public sector will collapse because they can't cope with the patients that we are managing at the moment. So, I can just give you two example, one example is the patient that I just saw on Tuesday with back pain. So this spine surgeon referred to me back pain, so we discuss and decided, okay we gonna do a PET scan.*

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So, the PET scan is done next day. And then the PET scan showed a lung lesion, lung mass, so we biopsied the lung masses the next day which is Friday and I got her pathology report today. She has lung cancer with bone metastasis.

And another patient that I saw two weeks ago at Picaso which is a lady from Puchong. Mine you, it's in Puchong, KL, okay. So, she was seen last year May in the clinic in Puchong and she was than referred and referred, referred finally Serdang and Serdang, another appointment to do the mammogram, another appointment to biopsy, another appointment to reveal the biopsy result and she only had surgery on in January.

So, that is in KL and this is from May to January for patient with breast cancer which is the most common cancer in Malaysia affecting women of 40 years of age and to wait seven months to get to the first treatment. I am not saying even the other treatment for breast cancer like chemotherapy, radiotherapy or hormone but surgery. It takes that long.

So, it has to be improved because cancer care so important. It's number three now in terms of importance. [Dicelah] Not, number three, in terms of importance, yes after cardiovascular disease (CVD) and infections. It's still number three.

But yes, this cancer care is very, very important. So, that just some… [Bercakap tanpa menggunakan pembesar suara]

Dr Gunalan@Arumugam Palari [MMA]: *Professor, you— okey.*

Prof Dr Nur Aishah Mohd Taib [MMA]: *Ya. Just to add on little bit. I think the issue sometimes is not just treatments. So, having to get patients to timely treatments for cancer treatments you need timely diagnosis.*

Most of the diagnostic test are not covered by the insurance because they are done in outpatients setting. So, sometimes patients need to be admitted as mentioned just now you have to increase the price or the cost of the care because you need to admit because they cannot afford to pay out-of-pocket.

So, I would say do not just think about treatments when you're thinking about the— you see I think what Mastura was saying about services and financing is very true. Cancer services if you ask pukul rata *in Malaysia is available, but it's available in the private sector, not in the public sector.*

Therefore, we have to find the way to finance diagnostic care as well as treatment probably in the private sector but thinking of a way of financing it through the public funds because a lot of our patients cannot afford it.

So, from the cancer point of view, DRGs may only may be good and well if you are using social insurance. If it's a private sector insurance-based DRG, are we saying that the payor is going to tell you that we have to pay less but for what quality?

So, I think we have to think very carefully about having DRGs being pulled out when we don't have social insurance because it's really the payer making judgement of what they will pay or what they will not pay. And this payer is private sector. Thank you.

Tuan Sim Tze Tzin [Ahli PAC]: *Just to comment on this, Pengerusi. The government now is thinking about a basic insurance. I mean we can blame the— you know the two arguments to national health insurance because we are paying tax.*

So, and then there's universal healthcare, so to speak on the general hospital. You suddenly ask people to pay is politically untenable-lah. *I would say even here, we are very good friends but some Tom, Dick and Harry can just make a mess out of it and you can't achieve.*

So, the government, Bank Negara and all this they come out with a kind of like compromise-lah, *it's a basic healthcare. You buy a certain, very low cost but cover certain basic things. Do you think that can actually works for DRG or not? Where the pool would be more, there will be more people buying because it's affordable.*

Dr Gunalan@Arumugam Palari [MMA]: *Yes. I think as long as there is a great amount in terms of the costings and we can actually to not have any*

interference for the insurance side of things do dictate what can and cannot be done. But the societies, the oncology society is the one who are actually deciding what is the treatment plan, protocol or whatnot with cooperation from the private hospitals to agree that, look do not markup your prices so much.

For example, cancer care. Most of the generic ones are cheap, from India and China you can get cheap. But the bioequivalence nobody knows. But the ones that we be getting original from US and Germany or whatever are expensive. But when they are imported and brough in here, there is a big [Tidak jelas] is actually marked up. And before— even reaches the hospital, there is another mark up as well. So, if you are RM10,000 medication is marked up 200 times of 300 times, it's going blow the budget, okay.

So, there has to be some reasonable markup. Because we also understand from the hospital point of view. Chemotherapy, you have to have proper equipment. Cytotoxic, what do you call CDR?

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Dr Gunalan@Arumugam Palari [MMA]: *Cytotoxic drug reconstitution, yes. Cytotoxic drug reconstitution, very toxic drugs, pharmacies has to be properly prepared, cold chain and all the things. They had to be done properly. So, this actually additional cost.*

So, the private hospitals mark up in order to actually provide this particular service has to be reasonable. I think if you speak to APHM and whether they can agree to a reasonable amount that covers their cost and the markup is not so high maybe that particular social healthcare insurance which is at the lower premium to enter might work.

Dato Dr Kalwinder Singh Khaira [MMA]: *So, I think one the other think which you know, which we would like to say is that, healthcare is one aspect where I think profiteering is not something that should be there*-lah. *I think all of us has a responsibility.*

Just now as mentioned about pharmaceutical, about medical devices, I think some form of regulation should be there, so that you know, so that the costing is not overly profiteering-lah, *so in that sense. So, you know I think that is also is important.*

The other thing is of course like we mentioned doctors are regulated. Doctors practice is regulated. Doctors practice is regulated on the Medical Act under MMC. Doctors practice in the private side is regulated under the Act 586.

But there are lot of things which we feel that can be— nobody. You know, even though our topic of discussion today was on the insurance health premium but

we have had I think a lot of doctors are ventilated about the problem that they phase with the insurance industry also.

Then, but there is no way of rectifying it. As was mentioned you have the OFS, the Bank Negara but it's not working. So hopefully, from the Parliamentarian point of view, you know when they bring it this issue up maybe there should be some form of committee or some other oversight so that this gets done.

Bank Negara is very powerful, insurance industry comes under Bank Negara. We do not know what kind of regulations are there, what kind of oversight is there but I think some form of oversight should be there.

Because was mentioned just now, who are the people who makes the decision? It is the non-clinical staff, medical officers. I mean in any other professional organisation, that will not be allowed. But who is making the decision to say that who is oversighting them? So, I think this is again something that has been brought up. It has to be somebody of a professional level to make the decision and to interact with the doctors it there are issues. That doesn't happen.

So, where's the oversight? So, I think that's the other thing we should you know, which I think we are saying.

Datuk Dr Thirunavukarasu Rajoo [MMA]: Yang Berhormat Datuk Pengerusi, saya Dr. Arasu, pengamal perubatan swasta, *President-elect MMA. Okey, I just want to highlight. Of course, today we spoke all about curative care, hospitalisation. One of the most important things that we failed to see is that why the health inflation in Malaysia is higher compared to neighbouring countries is because our out-of-pocket is almost 35 percent compared to neighbouring countries where they have better financing mechanism.*

So, that is also we should be communicating it properly to the public like what YB Sim said just now, it's a political suicide to introduce, right? But that is the reality. So, today we can see health is a political issue. That is why the Health White Paper was past on bipartisan so that both parties in the interest of the rakyat *they should come in.*

The other thing is that primary care. If you really want to strengthen the healthcare and also to reduce the cost, you have to strengthen you preventive and promotive care. So, this is where the Parliamentarian both sides should come together and ensure there are clear policies that actually assist the sustainability of primary care.

This is what happens in all develop countries but unfortunately, we are not. So, the other thing is that what are cost drivers in the private sector? Third party

administrators are driving, is a middleman in healthcare. But this has been highlighted to Bank Negara numerous times.

I have been involved in this for the last 10 years. In many dialogues we met them. Even the two years ago under the Malaysian Productivity Corporation (MPC) and then the have PEMUDAH.

I personally under MMA we highlighted twice. Bank Negara, we ask them, "What are you doing?". "This not under us we cannot regulated them." So, basically what is the role of Bank Negara apart of just issuing statements on this and that and just putting up data? The Bank Negara, the other thing that we highlighted to them five years ago was also the need to fund digitalisation in the claims processes in the private sector.

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So that, you know exactly where the money is going. They should be investigating all these things. So, Bank Negara again failed to do a lot of things in the last five years. So, why I'm [Tidak jelas] here, I've been to PACs for many, many times, for various issues, poison bill, tobacco, vaping, so many things else I'm here. This is the first time that I've seen that the PAC has an interest on the real healthcare and we see hope. We see hope and Yang Berhormat Sim has championing about this to the public. So, I think we should take advantage of this, we hope that this is not just another talk and town hall engagement, then debate in Parliament and finally, nothing happens like what's happening to the Health White Paper.

So, we seriously hope— we are here for the last two hours and also you are here for the last two hours is not a waste of time. We sincerely hope you all as a leader of a country debate this in the Parliament, make sure all the Parliament debate this and ensure that this is implemented and executed. Otherwise, this just going to be another talk and another paper will be coming here and we will be doing that. So, sorry for being blunt.

We sincerely hope you'll look at something about it and please assist to strengthen primary care and also don't forget, the ease of doing business in Malaysia's gone down. Why? The regulatory burdens. So, please look into the regulatory burden. There are 54 laws and regulations regulating the private sector especially for the GPs is very difficult. So, a lot of policies, a lot of failed policies in the past have led to the contract doctor's issues. Contract doctor's issues has caused the blood of clinics in the last four years. So, we have to address it holistically and understand the entire supply chain in the ecosystem. They cannot solve piecemeal because it doesn't solve anything. With that, thank you.

Dato Dr. Kalwinder Singh Khaira [MMA]: *Thank you.*

Dr. Kuharaj Balasubramaniam [MMA]: *Just to add on to the cost of setup even for a private clinic. Private with the Private Healthcare Act implementation in the rules and regulations. My mother started up a clinic, it cost her RM25,000. Now, to start up a clinic, it costs you at least a minimum of RM250,000. So, because of the regulatory burden and requirement, we need to have a resuscitation trolley, treatment room separate, incline from the renovation cost alone. If the clinic is this thick, the hospital manual is that thick. [Menunjuk isyarat tangan] There's so many regulations. Every private hospital has to have an ICU, without an ICU— so the cost of setup is high. That is always must back unfortunately to the consumer.*

Dato Dr. Kalwinder Singh Khaira [MMA]: *Okay.* Dr. Venu.

Dr. Timothy Cheng Tsin Jien [MMA]: *I just want…*

Dato Dr. Kalwinder Singh Khaira [MMA]: Dr. Venu.

Dato' Dr Venugopal Balchand [MMA]: Dr. Venu *again, a heart surgeon. As a heart surgeon, I'm very conscious of time. Because once I stop the heart for an operation, I only have 19 minutes to do the job. Now, I'm extremely grateful to the PAC for being here with us for the last two and a half hours also. I'm also conscious about the fact that we are more than thirty minutes behind the time. So, I just want to wrap up a lot of what has been said today by saying that when I qualified as a doctor 40 years ago, it was still the vocation of medicine.*

Today, it does metamorphose into that industry of healthcare and there are so many players, so many agendas, so many vested interests that it would be foolish to take a myopic and knee-jerk reaction to try and solve an issue. I think the PAC with all the comments that have past today, I think I— and I sincerely hope will look at this problem very holistically and come up with a suggestion or an implementation that looks at all the contributing factors. Number one.

Number two, you take a walk in any private hospital and you will see a lot of people wearing the hospital tags. But what is never mentioned is that 40 percent of them have nothing and I repeat absolutely nothing to do with patient care. They are from the business entity of the institution. I think what the PAC is obliged to do is to improve patient care. That is why we are all here. Every single one of us in this room is here because we tend to look after a patient. So, I think we should not confuse financial kind of manipulations with actual patient care and it will be very disingenuous to take money away from the patient and put it into the hands of people who probably don't need it.

The final kind of parting statement that I would like to say is that when Barack Obama empowered Hillary Clinton to come up with a White Paper on Healthcare in America, the final conclusion side which came up in an article in the Wall Street

Journal was that one of the most important causes for the rising cost of medical care in America was this new broadband of non-revenue generating medical administrators. Thank you.

Dato Dr. Kalwinder Singh Khaira [MMA]: *Okay. I think— from our side, I think we will…*

Dr. Timothy Cheng Tsin Jien [MMA]: *Sorry President, I just have one— just one analogy and one suggestion in terms of a political suggestion. So, the first analogy is like treatment is like taking a flight. So, you can buy your food like DRG AirAsia but the flight processes are going to be increase if you don't control petrol prices, aircraft. You can regulate pilot salary but your flight prices also will increase. So, when we look at this, we really need to look at it as a whole lah even a comment here.*

The second political suggestion is a one percent payroll tax. If you consult a health economist, even if you increase, you— in 2020 we collect RM70 million from this RM1 fee. There are costs to increase 10 times to RM10. You will get RM700 million. But if you look at EPF, so again example we have 17.2 million in the labour force. Only eight million pay EPF. But if you take one percent from all workers which is 17.2 million, you'll stand to gain annually about RM9 to RM10 billion from this one percent payroll tax. If you have political capital on it that much to push for something, this could be something that you could potentially push for because that will make a significant difference rather than increasing— I mean because 10 billion all of us see a lot more than RM700 million lah.

Dato Dr. Kalwinder Singh Khaira [MMA]: *Okay. Thank you. So, I think in conclusion if I may. I apologize for taking up a lot of the time.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *I have one— two more questions…*

Dato Dr. Kalwinder Singh Khaira [MMA]: *Oh sorry, sorry.*

Tuan Sim Tze Tzin [Ahli PAC]: *One question.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *From Bayan Baru and also— oh, three more questions. I'm so sorry.*

Tuan Sim Tze Tzin [Ahli PAC]: *I think we are all here to make changes and we want to try to do whatever that you guys suggest. But, there's a lot of conflicting interest here ya. Let's be honest and then everyone wants to milk something out of it* lah*, okay. But however, I have a very simple question. Recently the government has actually announced about price transparency for all hospitals as well as GPs. Price transparency I think is one of the ways to make sure that there's no escalating of cost. But I was told that MMA objected to it. Is that true and why?*

Dato Dr. Kalwinder Singh Khaira: *If I may say that— so, I think in hospitals, APHM says is okay. The only objection that from MMA had was for GP practice, not for private hospitals. Private hospital is a— the prices are fixed. So, MMA is— we had a meeting last week with the Yang Berhormat MK. So, the reason was a few, was in terms of the act, there got price marking and price display. This was Act 723. So, one of the issues brought up was price display.*

Now, GPs have this— on of the main issues was that it equates to selling products. Even when we had a representative from the KPDNHEP, it was telling prices of durian, prices of you know, all these doctors must do. But doctors for a consultation, they do investigations, they do imaging and then finally you give medicine which the patient needs. Doctors do not sell a medicine. Doctors will prescribe the medicine based on what the patient needs. So, even if you write a prescription there, this is the cost of Panadol, this is the cost of— it doesn't make any difference because the doctor is still prescribing.

But the issue that was brought up was the price of the medication for doctors differs. Pharmacist prices are cheaper. So, when the doctor brought up the issue, I put my medication there, Panadol five dollars. Pharmacists sell the medication for two dollars. Because the doctor's costs price sometimes higher overheads. Now, what's going to happen? You take a viral photo of the pharmacy and the doctor, "Doktor potong leher." Doctor is cutting— without knowing what is going on. So, the patient who sees it, "Eh, I know this doctor. But, eh, I thought he was an honest person. He is making money from me." So, there is this impression that it can affect the thing.

But the thing I think is all these whiles, can a patient get the price from the doctor? Yes. It is no secret, you can get. But the issue was about price display, price marking. You can ask the price on the GPs, they have no objection. They are no objections with that.

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The issue was about price display. Price display means you put out. They say even you can put it up while I pay or whatever, but all that is not there yet. Because all that and the other issue was that the enforcement. The enforcement of it doesn't come under KKM. It comes under a different ministry. It comes under KDNHEP. So again, the GPs are saying why are being put up to so much regulations.

Tuan Sim Tze Tzin [Ahli PAC]: *I think one of the issues of resistance is because that GPs' fees is too low. It let's say we raised the GPs— can it be done? Can it be compromised because price transparency, I think it's fair.*

Dato Dr. Kalwinder Singh Khaira [MMA]: *Doctors support price transparency. We have nothing against price transparency. The issue is price display. Because it can have an effect on the doctors because each clinic's cost price is different.*

Tuan Sim Tze Tzin [Ahli PAC]: *They can decide. If let's say they sell a RM5, okay the patient can say okay. Doctor can tell them. You want to buy next door? Next door is RM2. You can go. I mean, we sell everything we have to be transparent. Even now we go to buy laptop it has been displayed the price.*

Dato Dr. Kalwinder Singh Khaira [MMA]: *Correct. MMA is not against price transparency. We can put it on record. MMA is all for price transparency. We have also said and the Minister has agreed that they will be delayed until the fees. At the moment, if I may give some history, a GP's consultation rate is fixed at RM10 to RM35. This has been there for 33 years. It has not changed for 33 years.*

The other issue we have with the TPAs. It was mentioned just now TPAs are third party administrators. Third-party administrators now in the urban areas control up to 60, 70 percent of the business. They dictate the consultation rates. Some of them are only paying RM15, RM20 and they also dictate the price of the medications.

How do you display the price because the TPA told you Panadol is RM2. You can't charge more than that whether you like it or not. That's it. A lot of the things is there. As we have mentioned, TPAs are not regulated by any ministry. We have gone to KKM, we have met with MOH YBMK we asked them. The answer given to us was this is not under us. We have written out, we have even brought up to other ministries, the Bank Negara and all that. They say nothing.

Tuan Sim Tze Tzin [Ahli PAC]: *Can they tell us what the TPA's role in the industry?*

Dato Dr. Kalwinder Singh Khaira [MMA]: *TPA's role is like that. For example…*

Tuan Sim Tze Tzin [Ahli PAC]: *TPA. Third-party. What's their role?*

Dato Dr. Kalwinder Singh Khaira [MMA]: *For example, let's say you are a company. You're PETRONAS. Previously, PETRONAS patients will go and see a clinic or a doctor of their liking. They can't do that. PETRONAS has a TPA called as AIA. They use AIA which means that AIA will look for the panel clinics. AIA pays the doctors RM20 for consultation. It can be a five minutes consultation. It can be a twenty minutes consultation. They will pay you RM20 for the consultation. Your blood that they'll take you'll have to send to a certain lab. You just charge for the— you can only charge for the blood taking. They will dictate where the blood. The medication prices are also controlled and at times, the type of medications are also controlled. Which*

means that this is what do you mean by TPA and I think every major corporation, GLCs, private sectors at the moment is under a TPA because when they go to a— when this TPA go to a company, they will tell you I can save money for you.

At the end of the day, it is a business decision. To enemy, it is not against price transparency. It is not objecting to price transparency. It has some reservations on the way of the implementation. It has reservations on the enforcement. Until today, we still have doubts on that. Hopefully, we will sit down with KKM and talk on this again. We also feel that another act should not be coming to impose on doctors. Act 586 should be enough. We have told YBMK, if everything can be done under one act, we are okay. But to bring in another act under another enforcement agency, we are worried. We are worried. We don't know what will happen. They've come to the clinic and say this is not there, that is not there. And you read in the papers doktor masuk penjara*, doctor charged whatever, I know. We don't know. Prevention is better than— so, of course, it may look— the other reversal which sometimes was put to us is doctors have something to hide. That is not true.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, I think we go to the second question. Because it is already 4.54. We will end up this proceeding by 5 ya. Make it short.*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Thank you, Datuk Wira Pengerusi. A short one. Is there any other alternative healthcare model that would be able to help to reduce all these cost of private healthcare? For example, private-public partnerships. Just your view on that. Secondly, what is your view of these private hospitals being listed in stock listings? Thank you.*

Dr. Gunalan@Arumugam Palari [MMA]: *For the first question about public-private partnership. We are more than happy to support it. Purely because we have done it before. During COVID-19, it was just purely a public-private partnership. ICU care, surgeries that could not be done in the government side were sent over to private hospitals. We took a bulk of their work from the public hospitals were done in the private hospitals. We support it. The only discussion probably you need take place is the mechanism of funding it. How do you want to fund it? To me, if you can follow the Australian model of one single payer that can allocate money to both the private hospitals as well as public hospitals but for certain patients who have their own insurance, they make use of their own insurance actually go to a private hospital. But if their patients are willing to wait it out, they want to spend money from the public system, then they just go ahead and do the surgery in the public healthcare system. Only thing is that they have to wait.*

We have talked about example, outsourcing of cardiac surgery. Hospital Serdang is actually having a backlog of cases. There are at least about seven to 10 cardiac surgeons in the private centres in Klang Valley. They are actually able to support taking on some of this work. But the negotiated fees for some of this thing has to be reasonable. Because the hospitals have to invest in the heart lung machine, the perfusionists, the medication and all of that. If you go down to a too low of a costing following the costing supported by case mix, sometimes it may not be enough to actually support the costing for the private hospital. So, if we can come to an agreement of what exactly is a fair amount, then I think most private hospitals and most doctors will support it.

For the second part of it, should hospitals be public listed? I think that's more of an investment per say by the government side. But quite a number of hospitals are actually privately invested. At the moment Hong Leong Group as well as a Columbia Asia Group is all basically funded by a private entity. They are not talking about a public listing yet. But other big groups by IHH, KPJ and all are actually being have some form of government-linked KPJ— have government-linked investment in it.

But at the end of the day, we really look at it that government-linked companies have invested in healthcare, they've actually done a good job because these hospitals are now sitting in areas like Muar, Batu Pahat and even Kluang, for example. These are all areas that have population that needs access to private healthcare. If you look at Melaka, for example. Although a lot of people talk about hospitals catering to medical tourism, the northern part of Johor for example Segamat, Gemas, Machap, Batu Enam, they all come to Melaka for their care. Because Johor Bahru is too far for them. Having place hospitals in certain areas, supported by the GLCs and GLCs investments, it has actually been a good thing as well. So, I am not saying it is a negative thing. I think if the government is not able to support funding building the hospitals in these areas, at least let the private hospitals or the private entities do so.

Datuk Dr. Thirunavukarasu Rajoo [MMA]: *Yes, YB just one more low-hanging fruit that we should consider is that for the private insurance, so at the moment for emergencies, they can go to the emergency department of the private hospital. What the insurance can do, for emergency cases they can always go to the GP first and referred. They can reduce abuses. These are some of the things that actually the private insurance should consider.*

Dr. Liew Shan Fap [MMA]: *Dr. Liew again from Sarawak. Talking about this, just now, I have mentioned with the increase in healthcare cost in private sectors, the gap between public hospitals and also private hospitals is much wider. I think our role*

is to narrow down the gap. I think what my suggestion is, in order to have this if we have another category hospitals, for example, step-down hospitals. Another is probably a community hospital which can cater to inpatient care, yet you do not have so much of a requirement expectation from a patient. I think when you have considered hospital, you can consider regionalise. How do we regionalise it? A hospital in Sarawak, the expectation, for example in a Lawas for example and in KL should not be the same regulation and enforcement and expectation.

Gleneagle Hospital in Lawas, for example, patients cannot afford. There's not feasible to have that, although you provide the same quality care. I think at the end of the day, the need to meet by also the affordability. The accessible and affordable healthcare should be coming together. If they have expensive healthcare in the city in private, nobody can afford it. Only a number of people can afford it. Then it is also not helpful.

I think immediate measure, another category of hospitals that it between government hospitals and also a private hospital with the lower cost should be considered. How do we do it? I leave it to you. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Baik. Terima kasih saya ucapkan. Dah pukul 5.01 petang. *There is no question from Seputeh because already questioned by Yang Berhormat Betong. The same question, the second question just now.* Saya ucapkan ribuan terima kasih sekali lagi kepada semua doktor. Selalu jumpa doktor tak banyak cakap. *[Ketawa]*

Saya macam *suprised.* Apabila saya jumpa doktor, *even me myself* jumpa doktor sebelum saya jumpa doktor, macam-macam soalan saya nak tanya. Tapi bila jumpa doktor, doktor jawab sepatah, sepatah. Saya tak jadi nak tanya *further question. Anyway* banyak input yang telah pun kami perolehi daripada penjelasan semua. *I mean,* sahabat-sahabat yang hadir yang hadir pada hari ini. Ada juga *different dimension* dan juga *different view* yang mana sangat boleh memberi banyak manfaat untuk kami menyiapkan laporan nanti.

Saya ucapkan sekali lagi terima kasih kepada Yang Berbahagia Dato' Kalwinder Singh Khaira, Presiden Persatuan Perubatan Malaysia; Yang Berusaha Dr. Vasu Pillai Letchumanan, Setiausaha Agong Kehormat MMA dan juga Yang Berusaha Dr. Gunalan@Arumugam Palari, Ahli Jawatankuasa MMA dan semua yang hadir pada hari ini. Yang tak dapat saya nyatakan satu per satu. Kami amat hargai segala kerjasama dan juga masa yang telah diluangkan bersama dengan PAC pada hari ini.

Pastinya, kita nak mencapai satu kata sepakat oleh semua pihak demi kebaikan kepentingan rakyat Malaysia seterusnya. Terima kasih sekali lagi. Saya

tangguhkan pada jam 5.02 petang. Selamat berbuka puasa buat mereka yang beragama Islam. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 5.02 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Rabu, 5 Mac 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

(i) Pusat Perubatan Universiti Malaya (PPUM)
YBhg. Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman
Pengerusi (PPUM), Naib Canselor Universiti Malaya

YBrs. Prof. Dr. Nazirah binti Hasnan [Pengarah, Pusat Perubatan Universiti Malaya (PPUM)]

YBrs. Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya]

(ii) Tung Shin Hospital
YBrs. Dr. Ashim Kumer Nandy
Pengarah Perubatan (Bahagian Perubatan Barat)

YBhg. Datuk Ang Chin Tat
Pengarah

Puan Teng Yu Yuet
Ketua Pegawai Operasi

Encik Chung King Keong
Pentadbir

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

RABU, 05 MAC 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Datuk Ali anak Biju [Saratok]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Tuan Haji Azli bin Yusof [Shah Alam]

Tidak Hadir *(Dengan Maaf)*

YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]

URUS SETIA

Encik Ahmad Johan bin Mohd Affandi [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Puan Mazidah binti Mohamed [Ketua Penolong Setiausaha (Seksyen Sinergi dan Kolaborasi Strategik), Parlimen Malaysia]
Siti Noor Akmar binti Zulkafli [Juruaudit (Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam

Encik Amiruddin bin Abdul Karim [Penolong Pengarah]
Puan Ilyani binti Md Razak [Ketua Penolong Pengarah]
Encik Nor Zahidi bin Abdul Rahman [Ketua Penolong Pengarah]

Kementerian Kewangan Malaysia (MoF)

Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Encik Huzairi bin Zainal Abidin [Ketua Seksyen (Bahagian Kawalan Kewangan Strategik dan Korporat)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)

PKPj Suzana binti Alias [Ketua Cawangan (Bahagian Penyiasatan Tata kelola)]

Kementerian Ekonomi
Encik Che Kodir bin Baharum [Pengarah (Bahagian Perkhidmatan Sosial)]
Puan Noor Diana binti Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K), Bahagian Perkhidmatan Sosial (Bahagian Infrastruktur dan Kemudahan Awam)]

Jabatan Akauntan Negara (JANM)
Puan Noor Azira binti Abd Rashid [Akauntan]

SAKSI-SAKSI

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YBrs. Prof. Dr. Nazirah binti Hasnan [Pengarah, Pusat Perubatan Universiti Malaya (PPUM)]
YBrs. Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya]

Tung Shin Hospital
YBrs. Dr. Ashim Kumer Nandy [Pengarah Perubatan (Bahagian Perubatan Barat)]
YBhg. Datuk Ang Chin Tat [Pengarah]
Puan Teng Yu Yuet [Ketua Pegawai Operasi]
Encik Chung King Keong [Pentadbir]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

RABU, 05 MAC 2025

Mesyuarat dimulakan pada pukul 11.44 pagi

*[Yang Berhormat **Datuk Wira Mas Ermieyati binti Samsudin mempengerusikan Mesyuarat**]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. *Assalamualaikum warahmatullahi wabarakatuh.* Salam sejahtera dan selamat datang saya ucapkan kepada ahli-ahli. Naib Pengerusi PAC Parlimen, YB Teresa Kok; Yang Berhormat ahli-ahli PAC Parlimen Kelima Belas, ahli-ahli ex officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen selaku wakil Jabatan Peguam Negara.

Yang Berhormat ahli mesyuarat sekalian, pagi ini PAC Parlimen akan mendengar keterangan dan juga penjelasan berhubung dengan isu peningkatan bayaran premium kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, di bawah Kementerian Kesihatan dan juga Bank Negara Malaysia. Sebagai semua sedia maklum, prosiding ini diadakan bagi tujuan untuk mendapatkan penjelasan mengenai faktor menyumbang kepada peningkatan premium insurans kesihatan, caj hospital swasta termasuklah kos rawatan perubatan, kemajuan teknologi, perubatan, kos operasi hospital, inflasi dan juga faktor luar seperti pandemik.

Dalam usaha untuk kita mencari jalan mengurangkan impak peningkatan premium insurans kesihatan dan juga kos perubatan serta pastikan akses kepada penjagaan kesihatan yang lebih berkualiti, adil dan juga mampan untuk semua lapisan masyarakat, PAC berpendapat adalah wajar untuk kita mendengarkan penjelasan daripada semua lapisan pelbagai pihak yang terlibat dalam isu ini.

Jadi, hadir di hadapan PAC pada hari ini yang pertamanya ialah Profesor Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman, Pengerusi PPUM merangkap Naib Canselor Universiti Malaya. Yang keduanya, Profesor Dr. Nazirah binti Hasnan, Pengarah PPUM. Pengarah PPUM daripada Hospital Tung Shin-kah? Bukan?

Encik Ahmad Johan bin Mohd Affandi [Parlimen Malaysia (Parlimen)]: Tak, tak. *[Bercakap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Bukan ya?

Encik Ahmad Johan bin Mohd Affandi [Parlimen]: PPUM.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Yang ketiga Dr. Ashim Kumer Nandy *[Dicelah]* okey Pengarah Perubatan daripada Hospital Tung Shin ya. Ada? Okey. Seterusnya Datuk Ang Chin Tat, Pengarah. Okey. Puan Teng Yu Yuet, Ketua Pegawai Operasi; dan Encik Chung King Keong, Pentadbir, *alright*. Terima kasih. Selamat datang PAC ucapkan kerana sudi hadir dan juga memberikan komitmen untuk memberikan penjelasan dan juga penerangan kepada PAC pada hari ini.

Sebelum saya menjemput saksi untuk memulakan pembentangan, saya ingin memaklumkan kepada semua ahli mesyuarat sekalian bahawa prosiding PAC ini adalah tertakluk kepada Akta Rahsia Rasmi 1972 [Akta 88] dan Peraturan Mesyuarat 85 iaitu Peraturan Majlis Mesyuarat Dewan Rakyat sampailah prosiding ini selesai dan juga sehingga laporan dibentangkan di dalam Dewan Rakyat.

Jadi, tanpa saya membuangkan masa, saya dengan ini menjemput Yang Berbahagia Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman daripada PPUM untuk memulakan pembentangan dan diikuti oleh Dr. Ashim Kumer Nandy daripada Hospital Tung Shin, dipersilakan doktor. Terima kasih.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [Pusat Perubatan Universiti Malaya (PPUM)]: *Bismillahi Rahmani Rahim.* Terima kasih Yang Berhormat Pengerusi dan juga ahli-ahli mesyuarat yang saya hormati. Terima kasih. *Insya-Allah,* sebagai saksi yang dipanggil dalam PAC kali ini, *insya-Allah* kita akan cuba sebaik mungkin untuk menjelaskan perkara-perkara yang sepatutnya dibentangkan dengan penuh tanpa ada prejudis apa-apa.

Sebelum saya teruskan pembentangan ini, mohon saya perkenalkan dua orang yang akan membentangkan. Pertama di sebelah kanan saya adalah Profesor Dr. Nazirah binti Hasnan. Profesor Dr. Nazirah binti Hasnan merupakan Pengarah Pusat Perubatan Universiti Malaya yang mana beliau berurusan secara terus dengan perkara-perkara yang melibatkan dengan hospital, okey. Sebelah Profesor Dr. Nazirah Hasnan kita ada Prof. Dr. Maznah Dahlui. Beliau merupakan *health economist* Universiti Malaya yang menasihatkan Universiti Malaya berkaitan dengan perkara-perkara kewangan terutama dalam aspek insurans yang kita akan bentang pada pagi ini.

Jadi, saya rasa sebelum— untuk kita tidak buang masa, saya rasa saya mohon untuk Pengarah Pusat Perubatan Universiti Malaya, Profesor Dr. Nazirah Hasnan untuk memberi sedikit gambaran berkaitan dengan hospital Pusat Perubatan Universiti Malaya yang mana kita sedia maklum bahawa PPUM ini merupakan hospital pengajar yang aktif di dalam penyelidikan dan juga pengajaran. Jadi *Prof., over to you Prof*. Ya, boleh, boleh.

Prof. Dr. Nazirah binti Hasnan [Pusat Perubatan Universiti Malaya (PPUM)]: Okey. *Assalamualaikum warahmatullahi wabarakatuh*. Selamat pagi. Saya ucapkan terima kasih kepada YB-YB semua yang memberikan kita *opportunity* untuk menjadi saksi dan untuk memberikan penerangan di sini. Saya Pengarah Pusat Perubatan Universiti Malaya dan pusat— boleh *move to the next, sorry. I don't have*. *[Merujuk kepada slaid pembentangan]*

Ini adalah sedikit pengenalan terhadap PPUM. Ditubuhkan semenjak 1968, hospital pengajar universiti yang pertama di Malaysia. Kita adalah di bawah kategori Hospital Pengajar Universiti di bawah Kementerian Pendidikan Tinggi. Kita menerima bajet daripada Kementerian Pendidikan Tinggi.

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Seterusnya, mungkin saya akan *skip*-lah *these next few slides and I will go straight to responsibility* kami. Tapi kalau melihat kepada lembaga pengurus, kita ada wakil-wakil lembaga pengurus daripada MOF, MOHE dan juga MOH.

Seterusnya, struktur organisasi kami. Kami adalah hospital yang sangat besar, lebih daripada 50 jabatan klinikal dan bukan klinikal dan di bawah saya ada empat timbalan pengarah.

Seterusnya, ini adalah fungsi utama kami yang kami sentiasa tekankan. Oleh kerana kita ditubuhkan di bawah Kementerian Pendidikan Tinggi di bawah Universiti Malaya, objektif kami yang utama adalah tentang pengajaran dan latihan dan seterusnya *research* dan *innovation*, menyokong keperluan fakulti-fakulti di bawah Universiti Malaya. Jadi, untuk menyokong *training* pengajaran dan latihan serta penyelidikan, kita perlu mengadakan perkhidmatan klinikal yang mantap dan itu adalah fungsi ketiga kami, *to give clinical services.*

Dan ini adalah sedikit *fact checks* tentang PPUM. Kita ada 1,681 katil, 44 wad, 44 katil ICU, sebanyak 5,899 staf di bawah lantikan PPUM, seramai 419 staf akademik klinikal yang berkhidmat di hospital. Di dalam 5,899 tersebut, kita ada 134 pegawai perubatan dan 2,246 jururawat dan selebihnya adalah staf-staf *allied health professionals* ataupun sains kesihatan bersekutu dan juga staf sokongan yang lain.

Seterusnya. Okey, kalau lihat di sini katil ICU seperti yang saya sebutkan tadi, boleh— sekejap. Okey, dewan— katil ICU saya sebut tadi ada 40, wad ada 44. Daripada 44 wad itu, kita telah— *admission* kita— kejap, kita campur sikit, maaf. Ke belakang, ke belakang. *Admission* kita adalah 48,000 *admission* setahun dan jumlah pesakit luar kita adalah lebih daripada 1 juta setahun. *So, that is* tanggungjawab kami yang besarlah; lebih daripada 1 juta pesakit yang datang kepada kita setahun.

Next one. So, daripada itu *consultation* kita kalau dilihat di sini di klinik pakar sahaja lebih daripada 1 juta dan dari itu yang pergi ke farmasi kita lebih daripada tiga juta *prescription* telah dikeluarkan oleh farmasi kami. Makmal lebih daripada enam juta perkhidmatan makmal yang telah dijalankan. 1,400— hampir 1,500 pesakit telah dimasukkan kepada ICU. Selain daripada itu, kalau lihat di sana dewan bedah 16,991 pesakit telah dibedah. Semua ini adalah data-data daripada tahun 2024. Kita juga ada rawatan harian di mana ini mengurangkan keperluan untuk masuk ke pesakit dalam dan ia melibatkan 60,000 pesakit.

Seterusnya. Ini adalah perkhidmatan-perkhidmatan yang sedia ada, boleh *next.* Ini menunjukkan statistik kehadiran kita yang semakin meningkat saban tahun dan kalau dilihat di sini, tahun 2020-2021 adalah tahun COVID-19. Itu adalah kesan kepada COVID-19 lah di mana kita terpaksa menutup separuh daripada perkhidmatan kami dan menumpukan kepada pesakit-pesakit COVID-19. Tetapi bila semenjak tahun 2022, peningkatan telah terjadi dan kami menjangkakan peningkatan pesakit akan naik selepas ini.

Seterusnya adalah— seterusnya, terima kasih. Perbelanjaan ini— perbelanjaan kita menunjukkan perbelanjaan yang tinggi, makin meningkat setiap tahun berbanding dengan peruntukan daripada Kementerian Pendidikan Tinggi.

Seterusnya. Kesan yang kita akan alami merujuk kepada tajuk perbincangan pada hari ini. Kesan yang kita akan alami adalah *the overflow of patients* sekiranya premium insurans itu meningkat dengan tinggi dan juga kadar caj perkhidmatan swasta meningkat naik akibat kos-kos yang semakin meningkat. *There will be an overflow*-lah kepada *public hospitals* seperti di KKM dan juga di *public hospital* Kementerian Pendidikan Tinggi seperti PPUM.

So, itu adalah jangkaan kami dengan kenaikan yang dialami oleh rakyat Malaysia. Seperti yang ditunjukkan tadi, perbelanjaan kami memang semakin menaik dan memang ini kita lihat semenjak selepas COVID-19, kos-kos bahan hapus, kos-kos penyelenggaraan dan juga kos-kos *equipment* dan sebagainya memang meningkat naik, Ini memang telah kami perjelaskan kepada Kementerian

Pendidikan Tinggi. Ini adalah salah satu fakta untuk kita memohon kepada Kementerian Pendidikan Tinggi untuk peningkatan bajet juga.

Seterusnya saya jemput Prof. Maznah yang akan memberi penjelasan tentang isu *medical insurance* dan juga *social health insurance* dan impak kepada perkhidmatan kesihatan di Malaysia.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Ya, silakan. Untuk makluman Yang Berhormat Pengerusi, Profesor Maznah merupakan *health economist* yang di Universiti Malaya yang mana sering menasihatkan universiti dalam perkara-perkara yang berkaitan yang sedemikianlah. Prof, *please.*

Prof. Dr. Maznah binti Dahlui [Ketua Jabatan (Jabatan Penyelidikan, Pembangunan dan Inovasi) Universiti Malaya]: *Bismillahi Rahmani Rahim. Assalamualaikum warahmatullahi wabarakatuh*. Terima kasih kerana memberi peluang kepada saya untuk menyampaikan sedikit penerangan berkenaan dengan masalah yang sedang kita bincangkan. Izinkan saya bercakap dalam— menyampaikan dalam bahasa Inggeris*. So, this is pertaining to how we— to curb the increase in health insurance premiums.*

Basically, this is about the strategies for sustainable and affordable healthcare. Boleh *next? So, a little bit of a background* ataupun *an introduction of this topic. We understand that there is rising of health insurance premiums. A global concern, this is not an isolated case* yang berlaku di Malaysia tetapi juga di merata dunialah*. And then— and* adalah satu perkara yang penting berkenaan dengan *health insurance premium* ini kerana harga ataupun bayaran jumlah premium yang kita bayar adalah merupakan satu faktor yang akan melibatkan *affordability, accessibility* dan juga *financial protection especially to the people when they need healthcare services. And therefore, there is a need for us to reform in order for us to ensure sustainable have coverage.*

Next, please. So, what are the factors that increase the health insurance premium? Okay, we understand on the rising medical cost and inflation and the rise in medical cost is— of so many cases ataupun *reasons, among which is the increase in the cost of drugs, okay. The advancement in technology for treatment and of course, the increase in the demand for healthcare services especially for ageing population and* kita tahu *that the prevalence of chronic diseases* semakin meningkat di negara kita disebabkan tabiat ataupun cara hidup yang tidak sihat*. And you have also to understand* negara kita sebenarnya masih lagi *struggling* dengan penyakit-berjangkit. Okey sekarang ditambah pula dengan *prevalence* penyakit tidak

berjangkit yang sangat tinggi *especially with regards to cancer* dan juga *mental health, okay*.

Premium ini pun terpaksa dinaikkan oleh para *health insurance company* ataupun pemberi *because of administrative and operational expenses. We know that there is a huge administrative and operational expense incurred for them to run their business* ataupun *to offer health insurance.*

And most importantly, there is risk-pooling inefficiencies in private insurance because private insurance ini dia premiumnya adalah berdasarkan kepada *individual risk rather than community rating.* Bermakna jika *you* ada penyakit ataupun ada masalah kesihatan, premium insurans yang *you* perlu bayar adalah lebih tinggi. Sedangkan kalau *community rating* seperti di dalam *social insurance,* kita *share the resources and* kita *share the burden of diseases. Next, please.*

So, there are strategies that have been put in place ataupun *recommended in order for us to control the increase in health insurance premiums, especially the private health insurance premium.*

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First of all, we need to strengthen social health insurance. Unfortunately in Malaysia there is no wide coverage of social health insurance other than the one that we have for SOCSO.

So, I think it is high time for us to have a social health insurance because social health insurance as I mentioned just now, memastikan bahawa setiap penduduk ataupun setiap *netizen* mempunyai kaedah untuk *access healthcare services* tanpa memberikan beban kewangan kepada mereka. *And then, it's also for expanding of this pooling and cross-subsidisation.*

Sebagai rakyat Malaysia*, I think* sama ada yang kaya ataupun yang miskin*, I think we have to work as a team* ataupun kita berkongsi masalah dan juga beban penyakit dan berkongsi sumber kewangan untuk kita mendapatkan kesihatan—perkhidmatan kesihatan*.*

Third is with regards to promoting preventive healthcare…

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Soalan daripada Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: Saya nak tanya tentang *what is difference between social health insurance and national health insurance?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Sebenarnya *it's just a* nama saja yang berbeza tetapi pada kaedahnya adalah sama. *National health insurance* bermakna untuk sesebuah negara, *social insurance* maknanya sosial. *So, it's interchangeably. So,* ada negara yang panggil sebagai *national health insurance* tapi pada dasarnya, ia adalah *social health insurance, okay.*

So, with regards to promoting preventive healthcare and wellness programme, we know that mencegah adalah lebih baik *because we know that the treatment is very expensive and not only that, morbidity* dan juga *mortality* ini. Kalau *morbidity* itu melibatkan *reduce in quality of health of an individual and therefore reduce in productivity and mortality as we know,* secara keseluruhannya akan menyebabkan negara kerugian.

So, it's better for us to promote and we have shown and we have made the calculation that the treatment of diseases is very expensive especially with regards to cancer. Although there is no absolute prevention for cancer but at least from the beginning, if we're able to detect early when it's at the earliest stage, there are some mechanisms ataupun *intervention that we can take up to prevent it from being a more severe case.*

For example, for breast cancer treatment, for the treatment of first stage is only like about RM3,000 to RM4,000 tetapi *for the treatment of second stage and onwards, almost RM14,000 and up to RM50,000 or RM60,000 per year*, jika melibatkan rawatan yang *advanced.*

And then, with regards to number four, regulating insurance industry practices, I think what we are doing now is actually the government is also trying to regulate insurance industry practices because jika tidak di-*regulate,* makin banyak *moral hazards* yang akan berlaku *especially* perkara-perkara yang boleh merugikan rakyat.

When we talk about health insurance, we are talking about terms seperti *adverse selection* di mana *the company of health insurance tend to memilih* ataupun masukkan pesakit ataupun rakyat ataupun *people* yang tidak ada *risk* ataupun mempunyai *risk* yang rendah untuk sesuatu penyakit.

And then, when we talk about moral hazards, we are talking about the practices of health providers apabila mereka tahu bahawa seseorang pesakit itu ada *health insurance, they tend to* membuat penyelidikan ataupun *investigations* ataupun rawatan yang tidak perlu sehingga boleh menyebabkan kos itu menjadi tinggi. *And then,* nombor lima adalah berkaitan dengan…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tuan Pengerusi, boleh saya— Prof., *you mentioned the number four* itu, *regulating insurance industry practices. At the moment specialist doctors, they are regulated, right?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Yes.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, now you proposing insurance industry. There is one more; private hospital. You're not suggesting private hospital also to be regulated?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Saya akan jelaskan— berikan penjelasan lebih nanti...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay.*

Prof. Dr. Maznah binti Dahlui [PPUM]: …dalam *slide* yang berikutnya. Terima kasih dengan soalan itu. Nombor lima adalah berkenaan dengan *encouraging public-private partnership. I think this has been promoted* ataupun memang telah diuar-uarkan untuk dilaksanakan *even* di dalam *health pillars* untuk *white paper.*

And then, nombor enam adalah berkenaan dengan *leveraging technology and data analytics. We know that the advancement in technology and with the AI and whatnot, this will actually help us as one of the mechanisms to control the increase in health insurance premium. The next slide* akan menyatakan dengan lebih terperinci.

So, with regards to strengthening the social health insurance, we know that— we can say that, we are fortunate and we can we be proud that actually we have been achieving universal health coverage according to the World Health Organizations even in 1985, okay. But then, I think over the years, there are some things that are static in terms of health indicators that we need to do something in order for us to really move torward universal health coverage, especially now we are talking about sustainable development goals.

And then, reduced reliance on private insurance for essential services…

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Nak tanya *on the universal health coverage* itu, dia punya indikator itu bagaimana Malaysia mencapainya? Apakah dia punya…

Prof. Dr. Maznah binti Dahlui [PPUM]: Sebenarnya *universal health coverage* ini ada tiga *pillars* ataupun tiga *domain.* Yang pertama *is* berkenaan dengan *what is the coverage of the people in a country that is able to get access to the healthcare services?*

The second is that how much do they need to pay? So, what are the implications, financial implications to the people when the need to get access? Adakah orang kaya sahaja ataupun orang yang berkemampuan sahaja yang mendapat perkhidmatan ini*? What happens to* orang yang tidak berkemampuan? *Okay.*

And then, the third one is with regards to the scope, kerana setiap negara, Kementerian Kesihatan mereka akan memastikan bahawa *they will have a comprehensive scope in terms of* daripada *womb to tomb.* Maknanya daripada perkhidmatan kesihatan ibu mengandung, kepada kanak-kanak, kepada remaja, kepada *geriatric* ataupun orang tua, kesihatan wanita, kesihatan lelaki, *dental treatment, physiotherapy* ataupun *rehab.*

So, these three things are the indicator to show dan *sorry— these three things are the pillars in which they see* kita di tahap mana. Indikator adalah sebenarnya berkenaan dengan *mortality and most importantly is with regards to morbidity and mortality.* Contohnya *what is the mortality rate* untuk ibu mengandung? *What is the mortality rate of toddlers* ataupun *mortality rate of babies? So, these are the indicators.*

So, kalau melihat indikator sebenarnya kita memang bagus. Okey. Cuma lagi *indicator* seperti kematian ibu mengandung agak statik walaupun kita dah mencapai kepada tahap *0.4 percent* tapi dia tak berubah, dia tak turun lagi *for the last two decades. But overall, our indicators are good. So,* boleh saya teruskan? Okey, terima kasih.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Boleh tanya sikit? *Sorry Prof. As you go along*, kita tanya soalan.

Prof. Dr. Maznah binti Dahlui [PPUM]: Tak apa.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Takut lepas habis, lupa pula. *Number two* itu *reduced reliance on private insurance for essential services. What do you mean? That's one and then next one, bundled payment for healthcare DRGs.*

We've been hearing opinions from others or doctors and all that. Some are not agreeable with DRGs. Can you beri pencerahan sikit Prof.? *Thank you,* dua soalan itu.

Prof. Dr. Maznah binti Dahlui [PPUM]: Terima kasih, saya sangat suka soalan itu kerana memberi saya kesempatan untuk memberikan penerangan yang lebih lanjut.

So, when we talk about reduced reliance in private health insurance is that by having social health insurance, bermakna setiap rakyat, setiap penduduk akan boleh akses *the essential healthcare services.* Macam saya cerita tadi pemeriksaan ibu mengandung, untuk kanak-kanak, untuk orang OKU, untuk penyakit-penyakit *non-communicable* seperti kanser, seperti diabetes*, hypertension. So those are essential, okay.*

Tetapi *on top of it,* bila semua rakyat kita ada *social health insurance, that means we are able— we can say that it is guaranteed that almost 100 percent— those* yang *cover*-lah, *because* ada juga yang mungkin tak nak ambil*. So, most of them will be able to get the essential health services that they need.*

Kalau dia sakit, dia akan dapat rawatan itu. Tetapi— *but that does not mean that* bila *you* dah ada *social health insurance, you* tak perlu *private health insurance.* Kalau *you* mampu, apa salahnya kerana *we know that with private health insurance* mereka boleh bayar ataupun *they can cover* wad yang lebih tinggi, tahap wad yang lebih tinggi. *For example. first-class ward rather than—* yang *essential usually third-class. And then…*

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Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Prof. maksud bawah *that private insurance you mentioned* itu *social insurance*-lah. *For essential services?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Essential services should be covered by social health insurance.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Social insurance, okay.*

Prof. Dr. Maznah binti Dahlui [PPUM]: Tidak ada di dunia ini *social health insurance* yang tidak *cover essential services. Below point...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: DRG, DRG.

Prof. Dr. Maznah binti Dahlui [PPUM]: Okey. Nanti nombor dua ya saya terangkan lagi. *This is also important because* kita tahu bahawa dengan ada *social health insurance, people no longer need to do out of pocket.* Kalau adapun *out of pocket is just for co-payment because out of pocket payment is very dangerous to the people because* walau bagaimana banyak duit sekalipun— bila ada penyakit-penyakit yang mahal seperti kanser, *it will make them impoverished* ataupun menjadikan mereka miskin. *So, government subsidies for vulnerable groups I think this one everybody understands.*

Now with regards to bundled payment to healthcare providers. This is actually just a tool on costing mechanism untuk *diseases* yang kita dah *standardise*-kan dia punya *grouping. Because we know* kalau kita ikut ICD-10— *that is the diagnosis coding* yang diberi oleh *World Health Organization dan* sekarang kita menggunakan ICD-11, ia tidak boleh menggambarkan kos untuk sesuatu penyakit. *Bundled payment* ini, *first of all, DRG* adalah menggabungkan *coding* untuk diagnosis dan *coding* untuk prosedur.

Kita tahu kos untuk sesuatu penyakit itu bergantung pada prosedur yang dikenakan dan prosedur ini juga termasuklah ubat-ubatan dan juga *investigation* yang kita lakukan selain daripada *intervention* seperti surgeri dan rawatan yang berkenaanlah. *So*, bila kita kata *bundled payment* ini maknanya kita dah *group*-kan *diseases* itu berdasarkan kepada dia punya *resources that are being used.* Contohnya, dalam penyakit jantung ataupun *cardiac diseases,* katakan ada 40 coding di dalam ICD-10 okey. Tetapi apabila kita jadikan dia sebagai DRG berdasarkan kepada penggunaan *resources* ataupun prosedur yang dilakukan, dia akan menjadi dalam 10 ataupun 15.

So, 10 atau 15 DRG *group* ini, dia ada kos yang *related to it. So, this costing is another exercise* untuk melakukan *case-mix. Case-mix system* ini menggabungkan antara DRG *that is grouping of diseases* yang telah di-*standardise*-kan bersama dengan kos yang telah dikira. Saya pun kurang faham kenapa *private hospital* membangkang ataupun sedikit *concerned about*— bukan sedikit *concerned, is very concerned about* apabila kita melaksanakan DRG ini akan *affect* mereka. Sedangkan kos ataupun tarif untuk DRG mereka itu yang telah diseragamkan dengan DRG semua hospital, sama ada *private* ataupun *public,* sepatutnya sama.

So, now we aren't comparing orange to orange. Kalau sebelum ini, kalau *you* kata *you* punya penyakit *angina pectoris* ataupun *myocardial infarction which is* serangan jantung. Mungkin *you* punya *diagnosis coding* itu sama dengan kita tetapi bila kita buatkan *group* kita tengok dia berbeza kerana mungkin *myocardial infarction you, you* rawat cara lain sedangkan *myocardial infarction* kita, kita rawat cara lain. Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *One of the proposals from doctors that we met, we must— earlier, I mean first we have to do pilot project first on this matter*-lah. *That's what— one of the suggestions.*

Prof. Dr. Maznah binti Dahlui [PPUM]: Okey. Sebenarnya KKM telah melaksanakan DRG ini sudah 10 tahun dan *teaching hospital* seperti UKM dan

sekarang PPUM telah pun melaksanakan sistem DRG. Masalahnya sekarang terdapat dua *grouper* yang digunakan yang berbeza. KKM mereka telah membentuk *grouper* mereka sendiri 10 tahun lepas. *They took 20 years to develop and* baru *10 years ago* mereka laksanakan.

UKM berdasarkan kepada *IRPA project* di mana beberapa hospital universiti telah duduk bersama menghasilkan DRG tapi pelaksanaan itu cuma berlaku di UKM *for the last 20 years.* PPUM kita dah laksanakan *in the last four years. So,* sekarang ini ada dua *grouper*. Saya telah dilantik oleh KKM sebagai Pengerusi untuk Jawatankuasa Pembentukan DRG Kebangsaan Malaysia dan kami sedang memikirkan bagaimana kita nak melaksanakan DRG untuk semua.

Kita ketahui juga bahawa *private hospital* mereka gunakan DRG ataupun *grouper* daripada luar negara. Ada yang daripada Australia, ada yang daripada Kanada, ada yang daripada Amerika tetapi sekarang ini *is high time that we use one grouper so that we compare.* Kita sedang— disebabkan *announcement* yang dilakukan oleh PMX bahawa DRG Kebangsaan perlu dilaksanakan pada tahun 2025, *so* kami sedang mengadakan perbincangan yang lebih agresiflah kerana mungkin kalau kita nak *start developing* DRG daripada *zero is going to take a long time.*

Grouper ini sebenarnya dia adalah *logarithm* ya, *logarithm* di mana satu penyakit apa dia punya komplikasi, apa dia punya *severity* dan apa dia punya *comorbidity*. Kita gabungkan dan kita *compile*-kan dia menjadi satu *grouper*-lah, satu *group of diseases* dan kita boleh bandingkan nanti dengan hospital-hospital lain.

Tuan Sim Tze Tzin [Ahli PAC]: Tuan Pengerusi. Dr., Prof., *I* bukan pakar ya *so, I don't know the details of it.* Akan tetapi saya difahamkan bahawa DRG ini sebenarnya perlu mengikut kesesuaian negara masing-masing. *There's no like one size fit all and it shouldn't be imported from* Australia kah, Amerika kah *because their situation is different. Their— maybe they eat too much McDonald's, you know.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *So*, saya rasa perlu di Malaysia. Ya, *I think we need to develop our own. However,* saya pun ada *feedback from certain expert on this. They feel that UM, PPUM or UKM you are teaching university. So, when you do your grouper, you tend to have more, what do you call* kakitangan *because you are teaching students, you know, you have more nurses, practice. So, your* kakitangan itu *there will be more than staffing* itu*, so whether you can slim it because in the private practice— what is efficiency. I just need this procedure, I just need one nurse, two nurse or something like that.*

So, is this considered in your grouper and when you elevate it to a national— because the private hospitals they want American or whatever because they can charge higher because their cost is higher. Okay, then of course they want the most efficient staffing. But for us Malaysia we need to also have efficient staffing but PPUM is totally different because you are teaching university.

Prof. Dr. Maznah binti Dahlui [PPUM]: Okey. *We are talking about Case-mix system. Case-mix system is where the DRG and then the costing.* Yang tadi itu saya cerita fasal DRG. *So, with regards to costing* sebenarnya kos ini, *costing mechanism* yang digunakan untuk mengira *Case-mix cost* ini berbeza daripada *costing* yang *mechanism* yang digunakan untuk kos sesuatu penyakit, okey. *Costing mechanism* untuk DRG setiap hospital berbeza. *Mechanism* itu sama tetapi tarifnya yang— hasilnya akan berbeza kerana dia melihat kepada, *like you said just now* tahap kepakaran, bilangan staf *and then* contohnya *facilities* yang disediakan.

Private hospital boleh masukkan, perlu masukkan semua kos-kos yang terlibat dan *definitely we are expecting their DRG* punya tarif akan berbeza daripada hospital *public* dan juga hospital pengajar. Hospital pengajar mungkin masih mahal tetapi disebabkan *teaching* dan juga *research* yang— komponen yang kita masukkan. *So, this is where I think this the misunderstanding from the part of the private hospital because they thought that* dia akan ada keseragaman dari segi kos.

Sebenarnya kos itu tidak diseragamkan, yang diseragamkan adalah *grouping of diseases. So that, the disease that you treat and disease that I treat is the same,* lepas itu kos itu memang berbeza kerana kos bergantung kepada *you* punya hospital, *you* punya kapasiti dan *you* punya fasiliti. Mungkin hospital *private* dia akan menggunakan robot untuk merawat penyakit dalam *group* itu tetapi hospital lain tidak menggunakan robot.

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Obviously, yang menggunakan robot akan lebih mahal. Okey? *So, this is where they misunderstood*.

Jika diadakan *social health insurance*, tidak bermakna semua hospital bayar kadar yang sama. Dia akan ada *negotiation on the tariff between the hospital provider and the social insurance* ataupun *national health funds, whatever you want to call it.* Contohnya di Indonesia, setiap hospital berbeza tarifnya walaupun DRG-nya sama. Hospital yang *tertiary*, hospital yang *complicated*, hospital yang besar, harganya *or* kosnya akan lebih— bukan kos, tarifnya akan lebih daripada hospital yang kecil

walaupun merawat penyakit yang sama. *So, this is where I think it is* keperluan untuk kita memberikan penerangan yang lebih lanjut kepada *private hospitals.*

There are several townhalls that we have done. The first townhall was done one month ago, di mana kita menceritakan berkenaan dengan ini. *We actually got a positive feedback from them when they understood.* Banyak hospital-hospital di bawah KPJ telah menjalani *workshop pertaining to this and they totally understand*. Ada banyak kebaikan bila kita gunakan *case-mix system* ini. Contohnya di PPUM sendiri, kita dah tahu sekarang di mana tahap *efficiency* kita. *Before this, we don't know because we don't know to whom we want to compare.*

But with the findings that we get from the KKM hospital, KKM hospital ada tiga *level; district hospital, state hospital and tertiary hospital* ataupun *specialised hospital. We can see clearly that the costs for the same DRG will be different. Okay?* Dari situ, KKM pun boleh tahu bahawa ada *district hospital* yang perlu diberi bajet lebih kerana walaupun dia *district hospital,* tetapi dia merawat kes DRG yang lebih *complicated.* DRG ini ada tiga *level* untuk satu *disease; severity level one, level two* dan *level three.* Kebanyakan hospital *district is expected to treat level one, state hospital more of level two dan tertiary hospital more of level three.*

Pada asalnya, bila kita buat *exercise* ini di hospital pengajar, kita dapati bahawa kita ada banyak *severity level one. So, this is where we discussed with the* pengurusan *that is we have to do something. So that— because we have the expertise, we should treat more severity level of DRG. So that, so there are various mechanisms that can be put in place in order to do this. For example, the mild cases should be diverted to the peripheral hospital rather than be treated by the tertiary hospital.*

Dr. Ashim Kumer Nandy [Pengarah Perubatan (Bahagian Perubatan Barat), Hospital Tung Shin]: *Can I just add on? Thank you for the clarification on DRG. So, you cannot compare the DRG private sector with the DRG government sector. That is what I gather because…*

Prof. Dr. Maznah binti Dahlui [PPUM]: *We can.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Not in terms of costing because…*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *It's an apple and orange, case-mix maybe, right?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *So, the focus for today's meeting would be more on getting DRG hypothetically applied into the…*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Implement…*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *…private sector rather than the government, I presume, or MOE-public sector. Maybe MOE-private be coming into this context because the insurance industry is actually— has got nothing to do with public healthcare. 90 percent or 100 percent of the insurers— I mean the reason why we are having this meeting was [Tidak jelas] rising in insurance premiums and therefore, it's more relevant to talk about DRG for private rather than public.*

But of course, your experience in public DRG may help, but the costing issues are different because the fundings are different, expenses, CapEx, OpEx is totally different, government and private. So, it is a big difference there. We have different models, again, of private hospitals. KPJ operates on one model, IHH another model and some NGO hospitals work on different model. So, this is DRG (private) we are talking about in this context here.

Prof. Dr. Maznah binti Dahlui [PPUM]: Tapi Puan Pengerusi...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Can you please give us your name again and your post for our record?*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Sorry. I am Ashim Nandy and I am actually the Medical Director of Tung Shin Hospital.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, terima kasih. *To response?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Nak teruskan atau nak cerita lagi berkenaan dengan DRG? *[Ketawa]* Kerana ya, kerana *like I have said just now*, DRG ini sebenarnya diguna— sepatutnya jika sudah ada kebangsaan, diguna pakai oleh semua hospital. *DRG is irrespective whether what type of hospital you are, you should use the same DRG. So that, we know that we are treating the same cases, yet our costs are different because our financial income and whatnot are different.*

Dr. Hajah Halimah Ali [Ahli PAC]: Datuk Wira, boleh tak *explain what you mean by cost mix? What exactly…*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Case-mix. Case-mix.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Case-mix.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Sebelum *explain now the case-mix* itu, saya nak tanya *since* PPUM dah pun buat

kan DRG ini, perlu tak staf, *dedicated staff* untuk laksanakan ini dan juga ataupun perlu hanya staf sedia ada saja melaksanakan DRG ini?

Prof. Dr. Maznah binti Dahlui [PPUM]: Terima kasih, Puan Pengerusi. Apabila kita *present* kepada— PPUM *present* kepada KPT dan KPT mahu perkara ini dilaksanakan di semua HPU. Sekarang ini Prof. Nazirah telah diberi geran untuk kami melaksanakan ini. Sebenarnya tidak susah kerana asalkan setiap hospital itu ada *electronic medical record* dan setiap hospital itu memastikan bahawa apa yang disarankan oleh *World Health Organization* dan juga KKM iaitu membuat *coding* diagnosis ICD-10 dan dilaksanakan. Biasanya *ICD-10 coding* ini dilaksanakan oleh doktor yang membuat *discharge summary*.

So, this should be in place dan kita perlukan *grouper. Grouper* ini yang macam saya kata tadi, ada *grouper* KKM dan ada *grouper local* daripada *local vendor*, *that is case-mix solution*. KPT mengguna pakai ataupun kita membeli lesen ini untuk kita gunakan sebagai kita punya *grouper. So, all we need is just a coders* untuk masukkan ataupun kita *extract* data ICD-10 ini daripada *electronic medical record* dan juga *data procedure coding* iaitu ICD-9-CM dan akan dilaksanakan oleh *one or two coders* untuk masukkan dalam sistem *grouper*. *So, it is not that difficult.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tadi, *explain on the case-mix* tadi.

Prof. Dr. Maznah binti Dahlui [PPUM]: Okey. *Case-mix system, okay. Case-mix* ejaannya *case, hyphen, mix*. *Case-mix system* ini menggabungkan DRG dan *costing*. Okey? Boleh? *So*, DRG ini adalah sesuatu yang diseragamkan dari segi *grouping of diseases according to the resources that is being used, according to the clinical characteristics of the patient. One is pertaining to* dia ada *comorbidity* ataupun tidak. Kedua, sama ada *severity* dia ada komplikasi ataupun tidak. Yang ketiga adalah berkenaan dengan keterukan ataupun *the severity level of the disease*.

So, kalau contohnya *case-mix* untuk jantung macam saya cakap tadi, dia ada tiga *level. Level one, level two, level three*. Kalau *you* kata dengan saya, *what is the cost* untuk *level one, it's about RM4,000* kalau berdasarkan kepada PPUM punya kos. *What is the cost for severity level two?* Ini penyakit yang sama ya, tapi *level* dia lain disebabkan yang *level* satu dia tak ada *comorbidity*, dia *straightforward* sakit jantung sahaja. *Level* dua itu dia ada sakit jantung datang dengan *hypertension* dan ada diabetes pula. *So,* yang ketiga pula, dia datang dengan komplikasi. Dia sakit jantung, dia ada *comorbidity* iaitu darah tinggi dan diabetes ataupun kencing manis dan dia pula ada komplikasi *heart failure* ya. Jantung dia lemah. *So, severity level*

dua harga dia lebih kurang— kos dia. Ini saya cakap fasal kos. Kita tidak mengira tarif lagi. *Severity level* dua kos dia RM8,000, *severity level* tiga kosnya antara RM14,000 hingga RM20,000. Okey.

Okey, apa beza kos dengan tarif? Kos adalah *what is the cost* bila kita nak mengadakan sesuatu *treatment. So*, tarif itu bila kita dah *negotiate*. Contohnya, PPUM belum lagi melaksanakan tarif. Kita cuma kira kos, tetapi dari segi pembayaran oleh pesakit, kita masih lagi ikut sistem lama, *that's itemised billing*.

So, tapi, *should we implement social health insurance?* Kita akan bincang dengan *the social health insurance that severity level one* ini kos dia RM4,000, tetapi kita nak bagi tarif dia berbeza-beza. Kalau rakyat B40, kita bagi subsidi, mungkin kita caj RM2,000.

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Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Prof, boleh cerita sikit fasal tarif lagi sekali tak?

Prof. Dr. Maznah binti Dahlui [PPUM]: Okey, tarif ini...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tarif ya. Tarif ini macam pendirian Trump itu tambah tarif yang kita tahu. Ini tarif yang lain pula ini.

Prof. Dr. Maznah binti Dahlui [PPUM]: Tarif ini maknanya *you* nak beri subsidi ataupun *you* nak caj keuntungan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ah, okey.

Prof. Dr. Maznah binti Dahlui [PPUM]: Okey? *So,* kalau kita ada tarif mengikut kelayakan seseorang pesakit, kalau dia B40 kita kata kita nak bagi subsidi, okey. Walaupun kosnya RM4,000 dia bayar RM4,000 sahaja. Tetapi kalau macam *private paying patient* kita nak kata kita nak *40 percent* keuntungan. *So,* kita akan caj dia lebihlah.

So, ada beza antara tarif itu. *This is the*— tarif inilah yang boleh di-*negotiate* oleh *private hospital* dengan *the payor.* Tak kiralah sama ada *social insurance* ataupun *company* ada *employer* ataupun *private health insurance.*

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya, sekarang ini PPUM dapat— *are you getting private insurance* punya *patient* tak?

Prof. Dr. Maznah binti Dahlui [PPUM]: Ada juga.

Dr. Hajah Halimah Ali [Ahli PAC]: *But mostly* dia *GLCs and all that?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Ada *patient* yang bayar sendiri. *This is we call private paying patient.* Sama ada dia pakai *out of pocket,* duit dia sendiri ataupun dia ada insurans yang *cover* dia.

Prof. Dr. Nazirah binti Hasnan [PPUM]: *So,* untuk pengetahuan YB semua, di PPUM 50 peratus daripada pesakit kami adalah pesakit daripada *Federal workers* dan juga *pensioners* dan tanggungan. *So,* itu kita tidak caj langsung. 20 peratus adalah daripada badan berkanun, *state government* dan *local government. That is* yang itu mereka datang dengan GL dan dibayar masing-masing.

Tetapi, harga yang kenakan adalah *very subsidised* hargalah. Seterusnya, *we've got 30 percent* yang sebenarnya membayar *out of pocket* ataupun...

Seorang Ahli: *Private health insurance. [Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Nazirah binti Hasnan [PPUM]:...yang bayar dan *claim* daripada insurans masing-masing. *So, that's the...*

Prof. Dr. Maznah binti Dahlui [PPUM]: Ataupun daripada *employer.*

Prof. Dr. Nazirah binti Hasnan [PPUM]: Ataupun daripada *employer.*

Tuan Sim Tze Tzin [Ahli POC]: *Sorry. Do you have a guarantee letter insurance— by private insurance?*

Prof. Dr. Nazirah binti Hasnan [PPUM]: *By private insurance guarantee letter. Currently, we— individual private insurance, we are not able to accept because we are unable to fulfil certain conditions. That is if you have your own private insurance when you come to us; number one, the hospital will have to verify with the insurer.*

Number two, a discharge summary will have to be given within 24 hours. That is something that we cannot comply with yet because of the sheer number, the sheer volume of the cases that we have.

It's very different to private hospitals where the doctors are paid for the patients that they see. And they see the patient and they bill, discharge within 24 hours. This is not the comprehensive summary but the discharge notes and bill.

Prof. Dr. Maznah binti Dahlui [PPUM]: *The HMO* kita terima. *Any more questions with regards to this slide?*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Teruskan.

Prof. Dr. Maznah binti Dahlui [PPUM]: *Okay, next please. So, this is the to elaborate* ataupun *to explain,* bila kita bercakap berkenaan dengan *expanding risk pooling and cross subsidisation. This is something* yang *the government can do.*

First, we mandate broader participation in insurance scheme especially social health insurance. Banyak negara di *neighbour* kita yang telah ada *social health insurance,* okey. *Even* Singapore pun walaupun tidak secara menyeluruh, mereka

ada dua *social health insurance.* Tetapi di Indonesia hampir 95 peratus daripada rakyat mereka sekarang ini di-*cover* oleh *social health insurance.*

Kalau dulu kita tahu bahawa *the prevalence of diseases there* sangat tinggi dan ramai rakyat mereka tidak dapat *access to the healthcare services.* Sekarang ini hampir *95 percent* boleh mendapat *healthcare services because they're covered by social health insurance.*

Mana-mana— kebanyakan daripada *social health insurance scheme and some insurance scheme in the country,* mereka menggunakan DRG sebagai mekanisme untuk pembayaranlah.

Then risk sharing between low risk and high-risk population. This is where bila kita ada *social health insurance, we are actually sharing the risk.* Bukan sahaja orang yang ada *high risk* yang terpaksa menanggung kewangan ataupun perbelanjaan diperlukan untuk penyakit dia tetapi kita tolong-menolong antara satu sama lain. *There is a* tabung, *everybody put money in there. Then, this money* boleh digunakan untuk membayar rawatan untuk yang memerlukan.

Then, integration of employer-based and government-sponsored plans. kita tahu bahawa sekarang ini walaupun ramai juga— *almost 40 percent of our people actually out of pocket* daripada *National Health Account.* Tetapi, kita ada ramai yang *government-sponsored as well as employer-based. For example— this is just to give an example that the Singapore MediShield Life and the Germany social health insurance model.* Sebenarnya *social insurance model* ini banyak ya di negara-negara yang melaksanakannya.

Next please, so, we have to promote preventive healthcare and wellness programs because we know that early disease detection reduces treatment costs. Kita kalau boleh biarlah kita merawat banyak *severity level one* dari segi *population* Malaysia. Tetapi untuk hospital kami *for example PPUM, it's a tertiary hospital* di mana kami ada banyak pakar dan kami ada *high technology. We wish to only treat—* bukan *only*-lah*, we wish to treat more of the third level severity.*

Encourage healthier lifestyle through incentive. I think kita kena *promote* lebih banyak lagi *intervention* untuk menggalakkan rakyat kita menjalani tahap ataupun gaya hidup sihat seperti yang dilaksanakan di Singapore dan juga di Thailand.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Doktor, pada pandangan doktor, adakah yang hari ini masih belum mencukupi lagi?

Prof. Dr. Maznah binti Dahlui [PPUM]: *Definitely,* masih tidak mencukupi.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Setakat ini daripada pandangan doktor berapa *percent* yang maksudnya yang kita jauh lagi untuk menggalakkan menjalani kehidupan yang lebih sihat untuk rakyat Malaysia?

Prof. Dr. Maznah binti Dahlui [PPUM]: *Difficult to say but definitely* belum pun mencapai *50 percent* yang diharapkan. Contohnya, kita ada banyak kekangan *even we want to* mengadakan— minta maaflah cakap, kalau kita nak mengadakan RUU untuk *anti-tobacco,* untuk *sugar* kan. Masih lagi banyak masalah yang perlu kita atasi.

Then when we talk about physical activity, we know that tidak sihat ataupun tidak selamat untuk kita nak berjoging di tepi-tepi jalan. *So, there are so many… [Dicelah]* Ya. *Then,* lihat kita punya *prevalence of obesity; 40 percent.* Sekarang ini *hypertension* pun dah *40 percent. So,* banyak lagi yang kita perlu laksanakanlah *in terms of prevention. Insurance premium...*

Tuan Haji Azli bin Yusof [Ahli PAC]: Datuk Wira. Prof, mencelah. Saya memang sokonglah *preventive healthcare, wellness programs* apa semua ini. Memang semua ini bagus. Cuma saya ada *hypothetical question*. Bila kita adakan program ini, kita sebenarnya mengelakkan *early disease.* Kita *prolong life* tapi akhirnya bila tua nanti kita pun akan memerlukan perkhidmatan ini juga.

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes.*

Tuan Haji Azli bin Yusof [Ahli PAC]: Okey, jadi soalan saya ialah apa bezanya dari segi kos perubatan merawat orang sakit tua dengan merawat *diseases* yang...

Prof. Dr. Maznah binti Dahlui [PPUM]: Ini satu kita panggil *chronic disease.* Satu kita panggil penyakit untuk orang-orang yang seniorlah. Contoh orang yang senior ini adalah macam sakit lutut atau *osteoarthritis*. Benda itu memang susah nak elaklah.

Tapi penyakit kronik ini macam *hypertension* boleh dielakkan daripada awal lagi ataupun jika kita tak boleh elak pun kita ada *hypertension* tapi *it's controlled.* Yang penting kita dapat mengelak komplikasi itu daripada berlaku.

Having hypertension kalau di Malaysia ini *insya-Allah,* rawatan itu memang ada tetapi *whether or not it's controlled* kerana untuk *control hypertension* ini, tekanan darah tinggi ini bukan sahaja rawatan tetapi cara hidup, makanan dan juga fizikal aktiviti, *stress factor* dan ada banyak lagilah.

Jadi sekurang-kurangnya kita perlu merawat darah tinggi sahaja. Kita tak perlu merawat komplikasi darah tinggi seperti strok, seperti sakit jantung, *which is more expensive.*

Prof. Dr. Nazirah binti Hasnan [PPUM]: Boleh saya tambah? *So, when to talk about preventive healthcare* ini ia *not*— kita ada *preventive healthcare primary prevention,* kita juga ada *secondary prevention.*

So, primary prevention ini *is where we do it at the public health level. So, the then* kita *manage to that patient* tak sampai ke hospitallah. *So that, all they need is just the essential healthcare support the public* di *primary health clinics.*

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But bila *secondary prevention* orang dah kencing manis, orang dah ada sakit jantung, orang dah ada darah tinggi, *so we need to make sure that they do not get complications as a result of their diseases.* Seperti contohnya, kalau orang yang sakit darah tinggi, kalau darah tinggi itu tidak di-*control* dengan baik dia akan boleh kena *stroke*. Bila kena *stroke* dan *it results in disability. When it results in disability then it results in requiring rehabilitation, requiring equipments* dan sebagainya*. So, the cost of care* akan lebih meningkat.

So, when we talk about prevention sebenarnya *it is very* besar maknanya. *So, for the primary prevention, the wellness programme* itulah yang perlu kita tekankan di sini ya.

Prof. Dr. Maznah binti Dahlui [PPUM]: *So*, untuk *primary prevention* itu biasanya kita lakukan *general health screening*. Untuk *secondary prevention* ini kita *screen* untuk komplikasi.

Di PPUM, kita ada *a very good secondary prevention programme* untuk *diabetes patients* di mana kita memastikan kita membuat pemeriksaan mata, retina mereka supaya mereka tidak mendapat komplikasi mata *because you can be blinded, you* boleh jadi buta disebabkan diabetes yang tidak terkawal. Untuk potong kaki, untuk *vascular disease* yang tidak terkawal di kalangan diabetes. Juga, kalau penyakit darah tinggi ini juga boleh menyebabkan diabetes dan darah tinggi boleh menyebabkan *chronic renal failure*.

Dr. Hajah Halimah Ali [Ahli PAC]: Prof, sebelum apa itu mungkin nak tanya Naib Canselor *kut.*

Seorang Ahli: Apa dia? *[Bercakap tanpa menggunakan pembesar suara]*

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanya Naib Canselor. *Okay, number two; encouraging healthier lifestyle through incentives,* kan? *You're talking already*

yang dah *you know our culture, the Malaysian culture,* makan, makan, makan tidak kisah pagikah petang, siang, malam *or whatever*, kan? *All available. What about the needs itself? Control environment* kita.

Maybe, ada tak UM *and* PPUM buat kajian *because you are teaching hospital, the cause, the root causes of* kita punya *lifestyle, cause* penyakit-penyakit ini*? Chronic diseases and NCDs and all that* itu*.* Contoh macam iklan, kan? *Advertisement is everywhere. All* fasal makan. Tengok TV *you seat there and then* anak-anak kecil-kecil itu kecur air liur dia. *So, that kind of things you know.*

It is not just the individual citizens yang nak makan tetapi *the controlled environment, they can't control that. Maybe is the* akta ke? *The government part of it whether it's their— PBT itself and including what comes into* yang nampak dengan mata dengan telinga ini. *So, you have got any* apa tak?

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Terima kasih YB. Sebenarnya perkara itu satu soalan, satu komen yang saya kira sangat baik.

Perkara ini kita perlu lihat secara menyeluruh. *It's all the whole ecosystem. Well, I tend to agree with you* YB. Perkara ini contohnya di Universiti Malaya sebagai contoh yang mana kita ada 44,000 *students*, 12,000 staf termasuk di PPUM dan 1.5 juta *patients more of less average. It is a huge community* dekat situ. *I think the most important thing, I think the whole ecosystem* itu *must be towards the lifestyle* yang sihat. Itu yang paling utama.

Maksudnya kalau *student* ini 44,000 ini kita tak nak dia keluar untuk buat benda-benda yang bukan-bukan. Jadi, dia nak pastikan bahawa hidup sihat itu berada dalam keadaan generasi mereka.

Apa yang mereka perlu buat untuk petang-petang sebagainya, contoh. Kita perlu adakan semua futsal, *pickleball,* benda-benda yang mereka suka main. Tapi tidak bolehlah platform-platform itu dibuat dengan cara padang tidak okey dan semua tidak okey.

Ini satu perkara yang saya *have to give a credit to the government* memang dia *give us a quite significant amount of money* untuk kita naik taraf semua pusat-pusat sukan di Universiti Malaya. Jadi, kalau kita tengok sekarang di Universiti Malaya memang agak aktif petang-petang, padang-padang daripada PPUM *itself* sampai kepada *[Tidak jelas]* memang kita aktif dalam aktiviti-aktiviti sukan. Itu sangat penting.

Jadi, di samping itu juga dalam kaca mata— dalam aspek budaya sihat ini juga kita telah tekankan cara makan. Cara makan ini juga penting. Contohnya di

PPUM, di UM kita dah kata bila kita buat air gula dengan air teh O itu kena asing. Dia tidak boleh dicampurkan bersekali. Kita haramkan.

Prof. Dr. Nazirah binti Hasnan [PPUM]: Haramkan gula. *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Haramkan gula. Itu salah satu contoh yang kita pergi ke arah situlah. Jadi, *the whole ecosystem* itu kena lihatlah. Kalau kuih itu, tidak bolehlah kuih itu terlampau banyak yang menyebabkan gula-gula di situ.

Jadi budaya-budaya itu yang kita sedang buat dan saya rasa sangat aktif dibuat di dalam Universiti Malaya. Jadi, *the whole ecosystem* itu perlu dilihat samalah, YB.

Dr. Hajah Halimah Ali [Ahli PAC]: *As far as advocacy* itu *the Health Ministry itself as a teaching hospital, that was I was mentioning. You all* adakah tidak buat yang *[Tidak jelas] multicentered*-kah, apa bendakah kajian *or whatever,* kan?

Prof. Dr. Nazirah binti Hasnan [PPUM]: Terima kasih. Mungkin— kebanyakan daripada *research* yang kita lakukan, banyak berkolaborasi dengan rakan-rakan pakar di KKM *and especially in public health research* memang berbentuk *community research* dan kolaborasi, bukan sahaja dengan rakan-rakan di KKM tetapi juga di universiti lain dan juga pihak komuniti sendiri. *So, in terms of advocating healthy lifestyle and research on* pemakanan dan *lifestyle activities yes, we do. We are— we see ourselves as advocates.*

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Di Universiti Malaya kita peruntukkan *certain amount of money* untuk *do that kind of research*. Memang ada.

Dr. Hajah Halimah Ali [Ahli PAC]: Masih banyak lagi... *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: *Of course, YB.*

Prof. Dr. Nazirah binti Hasnan [PPUM]: *But of course,* YB. *There's a lot more that we need to do.*

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Itu yang kita mohon untuk tambah peruntukan itu. Itu yang Puan Nazirah selalu berkata itu. Ya. Memang *we put a certain amount* untuk buat benda-benda yang begini.

Prof. Dr. Nazirah binti Hasnan [PPUM]: Ya. *Maybe I can share the initiatives by KPT for— this is the third year running.* KPT memberi geran untuk kami melakukan program komuniti di mana *all the university hospitals are given area of coverage*

where we go out to the community bukan sahaja untuk menjalankan *health screening* tetapi untuk meningkatkan literasi kesihatan di kalangan penduduk dan juga membuat *community engagement in the various areas of health.*

So, this is something that we have been doing for— ini tahun yang ketigalah. *So,* dari segi advokasi di peringkat komuniti memang kita telah jalankan. *Whenever we go out to the community that we serve, we work together with our KKM partners* melalui pejabat kesihatan daerah.

Dr. Hajah Halimah Ali [Ahli PAC]: Ya.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Saya nak tambah satu lagi yang saya rasa *it is a very important to note that, you know,* Universiti Malaya kita memang *approach* kepada komuniti *through the 222 programme. Through 222 are Members of Parliament* untuk kita masuk kepada semua tempat. Itu adalah salah satu yang kita yang kesannyalah.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey *doctor*. Dr. Maznah, bagi sayalah, *you know,* ini nak tukar tabiat makanan, kurangkan gula, kurangkan apa ini, ini adalah satu— *it takes one generation to change the habit*.

Bagi saya, saya dah dengar semua kempen, slogan daripada KKM ini dah lama tetapi tidak jadi punya. Selalu *you* tengok Parlimen kita ini *you* kata mahu *order* itu kopi kurang manis, teh tarik kurang manis. Bila sampai, juga sangat-sangat manis. *So,* sudah jadi tabiat. *I think very, very difficult to change. But I mean set that aside* kerana kita hari ini adalah berkenaan *healthcare*, macam mana turunkan *healthcare* insurans dan sebagainya.

So yesterday we have a group of specialists came to our proceeding then some of them they suggested that this DRG thing is better for the government to implement in some selected hospitals dulu*. That means that try to run pilot. Let's say maybe in UH or UKM hospital and so on.*

Also, some of them are very skeptical over this DRG. They say cancer shouldn't be put under the DRG category because cancer is too complicated in terms of treatment.

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So, I think they also mixed up like DRG with the costing and so on. I think in the medical fraternity, I mean among the specialist they are not very sure but DRG frankly speaking. So, I mean for me I think that is very good the government PMX ask you all to start the from UH— I think it's PPUM, I think is a very good thing. Maybe PPUM and one or two maybe private hospital can kickstart first then from there,

you know, we can modify and the whole nation can implement it. What do think about this?

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya YB terima kasih atas cadangan itu, *that is what we are doing now.* Dalam jawatankuasa yang saya *chair* ini *that's our role to select which is the DRG that will best suit all the hospitals in the Malaysia. So, in that* jawatankuasa ada juga *private hospital*, wakil daripada APHM yang kita panggil untuk kita duduk bersama *and look at logarithm whether it is suitable for them. And I do understand that there are certain that should be excluded from the DRG.*

Which you mentioned rightly is cancer. That is also the things that we can discuss. So, that is why we meant by DRG Kebangsaan *where every stakeholder* duduk bersama dan setuju dengan DRG *grouper* yang akan digunakan. Kerana sekarang KKM guna lain, hospital *private* guna lain, hospital pengajar guna lain. *So* kita duduk bersama *and we see how to adapt and adopt okay, to customise it* untuk menyesuaikan dengan semua hospital-hospital di Malaysia. *So that if everybody agrees to the grouper* dan kita boleh laksanakan.

Dari segi pilot projek, kalau *if you say about the existing grouper* memang telah pun dilaksanakan. *But I do agree with you and this is what we plan.* Bila kita sudah *develop* satu DRG Kebangsaan, *it needs to be piloted in* hospital yang boleh *represent public, KKM, Ministry of Defense,* hospital pengajar *dan juga private.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi*, during our session with MMA,* mereka sebenarnya mencadangkan bahawa bukan semua boleh di-DRG-kan okey. Jadi, mereka cadangkan *actually to control the healthcare cost of— spiraling out. It is said that actually a lot of common diseases are actually below RM10,000. 65 percent of hospital treatment* kosnya sebenarnya adalah *below than RM10,000. So, they suggest to the government to do grouping* lah *for those.*

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: *So that everyone cut across, everyone has a consensus*-lah. *So, then they will reduce the cost. Then the most sophisticated one you go to DRG. What do you think about that Professor?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Saya rasa— bukan saya rasa, *this is the practice* okey. Semua *diseases* perlu di-DRG-kan. Tetapi tidak semua *diseases* perlu diberikan *costing. For example, just now,* kita perlu ada DRG untuk kanser tetapi mungkin *this is where* DRG kanser ini kita tak *attach*-kan *the cost*, kita tak

jadikan dia ataupun masukkan di dalam *case-mix system. In fact,* jika di *attach*-kan kos kita, ada tiga *level* yang saya *mention just now.*

So, there is where we can also decide the payor (pembayar) perkhidmatan kesihatan ini sama ada *social health insurance* ataupun kerajaan ataupun *private health insurance, they can decide later on that DRG* yang ini mereka tidak mahu berikan tarif, *they want to follow the usual one.* Boleh, tetapi itu semuanya perlu di-DRG-kan. Contohnya, 10 orang diberi nama. Tetapi mungkin orang yang nama daripada Z itu kita *exclude*-kan bila kita hendak buat tarif, itu maksud saya.

Ya okey so boleh kita teruskan kepada *next slaid? So, regulating insurance industry practices. So, I think* ada soalan tadi berkenaan dengan ini *so this is where government intervention in premium pricing. I think what*— tujuan mesyuarat hari ini pun adalah untuk memastikan bahawa *private health insurance* tidak boleh sewenang-wenangnya menaikkan premium mereka. Mungkin kita perlu *give a ceiling* ataupun *cap pertaining to how much they can increase.*

Dan *this is where also* mungkin kerajaan boleh bantu. Contohnya, untuk *case-mix severity level 3 okay,* mungkin untuk membantu *private health insurance* ini kita *top up.* Okey mungkin *they cannot cover* kalau macam kebanyakan daripada dia punya pelanggan*, the clients who prescribe to the private health insurance they are all* jatuh dalam *severity level 3* okey*.* Mungkin mereka tak mampu hendak *cover so this is where government can decide maybe government wants to cross-subsidise this type of case-mix.* Dan *case-mix level 1, let them pay* macam yang di cakap oleh YB sebentar tadi.

So, and then kita perlu ada satu badan lah untuk *regulate*-kan *schedule* ini. Kita ada pembiaya kesihatan *(payor)*, kita ada pemberi perkhidmatan kesihatan dan kita perlu ada *regulator* okey untuk memastikan bahawa *healthcare provider* ini tidak sewenang-wenangnya hendak *claim.* Kadang-kadang *severity level 1* tapi dia *claim* sebagai *severity level 2.* Okey ada *fraud* di situ. So kita perlu ada *regulator*-lah, *regulation* daripada segi itu.

Di *Japan, for example, they have the fee schedule and* di Korea mereka ada HIRA okey. *So,* HIRA dia akan memastikan bahawa semua *claim* yang dibuat oleh hospital-hospital kepada *social health insurer* itu ada kes-kes yang *genuine* ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Prof., can I go back to my earlier question about regulating private hospital.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ini *insurance. What about private hospital?*

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya *I think* kalau semua *private hospitals juga* melaksanakan DRG ini *so— and then* mereka beri kos mereka, *we understand. If your cost is that much, that is the cost,* kita tak boleh buat dia rugi. *Okay but at least we know* dia bukan saja-saja hendak menaikkan tarif dia, dia bukan saja-saja hendak caj RM10,000 *for example.* Kalau kos itu memang RM10,000 *we have to accept. So, this is where it's very transparent* kalau *you* buat *case-mix system* ini.

Ini kerana *we are comparing the same grouper and we know the same group of diseases and we know what is your cost. Your cost will not be the same as our cost and therefore your tariff will not be the same as ours. We understand if your tariff is more expensive than ours. So, this is what* yang mereka faham.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Sebab kalau *you regulate through this DRG that means you are regulating the private hospital as well. It's not— but it's not full.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *In a way we are regulating, DRG is just the tool to make…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This doesn't cover medicine cost, trucks* semua tak *cover* lagi?

Prof. Dr. Maznah binti Dahlui [PPUM]: *Kalau you* hendak buat yang *full case-mix system,* masukkan juga kos dalam DRG itu, dia *cover* semua. Dia *cover* prosedur, dia *cover investigation,* dia *cover medicine.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you Prof.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *So, this is with regards to encouraging public-private partnerships. I think* ini sudah banyak kali dinyatakanlah *with regards to collaboration in order to improve efficiency and reduce cost. I think* seperti yang *practice yang* telah dilaksanakan semasa musim COVID, masih diteruskan. Contohnya, *decanting* untuk kes-kes yang tidak upaya dilakukan oleh *public hospital* kepada *private hospital in order to help them as well as for the public hospital to focus on more other diseases.*

And then government subsidies for private providers offering affordable plans. Okey ini macam yang saya cakapkan tadi mungkin *government* boleh bantu untuk mereka tidak menaikkan premium ini supaya jika mereka terpaksa membuat bayaran yang tinggi atas kes-kes yang *severity level 3* itu *then* kita boleh *subsidise*-lah.

Joint initiative for chronic disease management. I think this is has already been practised okay under the conjoint board. Conjoint board ini tapi ini di kalangan *public hospital under KKM* dengan *under* KPT-lah di mana ada *conjoint board* untuk setiap disiplin.

They sit down together. This is not only for training of the specialist but also on other matters, guidelines, standard operative procedure ataupun *clinical pathway.*

■1300

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Setakat ini, sejauh mana keberkesanan *conjoint* yang telah pun dilakukan?

Prof. Dr. Maznah binti Dahlui [PPUM]: *I would say it's still in the process*, belum lagi *100 percent* kerana *sometimes to make the clinicians of the same discipline to sit down together* dahlah susah, *then to get them to get agreement pun* lagi susah, okey. Tetapi ada juga…

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kita memahami, PAC memahami sebab bila dah panggil banyak ini pun, banyak..

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes, yes.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]:...banyak perkara, banyak...

Prof. Dr. Maznah binti Dahlui [PPUM]: Tapi *credits to KKM because* banyak *clinical pathway* yang telah mereka keluarkan. Cuma lagi*, clinical pathway* ini cuma dilaksanakan di KKM hospitallah. Ada juga yang dilaksanakan di *tertiary hospital* kerana kita pun perlu tengok kesesuaian dengan kita punya pengajaran dan *research* tetapi tidak dilaksanakan di *private hospital.*

So, we are hoping that, again with the DRG, okay because a DRG ini sebenarnya salah satu daripada kebaikannya adalah untuk mengadakan *clinical pathway and clinical pathway* ini adalah rawatan yang berdasarkan *evidence value-based medicine. So, this*— ada banyak kebaikan jika kita melaksanakan sistem *case-mix.* Untuk hospital itu sendiri, dia boleh melihat kepada *efficiency* dia dan yang paling penting dia boleh membetulkan ataupun memperbaiki kualiti perkhidmatan yang mereka laksanakan.

Daripada situ, kita boleh tengok ada yang *unnecessary length of stay.* Kerana *clinical pathway* ini dia dah *standardised*-kan. Okey, biasanya kalau *severity level one* ini kalau sakit jantung ni, mereka duduk empat hari saja dekat hospital tetapi kalau ada hospital yang caj tinggi itu mungkin disebabkan mereka menyimpan pesakit itu lebih daripada empat hari, *which is unnecessary.* Tetapi dia akan kata,

*"Oh, because our cases are most severe", t*etapi dia tak boleh berkata demikian jika kita gunakan *DRG because we are now talking about the same group of disease, so dia tak boleh nak cakap because ours is most severe and we have to keep them for seven days. We will tell back because the DRG is a such has been shown that the same DRG* dekat mana-mana pun rawatan yang diberikan, untuk *length of stay this is the standard or the accepted average length of stay.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: Pengerusi.

Prof. Dr. Maznah binti Dahlui [PPUM]: Berdasarkan bukti.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Yang Berhormat Pengerusi, Prof., saya nak tanya sikitlah. Daripada pembentangan Prof. tadi, saya lihat bukan mudahlah nak meletakkan entiti swasta, kerajaan dan sebagainya untuk setuju dalam sesuatu perkara. Jadi, saya nak tanya sikit— sebenarnya isu ini juga tadi saya dalam *select committee* kesihatan. Adakah Prof., pada pandangan Prof., perlukah penubuhan suruhanjaya kesihatan?

Prof. Dr. Maznah binti Dahlui [PPUM]: *I think* kalau suruhanjaya kesihatan ini *should not only before this*-lah, *because I mean* bila kita cakap fasal…

Dato' Adnan bin Abu Hassan [Ahli PAC]: Maksud saya, *I am talking about how to* nak *regulate* ini kan, bukan mudah sebenarnya. *You* tengok tadi kepala daripada swasta, kerajaan dan sebagainya...

Prof. Dr. Maznah binti Dahlui [PPUM]: Tetapi daripada sesi *townhall* yang kita adakan, mereka *agree with the* pelaksanaan DRG tetapi mereka *disagree* jika dimasukkan ke dalam aktalah, maknanya *made mandatory. So,* kalau kita dah ada suruhanjaya, *most likely, most of directives will be like a mandatory thing* kan. *Of course*, kalau *personally,* saya memang suka kalau kita ada suruhanjaya *because to make everybody agree* sebagaimana yang berlaku di Indonesia. *It's easy for them to control because they have* suruhanjaya dan juga akta. Suruhanjaya saja tak cukup jika tidak dimasukkan ke dalam..

Dato' Adnan bin Abu Hassan [Ahli PAC]: Sebab saya lihat, *at the rate we are going now, actually* masing-masing bercerita tentang *interest* masing-masing.

Prof. Dr. Maznah binti Dahlui [PPUM]: Betul.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *We are talking*— kita *bring in* itu hari dalam kita punya prosiding *specialists* daripada *private hospital,* dia cerita tentang *interest* dia. *So,* nak *to blend* dengan nak bersetuju ini untuk bersama ini dengan kepentingan masing-masing ini, saya rasa mesti ada satu *regulator.*

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Pada pandangan sayalah. Jadi...

Prof. Dr. Maznah binti Dahlui [PPUM]: Inilah yang saya cuba nak cakapkan dalam..

Dato' Adnan bin Abu Hassan [Ahli PAC]: Mungkin...

Prof. Dr. Maznah binti Dahlui [PPUM]: …slaid sebelum ini.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Terima kasih.

Prof. Dr. Maznah binti Dahlui [PPUM]: *Ya. Can we move to the next slide? This is a review of technology and data analytics. So, since* negara kita pun memang ingin memacu ke teknologi dan juga AI, *so, I think this is the best time*-lah *for us* untuk melaksanakan ini. Mungkin *insurance companies,* mereka boleh kurangkan kos *admin* jika dia menggunakan teknologi dan juga AI kerana kita tahu bahawa kos *admin* untuk insurans ini, *especially with regards to* membayar *claim* ini sangat tinggi dia punya kos.

Telemedicine. Ini pun telah dilaksanakan di PPUM sendiri, kita telah melaksanakan *telemedicine and perhaps, actually our vision, our Pengarah's vision and of course our VC's vision is towards virtual hospital, di m*ana ada penyakit yang *patient* tidak perlu pun datang ke hospital. *Just* melalui *telemedicine* ataupun *teleconsult should be sufficient.*

And then blockchain for secure and efficient claim processing because bila kita gunakan *bundled block* seperti dalam *case-mix system,* sebenarnya dah tak payah dah nak buat, *itemised billing* ataupun untuk *private hospital* tengok satu, satu*. Private hospital* ini memang mereka membuat pengiraan kos berdasarkan *itemised billing which is very tedious* tapi kalau *blockchain,* kita dah tahu DRG ini berapa *cost [Tidak jelas]* berapa kos dia, berapa harga ataupun tarif dia.

Jadikan, *patient* pun bila nak masuk hospital itu, bila dia dah tahu dia masuk dalam *grouper* mana, dia *more or less* tahu berapa yang dia kena bayar, begitu juga dengan pembiayaan— *so,* kita boleh *forecast,* kita boleh *predict what is the cost* ataupun *financial implications* untuk sesuatu penyakit di bawah *grouper.*

Next one, I think that is the last slide.

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Prof, can I just add one question here? I think one of the factors for this price increase for insurance premiums is because of the cost of healthcare in private hospitals have increased. A very important component of the cost for private healthcare in private hospitals is medical devices, consumables and drugs, big pharma and small pharma. So, that I*

think about, easily—I think you're a health economist— constitutes about 20 percent or 30 percent of the dollar that the patient pays to the private hospital.

Prof. Dr. Maznah binti Dahlui [PPUM]: *So, that is why we need clinical pathway that is agreed, so, that we— I mean sometimes if the hospital,* dia ada robot tetapi rawatan itu tidak memerlukan robot, dia nak gunakan robot.

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: Ya, betul. *So, I am coming to regulations when we are talking about regulations, parallel hospital, industries, I think the supply chain to private hospital also has to be regulated from them making runaway profits…*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Totally agree.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *I think that's very neglected area but a very big component of the healthcare cost. And secondly, the second question is— okay, what is the hard evidence that you have that DRG actually brings down healthcare cost without affecting healthcare outcomes?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *I think I've…*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *We would like to hear from the health economist.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *I've said just now, DRG is not the factor that can bring down health insurance premium, no.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *It's not.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *It's one of the mechanisms that can be used to show the transparency of costing. Because we do not know actually what is the cost, that actual cost of the particular treatment for that particular DRG, but once we know, once you implement this, you yourself already know what is your actual cost when you want to treat this particular group of disease and then you decide on what tariff you want.*

The problem now, that you yourself do not know what is the actual cost. To be frank, if you continue to use itemised billing— this is something yang *private hospital* pun tak tahu*. If you continue to use itemised billing, you are just concerned to the treatment that you give. It's very difficult for you to sustain the running of your hospital because* dalam *case-mix system,* bila kita masukkan kos ke dalam *DRG, we are taking into considerations of what is the cost to pay to the* pengarah *which are not directly related to giving treatment to the patient. What is the cost of the* anjung, *for example, you have very nice lobby. What is that cost? How that cost translated to patient?*

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: *[Bercakap tanpa menggunakan pembesar suara] ...talking about transparency, right?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *So, this is about transparency. So, when you have the cost, again I have to emphasise* kita cakap fasal DRG, kita cakap fasal kos untuk DRG. Bila kita cakap fasal kos untuk DRG, kita cakap fasal *case-mix system* tetapi *for the sake of this meeting,* saya lebih fokus kepada kita kena *settle* dengan DRG dulu. Sama ada *later on you* nak masukkan koskah tidak, itu bergantung pada *you* punya *payor.* Kalau macam *social health insurance,* suruhanjaya, *for example, you decided* suruhanjaya yang memantau semua ini, *give the directive to social health insurance that you only pay according to case-mix system.* Itu mereka dah tak ada *choice but they still have the DRG and they still have their own cost.*

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: *I think* YB...

Prof. Dr. Maznah binti Dahlui [PPUM]: *I* dah penat dah.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: *I think to make it clear, we pass back— probably pass back to our* YB Pengerusi.

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Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih, dah selesai. Saya bagi Sik, lepas itu Bayan Baru dan Seputeh. Ha, berderet.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Seputeh. *[Sambil mengangkat tangan]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ha, Seputeh *last*-lah.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya, terima kasih Datuk Wira Pengerusi...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Before we go to* Hospital Tung Shin punya presentation ya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Oh ya. Ya, Prof. tadi banyak membangkitkan soal DRG ini ya dan *presentation* yang lain pun daripada agensi lain pun samalah ya. Namun kita pun tidak dapat ada kepastiannya bila kerajaan akan memuktamadkan pelaksanaan kaedah ini. Di pihak PPUM sendiri mungkin sudah lihat ya, okey dari segi *benefit* dia, kelebihan itu sudah pun ada kita tengok ya untuk nak *control* kos dan sebagainya.

Namun ada juga kesan-kesan buruknya itu yang sudah pasti kita juga kena ada *plan* untuk nak memastikan, meminimumkan kesannya itu termasuklah risiko pengurangan kualiti rawatan itu ya, itu akan berlaku.

Prof. Dr. Maznah binti Dahlui [PPUM]: Tidak.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya? Sebab orang lihat maknanya dia sudah menjadi— tumpuannya ialah dari segi kos dan bukan lagi berbanding keperluan pesakit itu. Itu risikonya ya, maksudnya.

Prof. Dr. Maznah binti Dahlui [PPUM]: Tidak, tidak. Untuk DRG tidak.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Tidak.

Prof. Dr. Maznah binti Dahlui [PPUM]: Untuk *case-mix system,* mungkin. Tapi untuk DRG sendiri tidak.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Itu banyak pandangan mengatakan— itu risiko dia pada saya ya. Akan ada kebarangkalian di situ, orang akan kurangkan kualiti ya sebab dia sudah ada sasaran dia berapa kos dia kan.

Prof. Dr. Maznah binti Dahlui [PPUM]: Tuan Yang Berhormat, mungkin— izinkan saya jelaskan berkenaan dengan ini. Di Indonesia, *for example,* semua hospital melaksanakan sistem DRG tetapi dari segi tarif itu mereka *negotiate* dengan BPJN *because* ini adalah badan yang membayar *social health insurance*-lah. *This is where* mungkin dalam *social health insurance* itu premium yang dikenakan itu terlalu rendah kerana pada asalnya para penyelidik katakan sepatutnya harganya IDR100,000 tetapi Kerajaan Indonesia potong dua pertiga. Jadi, mereka hanya membayar IDR30,000. IDR30,000 ini memang tak cukup.

So, it's not the issue of the DRG; it's the issue of the premium. So, di sini juga apabila kita nak memantau premium *private health insurance*, kita mesti pastikan bahawa premium itu tidak terlalu rendah. Ini kerana jika premium itu terlalu rendah, mereka tidak akan membayar kes-kes yang rumit ataupun *severity level* dua dan *severity level* tiga. *So, it's two different things.*

We are not— we are— memang banyak *private hospitals* bila mereka bercakap dengan kami pun *they always give Indonesia as an example.* Indonesia boleh dikatakan ada masalah dari segi premium itu terlalu rendah. Bila premium terlalu rendah, hospital tidak mampu untuk menanggung kos okey, dengan DRG yang sama. *This is why the quality of the treatment* mungkin dikurangkan oleh hospital tersebut.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Cuma maksudnya di sini kita perlu bantu pihak kerajaanlah ya. Bagaimana kita pastikan— ada mekanisme

pemantauan itu kerana ada tadi yang *regulation* itu kan. Kalau tidak dia— kita tidak ada satu garis panduan dan dia akan ada ruang juga kan, orang akan *manipulate* juga benda ini.

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Jadi, itu yang ingin saya tekankan. Maksudnya, okey kita setuju DRG namun perlu ada dia punya *term* dia yang boleh menjadi peraturan yang boleh diikuti.

Okey, yang *last* ini, Pengerusi. Mungkin saya— ini *last slide* ya. Saya tertarik dengan mesej daripada PPUM sebagai *the leader of the medical education* ini ya. Jadi, kita pun mengharapkan PPUM ini menjadi sebagai pelopor kepada pendidikan kesihatan, kepada seluruh rakyatlah ya termasuklah bukan hanya dalam kampus sendiri tetapi keseluruhanlah publik kita ini. Sebab memang pendidikan kesihatan ini nampak sangat hambar ketika mana mungkin orang dah rasa selesa sebagainya. Masa COVID-19 hari itu okey kan orang pakat tutup muka apa semua kan tapi sekarang...

Di Universiti Malaya dulu betullah masa saya pun dulu berjalan kaki daripada Za'ba masuk kolej di Akademi Islam. Lepas itu dulu ini ada kolej yang kita kata pukul 12 kena *stop* dah kafe-kafe, budak-budak masa itu perlu tidur dah tapi tak taulah sekarang macam mana.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Sekarang ini 24/7.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ha, itu masalahnya. *[Ketawa]* Jadi, maksudnya...

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya. Jadi kita mengharapkan sangatlah PPUM ini menjadi pelopor kepada pendidikan kesihatan pelbagai sudutlah untuk menjadi contoh kepada pendidikan— kepada universiti-universiti dan institusi public yang lainlah.

Prof. Dr. Nazirah binti Hasnan [PPUM]: Terima kasih banyak, Yang Berhormat. *Insya-Allah*, itu hasrat kami juga dan memang kita tekankan literasi kesihatan dalam semua rancangan yang kita buat.

Tuan Sim Tze Tzin [Ahli PAC]: Okey...

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya, Yang Berhormat saya sangat setuju kalau ada suruhanjaya itu, mungkin suruhanjaya boleh membuat kajian berkenaan dengan *the severity level* yang dirawat oleh hospital-hospital swasta. Ini

kerana sekarang ini sebagai penyelidik individu, memang kami tak mungkin boleh dapat data itu. Ini kerana dari situ kita boleh tahulah sama ada untuk *the same* DRG berapa banyak harga yang mereka letakkan.

Satu contoh adalah apabila kami *decided* untuk menjadi hospital sebagai hospital yang KKM *decant* dia punya *renal transplant* kepada kami ya. Kita dah kira kos dan kita dapati kos kita lebih kurang RM25,000, okey. Akan tetapi, *transplant* yang sama, untuk DRG yang sama, kita bandingkan dengan hospital swasta, *is almost RM80,000.*

So, that is why sometimes kita tak tahu bagaimana mereka melakukan pengiraan kos itu. Jadi, kalau dia dah buat DRG dan kita dah tahu dan kita *compare* benda yang sama, kalau mereka masukkan *exercise costing* itu untuk dapatkan *case-mix system,* kita pun boleh tahu berapa harga dia. Contoh yang nyata adalah pada tahun 2015, saya buat satu kajian yang telah disuruhlah oleh Pengarah Kesihatan untuk melihat berapa kos PCI kerana pada masa itu PCI itu *percutaneous* ...

Dr. Ashim Kumer Nandy [Tung Shin]: *Percutaneous coronary intervention.*

Prof. Dr. Maznah binti Dahlui [PPUM]: *[Ketawa]* Apa dia?

Prof. Dr. Nazirah binti Hasnan [PPUM]: *[Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Maznah binti Dahlui [PPUM]: Ya, yang masukkan *stent* itu untuk jantung. Salur darah jantung tersumbat dan nak masukkan *stent* itu kita panggil proses itu PCI. Okey, semasa itu Institut Jantung Negara memohon kepada KKM untuk menaikkan tarif PCI. Contohnya daripada RM20,000 kepada RM40,000 tetapi Pengarah Kesihatan pada masa itu meminta saya membuatkan *costing* apakah sebenarnya kos PCI. Saya telah membandingkan lima hospital; Hospital Umum Sarawak, Hospital Sabah, Queen Elizabeth II; Institut Jantung Negara; PPUM dan juga Hospital Pulau Pinang. Kos dia lebih kurang sama antara RM11,000 hingga ke RM14,000. Pada masa itu, yang paling mahal adalah PPUM kerana *volume* kita kecil, pada masa itu. Sekarang ini kes *cardiac* kami adalah yang kedua tertinggi untuk kemasukan pesakit.

Jadi, *that is when* Kementerian Kesihatan *decided that the policy is that they no longer want to send PCI* kepada IJN. Mereka hantar kes-kes yang rumit seperti *valve, valve,* apa itu?

Prof. Dr. Nazirah binti Hasnan [PPUM]: *[Bercakap tanpa menggunakan pembesar suara]*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Valvular disease* ataupun *heart whatever open heart surgery and whatnot* tetapi *no more PCI.* Semenjak itu banyak *centre* di— *cardiac centre* di hospital-hospital KKM yang boleh melaksanakan PCI. *So, this is where it is very important for us to implement case-mix. So that we are very transparent what the cost is.* Akan tetapi *DRG cost* ini dia akan ambil kira juga hospital itu, dia punya hospitaliti itulah. Dia punya hospital mungkin hospital baharu, lobi dia ada *aircond*, itu semua akan diambil kira. *So, I...*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Dr., yang tadi yang perbandingan yang Dr. buat itu, yang perbandingan Dr. buat yang lima hospital itu tahun bila ya?

Prof. Dr. Maznah binti Dahlui [PPUM]: 2015. Boleh tengok banyak ada publikasi berkenaan dengan itu. Tajuknya PCI, cari nama saya. *[Ketawa]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Sikit lagi nak tanya. Hari itu di bentang oleh Menteri Kesihatan antara isu yang agak penting untuk kita laksanakan DRG ini ialah untuk sistem data, untuk *match* dengan semua ya. Maknanya *public health* dengan kita punya *private* ini. Jadi, bagaimana Prof. lihat dari segi perlu ada peraturan ataupun bagaimana untuk *data sharing* ini?

Prof. Dr. Maznah binti Dahlui [PPUM]: Hari itu mereka macam membuat percubaan ketersediaan setiap hospital untuk menghantar data *and I think they've already sent the data and then now they are analyzing.* Ada hospital yang daripada mesyuarat yang saya hadiri memang ada *feedback*-lah. Ada hospital yang masih tidak mahu menghantar data sepenuhnya *because they don't want to send the raw data,* mereka hantar *structured data. Structured data* ini *is like* berapa persen. *So this is— they're still negotiating*-lah. Sebab ini ada masalah sulit ya, *confidential* ataupun PDPA yang perlu di— *the data safety* untuk pesakit yang perlu dia— itu.

So, they are still negotiating on how it can be done-lah, *on how raw the data can be sent,* yang boleh memenuhi kedua-dua pihaklah. Cukup *raw* untuk di-*analyse*-lah.

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Tuan Sim Tze Tzin [Ahli PAC]: Okey Pengerusi, terima kasih. Saya ada tiga soalan, tapi saya tanya satu persatulah senang sikit ya.

First adalah okey, *private specialist*, mereka sebenarnya— mereka ada cadangkan— sebab untuk melaksanakan DRG, dia memang mengambil masa yang agak lamalah untuk laksanakan semua. *So, they actually suggested a value-based approach* dengan mengira ROI.

Itemised billing, tetapi *they put a cost to every machine, every medical device, then* untuk mereka mendapatkan *certain* ROI dan sebagainya. Tetapi— *and eventually, become a costing*. Itu cadangan *the specialists group that we met. What do you think about that?*

So, my question is very simple. Okay, we are quite— thank you for giving us lecture on DRG. Very good. Very good. I've learned a lot today. Cuma, kita kena fikir *is there any other things that is possible? Is there a more advanced than DRG in future that we should do it, okay? Is there a Malaysian way of doing things that we don't have to follow DRG?*

So, thinking out of the box. Is there another alternative? Itu yang soalan pertama saya. Terima kasih.

Prof. Dr. Maznah binti Dahlui [PPUM]: Sebenarnya DRG ini pun dia ada banyak *version* ya. Dia ada *case-based*, dia ada macam saya cakap tadi, *group-based. Case-based* ini dia lebih terperincilah, *which is more complicated* ataupun nanti— *we are dividing it into further* jadi *small, small cake,* lagi *more difficult*, sedangkan yang *grouping* ini lebih *easy because it is based on homogeneous resources that is being used for that particular group of diseases* untuk *treat*-lah.

Sebenarnya *there are various mechanism. Yes, I do understand* untuk *provider payment mechanism. Capitation, for example*. *Capitation* ini di mana kita tengok dalam *population* itu ada berapa juta orang dan dalam *population* itu *what is the prevalence of certain diseases.* Tapi untuk ini, kita akan *cover diseases* yang *common* sahaja, sedangkan banyak lagi *diseases* yang mungkin dia tak *common*, tetapi *quite significant in terms of impact on quality of life* dengan dia punya *mortality rate* tinggi.

So, this capitation sebenarnya, okey kerajaan peruntukkan untuk kawasan Gombak *for example, since I am from* Gombak. *So,* untuk kawasan Gombak ini kita bagi RM1 bilion okey, *for one year* untuk *you* jaga penduduk di kawasan itu.

So, all the health providers dekat situ, dia akan memastikan bahawa orang semua sihat supaya orang tak datang dekat hospital dia pakai duit RM1 bilion yang diberi itu, contohnyalah. *That is very crude*.

Maknanya, kalaulah saya diberi RM1 bilion untuk jaga satu juta penduduk, saya akan pastikan penduduk di kawasan saya itu sihat supaya mereka tidak datang ke hospital dan diberi rawatan kerana rawatan mahal. *So, that is capitation.*

Di beberapa negara dulu memang dilaksanakan *capitation*, tetapi itu pun *very difficult for the government to sustain* kerana dia bergantung kepada *tax money*.

Kerana mungkin tahun ini kita boleh bagi RM1 bilion, mungkin tahun depan *you* kena bagi *I* RM2 bilion kerana penduduk bertambah. Sebab semua penduduk semua sihat, dia hidup panjang, umur dia panjang. *So, chronic disease* ini memang susah nak elaklah, *so it cannot sustain*.

So, ada banyak lagi *mechanism*. Satu is yang saya cakap tadi, berdasarkan kepada *disease-based. Disease-based* ini ada *bundle* seperti DRG ataupun ada juga yang tak *bundle* seperti *case-based.* Ini dua yang paling *common*-lah. Sebenarnya ada banyak lagi *mechanism* lain yang digunakan untuk mengenakan pembayaran.

Di negara kita, mungkin kalau— *it's so difficult. For the last 30 years* sejak saya jadi HO lagi, dah cakap fasal nak laksanakan *social insurance* sampai saya dah bersara. Saya dah bersara dan dilantik semula pun tidak ada lagi dilaksanakan.

Mungkin sebab kita terlalu melihat kepada kita hendak laksanakan *100 percent*. Sebenarnya tak perlu ya, kita boleh buat sedikit secara kecil. Mungkin buat di Selangor dulu, *since* Selangor pun dah ada *social insurance* yang mereka laksanakan untuk *health screening. So,* laksanakan. Bila berjaya, kita *expand, expand, expand.*

For the sustainability, kita perlu gunakan insurans sebab kos yang kita bayar kepada KKM untuk rawatan ini makin besar. Kalau *100 percent* yang diberikan kepada KKM, cuma lima persen saja untuk preventif kalau untuk *public health*. *So, this is again*...

Tuan Sim Tze Tzin [Ahli PAC]: Kejap, kejap.

Prof. Dr. Maznah binti Dahlui [PPUM]: Pada masa ini memang kita ke arah *social health insurance* dan melaksanakan DRG.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih. Soalan kedua saya adalah 70 *percent of our hospital charges are on hospital supply and services (HSS) which is a very difficult to quantify— I mean* macam *glove,* macam-macamlah. *The…*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Consumables.*

Tuan Sim Tze Tzin [Ahli PAC]: *Consumables. So,* ini untuk kita laksanakan— *the biggest problem now* adalah kita bagaimana kita boleh *control the escalating price or control the price of HSS*, *the consumables.*

So, if we want to regulate this— sebab kita nak tunggu DRG, dia ada berapa tahun lagi. *So,* tapi sekarang *consumables* sudah naik tinggi. Jadi, bagaimana kerajaan boleh *regulate in this? Do you have any solutions to that?*

Prof. Dr. Maznah binti Dahlui [PPUM]: *Yes. One of it is pooled purchase. For example,* dalam KKM, memang *itemised*— kalau dia punya *itemised cost* untuk

setiap bahan itu murah kerana mereka beli *in bundle*. Contohnya, dia beli besarlah, dalam jumlah yang besar. *Even for the GP, pooled purchasing, pooled procurement*.

Berbalik kepada yang PCI tadi kan, kenapa IJN punya kos tidak mahal seperti yang kita *expected*, kerana mereka ada *pooled purchasing*. Mereka beli PCI itu banyak, sedangkan hospital KKM, mereka beli *by individual hospital* dan mengikut bilangan pesakit.

Especially kalau pesakit itu adalah pesakit *welfare*, mereka— *patient* memang tak payah bayar, tetapi mereka akan caj mahal kepada hospital itu ya. *So, pooled procurement is one of the mechanisms that we can use* seperti yang disarankan tadilah, *to bring down the cost.*

Tuan Sim Tze Tzin [Ahli PAC]: Cuma *problem*-nya adalah *private hospital* sekarang menggunakan *consumables* itu untuk mengaut keuntungan yang maksimum. *They maximise their profits through that because it is unregulated.*

So, if you want to regulate this so that it doesn't maximize excessive profiteering, how do we do that? Because there are so many consumables. Complicated. I was told that there are 58,000 different kinds of consumables. Ubat-ubatan, *whatever. So, how do we regulate this*?

Prof. Dr. Maznah binti Dahlui [PPUM]: Tetapi yang saya faham adalah lebih kepada kos *the operator*. *The bill of the clinician* itu*, the specialist* itu yang sebenarnya mahal, kan?

Tuan Sim Tze Tzin [Ahli PAC]: *Specialists are regulated. Doctors* punya *fees and* itu *schedule-regulated, Schedule 13.* Cuma yang *not regulated* adalah *consumables*.

Prof. Dr. Nazirah binti Hasnan [PPUM]: *I guess YB,* kita tak boleh nak komen jugalah tentang *you know, how the private hospitals are profiteering from this because we don't know that.* Satu. *But yes there is potential to do that. But to control the cost, I think it needs many ministries to look at this.*

It's not just MOH punya isu. *We have to look at transport, we have to look at other ministries as well because the cost* itu *is not just within— the problem is not just within Malaysia, but it's a global problem. We know that the cost of consumables, cost of drugs, the cost of equipment, it's all is a global concern.*

So, we can reduce the cost in our country if we take into account all the other compounding factors that affect the final cost of the items that we are discussing about. So, it's not just Ministry of Health problem, but you know, multiple ministries.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Pengerusi, saya nak tanya satu soalan ialah yang PPUM ini adalah *public and private*-lah, kerana PPUM ada *private wing* kan? *So*, saya nak tahu sama ada *private wing of this UH*, sampai sekarang *can maintain or not? Can survive or not?*

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And also, is your cost lower than some of the private hospitals like Pantai, Sunway and all that?

Prof. Dr. Nazirah binti Hasnan [PPUM]: *Cost or charge? You mean charge. The charges?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Yeah.*

Prof. Dr. Nazirah binti Hasnan [PPUM]: *Thank you very much for the question YB. So, PPUM is a public hospital.* Sebab ia di bawah Kementerian Pendidikan Tinggi dan menerima peruntukan daripada Kementerian Pendidikan Tinggi. *So, we get our OpEx and also our development fund from* Kementerian Pendidikan Tinggi.

UMSC di bawah UM adalah *the private hospital* yang ditubuhkan di bawah Universiti Malaya. *It is not a private wing of PPUM. So, whatever* keuntungan yang diperoleh oleh UMSC bukan diberi kepada PPUM. *So, it is a private hospital of its own* di bawah UM.

Tujuan penubuhan UMSC, semasa ia ditubuhkan *was one objective which was to retain talents in the university because it was seen that the specialists are leaving the university to the private hospitals. So,* bila ada UMSC ditubuhkan ia adalah bertujuan *to create an environment where the specialists are able to do private practice and therefore we are able to keep the specialist* di dalam universiti.

So, this has achieved its' objective, somewhat. Those who want to leave mereka masihlah— *they'd still leave but we are able to keep our specialist in the university because they are able to do private practice and they are able to get an extra income.*

However, over the years UMSC juga dilihat sebagai membantu dari beberapa aspek. Contohnya, UMSC sebahagian daripada keuntungan ataupun *salary* daripada pakar-pakar yang menjalankan *service* di UMSC dikenakan levi dan ini dimasukkan kepada tabung kebajikan pesakit. *So,* tabung kebajikan pesakit ini boleh membantu pesakit-pesakit yang datang ke PPUM. *So, because as you can imagine when the* pakar-pakar menjalankan tugasan di UMSC, *they are taking time-off from their work in the university as well as in the hospital. So, because of that there is*

some levy yang dikenakan. *So, that whatever they earn* ada dikenakan *some percentage that goes back* untuk *social cos,t which is to* tabung kebajikan pesakit.

So, that is satu *I think another added advantage* yang kita telah dapat dengan adanya UMSC dan *for UMSC* mereka tidak ada hospital sendiri lagi. *What they have is an outpatient complex and their outpatient complex is where the consultations are being done.* Akan tetapi perawatan seperti pembedahan, *the investigation procedures like endoscopy, cardiology services* dan juga *all the radiological investigations* dan *laboratory investigations, these are done in UMMC* di mana *the services are paid for.*

So, if you're asking whether it is sustainable— currently, in the current scenario, yes, it is sustainable because we have a win-win situation and also this goes back to the university sebagai pendapatan.

Prof. Dr. Maznah binti Dahlui [PPUM]: Di PPUM juga kita ada *as mentioned just now 20 percent of full-paying patients and the charges is still less than the private hospital.* Itu sebabnya ramai *foreigners,* pesakit-pesakit daripada luar negara yang menetap di Malaysia, mereka suka datang ke PPUM untuk mendapatkan rawatan kerana walaupun mereka bayar *from out of pocket is still cheaper* daripada mereka perlu bayar kepada *private hospital.*

Prof. Dr. Nazirah binti Hasnan [PPUM]: Maaf YB, *you ask also* sama ada caj di UMSC, adakah sama atau kurang daripada *private hospital* yang lain. *On the average* kurang sedikit daripada *private hospital* yang lain. *Although of course the consultants charge according to the fee schedule* yang telah ditetapkan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Alright,* terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *That means, let say I go to your "private wing", UMSC…*

Prof. Dr. Nazirah binti Hasnan [PPUM]: *Yes.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Let say I need to do surgery. As long as I pay, I can do. I can maybe stay single person ward, get better treatment.* Ini boleh?

Prof. Dr. Nazirah binti Hasnan [PPUM]: Betul YB. *So, if you go*— kalau pergi di UMSC *you can choose your rooms.* Lainlah daripada kalau datang ke UMMC *you are given four-bedded ward option.* Akan tetapi, *the quality of care and the service that you get is very comparable because the consultant that is treating you in UMSC are the consultants that are working in UMMC.*

So, the standard of care we ensure especially we bring the name of UM, the standard of care is the same between UMMC and UMSC.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Just now when you show us the* pendapatan dan perbelanjaan, *I find that last year you all have the deficit of RM200 million.*

Prof. Dr. Nazirah binti Hasnan [PPUM]: Betul.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *So, your* perbelanjaan *more than* pendapatan. *Then who pays for the deficit* itu?

Prof. Dr. Nazirah binti Hasnan [PPUM]: *So,* yang itu *YB, what we showed you is* peruntukan yang diberikan daripada Kementerian Pendidikan Tinggi, *which is RM400-over million.* Perbelanjaan kami adalah *more than that, more RM600-over million. So, the gap* yang ada itu adalah *so we have to generate our income to cover the differences.*

So, how do we generate our, how do we get our income? Two sources. One is from patient care. The other one is from non-patient care. So, patient care as I mentioned just now, 50 percent of our patients do not pay because they are federal government workers and also pensioners dan tanggungan.

20 percent, alhamdulillah, we— starting August 2023, we started charging the badan-badan berkanun dan juga kerajaan negeri dan juga kerajaan tempatan. *We are able to get reimbursement for— we are able to bill,* keluarkan bil.

Selebihnya 30 peratus *are people either they've got GL* daripada majikan ataupun *they paid out of pocket or they don't pay at all and this is the people* yang kalau B40 dan sebagainya kita ada *mechanism* kita yang tertentu di mana kita membantu mereka.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih, Dr. di atas penjelasan itu tadi. Terima kasih kepada pihak PPUM dan seterusnya kita pergi kepada pembentangan oleh pihak Hospital Tung Shin.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Boleh?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Nak minta izin untuk keluarkah? Okey, boleh tak ada masalah.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Okey, terima kasih YB semua bagi pihak PPUM, bagi pihak Universiti Malaya. *Insya-Allah* kita akan cuba bantu apa yang boleh. Sekiranya perlukan maklumat tambahan *feel free to contact us and we are happy to assist in whatever way we can.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Insya-Allah,* terima kasih.

Dato' Seri Ir. Dr. Noor Azuan bin Abu Osman [PPUM]: Terima kasih. Assalamualaikum.

Prof. Dr. Nazirah binti Hasnan [PPUM]: Terima kasih banyak semua.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, Hospital Tung Shin boleh terus mula. Siapa yang akan buat pembentangan? Datuk Ang Chin Tat sebagai Pengarah Hospital Tung Shin. Sebelum kita mulakan kalau dapat Datuk perkenalkan *team* daripada Hospital Tung Shin untuk mudahkan pihak PAC mengenal pasti. Boleh ambil tempat di depan pun boleh, tak ada masalah.

[Ahli-ahli berbincang sesama sendiri]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh ambil gambar dekat luar tak? Kita nak mulakan prosiding. Gangguan-gangguan.

[Ahli-ahli berbincang sesama sendiri]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Alright,* kita nak mula. Okey, saya persilakan Hospital Tung Sin.

Datuk Ang Chin Tat [Pengarah, Hospital Tung Shin]: Okey, selamat petang Pengerusi PAC, YB-YB. *So, good afternoon to everybody. Let me introduce my medical director on my right, Dr. Ashim. Then my COO on my left, Ms. Teng and my admin manager Mr. Chung.*

So, very interesting to be here because after 144 years that we are invited to the Parliament to brief the Members of Parliament on how Tung Shin operates as a non-profit organization.

■1340

Yeah, Tung Shin Hospital was established in 1881. Back then, our forefathers already knew that the cost of healthcare is going to be a burden to the rakyat*. So, but then back in 1881 that Tung Shin started as traditional Chinese medicine. So, only in 1950 that we started the Western medicine. So, in 1992, we set up an academy of nursing. Then the model of Tung Shin hospital, we run as a nonprofit organisation with a principle of creating affordable healthcare to the public. So, in Tung Shin Hospital, we do not have any shareholders, we are registered with ROS. We do not give any dividends; we do not have any salary to the board of council, there are a total of 24 elected council members and then we are allowed to appoint five more council members after the election.*

So, the board of council members have no salary and we do not have any benefit. We do not enjoy any discount on healthcare; we do not get any special privilege, or you know, special discount on anything, even medicine and things. So, council members are there basically as a philanthropy. They are there to make sure that Tung Shin continues to run the objective and principle of the association and also to make sure that the public is enjoying good healthcare.

We do have donations from a lot of public. So, some of our medical equipment are actually donated by the public. So, we do not actually have to— I mean not all the time. Sometimes, we do not have to fork out the money to buy any machinery. So, our machinery is actually sometimes paid by the donor.

So, just now I saw the slide that our PPUM professor had presented to us. One of the concerns of the— I would not say our organisation. Some of the private hospital charges and fees are also because of the supply chain, which actually causes the increase of healthcare. For example, the drugs that are supplied to the hospital, they have been increasing. I would say like— I would not say every year. It is like, it can be every month, you know. That I think have to be looked into it.

The things like a lot of generic drugs also available in the market but are not being used by a lot of hospitals. Currently, with the machinery cost has been increasing as well. But with the late you know the China— China has come out with a lot of machinery and they very, very cheap. They can be very, very cheap but it has to be properly monitored because these are all the costs that contribute to the healthcare cost as well.

So, in Tung Shin Hospital, surprisingly, we only have 30 percent insurance patients and 70 percent of our patients are cash-paying patients ya*. So, before I go further, we would like to show you a corporate video of Tung Shin Hospital. Thank you.*

[Tayangan video]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Sorry, because we all have the experience in hiding in Tung Shin Hospital during the Bersih rally. [Ketawa] But anyway, can I ask the first question,* Pengerusi*? Or are you going to present some more, right?*

Puan Teng Yu Yuet [Ketua Pegawai Operasi, Hospital Tung Shin]: *Sorry, we don't prepare the slide. We thought it would be just a Q&A or open dialogue. So, perhaps you can just ask us what are the things that you would like to know from us.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okey, I'm more interested in your model. It's a kind of a charitable kind of hospital and also for community service. Can survive so long? Or do you still need to like we raise fund for schools, still need to, every year go to get— knock at doors, ask people to give donation to the hospital.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *YB, for the fact that we are still surviving after 144 years means we have a very good model*-lah*. [Ketawa]*

Ya*, first of all, just to brief you a little bit more. I think back in 2018, Tung Shin all the while has been given a tax-exemption license. So, a lot of corporations, individuals actually donate money to Tung Shin. Actually— we do not actually have to run any charity event except one that we did was to have the cardiologist center, which we do the— you know just now the doctor talked about the stent, right. So, we have that once in 2016, if I'm not mistaken. That was to raise RM10 million. Back then, our Prime Minister of that time also donated RM3 million to Tung Shin Hospital. So, we managed to raise RM7 million and total money spent is actually for that particular ward.*

■1350

After 2018, sadly our tax exemption license was revoked. I think…

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara] Tax exemption license revoked?*

Datuk Ang Chin Tat [Hospital Tung Shin]: Ya, ya*. While you*— ya YB*, we didn't come to you.*

[Ketawa]

Beberapa Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *How about now? How about now?*

Datuk Ang Chin Tat [Hospital Tung Shin]: *We managed to get it back end of last year.*

Puan Kok Suh Sim [Naib Pengerusi PAC]: *Got it back-lah? Listen.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *Only last year, only last year we got it back ya. Back then we knew we had no tax exemptions and we were— but it was so difficult YB to tell you because once a policy is set, it's very difficult for us to get back. But Tung Shin Hospital we have a very good reason to take it back. To be honest with you, we actually threatened to sue LHDN for that.*

[Ketawa]

Ya, ya*, seriously but then after they looked into our case seriously and they think that we are doing a very good job and they gave back to us at the end of last year. And we actually make the announcement after that. I think in January during our AGM, we made an announcement and to let the public know that you know LHDN actually gave us back the tax exemption license* ya*.*

So, moving forward we are also planning to expand the hospital with the model that we have and we have donors actually willing to— I would not say sponsor us. Subsidising us. And I hope that maybe the Government of Malaysia can also do so. Ya, *YB.*

Dr. Hajah Halimah Ali [Ahli PAC]: Ya. *Okay, congratulations on your achievement. The basic question; how do you survive compared to private hospitals? You said basically with all the costs, operation costs and things like that escalating and how do you survive and how do you maintain your specialist, your doctors, your health personnel? Is it declining? Are you having a risk of losing them or what? So how do you maintain it?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Definitely not easy, YB. We, Tung Shin Hospital our modus operandi is we want to be affordable excellence and we are very careful during our pricing strategies to make sure that we are not charging high and it's affordable to our community, especially our* rakyat*. But at the same time, the costs are escalating. It is not only the supply cost, the drug cost; it is the salary. The pinching of— we have a nursing college, we have been producing our own, you know, nurses but it gets pinched very easily not only from local but overseas. So we have no choice but to match their salary in order to retain them.*

So, all these are the costs that come to us. To be honest, whatever that we learn or whatever income that we have, we have to make it sure that we are financially sustainable in terms of operations. We are lucky enough that we have donors to come in to help us in the capital expenses like getting the equipment and sometimes they were donated to us. But paying on the maintenance and also, you know, it's not easy. We are quite hand-tied actually over the years. So— but for the past three years especially we see the escalations of the cost.

So, we have no choice but also to look into areas that we have to increase our charges to the patient. But we are also very well aware that the patients who come to us are cash-paying patients. So, we have to more— you know, is kind of like you know, monitor and— because one thing good is that we do not need to pay dividends to our shareholders, we haven't got shareholders. So, we want to make

sure that, you know, we sustain and if we have the surplus, we will plough it back to our redevelopments. That's how we actually manage it.

Dr. Hajah Halimah Ali [Ahli PAC]: *What's your turnover for your specialist?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Specialist?*

Dr. Hajah Halimah Ali [Ahli PAC]: *Ya, because you're having all the machines. Maybe robots. Do you have robots and all that?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *We haven't got robots, we have the machine. Our doctors— the doctors that join us, they are independent contractors but they have been a nice bunch of doctors. They also share the same vision and core values with us. So, although you know they can actually charge all the way to the fees schedule but with the understanding that we ask, they are also willing to actually lower down in terms of their outpatient charges to the patient.*

For instance, you know, under the MMA Schedule they can charge all the way up to RM235 and we actually have capped it to RM200 for the first consult. The doctors are actually working quite closely with us in actually you know, providing these affordable services-lah. *Of course, of course…*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *We are*— Pengerusi… *[Ketawa]*

Puan Teng Yu Yuet [Hospital Tung Shin]: *We also have doctors that they would like to earn more and they come and then subsequently they also leave for other private hospitals.* Ya, *that.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Just want to add on a bit. At the selection level, we try to see the type of doctors we choose, whether they share the same values as us. I mean that is, you know, we tell them straight away that this is what it is and are you willing to sort of do a little philanthropy or a charity. And at the same time, maybe have a reasonable income. And those who choose to join us most of them fortunately— some'd leave, of course, but— are happy with whatever the numeration they get. Of course, it may not you know tally with the private hospital incomes.*

But sometimes, some do so well in numbers, the number of patients they see. They do reasonably well. Of course, again, sharing with the hospital philosophy of keeping costs down. But again, you know the doctor's bills are not the factor here that you know, contributes to the total bill of the hospital. The hospital bills are actually a challenge you know, to match. And fortunately, the three factors why we are able

to survive, your question, is what Datuk Ang had alluded to number one, the philanthropies that support the hospital.

Number two, yes, the government which supports us with tax exemption.

Number three, we don't work on the model of shareholders. So there's no shareholder dividends. So, for every ringgit a patient pays to a private hospital of the non-Tung Shin model actually has to consider a certain segment of that ringgit to be paying to the shareholder, to be paying the corporate tax and also, they don't depend too much on philanthropy. So, these are the three main factors how Tung Shin can still survive with a reasonable profit, which is again ploughed back to hospital operational expenditures.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Eh, Kubang Pasu *you off the mic.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You* mahu sambung?

Datuk Ali anak Biju [Ahli PAC]: *Hello, thank you Pengerusi. Okay, so far, we're having this PAC I think— how many? Seven* ya. *This is the first time we are having the PAC proceeding with a non-profit hospital. Yourself quite an alien to me the first time I heard it because there is no such thing as a non-profit, that is what I thought. Then you came out with your very good model; business model and social model. This is one of the directions that the country can go into. We are very interested to see in more detailed your business model. What is your income if there is any? The income, how you charge and how do you sustain.*

Just now you mentioned philanthropy, government and business model but maybe we want to hear more detailed about the financial part of it. How do you charge your patient compared to other private?

■1400

Is it cheaper? How much cheaper? So, that is the crux of the matter, because the cost of the patient, the charges.

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Across the board in general, it is about 30 percent less than— I mean case to case. Same apple to apple, orange if you compare with other more premium hospital…*

Puan Teng Yu Yuet [Hospital Tung Shin]: *20. [Bercakap tanpa menggunakan pembesar suara]*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *It's about 20 now.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *20. [Bercakap tanpa menggunakan pembesar suara]*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *25 percent less. So whenever patient comes to me, to ask me whether I should be treated here or not, I tell them, we work on a different model. It's cheaper, it's just like AirAsia or Malaysia Airlines system. We still get you there to where you want to go but at the lower fee without the frills and the luxury at times, but we will still get you there. So, the concept of affordable and quality healthcare remains.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *YB, you are invited to Tung Shin Hospital. We would love to show you around, seriously. Having said this, just to answer you a quick figure, right? How do we do it that? We make sure that cost of goods for every year is above 50 percent.*

Which means that if anything more than 50 percent, we are not making profit. We are like breaking even. Technically Tung Shin Hospital is running a minimum loss sometimes. Why? Because every year we do, we continue our charity events such as we provide free Chinese medicines for 60 and above. Every Thursday, YB anyone from your constituency that wants to get free consultation, tell them to come Tung Shin Hospital, we give for free.

We also go to— we also have mobile charity that go to six places every day. Every day we go to six places, we do free charity, providing free services, free consultation, free medication. These are all Chinese medicines, acupuncture, massage for the patients.

We target rural area and people who are poor and old. But sometimes, we can't prevent people that drive extras and come to do get the free things. We do all— this charity continue to run even though we are making loses but thank God we manage to break even almost for every year.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk Wira Pengerusi, terima kasih. *First of all, congratulations. I think you have done a very good job for Malaysia.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *Thank you.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *First, I would like to ask you about, I don't know whether it's a secret or not. What is your total expenditure in a year? Total expenditure, your overhead, all the rest. How much altogether in a year, Mr. Chung?*

Encik Chung King Keong [Pentadbir, Hospital Tung Shin]: *Just look at last year 2024, our total revenue for hospital is RM181 million.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Hundred…?*

Encik Chung King Keong [Hospital Tung Shin]: *RM181 million.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *RM181 million?*

Encik Chung King Keong [Hospital Tung Shin]: *RM181 million.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not much.*

Encik Chung King Keong [Hospital Tung Shin]: *RM181 million. So, in terms of the cost like that Datuk Ang share, we almost break even. So, in fact our cost in total is about RM180 million.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Your colleague already mentioned most of time, you break even.*

Encik Chung King Keong [Hospital Tung Shin]: *Yes, also…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *My next question is how are you compared to Assunta Hospital and another one, this is a very special hospital, Lam Wah Ee, Penang. How are you compared?*

Lam Wah Ee is another good hospital. People pay based on their income and all that. That is number two. Number three, what type of patients yang pergi sana? Macam kita boleh pergikah?

Puan Teng Yu Yuet [Hospital Tung Shin]: Boleh. *All are welcome.*

Encik Chung King Keong [Hospital Tung Shin]: *It's halal. [Ketawa]*

Puan Teng Yu Yuet [Hospital Tung Shin]: *It's halal. [Ketawa] I think Lam Wah Ee…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I am not talking about halal or not, I am talking about our income, we can go or not? I know your* ubat halal.

[Ketawa]

Puan Teng Yu Yuet [Hospital Tung Shin]: Ubat *all halal. Lam Wah Ee and Assunta Hospital, we are all under the same group, non-profit hospital.*

So actually, during that in 2018 when the tax exempt status got revoked, actually all the nine hospitals got revoked. All nine non-profit hospitals, their tax exempt status all got revoked…

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Including Assunta.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Including Assunta.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, that is my hospital. Five minutes from my house that's why I go there all the time, the last 30, 40 years.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *So, we are all non-profit hospitals. Our modus operandi might a bit different.*

For us, we actually subsidise across the board. Meaning if you're on a reduced-price model, we do it across the board. Whereas for Lam Wah Ee, I think because they also have quite a lot of foreign patient, so they have tiered pricing. So, that will benefit those Malaysian and foreign patients.

There will have different tiers. Assunta, I am not too sure, I think it's pretty much similar to us. They also have mobile clinics that are going around but more towards the Klang— within the Klang Valley.

So, our cost actually what that we— the supply cost has gone up a lot, that's one thing. Last year, we were badly hit by the electricity bills. There is an additional tariff that adds on. So, we actually of the same kind of usage, we need to pay additional 30 percent.

Puan Teresa Kok Suh Sim*: 50 percent? [Bercakap tanpa menggunakan pembesar suara]*

Puan Teng Yu Yuet [Hospital Tung Shin]: *30 percent. 30 percent higher. So, it was really huge. Hospital has to run 24/7. A lot of things you cannot switch it off. So, no matter how we want to conserve our energy, the cost is there. And also Tung Shin, our building is already close to 40 years and our chiller also a bit old, therefore the energy consumptions also higher.*

So, this are our challenges. So, we are merely actually— get any of margin at our bottom line. So, and then the other part that challenges us was the attrition rate of our nurses. Not able to achieve to retain them because some of them they even some— even people from Hong Kong and China they came all the way to actually get our nurses. They're willing…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Oh..

Puan Teng Yu Yuet [Hospital Tung Shin]: *Because when we train our nurses, they are all free. They have free tuition. They have tuition fee not— taken care of. Their accommodation, even their exams and all that, even given the allowances. So, these people they came through and they even want to buy over their bond before they graduated. That's how desperate they are for nurses.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I want to ask you another question. With the RM181 million expenditure…*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *How many doctors you have? How many nurses? How many patients gone to you per year? We want to compare with other hospital.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *We have 47 resident doctors and we have others, about another 30 sessionals. That means they'd come for just a few sessions.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *How many beds do you have?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *For our Western block, we have 159 beds. For our Chinese medicine block, we have 64 beds. So, all in all, we have about 222 beds.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The last one, Datuk Wira, just to share one very touching story.*

I mentioned Lam Wah Ee because it is a very touching story. I got my orang kampung *from Kedah, Yan. He went to this hospital Lam Wah Ee and then he checked and then before he got the result, he went back, not sure how much he was going to pay. And then on the way back, the doctor himself, the surgeon himself, heart specialist called him. "You come back to hospital now, if not you die." Because all* dia punya sudah *blocked. All the four* sudah *blocked. So, he just went back and then doctor said, "You must have the operation today."*

■1410

He says, "I cannot afford how much it will cost." "Don't worry you don't have money. You must worry about your heart first...".

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Wah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Imagine ya. And then he didn't pay anything. He went back, I mean after he discharged, when he was discharged, he went back and then one day they make an appointment with him in the* kampung *and then they went to see him, see the houses. See the house, check what he has in the house, ask for his income. His income is low*-lah, *below B40*-lah, *below B40. So, at the end they charged only about I think RM2,000. So, I helped him to give some and the rest he got himself. Fantastic. This is a really touching story.*

Puan Teng Yu Yuet [Hospital Tung Shin]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Sekarang dia sudah okey. Dia ini tanam jagung, dia tanam nanas, dia *very hardworking, farmer* ya. *Not his land but his* pajak *only*. *So, this is a very touching story about Lam Wah Ee. That is why I mention Lam Wah Ee.*

Puan Teng Yu Yuet [Hospital Tung Shin]: Ya. *Yes, yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But*— kalau kita pergi tak bolehlah. Kalau YB Sim pergi, lagi tak boleh.

[Ketawa]

Tuan Sim Tze Tzin [Ahli PAC]: Pergi juga. *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dia *charge*— dia *charge commercial cost.*

Tuan Sim Tze Tzin [Ahli PAC]: *Actually, I* pergi...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Fantastic.*

Dr. Hajah Halimah Ali [Ahli PAC]: Okey nak tanya Tung Shin. *What's your occupancy rate, the beds? Bed occupancy.* Ya.

Puan Teng Yu Yuet [Hospital Tung Shin]: *Our bed occupancy is about 50, 50 percent.*

Dr. Hajah Halimah Ali [Ahli PAC]: *50 percent.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *50 percent is not much* ya.

Puan Teng Yu Yuet [Hospital Tung Shin]: *It's not very high. Turnaround beds, our length of stay is about 3.5 days, four days.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *What is the average occupancy rate for— I mean for the other hospital? I mean do you know?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *I think normally it's about 60...*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *I mean for the private hospital.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *...60 to 65, that's about the norm. Because our calculation on the occupancy rate is at the midnight. So, now we have more of daycare patients. So, if we are taking that into consideration, we do at daytime we can hit about 60, 65 but nighttime it will come down to about 50.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *How many beds you have and also how many rooms, you know, hospital?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *We have 159 beds for the Western block and 64 beds for the Chinese block.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau boleh saya tanya. Okey, *we are trying to find out a solution to the rising cost of private hospital* ya. *And then like what I said part of the cost is these consumables. How do you control the escalating cost of consumables? How do you contain it?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Very hard to contain ya. Actually, I think most of the private hospitals, when they price their— they charge their consumables they also take into consideration of putting in some you know adding in some other— the hidden cost. Example, like they cannot charge the HEPA filter, they cannot charge the other things that cannot recognized by the insurance and all that ya. They actually cost it into the supplies. That is how that you can see that, you know, if you buy one piece of diapers outside is RM1 but why hospital charge RM3? Because they also consider, you know, all this hidden cost that they don't know where charge.*

Because our system right now is all itemised. So, if you put like example our clinical supplies, say, example when we buy the supplies. If the diapers, under the regulations your diapers cannot go into general waste. You have to go into clinical waste. So, for clinical waste, for one kilo of clinical waste they're going to charge us RM5.50. So, with the diapers and you know and all the heavy things you into that ya, we put there housekeeping charge to the insurance. They will say, "Take it off, you cannot charge that…". You cannot charge housekeeping; you cannot charge linen, but we have to send the linen for washing.

So, all these things that it becomes like, you know, some hospitals they even think, "Okey, if we can't charge all this, I go for disposable.". So, single-use then you itemise, they can charge. You see? That's why the cost goes up. So, there is a ripple effect of a lot of things.

So, when we want to regulate, it may not be as easy as that. So, if let say you don't charge all this, your operating cost you do not know where to cover. If we want to charge, like for us Tung Shin we also consider, okay diapers it's unreasonable for us to charge RM3. But then again, we think about how we're going to cover all the other cost. So, the markup of the supplies usually will be much higher compared to what they can buy from retail. So, sometimes in the compassionate ground we tell for our long-term patients, we say, "Okeylah, you buy from outside-lah…". But then,

you know, there will be— we don't make any money from the diapers-lah*, but they, you know, allow them to buy outside.*

But most of the private hospitals, their operating cost, I can understand their operating so it can be high and definitely there to be somewhere that they need to absorb this kind of cost. Unless in insurance or the— when we talk about transparency, we allow that kind of transparency. Otherwise handling just clinical medical supplies and the clinical waste and the whole chain of managing to ensure the patient's safety, all require cost.

So, you know like our microbial test we cannot charge anybody. Our microbial test, our air sampling and all those things we cannot charge. Where to charge? But all those are costly. All those things are very costly. So, maintenance, PPM and all that they are all very costly. So, therefore in the medical supplies, that is one thing that most of the hospitals will have higher charges. That one is inevitable.

And another thing is that, you know, like what just now Prof. was saying, the suppliers are actually giving tiered pricing on the volume, it's a volume game. If you can actually have a bulk purchase, you have a bundled purchase, you will get a less price. But, example like Tung Shin ya, we being a standalone, who are we going to kongsi *to buy? We cannot* kongsi *to buy also. So, we* kongsi *to buy then auditor going to question us how come your bill is like this? We can't do it. So, single unit hospital usually the cost will escalate much faster compared to the chain hospital.*

They have a central purchase; they can actually get a much lower cost. Unless the regulations start from the upstream, start from the supplier, start from the drugs and then from there downwards. I think it would be better if they can give us non-profit hospital a different rate. [Ketawa]

Tuan Sim Tze Tzin [Ahli PAC]: *Ya.*

Datuk Ang Chin Tat [Hospital Tung Shin]: Yang Berhormat *to answer your question in short ya. We can't control the consumer product, how we control is because we are non-profit organization, so we do not add extra profit into it. So, whatever comes in, let's say if today with my RM1, tomorrow they decide RM1.10, we don't make profit anyway. So, our price in the hospital bill would not add into the profit. You are right, other hospital what Ms. Teng is trying to explain to you that other hospitals they definitely have profit, they were adding— let's say if they want to sell 30 percent more expensive, that is where the profit is.*

So, for us is because we are non-profit organization, so we don't make profit. So, we always keep our cost low because if Tung Shin Hospital buying the diaper,

our price is always like nonprofit, other hospitals would always increase. So, other hospitals buying at RM1.10 they increase a 30 percent, ours still don't increase 30 percent. [Dicelah] We can't control the consumer, only the policy can control the supply chain. We can't control them.

Tuan Sim Tze Tzin [Ahli PAC]: *Okey. I want to ask subsequent questions. Okey. See, let's say we treat one say appendix*-lah ya. *Maybe Tung Shin Hospital treats RM10,000 okey. How about private hospital? Because I want to benchmark because you— number one, you don't pay tax, so that's about 25 percent corporate tax. And then your shareholder dividend maybe another five, 10 percent or…*

Seorang Ahli: *No shareholders.*

Tuan Sim Tze Tzin [Ahli PAC]: *I know. Because I am comparing private hospitals— we are trying to find a model.*

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So, I want to see how much you are cheaper than a private hospital, comparing, say, appendix? How many percent?

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *[Ketawa] Perhaps I am the right person because I do have sessional practice in Pantai Hospital as well, Pantai Bangsar. I do appendectomy operations as well. So, in Tung Shin, for the same way of doing the appendectomy operation for the same risks, the cost in Tung Shin comes to— varies between RM10,000 to RM12,000. In Pantai, it's about RM16,000, RM17,000, RM18,000 or up to RM20,000. That's the difference. So, you have a gap of about RM5,000 to RM6,000 discrepancy there*-lah.

Tuan Sim Tze Tzin [Ahli PAC]: *50 percent different?*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *About 50 percent?*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *This is for appendix. Uncomplicated, two days stay.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, we talk about their 25 percent corporate tax. I mean, back on— on the back-of-the-envelope calculation, 25 percent corporate tax, they still have a 25 percent margin, right? Am I right?*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Yes., yes, yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Out of that 50 percent extra that they charged. Thank you.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: Ya.

Dr. Hajah Halimah Ali [Ahli PAC]: Boleh tak saya tanya *[Tidak jelas] insurance companies— patients with insurance, how many are using in Tung Shin?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *30 percent.*

Dr. Hajah Halimah Ali [Ahli PAC]: *30 percent? What kind of insurance companies are covering?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *All.*

Dr. Hajah Halimah Ali [Ahli PAC]: *All?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *It's the same. It's the same as other private hospitals.*

Dr. Hajah Halimah Ali [Ahli PAC]: *I think they love you better. [Ketawa]*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Because they love us,* ya.

Dr. Hajah Halimah Ali [Ahli PAC]: *Isn't it?*

Puan Teng Yu Yuet [Hospital Tung Shin]: Ya. *But their patients were saying they don't like us because they say your facilities are like a government hospital.*

[Ketawa]

Dr. Hajah Halimah Ali [Ahli PAC]: *You have aircon*-lah*?*

Puan Teng Yu Yuet [Hospital Tung Shin]: Ada, ada, ada. *[Ketawa]*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Most of the insured patients are actually in the middle age, younger age group. So, we do tend to treat the older demographics. The older patients with no insurance coverage. Okay. So, the newer, you know, the younger let's say 20s, 40s, 50s, those who have insurance coverage, they— those who come to Tung Shin actually come to see the doctors they like. So, we draw the patients because we have treated their relative or word of mouth or whatever, not by word— not by just walk-in kind of things. They do come to the hospital yes, and then they look for the particular doctor. So, that's how we get 30 percent of the insured patients. Cash-paying patients, of course, they will just walk in, just walk in.*

Whereas you've got insurance, and you have never been to Tung Shin or you never heard of doctors in Tung Shin, they will say okay, down the road is Sunway Velocity, I'll go there because you know, it's brand new, it looks five stars, premium and all that. So, those who come to Tung Shin with insurance usually do not mind the lack of you know, luxury and frills that the other hospitals provide. They don't mind because they come in to see the doctor to get treated and that's it. So, that's why we are 30 percent compared to other hospitals, insured patients are about 70 percent. The other way around, 70 percent or 80 percent insured, 20 percent out-of-pocket.

The out-of-pocket in the other private hospitals are the, you know, deep pockets. [Ketawa] Our out-of-pocket, not so.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Pengerusi ya, *I want to ask you know, I know that you have this TCM wing and also this Western medicine wing. So, when you say your revenue of last year was RM181 million, do you include the TCM revenues? Yes, right?*

I also believe the TCM section, they are more profitable compared to the Western one because TCM they just use acupuncture, you know, all this. You don't need all this very complex treatment and so on. Also, I always see a lot of these people are waiting for acupuncture and also consultation with the TCM doctors. Also, I was told that these TCM doctors actually, their salary, their income is very high one, right. Because some of them are from China, they are already experts in certain fields. So, maybe you can elaborate a bit, you know, about your payment, your gaji *to the TCM doctors and also the Western medicine doctors.*

Datuk Ang Chin Tat [Hospital Tung Shin]: *Okay, YB. I answer first before my Admin Manager which is also the Operation Manager for Chinese medicine. Our policy is that our TCM is supposed to be charity. Just now, I told you that we do charity a lot for TCM. Every day, we have mobile clinic to go everywhere. We go Tanjong Karang, we go Batang Kali, we go to Cheras Batu 9, we go to a lot— I mean far away and mostly are more what they're called, villages places. So, all free. Every Thursday, after 2 pm, all are free regardless how many people come in. I give you an example, you do acupuncture in Tung Shin Hospital, you get 100 needles, it's only RM36. So, it's not for the profit.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I paid RM70*-lah.

Datuk Ang Chin Tat [Hospital Tung Shin]: *You paid RM70 because they may have given… [Dicelah] So, your registration is maybe about RM30*-lah*, plus RM36.*

[Ketawa]

It's your first time there, YB?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *No, I have been there few times already and it's Chinese national, that doctor.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *I think with the…*

Datuk Ang Chin Tat [Hospital Tung Shin]: *That's the normally just acupuncture, right? Our locals are— we have two categories, two tiers. One is local Chinese practitioners; one is foreign practitioners which is the Chinese doctors*-lah.

The Chinese doctors we charge RM36 or RM38, Mr. Chung? Then, the local one is only RM20-something, less than RM30. But the registration fee, if first time we charge RM30. But if it's a repeating patient, we only charge RM2 per session. So, it's very cheap. It's very cheap.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm just wondering what type of sickness that you can go to this Chinese medicine?*

Datuk Ang Chin Tat [Hospital Tung Shin]: *For acupunctures, for acupunctures, any kind of patients. But mostly, acupuncture is for stroke patients after they got stroke. I always advise friends and people that ask me after they got stroke, I say you better get clearance from the Western doctors first before you come to acupunctures. Somehow, acupuncture does help to improvise your nerve system and your movement. But for other treatment, we have— our Chinese medicines are quite specialised. We have for women, for skin specialists, we have cancer patients. Cancer patients, it's not to cure you, don't get me wrong.*

Cancer patients it's for people who have been treated by Western doctors who want to recuperate their body, they come to have the Chinese herbs medicine. Most, a lot— the most popular doctors are doctors that actually do the, you know, we call the [Tidak jelas] doctors, there are oncologists. We have this specialist. Also, our internal medicine doctors also very popular. People like after COVID— after COVID, people who have a long cough, they're still trying to get back to their normal way, right. So, they will come to Tung Shin Hospital to see our internal medicine.

For your information, our herbs are all selected by our specialist herbalist which is specially employed to make sure that the herbs are genuine, not fake. We, board of directors, sometimes go to China to meet the supplier. Our trips to China, our hotels are all paid by myself, ourselves, not by the hospital. Hospital doesn't pay for us at all. We basically pay everything ourselves.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Herbs are only from China or you also have herbs from Malaysia?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Many from China.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Mostly from China* ya*?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Mostly from China. We have 500-over types, from China. Herbs.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I want to ask about this stroke person. What is the success rate like? I mean if somebody has stroke.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Stroke— Chinese medicine is many on the stroke rehab. Meaning, they have passed the acute stroke phase and get treated by the doctors, stabilised and they come to our TCM unit and they will do the stroke rehab. Stroke rehab usually would have the acupuncture together with the physiotherapy and occupational therapy combined. The integrated kind of treatment, that helps them to actually regain the strength.*

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So, not every post-stroke patient would be able to actually get that. It's really looking at the severity of the damage that has already incurred after the stroke. So, that's why all the patients going to our TCM side are usually being properly assessed by our Western physicians before they get into that…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, combination.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *So, there's a combination of both.*

Dr. Ashim Kumer Nandy [Hospital Tung Shin]: *Just to add on. Stroke rehabilitation that means after the acute episode of stroke and then to make them recover faster, acupuncture therapy is actually accepted worldwide now in Western medicine, all over the world, from Mayo Clinic to European clinics everywhere. Acupuncture is actually adjunct, an additional treatment and there are various, a lot of reports and very strong evidence that it is effective for stroke recovery if done in combination with Western physiotherapy and occupational therapy to get the combined— in the right setting*-lah ya.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi...

Datuk Ang Chin Tat [Hospital Tung Shin]: *YB Teresa, I just want to answer your question again, the TCM contributes 20 percent of our total revenue. It is only 20 percent. And the 20 percent— to answer the question that the 20 percent of revenue we barely make a little bit only. Our TCM again, I should tell you that it's a lot it's on charity. But if we really count it properly right, we may be even losing money because the management shares the same— we share the same management. We share the same building. The cost we don't know how to separate between the Western and the Chinese.*

So, there's a lot of things that actually, we try to maximize the expenses for the Chinese medicine. But then even that we barely make a little bit. I mean you are

welcome to— we can show you a bit more about how we operate in Tung Shin Hospital.

Tuan Sim Tze Tzin [Ahli PAC]: Yang Berhormat Pengerusi.

Dr. Hajah Halimah Ali [Ahli PAC]: *About Western medicine, how is your relationship with* Kementerian Kesihatan *about JCI and accreditation and all that? So how is Tung Shin?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *We work very closely with CKAPS of* Kementerian Kesihatan. *They just came actually last week. We are also accredited by the MSQH. We are going into our third cycle already.*

So, the Malaysian Society for Quality in Health (MSQH) standard is already very much at par with JCI. And for us Tung Shin, we are not targeting on foreign patients. So, we are not going for JCI. JCI is very, very costly. Just register for it, it actually costs a few hundred. Even when— if we want MSQH come and audit us, we need to pay RM108,000 for the accreditation. RM108,000 for accreditation.

Why do we want to go for that? Because we want to benchmark against all the hospitals in terms of quality. MSQH standards are very good. They are actually— so that we can actually have a benchmark to ensure that our quality of care is up to mark. So, we are MSQH-accredited.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *last question maybe. Okay, we are trying to look at a model that is not— that is affordable for Malaysians. That's why we asked Tung Shin to come. We asked PPUM to come. But PPUM is subsidized by the government. Tung Shin is actually considered— not to say you're subsidized; you are not profit-making at all. You are a charity.*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Self-funded, self-funded.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, self-funded. Can you suggest to us one hospital or a few hospitals that are actually generating profit? Profit I would say private hospitals, they will pay tax, they will pay— they will generate some profit for the shareholders or whatever but still cheaper than the chain so far. Do you have that kind of— from what I understand, one of it I can remember is CMH, the Chinese Maternity Hospital from Seremban. That's one model. But do you have any model that is in Klang Valley that's worth exploring for us?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *Actually, a lot of private hospitals, they are quite secret about their P&L. We are not quite sure. The other one that— that's how they're actually branding themselves. We really do not know how the actual modus operandi.*

The other one is actually Beacon that you want to consider because they do actually brand themselves to be a community hospital and they are— doing a lot of CSR for cancer treatment. So, maybe— but now they are also being bought over by the big chain. So, it is under Malaysian, Asia OneHealthcare already. So, under Columbia Group.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Just now you are saying about the accredited MSQH? Can you?*

Puan Teng Yu Yuet [Hospital Tung Shin]: MSQH.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: MSQH. *How about the JCI, can you?*

Puan Teng Yu Yuet [Hospital Tung Shin]: *JCI is actually Joint Commission International. That is a standard set by the US. A lot of hospitals will go for JCI because they want to attract foreign patients. Most of foreign patients and foreign insurance, they will look for this JCI-accredited hospital. So, usually, they would go for those accreditations, if they want international patients. For us, we just want to make sure our standard of care gets benchmarked and we are up to the standard. So, we go for MSQH. We were told actually the MSQH Standards are also at par with the JCI.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Thank you. So, it's already 2.37.* Saya ucapkan terima kasih di atas penjelasan. Sangat gembira sebab dengan kehadiran hospital yang lebih 100 tahun ke prosiding PAC dan juga memberikan sedikit perkongsian. Syabas dan tahniah di atas apa juga yang telah pun dilakukan untuk membantu lebih ramai lagi rakyat Malaysia mendapatkan rawatan yang terbaik.

Sekali lagi PAC mengucapkan terima kasih kepada Dr. Ashim Kumer Nandy, Pengarah Perubatan. Datuk Ang Chin Tat, Pengarah. Teng Yu Yuet, Ketua Pengarah Operasi dan juga Chung King Keong, Pentadbir Hospital Tung Shin. Kita tangguhkan pada jam 2.38. Terima kasih.

[Mesyuarat ditangguhkan pada jam 2.38 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Selasa, 17 Jun 2025

Bil. 5(l) 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan dan Caj Hospital Swasta serta Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

Association of Private Hospitals Malaysia(APHM)

(i) YBrs. Dr Tan Hui Ling,
Board Member APHM
(Association of Private Hospitals Malaysia)

(ii) YBrs. Mr Chin Keat Chyuan,
Naib Presiden APHM

(iii) Encik Anwar Anis bin Anis Ahmad,
Setiausaha Kehormat (APHM)

(iv) Encik Stanley Lam Kean Fatt,
APHM Board Member (APHM)

(v) Puan Erica Lam,
Bendahari (APHM)

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

SELASA, 17 JUN 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]

Tidak Hadir *(Dengan Maaf)*

YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Datuk Ali anak Biju [Saratok]
YB. Puan Vivian Wong Shir Yee [Sandakan]

URUS SETIA

Encik Mohd Sukri bin Busro [Ketua Penolong Setiausaha (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar Binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Farah binti Mohamed Rafiee (Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam (JPA)
Encik Ahmad Azhan bin Mohd Noh [Timbalan Pengarah Kanan (VU7)]

Kementerian Kewangan Malaysia (MoF)
Mohd Saiful Sungkih bin Abdullah [Timbalan SUB (Bahagian Pelaburan Strategik)]
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik Dan Korporat)]
Encik Ahmad Deedat bin Abdul Hamid [Sekretariat Gear Up (GEAR-uP, KSP Office)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Puan Azuraimi binti Ahmad [Penolong Pesuruhjaya (Bahagian Penyiasatan Tatakelola)]
Encik Mohd Zaidi bin Zainal [Penguasa (Bahagian Penyiasatan Tatakelola)]
PKPj. Premraj a/l Isaac Dawson Martin Victor [Pegawai Penyiasat SPRM (Bahagian Siasatan)]

Kementerian Ekonomi (KE)
Puan Noor Diana Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah Bahagian Perkhidmatan Sosial (Bahagian Perkhidmatan Sosial)]

Jabatan Akauntan Negara (JANM)
Encik Mohd Nizrulizham Bin Jamaludin [Akauntan WA12 (BPOPA)]

HADIR BERSAMA

SAKSI

Association of Private Hospitals Malaysia (APHM)]
YBrs. Dr Tan Hui Ling [Board Member APHM (Association of Private Hospitals Malaysia (APHM)]
YBrs. Mr Chin Keat Chyuan [Naib Presiden (APHM)]
Encik Anwar Anis bin Anis Ahmad [Setiausaha Kehormat (APHM BOARD)]
Encik Stanley Lam Kean Fatt [APHM Board Member (APHM)]
Puan Erica Lam [Bendahari (APHM)]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

SELASA, 17 JUN 2025

Mesyuarat dimulakan pada pukul 10.05 pagi

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin mempengerusikan Mesyuarat]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh.* Salam sejahtera dan juga selamat datang saya ucapkan kepada semua Yang Berhormat Ahli-ahli PAC Parlimen Ke-15; ahli-ahli ex-officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga pegawai Penasihat Undang-undang Parlimen Malaysia.

Ahli Yang Berhormat mesyuarat sekalian, pagi ini PAC kita akan mendengar keterangan dan juga penjelasan berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan juga Bank Negara Malaysia. Jadi, ini adalah merupakan prosiding kita yang ke-12. Sebagaimana semua sedia maklum isu ini tidak dilaporkan di dalam Laporan Ketua Audit Negara. PAC menggunakan punca kuasa di bawah peraturan 77(1)(d), Peraturan Mesyuarat 83(2), Arahan Perbendaharaan 301 (Pindaan) 2023 dan juga seksyen 5(3)(d) Pekeliling Am 1.

Yang Berhormat ahli mesyuarat sekalian hari ini hadir dan sama-sama memberikan komitmen dan juga untuk memberikan penjelasan di hadapan PAC pada hari ini yang pertamanya Yang Berusaha Dr Tan Hui Ling, Ahli Lembaga Pengarah Persatuan Hospital Swasta (APHM). Yang Berusaha Tuan Stanley Lam Kean Fatt, Ahli Lembaga Pengarah APHM. Yang Berusaha Tuan Anwar Anis bin Anis Ahmad, Setiausaha Kehormat APHM. Yang Berusaha Tuan Chin Keat Chyuan, Naib Presiden APHM.

Terima kasih saya ucapkan kepada semua yang dapat hadir di hadapan PAC bagi memberikan penjelasan pada hari ini. Semua ada yang tak dapat saya nak sebut nama dan juga turut hadir pada pagi ini. Sebelum saya menjemput saksi untuk memberikan pembentangan pada hari ini, ingin saya maklumkan bahawa prosiding

PAC ini adalah tertakluk pada Akta Rahsia Rasmi 1972 [*Akta 88*] dan juga Peraturan Mesyuarat 85 sehingga habis prosiding selesai dan juga laporan ini dibentangkan di Dewan Rakyat. Jadi tanpa membuang masa, saya difahamkan pihak APHM ada taklimat tambahan untuk dibentangkan kepada PAC. Dengan ini saya mempersilakan, terima kasih.

Mr Chin Keat Chyuan (Naib Presiden APHM): Terima kasih YB. Selamat pagi diucapkan kepada YB-YB, tuan-tuan dan puan-puan, saudara dan saudari sekalian. Bagi pihak Persatuan Hospital Swasta Malaysia or *Association for Private Hospital Malaysia* nama saya Chin ya. Saya ialah Naib Presiden APHM. Ingin saya merakamkan setinggi-tinggi penghargaan dan terima kasih kepada YB Datuk Wira Mas Ermieyati binti Samsudin, Pengerusi Jawatankuasa Kira-kira Wang Negara *or* PAC merangkap Ahli Parlimen Masjid Tanah atas jemputan kepada APHM untuk mengadakan prosiding bersama dengan Ahli-ahli PAC pada hari ini.

Now, terutamanya izinkan saya memohon maaf kerana Presiden APHM Datuk Dr. Kuljit tidak dapat hadir hari ini disebabkan komitmen yang tidak dapat dielakkan. Beliau sekarang berada di *Glasgow* dekat UK tapi dia *send his apologies and regards*. Kami memahami bahawa objektif mesyuarat hari ini adalah untuk hospital swasta berkongsi permintaan dan saranan berkaitan inflasi kos perubatan serta pendirian kami kepada PAC bagi laporan PAC kepada Parlimen.

Justeru itu, kami amat menghargai peluang untuk pagi ini ya untuk berkongsi pandangan kami berkenaan pelbagai isu penting dalam sektor perubatan swasta khususnya yang berkaitan dengan inflasi, kos perubatan, inisiatif kerajaan serta perkembangan dalam tempoh dua bulan kebelakangan ini. Oleh kerana ini, satu peluang yang berharga ya untuk dialog yang membina— kami pihak APHM memang berharap dapat bekerjasama *closely* dengan PAC untuk menangani cabaran serta mencapai jalan penyelesaian yang mampan untuk sistem penjagaan kesihatan di Malaysia.

Now, saya ingin juga untuk sekarang menyerahkan sesi pembentangan ini kepada Encik Anwar Anis, Setiausaha Kehormat APHM untuk menyambungkan pembentangan selanjutnya. Sekian. *Over to you Encik Anwar. Thank you.*

■1010

Encik Anwar Anis bin Anis Ahmad [Setiausaha Kehormat APHM]: *Bismillahi Rahmani Rahim. Assalamualaikum and very good morning to everyone.* Pertama sekali Yang Berhormat Mas, saya minta izin untuk meneruskan pembentangan saya dalam bahasa Inggeris*. Next slide, okey.*

Jadi pertama sekali agenda kita untuk pagi ini*, agenda we have out line five item. I think in line with this our second presentation to PAC, we want to update PAC on some of further findings that we have gathered on key cost drivers, our eight commitments. So, since the last time we presented to PAC, APHM has outlined eight commitments to share with various parties, so we would like to update PAC on it and update on what is the latest DRG in terms of APHM improvement, initiatives APHM has been going through and contributed to the government in 2025 as well as APHM's requests on tricky areas to the PAC for its attention.*

Next slide. Maybe as a summary, esteemed PAC members, we would like to just put out some statistics here to recap in terms of key cost drivers in private health care. So firstly, on the slide look at it on the left hand side, in terms of population growth. If you look at from 2020 to 2024, that has been quite organic and about five percent. However, what is key, is within that same period, the aging of our population, is certainly at double rate. So that 10 percent of our population has now become more than 65 years old and that has key impact on the demand for health care, right and also the rise in NCDs.

So, this is one key point that we need to consider the fact that while population growth overall has been quite organic at five but as we are an aging society, significant proportion of our population has become above 65, at double the rate of population growth. In the middle of the slide really is just to recap on GDP growth. I think this one I'm sure the PAC members all were aware but part of that as well is the medically insured. So, I think post pandemik mungkin lebih ramai rakyat*, a lot more people aware of the need to have health insurance.*

So that the significant growth in the number of people was medically insured as part of the population that 105 percent increase and this is DOSM statistics and a couple of other parties including LIAM Statistics and the last headend if you look at the fact that aging population, NCD and a growth in medically insured we do see that the inpatient admission numbers has certainly increased and we broke this down between public and private hospitals and if we look between 2023 and 2024 the inpatient admission in private has increased about 4 percent while the number of beds has increased by just 3 percent.

So, this is DOSM stats. From Roland Berger, presented actually at the recent APHM conferences as well. But that shows there's increased demand in health care and not just admissions and all that as well, basically in terms of outpatient treatment as well.

Next slide. Next, esteemed members of the PAC, allow me to outline the eight measures that were put out by APHM where we also have put it out as a press

release, also shared it with Bank Negara and others. One, firstly is to establish a working committee to review billing structure and fair pricing and I think during our first presentation to PAC, we try to explain and you can go back to those materials and look at the fact that we have to charge certain things perhaps perceived as being a lot higher because there are a lot of thing we cannot charge in our bill and because of that, we can use the term 'cross subsidization'.

So we do think again we need a working committee to review our billing structure. So that, the public regulator, anybody else can appreciate that we charge for the right item in the right place. Simple example really is just room rates where those have remained, I think I mentioned the last time, you know, 20 years ago, when you buy insurance RM200 still remain RM200 and because of that the gloves, medication, all that has to carry far heavier burden in terms of the billing and cost recovery in the hospital.

And for this, really need to collaborate with insurances, ITOs to create a fair pricing model especially on drugs and supplies, balancing that with affordability procurement and other costs as well. But this we really need government support, we need PAC support because somebody has to sit down between the hospitals and the insurance and payers to say okey, this needs to happen and how it needs to happen, timeline and so on.

Number two is to establish industry communication work group. We believe that what had been happening these past six, seven months will have an impact as to the nation as a whole. If the public sees that private hospitals and insurers are fighting each other, saying things against each other. We heard from certain insurers that there's number of new policy has dropped. So, if new policy sales are dropping, what that means, people will be shifting to public health care.

So, if people feel I cannot trust the insurer, I cannot trust the hospital, don't want to buy insurance, I'm not going to the private health care, I will end up in public. We can try to avoid these issues because otherwise the burden will shift to the government.

So, to develop this strategy again, we do need a third party to come in and guide us and push us along, so that we can work together. So, I think hospitals should really work together with public education to help policy holders make firm decisions on health care, understand that when they buy medical insurance, they don't have to buy a lot of other riders and so on, so that medical insurance remains affordable because we understand for the agents, obviously, when they sell insurance, lebih banyak saya jual, lebih banyak komisen saya*.* Tapi mereka tak faham *yang health insurance* itu sebenarnya *can be quite affordable.* Tak perlu nak beli *rider* yang

banyak*. So, some of this communication we need to work together between ITOs and hospitals, with assistance from the government and hopefully the PAC can support us.*

Thirdly, to form an independent health care cost and reimbursement committee. This is really to oversee fair pricing reimbursement, regular review of premiums and reimbursement structure. So, Bank Negara measures, we understand the three years actually will end somewhere next year. So that's quite fast right? Because three years will come up which means by next year, by middle of next year, we need to have all these things in place. Otherwise, we don't know what will happen after the three-year moratorium.

So, if you have an independent committee, which we certainly want to be part of and contribute, we can align with actual health care cost, market conditions and how much reimbursement so that insurers and us have further recommendations that delve deeper into this.

Number four, is to improve transparency of health claim volume and cost and again we do have more detailed explanation of this later. But this is to enable the industry really to discuss how much of premium are being paid to hospitasl, how much is actually going to for acquisation cost, right.

So, to sell insurance, to understand before the buying insurance their cost as well and how much the admin cost. So, while hospital are very transparent in terms of what their cost is, we do not know when you buy insurance and how much of it is actually going to pay their health care, how much is going for acquisition of the policy, that means to the agency force and so on and how much the admin cost for example other countries where they clearly say for example that when you buy health insurance as a whole, 75, 80, 85 percent must be paid back to health care providers and that kind of transparency certainly helps Malaysia as well. So those are the four, I'll proceed to the other four commitments and initiatives that are outlined.

Number five is we strongly encourage the establishment of a national medico-legal committee. I think we explained before that we see a huge burden in terms of health care legal cost and suits even involving government and then also encouraging defensive medicine. So, if we talk about and we touch on this, we talk about MHIT product and we going to use Clinical Practice Guideline (CPG) from MOH to be able to provide those product in more stream lined, standardized manner.

Doctors must be able to defend themselves, that say I've followed the CPG and if somebody decides to sue the doctor, or the doctors that were involved, there is some protection for them. This is impacting not just private health care but I'm sure the PAC members are aware that the government pay out the medical negligent suit,

so also increasing dramatically and again we are prepared to come in and spend time with the government, the PAC, and establish,, a national medico-legal committee, we can look at transformation for our medical legal system.

■1020

Number six is to review and adopt recommendations on reducing healthcare regulatory burden. Many of us in the private healthcare through APHM have spent years through MPC and another bodies to really provide recommendations that have been outlined in formal recommendations to the Ministry of Health on reducing healthcare burden and regulatory burden.

And we believe, this cost, if we can contain this cost, we can certainly then look at reducing operating cost and being far more efficient and making sure that we can contain medical inflation.

So, well, self-regulation is perhaps a few years down the line, we really need assistance to look at the recommendations that have been prepared formally through a government agency, with the assistance of the government through MPC and this includes, like I said, increasing the period of relicensing which is right now every two years. Splitting licensing, and I will very quickly give an example, until today, if you build a 200-bed hospital, we have to hire all the staff and then call MOH to come in for licensing. Can you imagine? 200 staff, 200 beds, the number of staff that we would have, our salary and wages would be close to RM3 million to RM4 million per month. And if the license is delayed by five, six months, you can take four months— I mean four million times six months and that is the cost that is being paid before we would start operating and again, somebody has to bear that cost, we mentioned that before.

Our recommendation to MOH for the past five, six years has been simple, split licensing into two. I licensed the physical facility, makna kita dah bina hospital 200 katil, kita lihat fasiliti, kita *license*. Katakan fasiliti ini selamat mengikut segala *regulation* daripada CKAPS. *So, the facility is licensed,* baru kita boleh *license the service. Then we hire the staff and so on. At this moment, the licensing is one step. We build, we have to hire only then we can call MOH and CKAPS for licensing.*

So, this recommendation has been there for a while. We really hope that some of this and other recommendations can be taken up.

Number seven, expansion and inclusion of primary care as part of the patient pathway. So, mungkin *this one contrary to what most people may think. Although we are private hospitals, mostly in secondary care and tertiary, we really do believe that to make the Malaysian healthcare system more efficient is for the primary care, and for the clinics and the GPs, to play a much bigger role. And surely, we are keen and*

willing to come in to train, to have co-developed policies because what we want again is for the patient to be safe.

You've seen the GP and the GP needs help. They have somebody to reach out to. They can reach out to the specialist of the hospital. They don't have to send the patient first. Only if needed, then they send the patient across. This will help the patient save cost, this will help the insurance save cost, this will certainly make the Malaysian healthcare system more equitable and efficient as well.

And again, our commitment is, if such a committee is created to look at transforming and including primary healthcare as part of the entire patient pathway, we at APHM will come in and play our roles.

And lastly, is to improve healthcare policy holder enrolment process. We mentioned this and again we have not had any discussion or seen any movement on this. Today, you can still buy an insurance policy without having any form of healthcare screening and this is resulting in a lot of under declaration. So, patients who have got preexisting conditions who are diabetic and so on so forth, are not declaring it when they buy insurance and so the insurance policy and premiums are lower.

So, we understand kalau pesakit ini dia dah ada komorbiditi, dia dah ada darah tinggi, kencing manis dan sebagainya, bila dia masuk hospital, merawat dia lebih rumit daripada merawat pesakit yang tidak ada komorbiditi. Tetapi kerana tidak ada deklarasi, *they are not declaring it, the insurance premium is lower, and when they come to the hospital, their bills are higher. And so, the insurance also finds it very difficult to pay the right amount of payout because they've collected a much smaller amount.*

So, this really needs to be fixed. Because like I said, in Malaysia today I can buy an insurance without any healthcare screening. So that's our eight recommendations and out of these eight, which we have not, we really had not yet received a lot of support to get this conversation going.

Jadi, mungkin di sinilah kami minta PAC dan pihak kerajaan untuk menubuhkan jawatankuasa ataupun forum-forum di mana perkara-perkara ini boleh dibincangkan *where it can be discussed and working committee where— like I said. we are more than willing to come in and assist to make sure that some of these things are moving ahead. So, I proceed YB? Okay.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ada apa soalan ataupun kita hendak selesaikan *the* taklimat terus? *We finish*-lah. Okey, *continue.*

Encik Anwar Anis bin Anis Ahmad [APHM]: Okey, terima kasih, YB. *Next slaid YB really is* sejak kita bertemu pada persidangan PAC yang pertama, *this is really just to share that we've been busy.* Selain daripada kerja hospital kita, di pihak APHM kami banyak meluangkan masa dengan pelbagai agensi untuk meneruskan perbincangan kita. Jadi, saya secara ringkas membaca slaid ini. Jadi, *we had multiple meetings* dengan *Ministry of Finance, MK II. We are—– and we've now officially been invited to be part of the joint ministerial committee*, tapi mesyuarat ini sepatutnya minggu lepas sudah ada, tapi *was also postponed.* Jadi, kami masih menanti mesyuarat ini, *the joint ministerial committee*itu *to start and the terms of reference and all that all to be finalised so that we can start working.*

We've also attended the working committee for DRG. This is together with MoF's Technical Committee. We have also participated in a policy workshop to look at the national healthcare benefit. Jadi, kami difahamkan untuk *MOH, they have already started discussion on a national benefit programme, what should be in the healthcare benefit and all that, how is that, what should be included and we also attended that workshop. It was a two-day workshop. There is also going to be a technical workshop on clinical data needs for DRG. So, this is from 23rd to 25th of June.*

So, this is an important first step. Jadi, untuk kita mara ke depan, kita memerlukan data. Jadi, pertama sekali *is to decide what data and to collect the data and analyse the data.* Jadi, ini adalah mesyuarat pertama untuk melihat *clinical data needs* untuk DRG. Jadi, selama ini belum ada lagi, tidak ada data untuk DRG. Jadi, mesyuarat pertama 23 hingga 25 hari bulan Jun ini. Dan daripada pihak APHM, *we have technical staff who will be attending the meeting*.

We also had a meeting with BNM's Governor and technical advisors. On going of course, is policy feedback on medicine and price transparency and we can explain that in some other slides. We also— our conference this year which was last week, members of the PAC, thank you to YB Sim for attending the conference and listening to some of the talks that we had. But the focus of the conference— tajuk *conference* kita pada tahun ini adalah *medical inflation and medical reimbursement. It was deliberate* daripada tahun lepas, memang kami sudah ambil keputusan bahawa *conference* kita pada tahun ini, fokus kita adalah *medical inflation and medical reimbursement, conference* tiga hari. Speaker-speaker yang kami jemput daripada *both experts, local experts* dan juga daripada Thailand, *Singapore* dan sebagainya. Fokus mereka *was on medical inflation and reimbursement strategy.*

Dan akhir sekali, *of course, at APHM, through our board members and otherwise, we've been actively looking at publishing articles to explain about*

healthcare, medical inflation, *hoping to improve the healthcare literacy and encourage informed dsicussion transition*.

This is just more information, maybe to just dive in bit deeper on DRG, because I think this is something that obviously is top of mind for policymakers and others. This is the slide we are taking from a speaker Prof. Supanit who presented at the APHM Conference. What we really want to emphasise on this slide because we have mentioned before we are supportive of how DRG— you know, to explore DRG or any similar mechanisms.

But Thailand introduced DRG in 1993 and they started with phase one, phase two, or rather version one, version two dan sebagainya. *And in 2002, Universal Health Coverage scheme was launched in Thailand*. Tapi yang penting, *members of PAC*, dah hampir 30 tahun DRG ini di Thailand, *30 years and apologies that the slide is a bit small, but if you look at voluntary private insurance*, maknanya *private insurance*, *health insurance* di Thailand, setelah 30 tahun ini pun, *voluntary private insurance is still reimbursed via fee for service. So, we have to ask the question, Thailand that has started 30 years ago, has Universal Health Coverage, why is private insurance not paid through DRG? Because, DRG limits options for private healthcare payors and for patients especially. So, if a patient has taken a very significant policy, they don't want to be limited in terms of their access to healthcare.*

■1030

So, we really have to ask that question. Why Thailand which is advanced in terms of DRG which has gone through multiple phases and has over 30 years of experience, has this particular model? It is the same in Singapore, it is the same in Thailand— Indonesia as well. So, we have taken the Thai example because we are ahead but that's a question that we all need to ask.

So, this is a zoomed-in view of that particular thing that I mentioned about private health insurance. Like I said, this is not our slide, this is Prof. Supanit's slide, who came from Thailand and this is how it shows, right. So, you have got three different medical benefits arms which are Ministry of Finance, the National Health Security Office and the Social Security Office. Those are both to public and private that uses DRG.

For private healthcare providers in Thailand, it is voluntary. Maknanya hospital itu dia boleh ambil keputusan sama ada saya nak terlibat dengan *National Healthcare Scheme* atau tidak. *But what is important for the patient, like I said at the bottom is voluntary private insurance is fee for service. I will not read the next slide but this is really just to summarise again from our conference, that was like I said last week, comments that were made about DRG. So, Prof. Maznah is heading the technical*

committee and she acknowledges like I mean, her experience is in rolling out DRGs in the public universities and her own experience and her own opinion that it will take a few years because like I said, data collection, data analysis, piloting it and moving ahead.

Dr. Khor, who is also in the Prime Minister Advisory Committee (PMAC) also the CEO of Angsana. I mean, his own opinion is that for DRG to take full implementation, it will take five to 10 years. So, we will leave the members of PAC to be able to reflect on their comments separately, we're moving ahead.

These are other initiatives from APHM where we have put in effort and supported the government in 2025 but we also— where we also face some challenges, all right. Here is again where we hope that we can outline some key concerns, where we hope the PAC will be able to take those concerns and help us address it as well.

So, the first one, basic MHIT at fixed prices. I don't know whether you are aware, it is actually APHM who suggested that we have a basic MHIT product when we met Bank Negara in October last year. So, the suggestion came from APHM because we recognise that the current design of the private insurance, health insurance, does not support us and our doctors in pushing certain decisions and doing certain things.

So, MOH has already started developing the basic MHIT product and we understand that Bank Negara is in fact going to be hiring a consultant to do this work together with MOH and BNM. But we want to clarify that when we launch MHIT, which I think the government has said that they want to launch it, latest by the middle of next year, what we understand in our discussions is that this is not DRG.

Basic MHIT means if we want to have some fixed price or fixed cost or ceiling cost in terms of let's take an example, total knee replacement and we want to say that under MHIT, total knee replacement is a certain price maximum with of course enough conditions so that we don't compromise patient care. Kita pun tak nak kita bagi harga katakan RM30,000 untuk TKR tapi ada pula doktor dan hospital yang masukkan implan yang sangat murah dalam lima tahun menjadi masalah kepada pesakit. *So, we also need the quality to be balanced. This is where we say APHM and the doctors must play a role. Because if we only want to go for the cheapest or set the price, we cannot compromise on quality.*

So, this one we need to be part of it but we have not seen any— a lot of discussion between the insurers and us. So, the ITOs seem to be reluctant because if you do one product across the whole country and the same for all the insurers and to make it affordable, we must be able to find a way of selling this product in a very

efficient way where the cost of selling it is not through expensive agency fees. Because of this, I think there is some discomfort but we need BNM and MoF to really encourage our insurers to push ahead and force to design this MHIT product. So that's number one.

Number two, medicine price display. Even when we came to the PAC the last time, we had said that APHM is committed to medicine price display and we specified that we are supportive to do it in the outpatient setting. And since the announcement by MOH, APHM members, APHM encouraged all members to start immediately and we believe that all our members started on 1st May, displaying outpatient.

There is a three-month grace period. During this grace period, we hope that we can engage MOH to discuss how to really do the inpatient display because we are still very concerned in terms of displaying inpatient pricing. Because this could result to medico-legal issues or poor decision making. If a patient decides I don't want a particular drug. Because if you even read the guidelines from MOH, it is really about giving the patient choice.

For outpatient, very clear. I don't want medicine from this hospital, I want to buy from the pharmacy, no issues. I don't want medicine A, I can discuss take medicine. But in an inpatient setting, in an emergency, in the ICU, how does the patient decide, "I want that choice"? And these are the things that we've said, we need clear guidelines. We need clear guidelines so that we can protect the doctor. Because the patient says, "Saya tak nak ambil ubat ini", how does a doctor in a hospital protect themselves from a medico- legal perspective? How do we make sure the patient has good clinical outcomes? And we are waiting for the government to come back to us in terms of discussing the issues related to the inpatient medicine price display.

The fourth one— the third one, sorry. Sales and Service Tax. This has come to us as a surprise because we've not really had a lot of engagement although we had one engagement with customs in December last year, where it was an open discussion. There was no direction given in terms of what the sales tax would be. But this was announced last week and the implementation timeline or effective date is 1st July. I hope the members of PAC understand that hospitals have not been subject to SST. We do not have the system in place. It is not that we were subject to SST and now we just turn it on or we increase the SST rate. We have not been subject to SST. So, we do not have it in place in our finance, in our billing and in our structures.

To be announced last week and to start on 1st July, it is almost impossible for us. It is also difficult and I give you an example. We are told that we have until 31st December, so before that is we have to show best effort. Tapi saya bagi contohlah.

Kalau hospital A dengan B ia mungkin tidak berjauhan *and this SST is on foreign patients. So,* katakan di Pulau Pinang *where it is a major economic contributor to our country, right? Foreign patients coming to Penang is a huge contributor to the state and also to the country. Penang is one example but certainly in KL, in Johor, in Malacca, you know it's a big contributor because they fly to us, they stay in our hotel, they shop, they consume but they also seek healthcare.*

So, I come back to the example, Hospital A, Hospital B are close by. Hospital B, the systems are now ready and they said maybe they can start on 1st September. Hospital A is still in progress because the systems are more complex. Why would Hospital B start charging SST? It will make healthcare in the hospital automatically six percent more expensive. Why would they want to start first? So, I think for healthcare and for foreign patients, for the imposition of SST, it cannot be different people starting at different times because the patient will decide why I would go to the hospital. I am going to pay six percent more. If my bill is RM50,000, it means RM3,000 more. This is going to create a lot of disruption. So, we hope that this will be looked into. The day after it was announced, we already wrote in to the Ministry of Finance, we've written in to MK2 asking for a discussion and for a clear deadline to start. So, I hope that one example gives you some colour.

The other is Sales and Service Tax imposed on foreign patients or non-Malaysians, rather, we understand the government's objective. It is to increase our revenue and not to burden Malaysians but foreign patients who are coming here because they feel Malaysia is very affordable. Another six percent to them and this is the logic from what we understand, because Malaysia has affordable private healthcare. Adding another six percent, they will continue to come to Malaysia. So, I hope the government also listens to itself, right. The reason the government is saying I can impose six percent is because healthcare in Malaysia is affordable. Okay, so that's number one.

So, that's six percent to foreign patients. However, we are also subject to SST for the hospital in terms of operating costs. Cost of rental and maybe Mr. Chin can explain because of various structures, some hospitals are renting their premise, some hospitals and groups on writ, so on and so forth. So, SST on rental will increase healthcare costs and here we are asking to reduce inflation and yet rental is going to have an impact on our operating cost immediately. Number one.

Number two, SST on construction. Hospital and healthcare if we consider to be a critical asset, we are now imposing SST on construction costs even to hospitals.

■1040

Again, our projects even small hospitals are RM200 million, RM300 million in terms of cost. Imagine another six percent SST on hospital construction. Who is going to bear this cost YBs? Right? So, on one hand we are having all these discussions on reducing healthcare cost and inflation but we are ourselves imposing additional costs on healthcare which the patients will have to bear ultimately. So, we hope that we can have discussions with Ministry of Finance and others as well as soon as possible because otherwise this will cause a lot of disruption.

And the fourth one is really about public-industry outreach. Right? So, we mentioned this in earlier slides. I think our contribution is we've been investing our own association money and all that to look at research, look at data, understand DRG, understand different models, look at AI, look at where and how we can make healthcare more efficient.

So, we've been doing this. However, we do hope that we can have support from the government in terms of doing this together with us as well because APHM on its own, will not be able to drive this public-industry outreach. YB, I continue?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Continue. [Bercakap tanpa menggunakan pembesar suara]*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Okay. So, already many requests to PAC but three key areas YB, really. Right? Just to summarise what we have perhaps said earlier. So, one is issue of insurance rates and why our bills, people find it's unfair, right? It's because insurance is only willing to pay for certain things at certain prices. We said it earlier, room and board for example. Nursing charges. In our first PAC session we showed you that actual nursing cost is three times, four times what the insurance is willing to pay. Because of that we have to push the cost to other areas.*

So, we really need to fix this issue so that we can be objective and look at the hospital bill and if the hospital bill is then reflective of the actual cost, then we can have those discussions with those hospitals who are not charging fairly. Because right now, all of us can say "Sorry, our bill is not transparent." We give you the bills but it's mixed up. Right? We're having to do cross subsidisation and everything else. So, it's very difficult to have that discussion. But if you can fix the bill, then we can talk to any hospital who's not doing the right thing, we can have more productive discussions with them. So, we need to review and revise billing structures.

Then, of course there's an issue of the underfunded segments, right? Yang Berhormat, for most of whether is KPJ, IHH, A1H, most of our hospital groups, healthcare is the only thing that we do. We do not generate income from other

businesses. But we keep hearing that the insurance saying their healthcare portfolio is not profitable or very slim margin. But they are very profitable in all the other areas. So, we hope that there is transparency in insurance premiums because we know that selling health insurance is the way to open the door to selling other insurance. I sell health, then I sell life and I sell others.

But, if we expect for medical insurance to stand alone and be as profitable as other segments in the insurance portfolio, how is that fair to providers? Because our margins are already very slim. This is the only thing that we do but we are asked to give a lot more discounts at the detriment of our future in terms of private healthcare. So really, unlike private hospitals and other certain lines of business, ITOs do not cross-subsidise. We don't know whether there is a law, whether there is a regulation, but this is the argument that is being put forward to say, "Healthcare portfolio must stand alone."

So, this issue certainly has got long-term impact. We can see that what is happening the last six months to 12 months. I think do look at financials from hospitals in the next quarter. It'll likely will see no growth or even negative. But, look at the financials. I encourage you to look at the financials from the insurers after this. So, that's number one.

Number two, we do need protective guidelines, policies and regulations. Just because we are at the most visible— in healthcare so you've got— everybody else when we talk about construction, people who construct hospitals, supply the hospital, putting in the systems, medical technologies, FAMA, the payors. But to the public what they can see is the provider, it's us because we are the one that's most visible. Because of that, all the pressures are being put on the providers.

So, already for many years, hospitals have been giving discount, generally up to 10 percent to insurers. But, now because of the moratorium put on the insurers, the demand to the hospitals is unsustainable. We are now being asked for 20, 25, 30 percent discount.

We have shared before, public listed companies in Malaysia, public listed hospitals, our profit margin is nine to 11 percent. We can give this discount for a short period. But, if you ask to do this for a long term it will certainly threaten our existence.

So, two issues. One is asking for excessive discounts; and two removing hospitals who don't give discounts from the panel. This limits patient's choice and this is not going to be sustainable for us.

While we don't want to mention it and we did mention that last time, I think it's important to note that many of our hospitals really are under GLICs and government-owned, right? They can see what our profitability is. What this means in terms of

return back to our own people, to the rakyat in terms of EPF, Tabung Haji and everything else, KWAP and so on and so forth. So, again those impacts will be felt down the line if it's not already felt already.

So, implementing a benchmarking system for ITOs would certainly make it better and make it more transparent and we are urging. Again, we may have to ask for donation among APHM members to do a study. But, in Singapore for example there's already a study right— to look at different payors. How are they behaving, how much of the claims that they reject. I think the government also needs to look at it between different insurers, how many claims are they rejecting.

One of the issues that we have today is to frustrate the doctor. The insurance just asks more and more questions. They will say it's deferment, please clarify, deferment, please clarify until the doctor will decide okay never mind, I don't want to charge. I will remove my fee or part of my fee out of frustration so that the guarantee letter is approved and finally the doctor and the hospital get paid.

So, we need transparency. Which insurance are doing this? Who are better and who's performing better and who's been a fair payor to both the doctor and a hospital. So, at the bottom level, we urge the PAC and the government to really address the detrimental impact on patient care and healthcare cost which is the result of this excessive discount demands and the depanelment threats that hospitals are facing.

Third and last, is we really need strong institutional support for industry-led initiatives. We have mentioned this and just like to recap it, right? A national medico-legal committee. We really need this because this impacts not just private hospitals but the government as well. So, we hope that such a committee can be established and we can contribute towards it.

Regulatory burden we've mentioned, it costs us millions and millions of ringgit. Today we understand that— and we are not blaming CKAPS. We know they are also understaffed for the work that they do. The engineering department MOH is understaffed.

They are not able to visit the hospitals in time. They are not able to review our plans on time. Because of that, it becomes a delay. The people, who we know the people in CKAPS they are working very hard. I mean we salute them. Sometimes even weekends they work but there is only a handful of them. But, because of this, the regulatory burden and the delays to us is significant. That is why our recommendations are to move relicensing to a longer period from two to five, is to split licensing and also move towards self-regulation to reduce that burden on the government and to reduce that regulatory burden cost on the hospitals.

Third is primary healthcare expansion. We've mentioned it and we really are committed to do this together and many of our hospitals have already started doing this. It may not be known to you but some of the insurance wording, some of the policy wording actually says that reimbursement is only for specialist care.

So, they have to go back to Bank Negara, they have to go back and redo their legal framework because their current policy wording says that what they pay is for specialist care. So, even you want to include primary care it cannot be done overnight. It requires BNM intervention and it requires legal intervention. So, that's one.

But certainly, we need all the government effort to look at what happens to a patient before they come to the hospital, also what happens to a patient after they leave the hospital. So, in countries where healthcare is more integrated, patients can leave the hospital earlier because you've got support when you go back home. You got clinical support, rehab support.

Today in Malaysia once you leave the hospital, if you are talking from the insurance perspective, once you leave the hospital, we cannot charge the patient if we do a home visit for physio. Already some insurances have said that even the follow-up visit post-procedure is out of pocket. You pay first and claim. We are now seeing that patients who had a procedure are not doing the two follow-ups that they need to do because they have to pay first and claim for it. That will result in poor outcome as well.

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And lastly, is really improving policy holder enrollment. We mentioned this before. We need to have some screening when we have policy holders buy insurance. We wish that— you know we were a society that was 100 percent honest. But we have to recognise that that's not the case. People are always under-declaring when they buy and that's creating a lot of other issues.

So, those are the four institutional support that we feel that the PAC can certainly play a role besides all the other things that we've mentioned. But if you can focus on these four, it will have some medium-term and long-term impact in terms of reducing the healthcare cost and hence, the healthcare burden to the rakyat.

That's the end of my presentation, YB.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih tuan di atas pembentangan kepada PAC. Jadi, saya bukakan soalan kepada semua Ahli Yang Berhormat.

Sebelum itu saya nak bertanya. Awal taklimat tadi ada menyentuh bahawa hari ini dah mula merasakan dan juga ada data yang menunjukkan bahawa *the new*

policy itu dah semakin berkurangan. *So,* boleh tak kongsikan dengan PAC apakah impak ataupun kesan dengan situasi kesihatan negara?

Encik Anwar Anis bin Anis Ahmad [APHM]: Jadi YB, yang maklumat itu *is from specific insurers*. Jadi kerana isu ini masih berterusan, *I mean still a new issue. But the insurers are saying that their enrollment of new policy, I think two things,* YB.

Satu adalah— ya lah, kerana isu-isu ini hangat juga di Parlimen dengan rakyat *depressed* dan sebagainya. Mereka yang berminat menjadi *insurance agent* sudah berkurangan. *So,* ada insurans yang mengatakan— insurans yang besar katakan, setiap tahun mereka ada tiga hingga empat ribu orang yang menjadi ejen insurans. Dan pada tahun ini, mengikut anggaran pada tahun ini, sudah menjadi separuh. Maknanya orang yang berminat jadi ejen insurans ini dah kurang. Ini kerana dia rasa, *"Oh, insurans ini orang semua kata tak telus dan sebagainya."* Jadi, orang yang nak jadi ejen insurans ini dah kurang.

Jadi, kalau orang yang menjual ini dah kurang memang penjualan akan kurang. *So that's number one, right?* Dan, impak ini mungkin pada masa ini tidak dirasai dengan sepenuhnya. *But you can imagine if the enrollment of people who are part of the insurance sales force reduces, then certainly the sales of insurance will reduce. But two also, of course with everything that happen,* ramai juga yang *let go of their policy. So, although there's a moratorium but there's also a certain percentage— 20 percent who you know were not under the 10 percent cap, people who have retired* dan sebagainya *who are willing to give up their policy.*

And, give up is one thing. But like I said, the sales of new insurance policy— what we hear— So, we need data, YB. I think what we've said that's why we need transparency of data. I think we want insurance to be transparent. I think insurance must come and tell you what has been their sales this year compared to last year. What is their agency enrollment volume this year compared to last year? Kerana *those impacts we will probably feel in the second half of the year. Even next year.*

Jadi kalau lebih ramai yang tidak ada insurans, lebih ramai yang dah *give up insurance* dan kurang *agency sales force* ini, saya rasa tahun 2026 lah impak dia sepenuhnya kepada— *we will start feeling the full impact* di mana lebih ramai akan mungkin pergi ke hospital KKM dan sebagainya.

Mr. Chin Keat Chyuan [APHM]: Ya *if I may, just to build on. I think you can also potentially YB, get data directly from Ministry of Health. Because based on our indirect ideas exchange with Ministry of Health, I think the current long wait list for those decanting* punya *procedures* itu *it's not coming down. That means we have a lot more people* kan— *whether you are talking about waiting for cardiac* punya *like angiogram* kah, *angioplasty* kah, *CABG* kah, kan? *All these is actually getting longer.*

So, by right if let's say we see the situation getting better, that means a lot of people actually get the private healthcare to complement the public services and all these it will not. That's one.

Secondly, as what Mr. Anwar *mentioned, we around our own community also, we have heard a lot of elderly people actually dropped off from the insurance. Because despite moratorium and all this, I think insurance company is still sending out individual letter* kan— *charging more than 10 percent premium hike in general. And some of the people who are retired more than 65-70 years old, they can't afford to pay.*

So, we have seen a significant drop off in terms of people who wanted to continue their private healthcare and automatically this category of people already fall back to government. So, I think that is already happening today as we speak. And, of course we do not have prepared the data on all this, but I'm sure the Ministry of Health together with ITO kan, *their LIAM and PIAM they should be able to have the data to support what we have just mentioned lah, YB.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Selamat pagi Pengerusi. Terima kasih kerana APHM hantar Mr. Chin, Erica dan juga Mr. Anwar *to be here* dan kita juga ada beberapa soalan lah.

Nombor satu, saya ada beberapa soalan lah. Minta maaf lah akan tanya berulang. Nombor satu saya nak *establish what is the real medical inflation in Malaysia? Okay, because* apa yang kita dapati adalah *about 15 percent.* Itu adalah daripada laporan oleh satu *so called industry survey* lah ya. *But I think the real numbers lies with the hospitals. You know it, okay.* Sebab kita dapat *15 percent is because of the real inflation plus the number of visit. The number of visit increase but that could be temporary or you know, because of COVID-19, they delayed treatment. So, it will fall back you know, like I was told that now it has plateau and it can go down.*

So, the inflation may not be 15 percent per se. So, I want— My first question is let's establish and APHM has— has APHM establish a real number of inflation because we want industry to tell us. We don't want a survey to tell us. Please, kalau boleh kita mula dengan soalan ini. Terima kasih.

Encik Anwar Anis bin Anis Ahmad [APHM]: Okey, terima kasih YB Sim atas soalan itu. *So firstly, you're very correct YB Sim. Right,* dalam data yang biasa diumumkan dan sebagainya, *the 15 percent* ada dua komponen. *And I think during our first PAC, we tried to explain*. Laporan-laporan seperti yang daripada Aon Hewitt, laporannya. Bila angka 15 peratus itu ada dua komponen. Satu komponen adalah

peningkatan dalam penggunaan kemudahan kesihatan *(increase in access, increase in number of claims).* Dan, kedua adalah peningkatan dalam kos.

So, secara umumnya kalau kita lihat, *at the different reports— some reports say 15, some say 12. But what we know is 60 to 70 percent of that is increase in claims. So, YB Sim you are very correct and that's why we try to show right, that the increase in the number of people coming to healthcare. Because of aging society and so on and so forth has increased. Even if you take the 15 percent number and if you say, 60 to 70 percent is increase in number of claims, that is already eight to nine percent.*

That means eight to nine percent of the 15 percent is because is increase in volume. Then, the other component is increase in cost. So, increase in cost is between six to seven percent. If you talk about that 15 percent number. Our own data shows that inflation for and we explained before inflation for per item is really close to CPI— it's four to five percent. So, where is that— how the bills getting bigger, right? We explained before over the years of course, if you look at the last five years— introduction of new procedures, laparoscopic, all that because there's more consumables and so on are also increases the cost.

But if you take all of that into account, kita ambil semua faktor-faktor ini, *actual cost inflation is six to seven percent and the balance is increase in claims volume. I do not have the specific article but even— and this was in one of the national articles. Even the data from Prudential shows that medical inflation per item— if you exclude volume increase, was actually four percent. So, even from the ITOs own data.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, kalau boleh soalan lanjut lah. Ada— Mr. Chin?

Mr. Chin Keat Chyuan [APHM]: *Ya, I just want to build on that. Like what Mr. Anwar mentioned, the earlier numbers that we have actually seen that is actually using medical trend rate. The medical trend rate it has the element of anticipating what happens in the future also. So, it is not really based on that current actual medical inflation— built on anticipating future* berapa lagi yang akan *increase and that increase including of the anticipation of the claim.*

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And truly like what YB Sim mention because of the delayduring that two, three years it was heaven for the ITO. Everybody hanya bayar premium sahaja kan? Tak ada orang dapat pergi hospital kerana hospital memang kan MCO memang tak boleh pergi hospital. Hospital *have almost zero elective procedures private* hospital tak adakan hanya *COVID, COVID and COVID.*

And because of that, the delay, when it comes, everybody start actually going after that elective procedures as one I think after 2022 second half of the year, the premium of insurance also actually gone up in terms of people buying healthcare policies because people start to realize that without healthcare policy, they are so vulnerable.

So 2022 until 2024, there was a clear case if you check with LIAM data statistics showing their update in terms of policy was actually increase by more than 100 percent. So, because more people buying – people want to also use dia punya polisi. *So, the update, the delay in terms of the procedures, together with all the things there have actually added. So if you minus that out like what Encik Anwar rightly said, ya the actual CPI index for us in terms medical inflation it is around 4 to 6 percent which is no different compare to others.*

But the moment when you combine the increase in terms of access and the claim rates that's how the whole thing double up from 12 to 15 percent and that stands out for Malaysia because there are using medical trend rates. There are many methodologies for us to actually look at how you can anticipate for all this but that methodology was actually being used-lah. Sorry YB Sim.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih. *Okay having so - can okay my another following question is can APHM really came out with a data because we cannot say 4 to 6 percent what is that you know, we can't. We have to have your industry wide data that you tell us okay. I think that is very important so that policy makers can make a wise decision. If you don't have industry wide, you know get lah I mean Erica IHH, you are KPJ come out with a really industry wide.*

Okay having said that, I also personally experience medical inflation okay. I have three kids, very rare lah ya my first kid you know we sent to I mean we decided to go to private hospital. That was about 10, 15 years ago lah it was 2000 I was charge 2000. Same procedure no complication or whatever, second kid comes we also feel that we have to first kid already in private hospital then second kid has to be there also. Same hospital, same procedures, same doctor nothing complication it become RM4,000.

Two years later ya just two years, almost 100 percent already. There another third one also two years later same hospital, same doctor, same procedure, no complication RM6,000. So, I think that is real inflation here also you know what you say 4 to 6 percent doesn't hold water. So, what is there why is that so you see? So, this is I think also the industry must look into it because I want to compare procedure to procedure. Is there a real inflation in because the doctors' fees are the same but I

believe is other things are other charges from RM2,000 to RM4,000; RM4,000 to RM6,000 why is that so can you explain to me. Thank you.

Mr. Chin Keat Chyuan [KDN]: *So, I think first things first, thank you so much congratulations YB on the three kids and very good planning two years each and its very good you know, I think fabulous.*

Tuan Sim Tze Tzin [Ahli PAC]: *As engineer I plan [Ketawa].*

Mr. Chin Keat Chyuan [KDN]: *Very good. Very good. But I think, first things first, the first question about the availability of the data from the industry beyond KPJ* dengan IHH dengan *all group is done. That one* memang kita ada. *So, after this meeting what we will do, we officially send you and that data is not done by us ya, it's done by third party* IQVIA*. So, we do have that breakdown of medical inflations using different methodology right, like medical trend rate is one, there are many, many ways to do it. So, we will look at our Malaysia, we look at the region, we compare with the global, so we have all the data breakdown so we will send it to you YB. So, you can tick it off. So, I think that one is done.*

Now, second part about this RM2,000, RM4,000, RM6,000 I can't comment because we don't know which hospital YB you are going to, definitely as you rightly mention about the doctor same doctors, the same schedule 13 never change right I don't think there's anything significant on that. So, I can't pin point specifics but please understand because gynae and pediatric it is relatively high risk when it comes to medico-legal especially delivering baby you are aware that when you deliver a baby, the risk associated with the baby is not only the first three months post delivery you know.

The baby can sue the doctors and also the hospital all the way up to 21 plus 3, I think 24 years old. I'm not sure how many of you are aware and for us to keep the medical record whether digital or manual I have to keep that record and there's reason why frequently you see how you walk pass hospital there are certain wards converted into a medical record room is because of all these medical records we have to keep because one day the patient is going to come back.

Eh! How come anak saya macam ini? *They will sue the doctors and they sue. Now one part of Anwar's presentation earlier mentioned about medico-legal. We need the committee to review. Before I joined KPJ, my doctors use to only pay RM500,000 for the premium coverage is enough for medico-legal. Today I make it mandatory minimum is RM3 million, minimum. Many of my gynae and my pediatricians they are even getting themselves covered up to 10 and beyond million.*

Now imagine if you were to buy anything more than RM10 million, how much premium you are paying? So, I think all this direct or indirectly is adding to the medical

inflation. Now is it real? I'm telling you seriously based on Columbia, the landmark case, based on what we have seen even in Hospital Penang, government MOH how the judge has actually fined MOH, right, KKM government to pay I think up to RM9 million, all this is real.

So, whether you are in government today you might not be protected for long. You know, I think sooner or later, doctors also need to even though you are government servant, you have to buy your own insurance. So, I'm not pin pointing how that 2, 4, 6 YB but I'm just saying that in general, doctor's risk and the responsibility is actually tremendous, you know. And, and I'm sure they will have to find ways, hospital also, because now, hospitals, there is no more firewall between clinicians and hospital. We are all bundled in together.

Tuan Sim Tze Tzin [Ahli PAC]: *But Mr. Chin, it doesn't justify 100 percent rise okay from RM2,000 to RM4,000 and then another 50 percent rise from RM4,000 to RM6,000 within a short span of 4 years it doesn't justify you see. So, I think the issue now is I want you know APHM really have to do every sector lah, every you know so that we have a real inflation because I experienced 100 percents increase in inflations you see in the private hospital.*

Mr. Chin Keat Chyuan [KDN]: Jadi *I fully hear you. Can I just give one example about nursing. The nursing cost post COVID as we mentioned earlier, I can give you clear data showing how many times most of the private hospitals because we are all fighting for nurses and then we are losing nurses to Singapore. Singapore losing nurses to Australia and New Zealand. We are also losing nurses to Middle East constantly right and on top all this, we have post-COVID because of the period where we have slowed down low elective and all this and suddenly post COVID where we need to be reactivate right, we were losing nurses big time.*

Nursing cost has gone up more than 30 percent as we all mentioned a few rounds here. Nurses, we are not talking about one nurse, right, for many, many patients and all depends on which ward like general ward versus ICU, CCU and all these nurses they work 24-7 like three shift and remultiply. If you are look it, most hospitals, I can't defend my case by showing you as private listed company right, where is our profit after tax despite saying about this RM2,000, RM4,000, RM6,000 over period of two years? Our margin never lies, right?

Our margin today let say KPJ if you looking at it, last year when I close my full year, I'm only closing around 9 percent PAT, Profit After Tax. So, you can say Chin you might have actually markup on your gloves, you might have actually markup on your nursing, you might have markup and all these. Net to us the end because of all

the depreciation on the building, chiller, whatever that you are talking about, right, to prevent infections, my aircon have to be on full blow 24-7,365 days.

My utilities for a new hospital itself is costing me RM350,000. Even though the bed occupancy rates are less than 20 percent because why? You can't choose to turn of aircon you know. The moment you turn off aircon you have infections and all this kan *so all this cost is real, my PAT is real YB.*

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So, I might be charging some patients a bit here and there. Again, I'm not responsible for that 222, YB. I'm just saying that the cost if you are saying that, "Chin, you guys are maximising". Please come to look at our PNL and then you will realise that running a hospital with multimillions kind of assets and cost, end up you only having that nine percent profit which Anwar already repeated again and again, right, between nine to 11 percent.

We are not a very profitable industry to be very honest because our gearing is very high. We borrow money to expand our hospital facilities. With all this nine percent aside, I keep using this right I really want to applaud on EPF because EPF gives 6.3 percent return without spending much on asset gearing and all these to borrow money right but we are the one who actually using all the human capitals and all to deploy and yet I'm only getting nine percent you know, only nine percent. Now, if I'm like insurance company getting 18, 20, 24 percent then we can be deemed like, "Eh, you guys are profiteering".

Today, when we talk to insurance, they openly tell us and this is actually being quoted right, Mark is actually the CEO of LIAM. In May, one of the TV podcasts, he clearly said yes, we are making profit. It's just that unfortunately they cannot cross-subsidise between blocks. They call it block right. Medical is medical, personal accidents, other insurance, property, car, they are separated out. I love the way how they do it because ultimately, they are still making hundreds of millions. It is actually being listed, right, in the newspaper and all.

For us, we cannot. I cannot cut out my A&E department versus my ward versus my others. We are being bundled in together as one you know, YB. So, this is where our big problem when they are still enjoying 15, 18, 21 percent profit after tax. We are private hospital here around nine to 11 percent and we are being deemed as maximizing our profit, you know. But I don't know where because the cost really is actually going up. The pharmaceutical and medical device cost after COVID, it is going up because of our affluent group of people asking for more and more better healthcare.

Today, all hospitals invest in robots. Now, if you say I don't mind robots, can. But less patients come to your hospital. Even total knee replacement, we are using robots today, YB. Today if you go to the hospital, they will use robot on you now. You can opt not to use robot. But robots increase the precision, increasing your mobility, after that after you sudah tukar *you* punya *knee, all these brings up cost. Same TKR last time used to be less than RM40,000, today, might be costing RM45,000 because of the technology advancement. Who asks for it? Patients demand for it.*

But it is going up. Seriously, YB I must agree with you. But profit go down still the same low single digit, why? Because all these money charged to patients are used back on the patients because of the technology that they are actually asking for— sorry, Stanly go ahead.

Encik Stanley Lam Kean Fatt [APHM]: *Maybe YB Sim, I would like to highlight to you. I cannot- I mean I don't know which hospital you go to but I just want to share the experience that I had in my hospital. In fact, to tell you the truth. The delivery packages are very competitive. The reason is there lesser and lesser of people to a general extent come to private hospital to deliver partially due to the fertility rate is coming down. Secondly, also must give credit to the government setup, right. A lot people choose to go government to deliver.*

In fact, it has become a situation in which in our hospital environment, we want the doctors actually to come forward together to do a package for people who want to deliver in hospitals, right. When we come to a package, what does it mean? So, hospitals take a cut, the doctor also must take a cut. But unfortunately, the real situation which I want to tell you is that because the risk is so high to deliver a baby, none of the obstetrics would like to do a package. They don't want. Because to deliver a baby, the medical legal exposure is very high right.

But in fact, right, I just want to tell you that right I don't know which hospital you go to, again I want to emphasise that delivery packages become very competitive. At least I can say in Melaka's perspective. All the hospitals are trying to compete with each other and the cost until it becomes not real and it is not making any commercial and legal sense in our environment.

To put it bluntly, people are more than willing to go to a confinement centre to pay RM10,000 to RM20,000 and not to spend to deliver a baby in the hospital when the charges is below even RM5,000. Even RM4,000 they are not willing to come to the private hospital and risk themselves. This is something that I think as a country we need to educate our ladies out there you know because to deliver a baby is a very high-risk procedure, okay.

Tuan Sim Tze Tzin [Ahli PAC]: *I think we didn't have to discuss just on delivering babies, okay. I think the real issue is medical inflation, okay. So, we focus back to the medical inflation but I just want to point my example of 100 percent increased.*

Puan Erica Lam [APHM]: *Ya, YB. Just to summarise from all of them. Yes, doctors' fees have not changed for the last 13 years but you and I all of us living in Malaysia, we do face the cost of living that is increasing. So, when the cost of living is increasing like exactly what summarising what my colleagues are saying. Operating costs have increased because some costs have increased tremendously. Then we are talking about the currency Ringgit Malaysia has not been performing very well in the past few years. I think we mentioned it in the last PAC. 90 percent of the medical equipment is all imported. When it's imported, we are talking subject to currency exchange. We are talking about innovation into drugs. So, as in the private as you can hear all of us are competing in private. So, the patients are demanding better drugs, better innovation, higher technology. All these will drive the technology, will drive the cost going up, So, you wouldn't be able to have somebody to come in to a hospital to say, "I'm okay to have a non-digital X-ray. I still want to see a film". I think nowadays in KL no more. They want in a thumb drive, emailed to them and all that. So, does it mean a film is— definitely film is cheaper in a way but nobody would want it anymore. So, indirectly, the technology advancement is pushing the cost to go up then coupled with all other things that we talked about.*

So, basically in summary according to all our colleagues, of course, medico-legal definitely is driving up the cost because the doctors have to practice a little bit more defensive medicine to make sure they don't get sued easily. Yes, thanks.

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, maybe YB Datuk Mas Chairman and YB Sim. I think I like the fact that you want us to give you the data. I think we appreciate that opportunity. We had taken certain slides from our study that we had. APHM had commissioned right, Medical Inflation in Malaysia. Drivers and Recommendations'. So, it is just not the data on the inflation but also our recommendations. We will certainly furnish that study to you again. What we will do because in the last three, four months we were also like I said been engaging other parties and also heard other data points, right. We'll compile other statistics and data together with the medical inflation studies that we did and send it back to PAC because even if you look at DOSM's own data on healthcare growth and healthcare cost, this is DOSM's owned data, 2024 data if you go to DOSM CPI 2024. The health cost increased. So, of course there will be anecdotal differences. It's 1.8 percent. So,*

if you disregard volume, you disregard everything else, DOSM's own data is 1.8 percent.

So yes, what everybody else has said that is a lot of pressure on us but we have been absorbing most of it and that is in the data. We do not deny that there could be differences. Certain specialities, more increase certain specialities become cheaper because of different drugs, innovation, technology and so on and so forth. But overall, we will be happy to share with you the data and we hope you will be data driven. Thank you.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya melihat ada lapan komitmen yang telah pun dibentangkan oleh APHM termasuklah dalam menubuhkan kajian harga lepas itu tentang penstrukturan *bill reformed* dan juga *transparency* dari segi *costing* dan sebagainya. *Actually,* boleh tak jelaskan pada PAC sejauh mana komitmen yang diberikan untuk lapan perkara ini dan berapa banyak hospital yang telah pun melaksanakan komitmen ini? Ada tak pihak yang audit dengan apa yang dilakukan?

Encik Anwar Anis bin Anis Ahmad [APHM]: *So,* YB *Chairman* mungkin penjelasan saya ini komitmen kami untuk perkara-perkara yang boleh melindungi inflasi kesihatan.

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Tapi kita tidak— *I'll be very clear, we cannot do this alone*. Kita tidak boleh melakukan perkara ini secara industri, secara *silo*. Jadi kerana itu, kami meminta agar pihak kerajaan membantu kami dalam memberikan struktur ataupun jawatankuasa yang sewajarnya kerana *if you look at the review of billing structure*, hari ini kalau pihak hospital nak tukar pun, kita memerlukan pihak insurans untuk setuju dengan kami.

Jadi kalau kita nak hari ini, katakan *nursing cost* yang kita caj RM200, jadi kita nak kurangkan *glove* itu daripada RM20 menjadi RM5 katakan, jadi *nursing* itu sekarang yang RM200 yang sepatutnya kos di ICU itu RM1,000, kita kena ada perubahan kos ini dalam bil kita.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ya faham ya.

Encik Anwar Anis bin Anis Ahmad [APHM]: Jadi siapa yang— jadi keperluan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Dari segi sekarang ini...

Encik Anwar Anis bin Anis Ahmad [APHM]: Setakat ini tidak ada yang— *I think* kita agak kecewalah, kita sudah bagi, kita sudah membentangkan kelapan-lapan perkara ini tetapi setakat ini tidak ada *any meaningful progress*, tidak ada.

Tuan Sim Tze Tzin [Ahli PAC]: Kalau boleh Pengerusi, *the* lapan *commitments that you have proposed, is actually private sector because private hospitals are private sector. Insurance is private sector as well. The government should not come in and really regulate or you know, because these are market forces. The dilemma of the government is that if they come in, they regulate and then your industry cannot grow because of too many regulations, you complain about too many regulations.*

So, I see that these are issues that the industry must work out on your own, not the government comes in. Government comes in, they will know— the government know best is to regulate and you have problems if there are too many regulations.

Encik Anwar Anis bin Anis Ahmad [APHM]: *YB, let me clarify. We are not asking for regulation. We are not asking for regulation. I'll be very clear but who is going to bring those two parties together, okay? So yes, we have recommendations that we can do but who is going to tell that*...

Tuan Sim Tze Tzin [Ahli PAC]: *But the government also no* punca kuasa *to bring for you…*

Encik Anwar Anis bin Anis Ahmad [APHM]: *No*, Bank Negara *has got* punca kuasa with the insurance, right? *MOH got* punca kuasa *with us. So, somebody needs to bring this to parties together. Somebody also needs to bring in Bank Negara and MOH together.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Adakah pihak APHM mengatakan bahawa PAC boleh mencadangkan supaya ada pihak ataupun ditubuhkan badan pemantau untuk melihat tentang isu, tentang kenaikan kos dan sebagainya? *Do you think that PAC* patut mencadangkan sedemikian?

Puan Erica Lam [APHM]: *Yes*.

Encik Anwar Anis bin Anis Ahmad [APHM]: Tepat sekali YB. *I think YB, at MoF and MOH level* memang ada *this joint ministerial committee* yang kami sedang menantikan mesyuarat pertama kerana kami belum lagi ada mesyuarat pertama, kami belum lagi melihat *the term of reference of that committee.*

Jika *committee* itu sudah ada elemen-elemen antara lapan rekomendasi kami dan juga sembilan daripada ITO. Jadi ITO sendiri ada sembilan rekomendasi dan kami ada lapan. Jika *joint ministerial committee* ini boleh merangkumi semua rekomendasi ini, okey, tapi jika ada yang tidak termasuk— Jadi seperti *if you take the*

National Medico-Legal Committee, kami berasa di antara BNM dengan MOH tidak akan melihat perkara ini. Ini mungkin memerlukan—

I don't know, AG's chamber. We are not experts in this but we need somebody from the government to come in to facilitate that discussion.

Kami ada pengalaman daripada— boleh kongsi pengalaman daripada negara lain dan sebagainya. *But yes, what we need YB Mas, is really for PAC to help us do this. We are not asking for regulation. Let me be very clear, we are not asking for regulation.*

Puan Erica Lam [APHM]: *We will ask facilitating*

Encik Anwar Anis bin Anis Ahmad [APHM]: *We are asking for PAC to take the lead.*

Tuan Sim Tze Tzin [Ahli PAC]: *I think what you can bring up is on the JBMKSS* ya, Jawatankuasa Bersama Menteri Kos Kesihatan Swasta*. I think that is a big— good platform that I think they are going to establish soon, right? So, to bring up all these things and trash it out there. But I think another thing is the private sector remains private sector, you see. So, you— the less regulation, the better for you guys, okay.*

Puan Erica Lam [APHM]: Ya, ya *we agree*.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *I just like to bring our discussion from a different perspective. You have been saying that your nine percent, nine to 11 percent profit, PAT is justifiable. You have got the right to get that percentage of profit. I mean, whatever you have mentioned earlier. I got that perception.*

At the same time, you say that the insurance companies are making huge profits, up to 21, 22 percent, which to you is too much. I mean, I got this impression from what you have presented. At the same time, can I make one statement? You correct me if I'm wrong. That means, without the insurance— take a very, very, very hypothetical situation. Without the insurance companies, without the health insurance, private hospitals cannot survive. Can we conclude? Can I make that statement? Is it wrong or right? That means your industry, for your industry to survive, you need insurance companies. Without that, you cannot survive. Do you agree with my statement or not? I hope to get your response before I do my follow up…

Encik Anwar Anis bin Anis Ahmad [APHM]: *Sure Tuan Zahir. So, Tuan Zahir, maybe I'll add some, then my colleague can answer as well, right. So firstly Tuan Zahir, in terms of profitability— let me make it very clear right. I think what we are saying is if somebody— if you were to put RM100 investment, what do you think is a fair return? I think that is our question. So, what we believe is, as far as a private health care is concerned and what we have given, data is very clear. Among all the*

various components in private health care, pharma, medtech, insurance, hospitals, we are the lowest. We are not saying that is very high or very low, but the fact is healthcare which is the provider is the lowest.

Okay, number two. When we saying nine to 11, why do we believe it's fair? Because we have very high reinvestment. What is that mean? Are that nine to 11, six to seven percent or even higher is reinvested back. What does reinvestment means? Every six, seven years, we have to buy new equipment to make sure patients are safe. If you got have eight, nine, 10 year-old MRI, that's starting to give you errors in reading and then errors in your treatment, would you accept it? You will not.

So, this machine must be replaced. Your OT must be updated, your infection control system, your air-conditioning, your chillers, your filters all must be replaced. So, reimbursement in health care is very significant. What we are saying is, at nine to 11 percent, if you compromise it further, you will compromise the sustainability of health care. We are not saying the ITO is overprofiting. I think if you tell us, should hospital do better, have a better profit? If you ask me personally, maybe we should be at 15 and 16 percent to make sure that we remain competitive in the region.

So, we are not making a comparison to say one is wrong. What we are saying these are the differences, and the difference is, among all the parties that involved in healthcare, we are the lowest. So, it is challenging if you squeeze the one that is already the lowest. That is our point, just number one.

Number two. Yes, we need private health insurance because that is how it has grown in Malaysia. Will we survive without private health insurance? We will— it may be painful. As of today, if today private insurance says we don't do cashless anymore. That means I don't give a guarantee letter. Everybody must pay and claim. Yes, maybe for one year, we will all suffer but in many other countries, it is like that. I pay and I claim. So, private hospitals also find, okay, what is the volume of patients who are willing to pay and claim? We will not build more. We will not build more hospitals because we know, okay, maybe 20 percent of Malaysians are willing to pay, who can pay and claim back from insurance. Our capacity will adjust to it. But that also means that the government will have to look after 80 percent of the patients. So, the question is not whether we will survive. I think, will the government survive when that happens?

Puan Erica Lam [APHM]: *Private hospitals started with all cash-paying patients. It started to expand because of the demand from the market because more and more people are buying insurance and shifting from the public system to the private. That is where we are landing, having this discussion today.*

So, can we survive? Answer is yes, we will be suffering at the beginning but after that without further capacity building up and everyone is going for medical tourism, probably we will continue, but we will by then achieve a profit of more than nine to 11? The answer is no. It will still be the same, nine to 11 because this has been going on for the last 20 to 30 years. That is our margin that we are accepted that is a fair profit after tax margin to reimburse back to the system. That is what we do.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Can I ask my follow up question? Okay, based from what you have presented, based from what your answers are. Now, with whatever eight commitments that you have put in, your frustration on certain things that have not moving forward etcetera, what are the planning of the private hospital in terms of growth? Are you all planning to increase number of hospitals, number of beds? What is your planning now?*

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Let's say five years. Your present does not take into consideration of the Israel and Iran war, et cetera, et cetera.

Puan Erica Lam [APHM]: *Yes, I understand*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Okay.*

Puan Erica Lam [APHM]: *Malaysia.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *All Malaysia and your planning as it is right now, you must have five, ten years plan.*

Puan Erica Lam [APHM]: *Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, what are your growth trade in terms of this?*

Puan Erica Lam [APHM]: *Okay. Allow me to speak maybe from IHH. Maybe a little bit APHM. Throughout the last two months, we've been in discussions a lot with Bank Negara, with MoF and MOH. What we are lacking of is certainty. Because we are really going out trying to support the base product. We understand that the public system is overcrowding. We are shouldering a bit of these social services to take a little bit M40 patients to come to private.*

If there's certainty and it is quite firmed out, rest assured, we would have expanded capacity. Because as we speak today, the private hospital capacity is unable to cope with that sudden incremental of that M40 patients coming to us. We really have to expand. Without that certainty, we don't know whether what we are expanding for? Expanding for totally private patient for insurance or expanding for medical tourism? That part we will continue the grow. When we see the business there, we will grow.

But to cater for the M40, we need a very strong certainty, a very secure environment for us to do investment. Because currently as we speak now, we are kind of like capacity used up for private patient already. Without that M40, are we still not growing? No, the answer is we will still continue to grow.

Chin has already announced his KPJ growing for another 3,000 beds. Sunway also building another total 10 hospitals and IHH is also looking into building another 1,000 to 1,200 beds in the next five years actually. To meet the growing demand for private healthcare.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *It means that projection does not cater for the M40?*

Puan Erica Lam [APHM]: *Not yet. But if we were to cater M40 will be higher. I think Chin would have more to say.*

Mr Chin Keat Chyuan [KPJ]: *YB, I love this question so much. I hope you'll be able to help me to bring this question to our shareholders, you know? Our projection for future next five, ten years is all depends on the appetite of our shareholders, right? The shareholders means who? The EPF, KWAP, Khazanah for IHH, right? You are talking about JCORP for KPJ, Columbia. So, all the shareholders they should be the ones who actually provide guidance to us in terms of what they expect management of the respective organisations to actually grow. But to be very honest, we see healthcare as an evergreen industry, right?*

Whether local because of aging population that represents opportunity. Because of NCD issue, that represents opportunity. Because Malaysia is strategically located in the position where we are so affordable and accessible to the health tourism. And if you look at the last few weeks the reports and all, Malaysian has been regarded as one of the best destinations for health tourism.

*So, if you ask me, Chin, definitely whether IHH-*kah *KPJ-kah Asia One Health and all, we are projecting growth? But it is the profitable growth or is not? This really depends on the environment and this is where we are working on now.*

Today if you asking me, Chin because of the potential policy makers, all YBs together with the government come in to say that we want to make it affordable. The question really, we want to ask is affordable to who? Who is paying for the service today? Do we have the health tourism complaining about that? Are we not being comparative?

If we are yes, that means that our price is actually priced sweet spots compared to Singapore, compared to Thailand? I think those are the questions we need to ask ourselves. Now, today the question is if today kita tanpa *private insurance, can we survive? The answer, we can, but we will suffer for a while.*

But insurance company also will be suffering. Because they are using medical health insurance as a door opening to sell their other products. If we decided today where they depanel us from everywhere, do you think policy holders will still want to subscribe to insurance? No. Because if I have an insurance policy, I hendak pergi Pantai hari ini*, you* di panel *Pantai. I* hendak pergi Prince Court, *you* di panel Prince Court, *I* hendak pergi Gleneagles, *you* di panel Gleneagles. *Why would I want to subscribe to you?*

So, these are actually the dilemma happening also in the industry. Because they are using it as their so-called their bargaining right. To say you give me discount, if not I'm going to depanel you. But when you start going every single provider and depanel semua itu, mana *patient* hendak pergi? *And you will end up getting bad names you know. And it really happened. Some the insurances being so difficult for this cashless feature. Some policyholders decided to also switch. So, I think it is entire ecosystem* punya *conversation today.*

We can't live without them, maybe. Suffer a bit. Can they live entirely independent on us? I also doubt. But ended up, I would be more scared if today government suddenly dia punya fasiliti *as good as private, and they are providing the best healthcare efficiency. I* yang takut itu*.*

Because that is free, kalau *free* tak ada *long queue, very good service from the government, I think I cannot survive, if you ask me seriously. That to me is the biggest, biggest threat but of course it's good for the Malaysian*-lah. *That means all Malaysians will get the best healthcare at the free of the cost.*

Encik Stanley Lam Kean Fatt [APHM]: *So, YB just want to tell you right. Private investors are very real. As long as it is not commercially viable, they will pull back. They will press the handbrake, you know. I mean, even though they have done a lot of projection and assume that they are going to expand, but whenever the whole thing doesn't seem to be viable, I'm sure they'll put a stop to it. I mean, they are all rational investors.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Pengerusi, *no question, but just sharing of some little bit of experience. Some industries, their profit much-much lower than nine. Especially the industry where I was with previously, construction et cetera. So in instances, some of the things is below five in fact. But the industry can still survive, can still contribute to the development to the country et cetera, et cetera.*

So, you mentioned nine to eleven is very, very minimal. That means the whole industry got to be holistically looked at in terms of profit margin-lah. *That means at your end is the lowest, that means your end as well as all the others got to bring down accordingly for the sake of the nation and for the sake of the* rakyat.

Puan Erica Lam [APHM]: *YB, just to share with you, I don't talk about the rest of the hospitals. I just share you Pantai Hospital Kuala Lumpur where I'm running. I can share with you the profit margin from— profit after tax of the last three years. During COVID-19 time it was the lowest reinvestment because the business just gone crash.*

So, 2023 to 2024 and this years. Last year we reinvested 60 percent of my profit after tax back into the hospital. So, meaning I only left with four percent back to my shareholders, that's all. The six percent I go back to the hospital.

All the major equipment reimbursement, our building has to upkeep and all that. To keep up the whole hospital to be acceptable level to the private patients, it cost a lot. It is not a normal small reinvestment. That's why I echo what Anwar said. We need that kind of percentage to continue to fund and reinvest back to the hospital.

So, 2023, I reinvested about 50 percent, meaning five percent goes back to the hospital, five percent went to the shareholders, that's all. If we're talking about the construction company probably they are talking about the same thing. The only thing is reinvested a lot. This is not even including a super expensive IT infrastructure as yet. If you would've put back the IT infrastructure, super high-end HIS, AI, all this probably you are talking about 80 percent of the profit.

Technology initial capital outlay it's very, very high. The repayment period for investment probably takes about seven years to 10 years. In order to optimise the technology itself. So, yes. It is true that private healthcare or healthcare itself is a very intensive capital outlay business.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Pengerusi. *I think Malaysians are getting— population are growing bigger. People are getting richer and sicker and also aging, I think your business will be ensured*-lah*, don't worry. That's why I think hospitals are— you know it's reinvesting building more hospital. Okay, but however, what I see is that from your presentation, you have eight suggestions you want the government to do, you want the insurance to do, you want a lot of people to do. But these are— you are still asking people to do, all right? What I'm asking is what is private hospital doing to cut cost?*

Puan Erica Lam [APHM]: *YB, the very first initiative it is what we supposed to do. Number one, we had to restructure our billing model which is often gives rise to a lot of arguments from public, "Why are you charging me gauze and all that?".*

So that's number one. We will do that. We are undertaking to do that but we can't do it alone when the insurance company telling us you cannot reprice like that because I do not design the product to reimburse. So, we are striving from that.

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Number two, we are also working on our procurement and cost savings. That part has been going on and on and on in our industry. It's just that now we have to re-intensify our efforts. To work even closer with the doctors. How do we strictly follow clinical practice guidelines onto treatment. To reduce so-called overused of medical resources? That part absolutely we are committed to do. After this whole discussion and arrangement absolutely, I think KPJ, Asia One, us, even Dr. Tan and Stanley. This is what we do every day. So, maybe KPJ can share with you how much they have actually done into the pool procurement to reduce the cost and the cost saving is back to the patient. It's not like the cost saving, we still keep in our pocket and then we all earn more money. If it does so, right, we will not do nine percent profit after tax. We should be earning more. I mean let's get real.

Tuan Sim Tze Tzin [Ahli PAC]: *What is the projection that how much cost? How much cost can you reduce?*

Puan Erica Lam [APHM]: *I can only. Okay, where should I say that. In IHH Malaysia we have pledged, we put in a very high aspirational cost savings up to nine-figure. Nine-figure cost savings. Nine digits of costs savings. Collectively nine.*

Tuan Sim Tze Tzin [Ahli PAC]: *What percentage? What percentage?*

Puan Erica Lam [APHM]: *Nine digits, nine digits.*

Tuan Sim Tze Tzin [Ahli PAC]: *Nine digits means how many percent?*

Puan Erica Lam [APHM]: *Percentage? Like one hospitals revenue. One entire hospital revenue.[Ketawa] One small hospital revenue. Yes.*

Dr Tan Hui Ling [APHM]: *Okay, I think since end of last year all the private hospitals have panic and really, really started cost saving measures. Things that we don't shout about for example, we can only focus on things that we can reduce the cost. There are a lot of elements we can't reduce the cost. Manpower is one of the biggest chunks we cannot reduce. If we reduce by not increasing salary, we know that we will lose all our staffs, okay. Anything else I think the cost has just been going up for us in recruiting staff because of market competition and etcetera.*

Those that we can control would be equipment that we can invest in. Now all of us now last time we hardly consider China brands. I can tell you now China vendors are our favourite. Please bring in more okay but we need those that have MDA approved which is a challenge. Most of the China products or even Taiwan products or even Japan products, medical equipment etcetera do not have MDA yet okay. So, that's our biggest problem whereas the European products are all MDA approved. But we know that they are more expensive.

Okay, so we are working on that as an industry which is why APHM exhibition recently, we have two halls just for China vendors. So, we are sourcing. We are

sourcing cheaper products and hopefully as good quality, okay? Things that are beyond our control are imported drugs. Imported drugs, that's beyond our control. With this US tariff, our biggest fear is the cost for importing these drugs would be higher because it will be more expensive to be made in US and other countries as well.

So, those that we can convert to generic some we can but some we really cannot. Because generics theoretically they work the same but they don't honestly. Efficiency, side effects are different. I mean, I myself use— even as simple, Panadol or Paracetamol. Paracetamol is generic. The drug name Paracetamol for different brands gives me different side effect. I get gastric discomfort for the generic brand. What more or a lot of other cardio heart drug etcetera. All doctors have also tried to work with the insurance. Those that really do not need admission, we really see them cutting down those admission cases, okay? Those that can be managed as outpatient they tried as much as possible, discuss with the patient go for outpatient option.

Okay so these are all ongoing that we never shout about but the truth is it's ongoing and the biggest so-called cost cutting is actually giving in to the insurance by offering them more discounts. We have insurance asking for 25 percent discount, 40 percent discount even. But it's impossible for us to give 40 percent discount. Giving 40 percent discount means I am subsidising your client. It doesn't make sense in a private sector. Even a charity hospital cannot run with 40 percent discount.

Puan Erica Lam [APHM]: *YB, I got the number already. The IHH Malaysia cost saving percentage is about two to three percent but our discount to insurance is five percent. How can? That's what this is now, in real life.*

Tuan Sim Tze Tzin [Naib Pengerusi PAC]: *I just point to this insurance— discount to insurance, 25 percent to 40 percent. How many cases they ask for this kind of discount? Out of like 100 cases, I am sure it is not everything.*

Dr Tan Hui Ling [APHM]: *All their clients.*

Puan Erica Lam [APHM]: *Every, everything, everything in the bill YB. [Ketawa]*

Tuan Sim Tze Tzin [Naib Pengerusi PAC]: *All cases?*

Puan Erica Lam [APHM]: *Everything. All. Yes.*

Dr Tan Hui Ling [APHM]: *All clients of theirs. Otherwise, you might be removed from being the cashless facility. In fact, I have one insurance that come to both of my hospital which when we had catch up with them every year, we do reviews with them every year. To us your bill size very reasonable. Suddenly in February we receive a notice, your hospital is being removed from cashless facility. I say "don't*

come and talk to me anymore. I don't even want to negotiate with you", and that's how they deal with us. Now they use these two to go to the bigger groups and negotiate. If you don't give me more discount this is what will happen to you. Look at the small fries, we are the small fry okay. Small hospitals, small fry. We can just de-list you like that. And that's how the insurers deal with us.

Puan Erica Lam [Bendahari APHM]: *But I'll give you a statistic. Last year my discount to the PHKL because I am very familiar with Pantai Hospital Kuala Lumpur numbers. The discount I'm giving to the insurance and all like it's about three percent of my revenue. But because last year we have gone for one round of negotiation already. Last year was nothing about this whole era, it's just pure business negotiation. I give you more business, you give me more discount. Immediately we see impact of increase by 1.5 percent. So this year 4.5. Now coming soon in April, January, April all the hospital groups already strike many, many deals, market forces discount negotiation. We expect our discount rate will go up another three more percent, six to seven percent.*

So, as a country why I choose Malaysia? We are talking about a cost savings to get three percent. Why we do three percent cost saving? Because to save the money to subsidise the discount. As simple as it is. Initially we'll be just leave it at it. The patient will get savings when we got savings. Now saving is actually go back to the discount. So, we have to give three percent discount then we save money from three percent, put the money back together. So that is as it is I can give it to you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey terima kasih Pengerusi. *Just now I listened you all talked about convince your shareholders then your profit is about nine percent okay for private hospital. So, then I look at you know I check the Malaysian construction industry. We used to think that they also make big money. So I check the net, it says that profit margin is generally range from two percent to 10 percent. That means in average is even construction industry, average profit margin is around six percent. So, then this shows that your, the private hospital your margin is actually even higher than housing construction industry.*

So, if we look at other countries right, we know that Sweden had been banning private hospitals into to be to go for listing, public listing. Then you have Canada, you have South Korea. They are all doing the same because private healthcare shouldn't be seen as a company. The tools who are making money. So I want to ask you all that just now when we heard, hear from you is that insurance company is a bad guy. So, our PAC in the end we also need to come out with our proposals to the Government on how to rectify the current problem now because every sector that we met, we all blame each other one. So, we need to come out with a solution and I

believe that you all are very sincere, you also hope that the government can also really look into your proposals but it seems that they are not forthcoming also. So, I want to check with you why do you think that if we suggest to the government to ban private hospital from going to be public listed companies.

So, that it will be— if Tung Shin Hospital can survive, you have Lam Wah Ee— this kind of community hospital they don't aim for making big money but they also provide quality medical service for the public. Are you all willing to consider that you know to have the kind of structural reform in your industry, private healthcare industry, that is not to be profit-oriented but of course you all need to make profit so that you can expand and all that. What do you think of this idea? Shall we propose to government to ban private hospitals from becoming a public listed companies?

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Encik Anwar Anis bin Anis Ahmad (APHM): *So YB, maybe I'll answer— I'll give some feedback and maybe Dr. Tan can add to when she comes back because her family has been involved in-not-for profit. So, one is sure. Then, government should stop taxing private hospitals, number one. Stop taxing private hospitals. We don't get any subsidies, none whatsoever. Then we can become not-for-profit as well. Number two, the not-for-profit hospitals survive not because of operational revenue alone. They survive because of donations. So, is government willing to subsidize us and give us donations as well? That's only so much that the rakyat can do.*

You want to compare the Sweden, Korea, lets tax our rakyat at the same rate as well. Then you can have private healthcare or not-private healthcare and government to sustain healthcare for the rakyat at those tax rate. Is the government willing to do it? All of this back in the government's court. Government can make those decisions, don't tax us, don't take our money. Subsidize us because that's what not-for-profit hospitals survive and increase the tax rate to the rakyat then you can do what those countries that you mention do it. I also want to come back to you YB Sim …

Tuan Sim Tze Tzin [Ahli PAC]: *I think, on …*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Let me complete if you don't mind. I also want to— because we already presented this at our first round right. If you talk about what we've done in terms of containment of cost, we've already showed this before, happy to go through the details. Look at the slides, we are not here to blow our own trumpet. If you will come here and say these are all the things that we have done and we done very good, can.*

Our objective to come to the PAC is really to say these are other things that we can do, that will benefit all of us as Malaysians. If we are here to come and say

these are all the things that we've done, we are very good, then it just sounds like we try to blow our own trumpet. But the fact is 2020 to 2023, if we do not do any cost containment at all, the CAGR in terms of cost because of medico-legal, staffing, equipment, inflation is 12 percent per year. But, because of all the things that we've done, the CAGR is seven percent. So, we absorb because of efforts that we've done.

If you want to know those efforts, we can have a separate presentation on all these line items, on all the things that we've done and we will give you example right now, okay. So, in terms of procurement, very clear. In terms of manpower, we are training nurses, subsidizing them, paying for their scholarships but what can we do? In Malaysia what people are willing to pay us for healthcare is that amount. In Singapore is three to four times of that amount and say you can pay our nurses three to four times of that amount. So, we lose our nurses. So, we have to train more then we can take in and we've been— all the hospitals do all that training. So, that's number one.

Number two, if you talk about our hospitals whether IHH, other public listed, one, we are going into solar, we've invested into solar not to reduce because we have zero subsidy in terms of energy cost. There is nothing from TNB. In the last three years we had multiple increases. Next one is July. Private healthcare will have 14 percent increase in energy cost. Sorry?

Dr Tan Hui Ling [APHM]: *[Bercakap tanpa menggunakan pembesar suara] Energy cost.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Energy cost 14 percent. What are we doing? So, if you ask us what we are doing, we've been investing into solar where we can, not all the hospitals can because of structure but we have. I just give you examples. But if you look at all these line items the reason why it is not 12 percent is because we have active interventions to bring it down. We invest into magnetic chillers, oil-free chillers because it brings down energy costs because we have no subsidy.*

So YB Teresa, we can go down the route of a socialist where we don't allow for a listing but again it's not just about private hospitals. Government has to be prepared to do it and we will like I said Dr. Tan and her family have been running not-for-profit. It doesn't survive on its operating cost alone. Maybe Dr. Tan, you want to add a little bit about having to survive on donations and all that for not-for-profit hospitals.

Puan Tan Hui Ling [APHM]: *Yes. May I use example Lam Wah Ee lah. So, Lam Wah Ee was— we have to go to a long story. Lam Wah Ee has started as donation, okay. So, it is run as a not-for-profit. Early days— I honestly tell you, early*

days 20 to 30 years ago, even as a not-for-profit hospital it can make money. Make money in order to invest back in the hospital. YB Sim you are from Penang right. Those days Lam Wah Ee always the first hospital to bring in the best machine.

Lam Wah Ee was the first hospital in the Northen region to bring MRI. But I can tell you now Lam Wah Ee does it have robotics? No. What best equipment is Lam Wah Ee shouting about now? Nothing. Nothing now. Because the cost of running of a hospital is going up so much. Now, Lam Wah Ee depends a lot on I would say freewill donation. They don't actively run donation campaign. But, a lot of patients out of gratitude when they pass on, the family members just donate. It can be as simple as RM500 but we have seen RM500,000, we have seen RM1 million, RM2 million in memory of who and who and who. So, these are donations to subsidize the operational cost of the hospital.

As well as the hospital also evolve in the way it runs. For example, we still keep the 12 beds that charge RM20 a night and that's of course that's still the VIP wards where you pay the real full private fee and this help subsidize the cost of the open bed wards. Of course, the doctors are not charging at full fee of what they are allowed to. All these are goodwill understanding with the doctors that you don't charge because it's not-for-profit hospital. In fact, at one time, if you remember I think five to six years ago— because it's not-for-profit there's no income tax and there was a reverse of all these benefits or income tax. At that few years, actually Lam Wah Ee was in the loss because MoF chase back the so-called tax and then you pay back.

So, for the last few years actually Lam Wah Ee has been running at a loss. Until I think last year it pick up but this year— two years ago it picks up but last year we saw that numbers went down again. Just enough to cover the cost. Also, with goodwill from a lot of vendors they actually give very special price whether it's drugs or equipment to Lam Wah Ee knowing that it is a not-for-profit. So, it's not as simple as why is it sustainable but there's a lot of people play their role to help keep it sustainable.

Encik Stanley Lam Kean Fatt [APHM]: *So, to answer YB Teresa just now question not to allow all these so-called public listed company to be listed anymore, right. So, to question here is— I have a few questions. First of all, who's going to pay the money to delist all these companies. Somebody has to come out with the money right. So, that's one thing I want to ask.*

Secondly, even then you delisted them from the public listed platform, doesn't mean that you help them to reduce the cost. The cost still remains the same. It makes no difference. They still need to hire staff, they still need to pay doctors, they need to

buy machines. All those things are still going on. It's the treatment that has drive the cost up. Secondly just want to tell you.

Thirdly, let me tell you this right. Even though I don't have any actual numbers in hand, but as far as I know private hospitals are much more far efficient in building hospitals. If let say private hospitals plan X million to build one hospital, usually the government need to have double or even more to build one hospital. Who is more efficient in utilizing funding to build hospital? Actually, is private. So, those are things I think the PAC have to think about right.

Ultimately, I hope my next year dividend on EPF would not be reduced as a result of all these things and if let say for example they pay and prioritize a company and the company is not being running as efficiently as it did before, and that is a destruction of value and it create very bad example for Malaysia as a whole because we are open trading nation. I just want to give another example right.

Years ago, there's a drugs company and medical devices company come to me and talk to me and said that they want to even quit Malaysia market because the market has become so unattractive. They just don't want to bring the drugs to Malaysia. Imagine that if let's say those situations keep happening, Malaysian even have no access to good drugs that have been launched globally because of our social mindset. So, this is among the things I think as a whole we have to think about for the country. It just not about facing one more piece of things but create a bigger issue for the whole country to manage.

Puan Erica Lam [APHM]: *YB Teresa, I think apart from all business talks let's talk about human factors. Private healthcare doing well and all that. We are keeping— one of the industries that keeping the largest workforce and 99.9 percent they are Malaysians. A simple hospital like 200 beds will take about 700 to 800 staffs.*

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Pantai Hospital Kuala Lumpur, excluding all the outsource, we are 1,600 staff. Sunway— 800 beds, 4,500 staffs. We are talking about all these are Malaysians. So, imagine that if you were to talk about private hospitals are not supposed to make a profit, I'm not quite sure how do we keep up with the families of all these average Malaysians and that's one of the reasons, why public hospitals facing the exodus of the healthcare workers. Because for that kind of professional services and that kind of training of years that they spent to horn their skills but they are not being treated fairly in terms of that.

So, when they cannot keep up their families, what do they do? They look out. They look out from Malaysia, they get out from Malaysia, that's the worst loss to us as a country. We are losing the talent. We are already losing. I heard about some of

the anecdotal stories that I heard from UM medical students graduates. One quarter has already been scouted by Singapore government hospitals. Singapore government's MOH, which means that as soon as they pass the MBBS, they will not stay in Malaysia. They will go straight down to Singapore and get trained as a houseman, MO and eventually, be known what's the pathway.

Likewise, Australia is taking our nurses, taking our MBBS graduates. They have started talking to them even as— before they even graduate. So, if you were to start saying this kind of saying, but the human factors are not being looked into, we will lose them. We are just training them for other countries. So, I do not want to end up one day right, Malaysians have to go overseas to seek treatment [Ketawa] because Malaysia is no longer attractive to keep up with the international standards. That is what we hope for. Thanks.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, saya nak menarik balik tentang diskaun tadi. Dari kenyataan yang diberikan bahawa terdapat unsur paksaan dan juga tekanan yang diberikan kepada hospital swasta untuk memberikan diskaun oleh pihak insurans.

Do you think that ini *is a the part of corporate threat?* Ugutan korporat yang diberikan oleh pihak insurans kepada pihak syarikat swasta? Satu, dan yang kedua, adakah ianya sepatutnya dilaporkan perkara tersebut kepada Bank Negara Malaysia ataupun mungkin juga kepada pihak Suruhanjaya Persaingan terhadap insiden-insiden yang berlaku ini? Sebab ramai yang tidak tahu tentang perkara ini. Jadi, adakah usaha daripada pihak APHM untuk melaporkan insiden demikian kepada mana-mana pihak?

Encik Anwar Anis bin Anis Ahmad [APHM]: Terima kasih YB atas soalan itu. Jadi, pertama sekali minggu lepas bukan sahaja *conference* APHM tapi juga *annual general meeting* (AGM) untuk persatuan kami. Jadi, antara topik ataupun isu yang paling hangat dibincangkan adalah perkara ini. Terutama sekali daripada hospital-hospital *independent* yang kecil. Ini kerana mereka rasa ya lah, *as a financial backing* dan sebagainya, mereka lebih *vulnerable.* Lebih terbuka kepada ancaman begini. Dan, pada hari yang sama, kami telah menulis surat kepada Bank Negara berkenaan perkara ini.

To be fair to Bank Negara, ada *technical committee* di mana bila masa kami berjumpa dengan Bank Negara dalam sebulan lalu, mereka sudah meminta bahawa kami memberikan maklumat ini kepada Bank Negara. Tapi permintaan Bank Negara adalah untuk ahli kita menulis kepada BNM dengan memberi contoh.

Now, tadi YB Tuan Zahir ada mengatakan memang pada masa ini, *it's a*— kami memerlukan, saling memerlukan insurans dengan hospital, saling memerlukan

each other. Ahli-ahli kami yang *especially* yang *smaller ones* risau. Kalau dia tulis pada Bank Negara dan perkara ini diketahui oleh insurans, kerana dalam *insurance policy* ini, *cashless* ini adalah *benefit*. Maknanya, dia tidak perlu bagi *cashless.* Jadi, dan tapi situasi di Malaysia ini, pesakit kita dengan ejen cara dia jual, dia kata *cashless benefit.* Jadi, sudah menjadi kebiasaan.

Kalau hospital yang tidak ada *cashless,* memang *insurance policy holder,* individu kurang pergi ke hospital itu. Jadi, pendek kata YB, kami sudah menulis kepada Bank Negara meminta masa daripada Bank Negara untuk kami secara sebagai persatuan, datang dengan contoh yang spesifik. Tapi kami kata berikan kami peluang untuk datang dengan contoh itu *to give them those examples, share them in details, in person* dan meminta nasihat daripada Bank Negara apakah langkah seterusnya? *What should we do next? Whether it's to MyCC or otherwise, we would like Bank Negara also to guide us. Because, they are the regulator for the insurance.*

Bank Negara sebenarnya dengan perjumpaan kami juga telah mengatakan bahawa pada pendapat mereka diskaun*, the upper limit is about 20 percent.* Daripada Bank Negara tapi yang kami lihat pada masa ini sudah melangkaui limit itu. *So, we have written to your question, we have written to Bank Negara. We are hoping that they will call us because among our members, they have already committed who is going to come with what examples, specific examples to show them and these are examples in the last one month.* Bukan kata daripada enam bulan dulu. *These are very real, specific examples that we want to share with Bank Negara.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau boleh saya tanya topik yang lain adalah tentang *third-party administrator* (TPA). Adakah TPA ini, apakah peranan TPA dalam *private hospital setting? Are they actually helping— how many percent of your customers or your clients, patients come from TPA? And then, are they incurringt cost, extra cost or driving up inflation in this medical inflation?*

Puan Erica Lam [APHM]: *Maybe the first question YB, to answer it's about 25 to 30 percent the TPA business in private hospitals because this is largely managed by the corporate employers' insurance for their own employees. But in terms of how much are they driving up the inflation, I don't think it's any difference from cash-paying patients or insurance companies. Because in the end they are just employee, they are coming to us to seek treatment, we would use the same treatment how we treat the cash-paying patients or even insurance companies. Not much of a difference actually.*

In fact, employees sometimes they have a very limited cover as employees. Then by that, they could only subject to a certain level of treatment. After that they have got to go back to government because the company do not tanggung *or they*

have to top up with their personal insurance or by cash. So, short answer is no differentiation in terms of inflation.

Encik Anwar Anis bin Anis Ahmad [APHM]: *If I can add, YB. So, TPA or third-party administrator, as Miss Erica said we don't think that is contributing to inflation per se because it is on a capitation model money.* Kalau ada syarikat yang ada 1,000 staf ataupun *manpower,* dia akan bayar kata RM3 *per staff per month for them to manage their healthcare benefit. Of course, the research also shows if you try to do that on a large scale yourself, it will cost you more. Then you have to set up your own department* dan sebagainya.

So, dan TPA ini ada dua fungsi dia. *One is also for a self-insured company. So, there are certain companies* yang tak beli insurans. Dia tak beli insurans. Maknanya, dia ada bajet untuk *healthcare cost* untuk staf dia. Tapi untuk menguruskan perbelanjaan ini, panel hospital mana *for the claim, to review the bill* dan sebagainya, dia *engage* TPA. *And like I said, buy at large, it is on a per-head cost. So, doesn't matter what the bill it's a per-head cost. So, that's number one for a self-insured organisation.*

Number two, insurans juga menggunakan TPA. *Smaller insurance* yang tidak ada *claim processing department* mereka sendiri akan meminta TPA untuk melakukan fungsi ini untuk mereka. Itu satu. Dan kedua, insurans yang jual insurans untuk korporat, di mana *the employee benefit.* Kalau *employee benefit* ini, bukan sahaja untuk *hospitalisation* tapi untuk *outpatient* juga. Dan, kebanyakan insurans— *most of the insurance* tidak ada *department* untuk *outpatient management of employee benefit.* Yang itu menjadi fungsi TPA.

Secara amnya, kalau ada syarat-syarat dalam apa yang boleh *cover,* tidak boleh *cover actually it's either from the corporate or from the insurance.* TPA itu melaksanakan apa menjadi syarat daripada insurans ataupun korporat yang menggunakan perkhidmatan mereka. Secara amnya, itulah fungsi PTA.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Sekejap. Sebelum *you go to next question,* cuma nak tanya. Apa beza TPA dengan PTA?

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]* PTA?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Preferred treatment something.* Ada ke— *it's* TPA lah yang diguna pakai. *Is it?*

Mr Chin Keat Chyuan [APHM]: *Actually, we are not sure about the PTA. TPA in general like what Encik Anwar said. In general, only look at the volume game. You can't be having a TPA manager and corporate if only 20 staff and all these. They literally need a volume for you to manage the administrative work.*

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The payer automatically is still either noninsured, that means they corporate themselves. For example, the TNB, Maybank for example or because the insurance company they in general don't work on outpatients but because some corporates prefer to have that for their outpatients punya *employee benefit. So, that's why they are outsourcing it. It is an outsourcing kind of work, general not adding too much. It is very, very marginal for TPA.*

Tuan Sim Tze Tzin [Ahli PAC]: *Do they charge you? Does TPA charge you something fees or something?*

Puan Erica Lam [APHM]: *Once upon a time, they tried collectively, we rejected. [Ketawa]*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. No wonder, no wonder, okay. Ya okay. Sorry, sorry. I want to go to DRG. DRG from your presentation just now, of course, there are a lot of challenges but let's say the government manage to pull through DRG. Will private hospitals committed— all private hospitals committed to DRG or do you still prefer fee-paying? I mean, itemised, is it itemised paying?*

Mr. Chin Keat Chyuan [APHM]: *Fee for service. [Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: *Fee for service, yes. Can you explain to us, please?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So YB, I think APHM's position all this while is very clear. We support DRG for a National Healthcare Scheme, we support, all right. Now, if the MHIT product becomes part of the National Healthcare Scheme and that uses DRG, we are supportive. And that is why as I said in October last year, it is us who proposed to have a baseline in MHIT product.*

Now, if that becomes part of the broader National Healthcare Scheme, whether it's paid for through EPF, whether paid for through employees, it doesn't matter but if that is the baseline coverage and that is on DRG and it's on a voluntary basis. As you said, in all these countries, whether it is Thailand, Indonesia or Singapore, it is the provider, the hospital decides I want to be part of this program and support it.

Now, why does that matter? It is because then how you design your facility is for volume. So, in Indonesia, I hope you know this is human nature, ya YB. In the sense that somebody who's paying for the 2 million dollar policy and all that, they find it very difficult to go to the same facility where there are 200 people waiting, very crowded, very noisy. This is human nature. So, even in Indonesia, the hospitals that provide BPJS under the BPJS scheme, by and large, design a dedicated facility or within the same facility dedicated areas for BPJS.

So, APHM's position is clear. DRG for the National Healthcare Scheme and even if MHIT becomes that, we are supportive. I think what the question that we keep asking is— and the concern we have is when DRG was being proposed as a scheme to pay for private insurance and we have asked this question. Give us an example in the world where DRG is used first and foremost for reimbursement of private healthcare insurance. Until today, we have not been given any example.

So, it cannot be that the rest of the world never figured it out and only Malaysia did and that's why we took the Thailand example. A country with 30 years of experience, why have they not asked to do that? So, I hope that makes our position very clear and that is why we have technical people, committee members, myself, Erica and others participating in various discussions for DRG, we are supportive. We want to provide the right technical data; we want to provide support so that we can design the DRG so that it is something sustainable for Malaysia but for the right purpose.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. So, is DRG going to be able to help to contain medical inflation?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, simple question ya and simple answer. If that were the case, Thailand should be cheaper than us. [Ketawa] Thailand is not cheaper than us. Indonesia should be cheaper than us. Indonesia is not cheaper than us. Korea should be cheaper than us, okay. So, I don't know which country is cheaper than us [Ketawa]. We are quite cheap. So, DRG I think can curb— okay, what we— if you look at the presentation that we had in our conference, what we want to reduce is wastage and abuse.*

Hopefully, hopefully, if properly designed, DRG can help us do that and that has to come again with the national healthcare structure, where if somebody had an MRI somewhere else, they don't have to repeat it somewhere else. If somebody had investigation, we know what needs to be done, we follow a CPG or a guideline based on DRG and we do that and the doctor is protected when they follow the CPG. Because DRG means the patient doesn't get to say, "Oh, I want a pretest MRI or I want a ceramic implant, although 75 years old".

So, hopefully with DRG, what we can have is appropriate treatment and reduction of wastage. Now, whether cost can come down, I think that is difficult to say, all right. But what we can have, is more efficiency and more people being treated but not necessarily for the cost to be down.

Mr. Chin Keat Chyuan [APHM]: *Can I try this YB? YB, I like the way how just now you mentioned. Do you want the government to come in to regulate everything right in the private? In the private, you should solve it out by yourself, you should be*

a market force, right? And YB, I really like this because that has been how private healthcare in Malaysia has been actually successfully attracting so many health tourists to come in and that health tourism has significantly contributed to the GDP growth in the country, not only for private healthcare, right? But in general, I think that is actually how the whole thing trends.

Now, if you ask me, Chin or APHM, do you see this DRG will actually significantly bring down the cost? I think it will but it has to start somewhere, start where? The government has to start the DRG process first because today in government healthcare for example, Malaysia is a heaven, right? We are heaven in terms of public health. Why, we are actually allocating budget based on your previously how much you spent and then this year how much you should get, right.

But DRG would then help you to really go deep down understand the costing, the cost structure and I think that is going to be a normal learning, you know. So, if you ask me, "Chin, is DRG still relevant?" I think it is relevant, relevant but then we need to have a system to capture the data, the coding and all this we need to start from where? From the government first.

The moment when we have successfully adopted the whole thing to get it what Encik Anwar said right, we need the entire healthcare financing model to be reimagined. Because today, government healthcare versus private is two different things, we don't cost subsidise you know, but we are complementing each other. But if you are using DRG to blindly it us impose on the private, one thing is for sure, the private healthcare system is going to collapse overnight without a thoughtful process, without a system in place, it will collapse.

Second, while we are doing this, we are going backwards as we all discussed before, right? We would not be able to reinvest as what Erica has mentioned, right? We would have no more resources to reinvest back and that means what? That means healthcare for Malaysia is going backwards or the health tourism they would not come to Malaysia because we would not be investing in high technologies and all this.

Patient would choose to go to Singapore, Thailand, Vietnam and other countries instead of Malaysia, that is for sure. So, then we have to go and ask ourselves, right, has this DRG imposed on private achieve anything and doesn't mean it will make it cost effective. The patient might end up having to pay and they will still go to the government because why? We will stop taking private patients for those reimburse values which are actually less than what we can actually cope.

So, we would then choose, you know. So, if you are saying that Chin CABG ya, we are asking your KPJ hospital kah *to charge only RM50,000 as per now they*

counting, we will stop. Because they have a lot of high-risk patients, I would never be able to manage it for RM50,000.

Tuan Sim Tze Tzin [Ahli PAC]: *I think, I think the— I like this discussion. This is a good debate because I think all policymakers must understand debate so that it find the best solution. So, from what I understand is that based on MHIT, they can't cater for everyone. They cater for the M40, okay but that is the base for everyone.*

But for the people who can afford the upper M40, T20, they can buy riders. Okay, they buy riders on that so they can say I want a presidential suite. I want originator drugs; I want one nurse to me, privately. That one is no problem. So market forces will actually— so for a private hospital, you have your— maybe KPJ, you have certain hospital DRG. The rest is still premium service IHH, you can skip your Prince Court for a premium. Prince Court will never do this DRG but a smaller hospital or certain you cater because that's a huge volume.

So, I think this hybrid system where the market can actually work together, although—

Then we cater for M40 who wants the base rate, base MHIT and actually it creates a business opportunity for you. Because there is a huge volume that you don't have access to it before they all go to government hospitals, right?

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Mr. Chin Keat Chyuan [KDN]: *I think YB exactly as you rightly mentioned, right? Leave it to the market to choose, like appetite. For example, if among our hospital group we do believe there are certain segment of hospital that can chew and digest with the MHIT product and all these, right? Why not?*

There will be certain category at the hospital maybe because of the core structure, maybe because of the positioning and all these from day one itself. They want to go for higher M40 ke *T20, leave them be. If the choice is actually made available, I think that is actually where the industry will actually very very much be looking forward to collaborate with the government and see how can we make it possible, you know. Instead of one size fits all.*

That means we are going to come in with this policy, everybody must actually embrace. I think that would be a bit difficult because our core structure even among our group itself is different. Don't even talk about across different group, YB. So, I think if that is actually what you are looking at from the direction of the government, I think that is actually something that we can explore further, YB.

Encik Anwar Anis bin Anis Ahmad [APHM]: *Yes. Maybe just to very quickly add. I think YB Sim what you mentioned is in fact some of the early conversation that we had with the Health Transformation Office (HTO) under KKM is really for base*

MHIT to function in that way to cater to an expanded pool of patients. Maybe coming back to YB Teresa and YB Tuan Zahir questions, right? For investors like Stanley mentioned, as an investor what you want is certainty because when you put your money it's not for one year. It's for five, 10, 15 years.

So that certainty I think as we develop DRG, who does it cover, how does it cover, if the investors can see that there is certainty in the product, they will be willing to come in, right? Even if it is a lower margin. Because YB Teresa you mentioned correctly, right? So, the certainty, the design of the product and who it covers will then encourage people to look at that opportunity.

If I just go back to the Thai example again, so in Thailand I think the statistic that we heard was 40 to 50 percent of the private hospitals do accommodate their national healthcare or the universal healthcare cover. So, you can already see that maybe 40, 50 percent of hospitals in Malaysia will decide, "Okay, I will participate in providing service to the MHIT product." Within the group they can also decide to do that because it gives you scale or volume and there will always be doctors who want to do more volume or doctors who are just come in to the private practice will decide I need more volume. I will participate in a hospital that does MHIT because I want to gain experience and do volume.

But then maybe when they reach 65, "Okay, it's time for me to slow down a bit and go to full private practice." So, all these market forces will dictate to a certain extent. So, you were right. I think if we are moving in that direction, there is an opportunity for all of us to contribute.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya. Terima kasih Datuk Wira Pengerusi. Saya berbalik kepada soalan yang sebelum ini dibincangkan iaitu *different* caj ya. Pesakit yang berinsurans dan yang tidak berinsurans itu. Nampak dalam prosiding kita ini ada perbezaan laporan repot oleh Bank Negara dengan APHM ini sendiri ya.

Jadi, sebagai rekod maknanya di pihak APHM menafikan bahawa ada perbezaan bahawa caj pesakit yang berinsurans itu lebih tinggi ya dan dikatakan bahawa APHM telah membuat repot yang *implement* di hospital itu, pesakit yang ada insurans itu diberi diskaun hingga 10 persen ya.

Namun, dalam laporan BNM sendiri bahawa memang berlaku perbezaan yang sangat ketara, beberapa kes pesakit termasuk pesakit yang dirujuk contohnya pesakit demam denggi dan sebagainya dan ada kes pesakit yang ada— maknanya yang tidak ada insurans itu— *sorry* yang ada insurans itu dicaj empat kali ganda pesakit yang bayar *cash* ataupun makna dia bayar *direct* dan yang tidak ada insurans.

Jadi saya ingin bertanya adakah APHM melihat beberapa cadangan Bank Negara itu termasuk pihak hospital ini perlu mendedahkan julat harga dan prosedur hospital sendiri kepada publik? Ya, itu antara cadangan yang agak maknanya yang agak kritikal ya dipihak Bank Negara termasuklah juga dilihat ada fenomena dipanggil *price disparity.* Pesakit yang berinsurans ini.

Maknanya pesakit insurans ini dia lebih cenderung dalam maknanya membayar lebih kerana dia kekurangan semakan harga itu sebab dia kata insurans yang bayar bukan dia yang bayar. Jadi, bagaimana mekanisme di pihak APHM itu nak pastikan bahawa tidak berlaku *price disparity* ini? Di situ nak lihat keadilan dari segi kita caj ya orang berinsurans dan tidak berinsurans itu sendiri. *Thank you.*

Encik Anwar Anis bin Anis Ahmad [APHM]: Terima kasih YB atas soalan itu. Pertama sekali bulan Disember dan Februari, dua kali kami sudah memberikan data kepada Bank Negara. Data maksudnya data daripada unjuran kami sendiri.

Our own analysis on the samples siasatan 10,000 *cases* dan termasuk sampel bil. Maksudnya daripada hospital yang sama, doktor yang sama yang merawat denggi untuk pesakit yang berbayar sendiri dan pesakit yang ada insurans. Bukan satu tapi atau *a whole set of samples.* Kami telah memberikannya kepada Bank Negara.

Kami minta Bank Negara juga— *so we were transparent* ya bukan sahaja kami buat *study* tapi kami memberikan *samples bill*, *line item.* Maknanya bil itu sampai empat lima muka surat, *line item* menunjukkan harga kepada pesakit yang bayar sendiri dengan harga pesakit yang di bawah insurans.

Kami juga meminta Bank Negara menunjukkan kepada kami atau berkongsi dengan kami di mana data mereka ini. Sehingga hari ini kami tidak diberikan data ini. Yang kami faham ya *the study was done by an external party. If it is possible for the PAC, please ask them to present this data openly because* kami nafikan, memang tidak ada.

Now, we do not deny there could be certain small parties or things happening. In any industry there are people who cause fraud ya *but by and large in our industry across the insured patients pays slightly lower. Of course, there are packages*.

Okay, so we have to be very clear tadi Stanley kata O&G *package* ataupun *TKR package* memang ada pakej untuk membantu *patients* yang membayar sendiri. *In those condition we say package for self-paying patients only*.

Ini untuk membantu kerana doktor juga merasa okey untuk pesakit yang bayar sendiri saya kurangkan konsultasi saya, hospital juga cuba mengurangkan kos dan *package everything together.* Tapi kalau kita melihat kepada *line items,* setiap item dalam bil empat, lima muka surat kalau nak kompleks bil sampai 20 muka surat,

tidak ada *line item* yang berbeza kepada pesakit yang bayar sendiri dan kepada pesakit yang bayar *under* insurans.

Pesakit yang bayar *under* insurans di bawah diskaun kolum sudah ada diskaun yang diterterakan secara jelas antara lima, 10 sekarang tidak tahu sekarang 20 peratus di mana *the total bill to the insurance actually is lower.*

So again, we demand, if you want, from the PAC, PAC can help us for Bank Negara to make it transparent to us where is this study from? Where is the data from? Show us examples of those bills where it happened.

Mr. Chin Keat Chyuan [KDN]: *So, YB in short* kita kata ini fitnahlah. *[Ketawa]* ini memang *daylight* fitnah *you know*. Fitnah— memang kerana saya tak— *I don't mind* kalau katakan beza diakan *400 percent versus maybe 350 percent you know plus minus* itu ralat itu. Tapi ini *you* katakan memang tujuh persen *versus 400 percent you know*. Ini memang tidak masuk akal langsung. Kita punya data ini ialah *cross* KPJ, IHH, Sunway dengan Asia One Health. *We pull together 10,000 cases, same hospital, same doctors*. Kita cari dia punya kes.

I asked myself one question also kalau katakan hari ini ada *patients* yang ada denggi, boleh tak dia masuk *private* hanya bayar RM1, 288? Tidak mungkin, tidak mungkin. *Even you have a suddenly diarrhea you* masuk *private hospital today, I don't think you can walk away with one RM1,288.*

I think Yang Berhormat Sim *you have to agree with me. No way. In Penang also you can pay RM1,200 for dengue because the number of tests,* yang *blood tests* yang kita kena buat dengan ubat itu tidak mungkin RM1,000. *So*, memang nak data ini yang seperti Encik Anwar kata kita memang *demand* Bank Negara, *please give us the data from where the source* tapi *they are all quiet. So,* tapi ini *causes a lot of problem.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, I also have complaints from my— from the* rakyat. *Cataract? Okay. Fee paying, I mean pay and claim RM3,000 and then let's say insurance RM6,000. So, how do you explain because these are husband and wife case, all right? Husband and wife, one with insurance, one without insurance. Same case, same year, same hospital.*

■1230

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, I think YB you mention that before the last time and I clarified. Simple question. Is it the same type of lens? Is it the same type of lens? So, people can mention all these examples but that's why show us the bill, ask if the same type of lens. A mono-focal lens for those who wear glasses, multifocal lens and mono-focal lens* harga dia berbeza berkali ganda*. It is the same for your cataract lens. Husband and wife ask them the same question, if*

both your lens is the same. Is your eye condition the same, right? If it's not, please don't make this kind of examples. Again, show us the bill and I will explain it to you.

Mr Chin Keat Chyuan [APHM]: *Can I try also. Look, lens definitely because I used to be from different industry. My lens can be a basic lens all the way from, like less than RM120 all the way to thousands. So, it's huge difference, that's one. Second, there are many times husband and wife come together. Some with insurance, some without insurance. The patients will ask our doctor for discount. Hospital will also sometime give discount especially for cash paying patient. Some, most of the hospital— in general doctors they are also human,* kan? Dia bagi diskaun*.* Yang takut ini *sometime when the doctors give discount, hospital give discount, that contributed to cash paying patient is actually getting lower compare to insurance because insurance you cannot give discount. We already given discount from up top, you know.*

So, when you come to general, the GL, we have to everything follow their line. So, we can't do our offsite kind of discount tapi *cash paying many time they're saying that doctor* tolonglah*. So, the doctor will actually take, some they even waive. They said, "okey lah my professional fee I don't charge." Then when they come the hospital, hospital also saying that, "okey lah you cash paying susah kan, we will give you another few hundreds."*

So, when you add this together, ikut *potentially contribute to the difference of RM3,000 to RM6,000— I don't know, on top of the lens different,* kan? *Husband* sana *you* katakan *I* nak *multifocal and all this, wife* pun tak tahu kan*. Wife* kena *call* nanti mungkin tak tahu*. So, I think that actually where the differences YB. But it cannot be the thing because based on what you have shown here, always insurance in general bill size will be cheaper because on top of that we already given discount to the insurance company, mostly.*

Puan Erica Lam [APHM]: *YB, second part of the question just now you answer about your question about the patient don't care about the bill because they're paid by insurance, right? So, individual you care about the money because every single dollar come from your pocket.*

Actually, you will ask what is the big picture to address this kind of buffet syndrome we call it. It's actually to maintain co-payment. So now, the product of co-payment actually very low RM500. What is RM500 for today? You go for 10 times of Starbucks, habis *already. Ya, so the question right now is co-payment it has to be mandatory, like Singapore in their country, they mandate it. Means no any insurance product can try to find a different way to bypass the co-payment.*

So currently there is some kind of like insurance product riders they will say you go to my preferred hospital— again, it's a tactic of negotiation. This one you can no need to co- pay, no need to bayar *this. You can go all the way green lane* tapi *you go to this hospital you file a claim or you could make it a lot of co-payment. Mandatory file a claim. So, these kind of things doesn't help the buffet syndrome. Buffet syndrome is about the consumer. You must make me feel that I'm responsible for myself, then I will start look into it.*

So once the provider design things so makes me feel like I no need to think. Very simple, very easy, that's where the buffet syndrome will continue to grow. So, as a private hospital APHM will make it very clear. We are in support of co-payment. It is now one of measures that we mention ya*.*

Encik Stanley Lam Kean Fatt [APHM]: *I mean maybe I can say a few things. In fact, I mean YB, you can send officer enforcement to check the private hospital. We can open up the price for you and you notice that— I mean, I can speak from my hospital point of view right, I mean inpatient, outpatient for insurance and cash they are the same.*

In fact, what we did, what the hospital did, most of the hospital did right in order to support the local patient, we have imposed surcharge on foreign patient, right. It's just to help the local Malaysian to have lower bill size. That's something that I think many hospitals has start to do it right in order to cross subsidize the local patients.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Pengerusi, *I want to ask question. Since you know whole morning I've been listening that what make the private hospital suffer also because of the insurance companies demand for discount, big discount, given up 25 percent. Can I ask you; do you think that the government should come out with the law to forbid such practice or do you think that since you all APHM is alliance right, can you impose you know among all the members of APHM to all gang up that you know say no to insurance company that demand for discount.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Thank you for that questions YB Teresa. So, I think in our various engagement even with Ministry of Finance we did say that you know we hope— because the one that can regulate the insurer is MoF and BNM rather right is really to set some sort of ceiling as a guidance. I think for them to put a regulation is difficult because all of us also charge differently, right? So, how about we say to set some sort of ceiling.*

We do hope that BNM can as a regulator for insurers say that look this what is reasonable. Beyond this is unreasonable. Cannot ask for more than that. So, we do hope that the government can step in and do that.

However, I think the challenge that we face is really we are very dependent on the insurer. But the second one is we explore this with— that suggestion also came from in fact from KKM and others, right, and so industry can do this. As we have since, even with the drug price transparency when the GP decided that, "okey if I cannot, if I now have to lower the drug price, I have to raise other charges." It's a similar problem. That means for them in fact it's worse because their consultation fee has not being changed for 30 years, right? Very low, alright RM35.

When they wanted to impose, when they said okey, all primary care we going to charge certain fees for administrative and management. It is the government MyCC who said that this is uncompetitive behavior. So, we have asked the same question. If APHM tells our members not to accept the insurers after certain amount, will that be anti-competitive? I think the opinion that we have at the moment is yes MyCC will come after us.

So, unless the government can give us assurance that for us to take that stand we will not be subject to anti-competitive investigation, we can do it. But at the moment, we understand is and we've seen this example with the GPs now. And then one thing to stand up and say okey, we we're going to impose. I think is a good thing, it's transparent. The GP's are saying, all the GPs will charge the same X amount as administrative fee and all that but already MyCC issued to say anti-competitive.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I don't know why it say to do with anti-competitive because you all as an industry say no to discount.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *I agree YB, I agree. We hope the government can make it clear that is not anti-competitive.*

Mr Chin Keat Chyuan [KPJ]: *Actually YB. It is a grey line sometimes many it comes to anti-competition, at the same time also what being deemed cartel when it comes to pricing signaling. Pricing signaling means that there is this part the vendor trying come to you and ask for certain pricing right and then collective fee as a group we sounded it off to other people and then coming together and saying no, right.*

I think this actually very sensitive. It really depends on which angle and how they actually looking at this. So, usually as a collective industry association there are a few dos and don'ts and one of the don'ts is actually we don't come together and talk about pricing lah *and all this. This is a something very sensitive. Of course collectively we all know because the insurance payer our friends also in industry right. So, when they are reach out to us, we share to others, they know, they always cross pressuring. "Hey, I just talk to Erica and Erica will giving 20 percent, are you know, she will give me 20 percent you know."*

That kind of things, they are always playing games. So we know, but then can we come together and saying that okey why not we come together and saying no together? That might cross the line sometimes. So it's a bit risky because we all have the reputation right. We don't want to get into the area where suddenly people saying that how can the industry suddenly come together and doing all this pricing signaling.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *If the government— let say Bank Negara come out with the ruling or whatever, let say that no discount right, no discount policy. It just that the government now say, no to* rasuah*. You know, people still pay, you still— you have very creative way to settle it with the insurance companies. That's why unless the industry you know come out and say no, otherwise whatever law and rule, you* masih ada jalan*, do a lot under table thing.*

■1240

Puan Erica Lam [APHM]*: I just want to make one comment. Actually, most of us are being, I would say, being pulled by the insurance how to walk, okay. And, if you realize the whole market shares of insurance are controlled by the big threes, okay. You say AIA, Prudential, GE or even Allianz. None of these are locally own. Or the profit that they make doesn't belong to Malaysia.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Puan Erica Lam [APHM]: *You realize that? But at least the private healthcare are all Malaysian-owned. What ever dividends- profit made, dividends pay out. Go back to Malaysian.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Puan Erica Lam [APHM]: *And the big three insurance are actually making the decision for the whole insurance industry because their market share is so big. So, so big. All of us are their mercy right, essentially.*

Tuan Sim Tze Tzin [Ahli PAC]: *Is APHM planning to set up your own insurance company? You fight them.*

Puan Erica Lam [APHM]: *It's very difficult, honestly, to – at this stage to break in to the market. Very difficult. I know Bank Negara is trying. Bank Negara is trying to do the Digital Insurance Scheme and they allow local consortium to be made. But, the respond has been so poor because all the investors – Malaysian investors, press the calculator [Ketawa] – It so hard to break into the industry.*

It is much more complex – but this is a point I want to make. Um..ya.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, I have one last question. Out of your patients, 100 percent, let say. Just now you tell me that TPA brings in 30 percent. How many percents insurance brought in and how many percent fee paying – I mean, pay for service?*

Puan Erica Lam [APHM]: *Basically, cash paying patients about 40 percent, generally*-lah, *rule of thumb.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay.*

Puan Erica Lam [APHM]: *About 30 percent is from insurance, 30 percent is TPA and corporates. So, balance 40 is cash*-lah.

Tuan Sim Tze Tzin [Ahli PAC]: *How about this medical tourist? How many percent?*

Puan Erica Lam [APHM]: *Medical tourist depends*-lah. *Let say you talk about Island Hospital. 60 percent of medical tourist, 40 percent Malaysian which is comprise of insurance, TPA and cash. But the typical hospital in Kuala Lumpur probably, let say like Sunway. They probably doing like 15 percent of the medical tourist. Balance 85 percent are – same ratio*-lah. *85 percent could be 30 percent insurance, 30 percent TPA and then the balance is cash.*

Tuan Sim Tze Tzin [Ahli PAC]: *Medical tourist usually cash, is it?*

Puan Erica Lam [APHM]: *Yes but now they started to change the shift. They starting to have in a foreign insurance company which are giving GLs to their citizen to fly over to Malaysia to seek treatment.*

Encik Stanley Lam Kean Fatt [APHM]: *Just this why information, YB. Nowadays, the insurance Indonesia, they rather their patients come to Malaysia than Singapore*-lah.

Puan Erica Lam [APHM]: Cheaper.

Encik Stanley Lam Kean Fatt [APHM]: *They try to shift everybody to come to Malaysia because Singapore's so unaccomodative and expensive, right. So,...*

Dr. Tan Hui Ling [APHM]: *And Indonesia also expensive.*

Encik Stanley Lam Kean Fatt [APHM]: Ya, Indonesia dia kata *also very expensive.*

Puan Erica Lam [APHM]: *So many complaints*.

Encik Stanley Lam Kean Fatt [APHM]: *Ya. So, - actually, for PAC member information, Malaysia really have creating a wave in the market, right, due to our competitiveness, right. So, I think, we as a whole have to protect to our healthcare industry for everybody. It is just not for the private hospital player alone but for other industries and for the government as well.*

This is something that we have done well and please continue to support the private hospital to make sure that it continues to do well. Whenever the private hospitals make gains, let say for example. I think the government also will benefit from it as well. So, lets put it in more holistic view about the industry and make it more sustainable, moving forward.

So, I hope we are not looking at specific issue, the bill issue, this and that, right. But look at more holistically how we advance this together. Because it is very important as a nation where to continue to remain competitive throughout which means innovation, reinvestment, adoption of technology, talent management – all these things come to picture to build a very robust industry.

It would not happen, you know. If let say for example we continue carry the mind set to make it the cheapest, to make it the most low cost set up, right? It would not carry Malaysia to the next wave.

Puan Erica Lam [APHM]: *YB Teresa and all the rest of the YBs – can you please go back to the slide that we talk about APHM ask quite which is number one. "Acquitable approach towards transparency". We gonna address indirectly issues about two-prong. One is we have to fix our own billing structure. That is create transparency better for the eyes of the patients, better for the eyes of the public and it also is a fair pricing for the any party to pay the private hospital provider.*

Another part is talking about the insurance company. We are looking for – there will have to be also transparency in the insurance premium. How would they look into how much that gonna go for their reimbursement back to the providers. If they keep thinking they only pay 50 percent of the premium collected, it won't work. It won't work because they're scheming everything down.

They're talking about what is acquisition cost, what is the agency cost, what is their administration cost. All this will indirectly address the issues about – how do I say this? Curbing the unnecessary practice or you call it under table thing-lah. *We actually private hospital don't do under table stuff. [Ketawa] Ya, ya.*

Encik Anwar Anis bin Anis Ahmad [APHM]: *Maybe just to clarify a little bit more on the two questions from YB Sim just now. So, one on the medical tourist. If you look in the overall capacity in the country, it's only about six, five to six percent is medical tourist, right because only selected hospital and selected area like Penang, Melaka – so in KL also much less.*

But overall in the country, if you talk about our capacity in private healthcare. It's only about five percent is medical tourist. So, 95 percent is still Malaysian. So, that's number one. Number two, just want to add on little bit from Erica's answers about the insurance TPA and self pay. It is not a clear – there is some overlap, right, as we mention just now. TPA is also paying off processing on behalf of insurance, TPA is also processing on behalf of corporate.

So, when we say, let say 20 percent, 30 percent, TPA, insurance, but the TPA is actually acting on behalf of insurance. But what you see in front is the TPA. So, it

is not mutually exclusive, there's also overlap there. So, just to clarify that. Thank you.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya, sikit, Pengerusi. Soalan saya *direct to point*. Dalam penerangan tadi maknanya TPA – APHM ini bersetuju dari segi cadangan untuk *mandatory pass disclosure* itu, adakah setuju atau pun... ? Itu satu. *So*, tidak?

Okey, yang pertama. Yang kedua, yang disebut tadi, mekanisme untuk DRG itu, di pihak APHM sendiri makna – adakah kalau itu sudah diberi – maknanya keputusan oleh kerajaan bahawa akan dilaksanakan. *Preparation* daripada APHM itu maknanya akan *complete*-kan mekanisme ini atau pun maknanya akan ada lagi bahawa pelaksanaan itu tidak dapat dilaksanakan untuk masa terdekat ini kerana yang *you* bentang tadi yang kita *refer* daripada Thai tadi tu, maksudnya ada – sebab kalau tidak ada kombinasi daripada – *combination* daripada APHM, maknanya DRG ini pun tidak dapat dilaksanakan kerana semua data daripada *you*.

Jadi, itu, masih perlu ada keputusan yang muktamad. *You* setuju atau pun tidak sebab kerajaan perlu – maknanya melihat keputusan daripada pihak *you* sendiri. *Thank you*.

Mr. Chin Keat Chyuan [KPJ]: *Thank you. YB, first question, your mandatory disclosure* untuk bahagian apa ya?

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Seorang Ahli: *The pneumonia?*

Encik Anwar Anis bin Anis Ahmad [APHM]: *So, YB referring to HSS, ya? Hospital Supplies and Services? We have been always transparent. Our bill is 100 percent detailed bill. And,* macam saya katakan tadi. Kami sudah memberikan contoh-contoh bil ini kepada BNM dalam bulan Disember *itself.* Jadi, *our bills, by law, from CKAP rule and MOH rule is we must provide detailed bill if requested.* Jadi, tidak ada soal di mana kami tidak *transparent.*

Kami 100 peratus telus dalam apa caj dan di mana. Dan ketelusan ini yang memberikan masalah, ya kerana ada kesukaran memahami mengapa *certain item* yang kita caj lain. Yang itu yang kita ceritakan kena ada *reform* dalam *billing.* Jadi, kami 100 peratus telus dan *it is by law.* Dalam peraturan *Act 586 and regulation* adalah menjadi tanggungjawab kami untuk memberikan *detail* itu.

Jadi, soalan pertama itu kami memang 100 peratus telus. Dan *on DRG, YB, I mean*, Tuan Chin boleh memberikan penerangan lanjut selepas ini tapi kami komited seperti yang saya katakan. Kalau lihat pada mesyuarat-mesyuarat yang dipanggil oleh KKM, kalau panggil mesyuarat hari ini, bagi tahu mesyuarat esok pun

kami masuk juga. Kami dengan cara macam mana pun mesti ada ahli kami akan masuk mesyuarat dan memberikan komitmen kami untuk membantu dalam meneruskan proses DRG ini.

Tapi, seperti yang kami katakan, DRG untuk *National Healthcare Scheme.* Itu kena jelas, ya. Jadi, kami memang komited. Daripada *statement* kami*,* daripada Tuan Presiden kita Datuk Kuljit dulu pun kita sudah memberikan komitmen bahawa APHM *supports DRG for National Healthcare Financing Scheme.* Memang dalam *public statement* kami sudah ada.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, rasanya tidak ada soalan lagi daripada semua Yang Berhormat. Jadi, saya ingin mengucapkan ribuan terima kasih kepada Yang Berusaha Tuan Chin Keat Chyuan, Presiden dan juga Pengarah Urusan KPJ Healthcare Berhad, Yang Berusaha Tuan Anwar Anis bin Anis Ahmad, Setiausaha Kehormat APHM, Dr. Tan Hui Ling, a Board Member of APHM, Miss Erica Lim dan juga YB Berusaha Tuan Stanley Lam Kean Fatt, Ahli Lembaga Pengarah APHM di atas komitmen dan juga kehadiran dan sesiapa juga yang terlibat tidak dapat saya nyatakan.

Terima kasih sekali lagi dan harapnya tiada lagi akan dipanggil lepas ini. *[Ketawa] I think* semua sudah berpuas hati dengan penjelasan dan jawapan yang diberikan.

[Mesyuarat ditangguhkan jam 12.51 tengah hari]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Selasa, 17 Jun 2025

Bil. 5(m) / 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan dan Caj Hospital Swasta Serta Impak Kepada Kesihatan Awam di bawah MOF, MOH & BNM.

(i) CompuMed Services Sdn. Bhd.
YBrs. Puan Fiona Rebecca Limus
Ketua Pegawai Eksekutif

(ii) PMCare Sdn. Bhd.
YBrs. Tuan Kamal Aryf Baharuddin
Ketua Pegawai Eksekutif

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

SELASA, 17 JUN 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]

Tidak Hadir *[Dengan maaf]*
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Datuk Ali anak Biju [Saratok]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]

URUS SETIA

Encik Mohd Sukri bin Busro [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Cik Jackie Mary Fernandis [Penasihat Undang-undang II, Pejabat Penasihat Undang-undang, Pejabat Ketua Pentadbir, Parlimen Malaysia)]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit Pejabat Jawatankuasa Kira-kira Wang Negara, Parlimen Malaysia]
Nur Farah binti Dzulkiffli [Pegawai Penyelidik (Seksyen Jawatankuasa Pilihan Khas)]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Encik Ahmad Azhan bin Mohd Noh@Mohamed Nor [Timbalan Pengarah Kanan (Bahagian Perkhidmatan)]

Kementerian Kewangan Malaysia (MoF)
Encik Mohd Saiful Sungkih bin Abdullah [Timbalan SUB (Bahagian Pelaburan Strategik)]
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Kawalan Kewangan Strategik dan Korporat)]
Encik Ahmad Deedat bin Abdul Hamid [Sekretariat GEAR-uP]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Puan Azuraimi binti Ahmad [Penolong Pesuruhjaya (Bahagian Penyiasatan Tatakelola)]
Encik Mohd Zaidi bin Zainal [Penguasa (Bahagian Penyiasatan Tatakelola)]
PKPj. Premraj a/l Isaac Dawson Martin Victor [Pegawai Penyiasat SPRM (Bahagian Siasatan)]

Kementerian Ekonomi (KE)
Puan Noor Diana Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah Bahagian Perkhidmatan Sosial (Bahagian Perkhidmatan Sosial)]

Jabatan Akauntan Negara
Encik Mohd Nizrulizham bin Jamaludin [Akauntan (BPOPA)]

HADIR BERSAMA

CompuMed Services Sdn. Bhd.
Puan Fiona Rebecca Limus [CEO]
Puan Siti Aminah binti Ismail [Business Analyst]
Encik Wan Mohd Amir bin Wan Othman [Assistant Manager Client Relationship Management]

PMCare Sdn. Bhd.
Tuan Kamal Aryf Baharuddin [Ketua Pegawai Eksekutif]
Encik Azmi Ramlee [Head Data Analytics]
Dr Muhammad Ainuddin Mohamad Rusli [Penolong Pengarah Perubatan]
Encik Khairul Adli Jaafar [Pegawai Kanan Data Analitik]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

SELASA, 17 JUN 2025

Mesyuarat dimulakan pada pukul 2.15 petang

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
mempengerusikan Mesyuarat]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh* dan selamat petang Yang Berhormat Ahli PAC Parlimen Kelima Belas, ahli-ahli ex-officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen.

Ahli Yang Berhormat sekalian, petang ini kita sambung semula mendengar keterangan dan juga penjelasan berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah MOF, KKM dan juga Bank Negara Malaysia.

Sebagaimana semua sedia maklum, prosiding ini diadakan bagi tujuan untuk mendapatkan penjelasan berkenaan dengan faktor-faktor yang menyumbang kepada peningkatan premium insurans kesihatan dan juga caj hospital swasta, termasuklah juga kos rawatan perubatan, kemajuan teknologi perubatan, kos operasi hospital, inflasi dan juga faktor luaran sebagaimana pandemik.

Dalam usaha untuk kita cari jalan mengurangkan impak peningkatan premium insurans kesihatan, kos perubatan dan juga memastikan akses kepada penjagaan kesihatan yang berkualiti, adil dan juga mampan untuk semua lapisan masyarakat, PAC berpendapat adalah wajar untuk kita mendengar dari penjelasan dan juga mendapat keterangan daripada pelbagai pihak yang terlibat dalam isu ini. Jadi hari ini ia tidak – isu ini tidak terdapat di bawah Laporan Ketua Audit Negara. Jadi kita menggunakan punca kuasa di bawah peraturan mesyuarat, Arahan Perbendaharaan dan juga di bawah Pekeliling Am Bilangan 1 Tahun 2024.

Jadi, Ahli Yang Berhormat, ahli mesyuarat sekalian, hadir di hadapan PAC pada hari ini ialah Yang Berusaha Puan Fiona Rebecca Limus, Ketua Pegawai Eksekutif dan juga delegasi daripada CompuMed Services Sdn. Bhd. dan juga Yang Berusaha Tuan Kamal Aryf Baharuddin iaitu Ketua Pegawai Eksekutif dan juga delegasi daripada PMCare Sdn. Bhd.

Terima kasih, saya ucapkan kepada semua pihak kerana hadir di hadapan PAC bagi memberikan penjelasan pada petang ini.

Jadi sebelum saya menjemput saksi untuk memberi keterangan dan juga penjelasan, ingin saya ingatkan bahawa apa juga yang kita lakukan di bawah prosiding ini adalah tertakluk di bawah Akta Rahsia Rasmi 1972 dan juga Peraturan Mesyuarat 85 sehinggalah prosiding selesai dan juga laporan ini dibentangkan di Dewan Rakyat.

Jadi, tanpa membuang masa saya dengan ini mempersilakan Yang Berbahagia Puan Fiona untuk memulakan pembentangan. Dipersilakan puan.

Puan Fiona Rebecca Limus [CompuMed Services]: *Thank you YB,* Datuk Mas Ermieyati, *ladies and gentlemen. Very good afternoon. Allow me to speak in English. Without further ado, I would like to start my presentation.*

Alright, so, first thing, thank you very much for the invitation to CompuMed and giving us this opportunity to share with everybody about the role of TPA and today we will be talking about our role. What are the benefits of TPA to our stakeholders and some propose strategies with regards to the impact to MOH, Bank Negara, MOF, with regards to the increasing in premium, as well as some new implementations that we are currently doing in CompuMed.

Alright, so, CompuMed was established in 1998, we are about almost 30 years old now. We were one of the early players in the market and of course, next to me Encik Kamal, who runs PMCare is slightly older than CompuMed by a year or two but, yeah, so, that's how old the TPA market is in Malaysia.

We come a long way and we would like to share a little bit about what was the journey of TPA in Malaysia. We have ISO 9001 and also 27001, 27001 being data security and all that. That has been one of the major focus with our clients, regardless of financial or non-financial institution and of course, we are base in Kuala Lumpur *and CompuMed has got its own core-system. Our core-system is called CHAMPS and it's stand for CompuMed Health Administration Management Programme System. So, that's exactly what we do. We administer and we manage employee health benefit and et cetera.*

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Alright. Now, role of TPA is, first thing first, providing an ecosystem to our clients— i.e., insurance companies or corporate companies. We serve as an intermediary where we like the 'inti' *to a sandwich, and we provide— we are squash to between insurance, private hospital, the providers, as well as corporate companies.*

So, our job is to manage claim processing, insurance extensive provider network which is access to our members, so that they are able to visit the hospital, clinics, pharmacies and other medical facilities. The ecosystem built is a wholesome one, I would say, to facilitate our members.

Other than that, providing that network is key and as of late, we have actually increase more, not just GP clinic and hospital which is how it first started. Today, we have got dental network, we have got optical network, we've got physiotherapy network and all that. So, the purpose of establishing networks are to ensure that: number one, our member gets easy access; but number two, ultimately as a TPA, we want to collect clean data because when we have that module, providers have to key in exact data format and whatever not. That way, we get to gather data and be able to work with data in a much more meaningful manner.

Of course, the other role that we have to do is cost management. Our job is to ensure that our clients get the best deal from the hospital, from the GP clinics and so on and so forth. So, we negotiate rates, we do audit of medical claims, we promote preventive care, and we do utilisation reviews for our client where we— we are like storyteller. After managing a client for about maybe quarter of a year or half a year or full year or if is it a repeating client, our job is to tell a story. We tell a story of who, what, where, when, how and why of the medical expenses of our client. So, usually we will do— is like us telling a story to management.

So, that's how we come out with data reporting. Of course, data reporting can be monthly, can be weekly, can be quarterly, can be annually. That's, later on, we will be sharing with you some of the reports or contoh *of the reports that we shared with our clients.*

So, this is the ecosystem that we spoke about earlier on. So, healthcare services: what we manage is basically cradle to grave, we say. Is like a one stop centre when it comes to taking care of our members. So, we start off with outpatient GP. So, when our members go to the GP clinic, it can be on a cashless basis or they pay. Outpatients' specialist: those who are in the hospital or outside standalone specialist centre like those eye centres and paediatric clinics and all that, hospitalisation, maternity, optical, dental, pre-employment, flexi benefits, wellness program and we also do health bulletin for our members as well as dialysis. So, each and every component are the access that we give to our clients.

So, now, in terms of technology and system, it is important that we have a strong technology, using strong technology to create a system that we use to manage all that we do. Upfront, we have to look very compose and very in control. But actually, behind the scenes, there is a lot of negotiation and I would say troubleshooting that we do behind the scene.

So, this is a— CHAMPS is actually a TPA system that is multitiered highly modular operating system that we use and its secure service deliverable to end users encompassing several modules that we spoke about earlier on. Of course, Bank Negara— we have to fulfil Bank Negara's requirement under the RMIT Policy and by having ISO:27001 ensures that data protection is in place, disaster recovery is in place, securities are in place. So, that's PDPA is also one of the key things that we have to incorporate into our system.

So, CHAMPS has got external and internal modules. So, the external modules as what we have shared, according to the ecosystem yang kita bagi, *is that* dia ada *GP clinic, hospital*

portal, dental portal, member module, HR module dan *agent module and also insurance module. So, all the stakeholders actually have got access to look at their own data. So,* contoh, *as a member, I open up my phone on a portal or a mobile apps, I'm able to look at my own claims, my own utilisation and my own provider, claims' history and all of that. So, the whole entire ecosystem is interlinked and information is transparent. So, transparency is key in managing healthcare.*

So, tadi *was external module.* Sekarang, *this one is mainly on internal modules*. Yang ini *is what we use to manage and operate in CompuMed. So, we have got call centre module which is 24/7, we've got claim processing, we have got provider management— their job is actually to recruit hospital, GP clinics, dental and all that— and we have got medical management. So, the team CompuMed has got about four medical doctors. Their job is to look at fraud, wastage and abuse, and also to look at all the difficult handwriting of doctors. You know, it sometimes is difficult to read. So, somehow, doctors and doctors they can read their own writing.*

So, it's more of ensuring that the entitlement of members are secured and they do not overclaimed or we have to ensure that the benefits are properly manage. We have data analyst as well. The job is to churn out report and tell the story. Of course, client relationship management, they are like the concierge services. They take care of our clients— i.e. the corporate clients or the insurance companies.

Alright. Now, in terms of reporting, as shared earlier, so, I like to just talk a little bit about how we embark on with our client. So, please bear with me a little bit. I just want to make this point about the important of data. So, when we engage with the client, first thing first is kita akan buat *client on boarding. With client on boarding, we take their entitlements, we set it up in our system. That's where we do product and plan set up in our CHAMPS system. Later on, we look at data transfer. And then, once data is transferred, and we will be able to manage it. There is a saying that says data is the route of all evil. So, if you don't get data, then it would be very difficult to manage anything or tell the story or whatever not. So, therefore, in CompuMed, data management is very, very important.*

The benefit of reporting is we are able to do data collection analysis for our clients. We are able to be transparent when dealing with our client and we are accountable. So, there is no—long time ago when we first started, when things were still on facts, so usually the member will go to the hospital and then they will put in admission request. So, hospital will always say, "Oh, we haven't heard from your TPA yet". So, we are always the scapegoat. So, the delay is always coming from us because— why? They will claim that fax didn't go through, line is busy and all that.

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So, over the years, we have evolved to say, okey, now it is all on portal, there is no traffic jams over internet. So, we know exactly when you request it. So that is where transparency of data has come in to play. So, we are able to managed expectation of our members, as well as our stakeholders in a proper manner. So, that is where accountably come in.

Number three is cost management and cost containment strategies. This one is basically negotiating better rates. Us as TPA, we negotiate with our client as well. For our clients, I mean, sorry. We negotiate with the GP clinics, with all the providers, hospital, dental, optical. We go on a willing buyer, willing seller concept. If u want to join and be a part of our network, by all means, but they are certain elements that we ensure that they follow. For example, submitting their claims online. So, they have to make sure that claims submissions is proper. So that, we get that proper information to be pass back to our clients.

So, the other one about reporting is that, we make informed policy decisions. So, some of our clients, they have got very high loss ratio, for example. With data, we can actually advise them and say that, you know, be prepared for a premium hike, because your loss ratio is very-very poor, for example. So, clients will also appreciate the fact that, in terms of budgeting and whatever not, they are able to managed it.

So, other things would be a how reporting health managed premium hikes? Number one, identifying cost drivers. When we know what we are working with, we can be more effective. So here, we are able to pinpoint the specific factors that are driving up healthcare cost. Which in turn, leads to premium hikes, if it is insured program.

The other one is promoting efficiency. Having this, allows us the opportunity to improve efficiency and reduce wastage, combatting fraud. Through this also we can managed what we called FWD – fraud, wastage and— FWA - fraud, wastage and abuse. So, it's about being proactive in managing instead of reactive. Kalau dah *discharge* semua tu, susahlah nak *negotiate* dengan doktor *and the hospital. So, it's about doing it on the ball, they say.*

Enabling data driven regulations by providing regulators with concrete data. It allows for a more informed and effective regulations. So, we do have discussions with MOH as well. The recent one was with Amalan. We do discuss about how do we look at cost containment and all that. So, we do share our— we have offered to share our data to them.

Just a few glance of how we generate reports, medical expenditure for in-patient benefits by age group, for example. So, here is just a sample of one of our client's data. We break it by age group. We looked at the total number of visits. We looked at total payable. So, all of these "A.L.O.S." stands for "average length of stay". So,…

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *This one,* hospital *or* klinik?

Puan Fiona Rebecca Limus [CompuMed Services]: *No, this is for our client's transaction and this one is for GP hospitalization, YB.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *No. What I means is that, let say your client is Sunway Hospital. So, this is what you will break down, right?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Yes, correct. Okey. So, how this works is, we have– let say we have a company with 20,000 head counts. So, of these 20,000 head counts, we break them into age group of less than 1, 1 to 6. That is on the age group. The second column is head counts with transaction. So, out of that 20,000 head counts population, these are the— there were 973 transactions, for example. The number of visits, the amount incurred, amount payable, amount uncovered, amounts uncovered are what the insurance company will not pay for. Then, you have got your average amount payable per visit and average length of stay (ALOS).*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Amount uncovered is the* hutang, *right?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Not* hutang. *For example, you buy a policy and it says that your entitlement is room and board to RM200. But, this employee or this member, they decide to checked-in to a RM400 - Room and Board. So, there is that difference of RM200. Now, that is what we call uncovered charges.*

So, insurance companies have their terms and conditions under the schedule of benefits. So, we managed it based on the schedule of the benefits. So, it's the contract between either corporate and insurance or individual member with insurance company. So, when you have that contract, kat dalam tu, *it says* lah. *What is covered, what is not covered.*

Another one that I like to share is that, who incurred 50 percent of the total utilization. So, this was in 2024. In this case, it was for a total head counts of 52,510. This corporate organization has got 52,000 members. Of that, 973 members had transactions. Of that, 118 members incurred 50 percent of the payable. Once we break it down like that, it doesn't become too scary already. Because, we know exactly who is incurring it and where are they incurring it from. So, in short, healthcare can be micromanaged when you know who they are.

So, here we share with client and say, principal as in the member themself, the spouse and the children. So, we break it down like that and we break it down by the product. Like in this case, it is an insurance client. So, it got product A, product B and so on and so forth. So, we are able to drill down to the most minute form of info or data.

Like here, we again break it down and say, 'Okey, who are these people, at what age they are?'. Like in this case, the more than 60 years old, they had 61 members incurring 80–4.9 million, for example. So, all of this data is what the insurance company used to relook at their premiums and so on and so forth. So, we even share with them and say, 'You know, of all your branches, it is the KL branch that has got the most members that was admitted to the hospital', for the example. Okey.

Of course, we are also able to share with them case types - surgical case versus medical case. Now, I would say maybe 20 years ago, when— we saw a lot of medical cases versus surgical cases. The ratio was four medical cases to one surgical case. A long time ago. But today, we are seeing almost 50-50, where medical cases are similar to surgical cases. So, that is also one of the reasons why costs had gone up. Because, the average cost for surgery, for example definitely is higher than medical case. Medical case, means your denggi*, gastric, the ones that didn't go in for surgery type.*

So, we looked at chronic diagnosis. As you know, Malaysia is one of the countries in the world that has got very-very high of everything. They said, high in cholesterol, high in diabetes and high in hypertensions. So, what we have done is, we looked at it and say, 'Type of diagnosis'. We looked at single diagnosis admissions and multiple diagnosis admissions. So, of course, all of these play a role in determining the cost of admissions. Like in the case of cancer, with single cancer admission. So, like this particular account, this particular group had 50 of them and they had 306 visits by this 50 people. The total cost incurred was two million. So, the non-payable was 156,000. So, average payable is about 38,000 for cancer cases, contoh.

So, these are all the information that were able to slice and dice for our clients, depending on their needs. So, this is another example of age range for cancer, cataract, diabetes, heart disease, hypertensions and what is the grand total that they are spending on.

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Okay, so here are some pointers that we feel that are the reasons why premium goes up. First thing first is if we look at this table, the mode of payment is cashless versus reimbursement ya*. So, that's the key thing. Cashless versus reimbursement. So, those that* yang *under cashless you look at the average length of stay is three days and the cost is RM4,600.*

But if you look at the one on the right side for reimbursement, the average length of stay is one day and it is RM1,000 for the same diagnosis and it goes on. Viral fever RM4,008 versus RM1,005. Pneumonia, bronchopneumonia RM7,008 versus RM1,006. Dengue fever, RM6,004 versus RM2,002. Bronchitis, bronchiolitis RM6,003 versus RM1,009 ya.

For some reason, when a person is admitted under cashless right? Hospitals will look at them very differently. And of course as a member if I'm paying upfront, I'm also very cost-conscious. All right.

Puan Teresa Kok Suh Sim [Ahli PAC]: *Credit card* kan?

Puan Fiona Rebecca Limus [CompuMed Services]: *No, cashless means that they hold a card which allows you— cashless means no need to pay upfront. The insurance company will guarantee or the corporate company will guarantee.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, kalau boleh saya tanya? *Can you tell me that – okay from your experience as a TPA, is there a different tier of charging by hospital?* Contohnya *cashless, guarantee letter one bill*, *one kind of charge. Then pay and claim another charge. Pay cash, cash paying another charge.*

Medical tourist another…

Puan Fiona Rebecca Limus [CompuMed Services]: *Another charge* ya.

Tuan Sim Tze Tzin [Ahli PAC]: *Is there a different tier or can you tell us about it?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Well for us officially they say there is none* lah ya. *Kamal?*

Tuan Kamal Aryf Baharuddin [PMCare]: *For us dealing with these the number of cases for pay and claim is not that many. So, we couldn't say either this is same or not. But from our experience, as far as hospital is concerned, the system-wise, the pricing will be the same. So, either you are a cash-paying patient or you are not a cash-paying patient, it will be the same.*

The only difference is when you are a cash-paying patient you tend to be more cost-conscious because that is your own money. And then you will talk to the doctors "Doc, Doc, I have only this limited budget, so what sort of thing that you can excuse me from do that particular screening or examination all those things?".

So, at the end of the day, the doctor will say, "Okay you are supposed to do these but if you insist to be excluded, you have to sign this undertaking is that actually in the event that we discover later you cannot blame the doctor." So, that's it here.

Puan Fiona Rebecca Limus [CompuMed Services]: *Ya, so officially they say there is no difference but I suppose for foreigners I believe just like the government hospital, there is a foreign rate.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay on this point, if I look at this pneumonia okay. Length of stay four days for cash-paying – cashless four days, pay and claim four days, same. But there's a RM7,800 and RM1,600. It's a huge difference of RM5,000?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *So why is that so?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Ya. So, of course…*

Tuan Sim Tze Tzin [Ahli PAC]: *Almost RM6,000 difference.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Ya, of course medicine is not black or white. I'm sure if we dwell into respective cases right there are differences in terms of the condition of the member for example. So, the difference would be perhaps the kind of treatment that they are in, the medication that they receive, the kind of medical investigations that they do.*

Of course that is if you look at it like that just on face value, you do see like a RM6,000 difference right? But, of course we need to dwell into it and look at what is the nature of the cases well. But yes, that usually there will be a lot, there will be a difference yup.

So reimbursement is key ya. *So, pay and file what we call in our industry, we call it pay and file. Meaning that you pay first and then you file it to the insurance company for reimbursement* ya*. Next.*

All right, so the next one is accessibility of hospitals, right? We notice that in Klang Valley or in Semenanjung Malaysia*, total policy sold for this client was RM5,658 and total head count utilization was RM4,047. Total claim was RM1,622. The incident rate is 7.9 percent versus Sabah and Sarawak*. Sabah dan Sarawak *they don't have so many hospitals, right? So, I don't know whether this is a coincidence but we do see a lower incident rate in* Sabah dan Sarawak ya.

Okay now the other one is average medical trend rates between Malaysia *as well as global. So, if you look at it, annual general inflation rate, all of that – can you bring it up a little bit? [Bercakap dengan pegawai] Okay, so you can see that the rates, annual general inflation rate is 3.6, Malaysia is 2.4. But, the annual medical trend is 9.2 globally. But in* Malaysia *we're looking at 15 percent right. So, annual general inflation rate, we're looking at 3.6,* Malaysia *one is 3.1. Of course, annual medical trend globally is 10.1,* Malaysia *is looking at 15 percent. So, in general, Malaysia's medical inflation rate is about 15 percent. That is also what MOH is quoting as well.*

Now, so another reason is we are top in non-communicable disease in Malaysia right? So, the look at it, Malaysia *active lifestyle, 84 percent of adults are not active in sports, fitness and leisure activities. While globally, 31 percent of adults are not active in sports, fitness and leisure activities. So, Malaysians are not very active in exercising and all that* lah *right? So, we're talking about lifestyle.*

Now the next one is we look at hypertension. 29.2 percent, one in three adults ya *of Malaysians have hypertension right. While 33 percent, one in three adults have hypertension, right. High cholesterol 33.3 percent, one in two adults in Malaysia have high cholesterol. Obesity, look at that. Obesity in Malaysia is 54.4 percent while globally is 16 percent.*

Puan Teresa Kok Suh Sim [Ahli PAC]: …Gemuklah… *[Bercakap tanpa menggunakan pembesar suara]*

Puan Fiona Rebecca Limus [CompuMed Services]: Ya.

Puan Teresa Kok Suh Sim [Ahli PAC]: *That means half of Malaysian population have…*

Puan Fiona Rebecca Limus [CompuMed Services Sdn Bhd]: *Are heading obesity. So, that one is based on BMI right*? *You look at your BMI*. *Am I right doctor*? Ya. *So, you look*

at BMI calculation. We should actually do a quick test and see what is the BMI in this room. [Ketawa]

Tuan Sim Tze Tzin [Ahli PAC]: *I'm sorry I think your stat is wrong you see.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Okey.*

Tuan Sim Tze Tzin [Ahli PAC]: *High cholesterol 33 percent is one in three adults is not one in two.*

Puan Fiona Rebecca Limus [CompuMed Services]: Ya betul.

Tuan Sim Tze Tzin [Ahli PAC]: *Okey you compare high cholesterol, 33 percent.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Yes, is it.*

Tuan Sim Tze Tzin [Ahli PAC]: *One in three adults, not one in two.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Thank you for highlighting.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, we are* okey lah *high cholesterol, we are still lower than global, am I right? Hypertension we are still lower than global am I right?*

Puan Fiona Rebecca Limus [CompuMed Services]: *If you look at it, yes.*

Tuan Sim Tze Tzin [Ahli PAC]: *Not too far away.*

Puan Fiona Rebecca Limus [CompuMed Services]: *But this we compared to global. But if you look at ASEAN right then we really top the charts* lah.

Okay, so those are the reasons for why premium hikes right, lifestyle. We talk about lifestyle, we talk about. So, there are many elements that— or contributing factors that causes premium to go up. So, we cannot just say that it is just one thing, right?

Now this is a healthcare journey from a TPA's perspective or rather from CompuMed's perspective. When we started in 1998, we had an estimate of about I mean in the whole Malaysia right, we have got 3,000 clinics and we had about 300 hospitals at that time. Combination of private and government, right?

But over 20 almost 30 years, 27, 28 years, we have grown to have 11,400 clinics and 380 private and government hospitals, right? So, what does this tell us? It tells us that access to care in Malaysia is awesome. It's wonderful,

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It is so easily available. But having said that, that is also the reason why healthcare cost has escalated so much right, because of the easy access. So long time ago in 1998 when we first started, hospitals were seen like wow you know, only for very serious stuff you go there, right. But normal stuff, you will still go to the GP clinic for example, right. But and the insurance company has said that okay, if you have dengue, if you have gastritis or the most serious one if you have chest pain, you can go to the hospital.

But for some reason at that time, of course employee benefits would also not a big thing then, right. So in terms of users, we've seen a lot of individuals insurance holder, those who buy the medical cards because corporate was giving but not everybody was doing

employee benefits in a serious manner, right. So along the way in the last 20 over years, more corporate companies are providing employee benefits, employee healthcare benefits. Most of these employees' healthcare benefit are on a cashless manner. So now, my company is giving me this benefit and it is unlimited, so what do I do? I use lah. *I don't care. It is not my money, it is the company's money, right.*

So, we have a lot of all this people have already started having this kind of mentality, right. It is buffet mentality, so because of that, they are not cost conscious. Their job is to use it whenever. So, all of these factors or all of these behaviours have actually caused the increase in medical cost if you asked me.

So today in 2025, we have that many clinics and that many hospitals. So how – what can we do? One of the things that we look at is insurance policy. Insurance policy if you are familiar with hospitalisation and surgical policy, it says that okay, if anything happens, you can directly go to the hospital. Now, if I am a – not if I am a mother with three children, if my child is sick in the middle of the night or maybe at 8 o'clock in the evening, where do I go? I would immediately go to the hospital, right. Padahal *I can go to the GP clinic, right because it was just a normal fever and all that. Our GPs' doctors are very good in Malaysia.*

But because I've already bought an insurance policy that allows me to have access to the hospital, I pergi teruslah, *right. So again, it is that shift in mentality or the shift in that mind set of insurance company perhaps can consider putting the gatekeeper which is the GP clinic, right. So, if they put in their policy and say, okay for diarrhoea you have to go to the GP clinic first. If it cannot be resolve at the clinic, then you go to the hospital for example. So at least they ease what we called a gatekeeper, right. But when there is no gatekeeping, everybody just goes to the most expensive the best. Because why? The specialist is at the hospital, okay.*

So, some of the strategies that we would like to share is number one, Gatekeeping Mechanisms, right. Implementation: promoting wellness programmes and preventive care to reduce chronic illnesses. Impact is that chronic diseases account for 70 percent of total healthcare costs in Malaysia. So that would be the target. Preventive care can significantly lower the burden by reducing hospital admission.

The next one is Cost-Sharing Model. This is not welcome but it is one way of ensuring that cost is at least managed. For example, when you implement co-payment, so we go on cost-sharing method right, and this will be reduced the unnecessary claims by up to 15 to 20 percent, as policy holders become more mindful of healthcare usage. So, if I have to take money out from my own pocket, I will think twice before going. So, cost-sharing model is quite healthy if you ask me.

Puan Teresa Kok Suh Sim [Ahli PAC]: *May I can have a suggestion? You see, we all buy car insurance, right. So, in order to save the what NCB…*

Puan Fiona Rebecca Limus [CompuMed Services]: *NCB, no claim bonus.*

Puan Teresa Kok Suh Sim [Ahli PAC]: *So, when our car got some minus scratch* lah *here and there, don't pump here and there…*

Puan Fiona Rebecca Limus [CompuMed Services]: *We don't…*

Puan Teresa Kok Suh Sim [Ahli PAC]: *We don't claim, right because we want to* simpan *you know one day…*

Puan Fiona Rebecca Limus [CompuMed Services]: *Until 55 percent, right?*

Puan Teresa Kok Suh Sim [Ahli PAC]: *Exactly. How come we–you know this healthcare insurance we can't do that?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Actually, they do. In fact, Kamal is managing NCB programme, maybe Kamal you can share.*

Tuan Kamal Aryf Baharuddin [PMCare]: *In fact, quite the number of insurance company now starting to introduce this for the individual policy. So, we are managing one of the insurance company for this NCB programme. Means that if there is no claim, what they do, this insurance company will give certain amount of money for those policy holders to redeem or purchase item either for wellness or other things related to healthcare.*

Puan Fiona Rebecca Limus [CompuMed Services]: *So, they give like perhaps complimentary wellness, executive health screening or maybe even deduction of next year premium. So, they do have just like NCB for cars.*

Puan Teresa Kok Suh Sim [Ahli PAC]: *Actually, for me you know you offer all that*, tak, *normally we don't need it also. For example, like Great Eastern, every year come to my birthday, I'll get the RM50 voucher. But I've to go to Gleneagle Hospital which is so far away from my house and then we know that you do a check-up already in many thousand and then you give discount RM50* ya, *you know this kind of thing is really useless* lah.

Puan Fiona Rebecca Limus [CompuMed Services]: *Insignificant, right?*

Puan Teresa Kok Suh Sim [Ahli PAC]: *You want–you give… you deduct in all that us see the cash let say come to next year you deduct how many* berapa ratus *and all that. Then only if you attractive you see.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Ya, so…*

Tuan Kamal Aryf Baharuddin [PMCare]: *Sorry. For the company that insurance company that we are managing totally different from what you just mentioned just now. So, this is where that depending on the policy the premium paid, so the amount also quite significant that covers certain packages of screening. So, you just go and redeem and enjoy it cashless as well. So, it is not that they just give discount or rebate of RM20 or RM50, RM100 but you need to top up your own money to do that. No, this one is depending on the policy, the premium that you paid, and that you can enjoy with the providers that funding under this programme.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Okay, another one is DRG Payment System. So DRG stands for Diagnostic-Related Group. So, this is like in a simpler manner it is like a running average of costing, right.*

So, for example, let say dengue fever. So that is pretty common in Malaysia. So, dengue fever we break it down and say what is the number of days, what are the drugs used, what are the investigation used. So, we have broken down components of dengue fever. From there, we have an average or what we called running average from our database.

So, if we have hundred cases of dengue for example, we know that averagely it is about RM8,000, contoh ya. *So RM8,000 is what we know is needed to manage dengue, right. So now, with our other hospital admission, the minute when it is touches RM12,000 for example, then it is an alarm to us and say why RM12,000? Why not RM8,000? So, it triggered us to look at it and say why it is so high and perhaps at the latest stage, we are able to negotiate with hospitals and say for dengue, we will only pay you RM8,000 under certain conditions, for example.*

Countries that have adopted DRG like Europe, Germany have seen their cost growth ya. *The cost growth, reduce by two to three percent annually. Because why? You know exactly what it is. So, in a way your exposure it is sort of like ring fence I would say, all right.*

The other one is transparent pricing. Implementation would be standardizing fees schedule and ensuring transparent billings for medical procedures.

■1500

The impact is according to LIAM, medical claim rose by 26.2 percent from 2022 to 2023. Now, transparent pricing can help control this escalating cost by overcharging. So, overcharging is when hospital just charge whatever because why, there is no limit to it, right. So, currently for inpatient of course the only one charge that we are able to be very stern and straight about is doctor's charges, right and the anesthetist charges because why, we have got Schedule 13 to protect everybody from – on the fee schedule. So, this one is if they are transparent then we will be able to do standardize billing.

Okey, so a little bit on new phase in healthcare management or at least what we are doing and this is something that everybody talks about these days, AI. You know, with artificial intelligence. How does the TPA uses AI and what is our adoption? So, the whole idea of using AI is having that competitive aged data driven decision scalability and innovation.

So, it's able to prioritize data privacy and all that. So, in CompuMed we have started adopting AI practices. Right, next and we are able to see that today we are processing some claims using AI because if we continue to use human or straight through processing, there is always limitation. So, just to show that AI is really helping, it has helped us to look at reducing our operation cost.

So, why do we need to be effective, right, because insurance company and our client are forever squeezing us on our TPA fee. So, we too need to be lean and mean, I would say. Ya, *next.*

Right, some of the things that we are doing is claim adjudication. So, claim adjudication is processing the claims. Meaning that a person who get admitted to the hospital has got – let say was admitted for 20 days, right. So, 20 days usually what happen now is of course we have parameters in the system and then we pump the data in there and then the result comes out but, more and more now we are using AI to analyze claim. So, it's able to do comparison and so on and so forth which actually gives us better outcomes and assessment as well. So, thank you very much, that's my presentation. Any questions?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih, Puan. Saya hendak mulakan dahulu dengan bertanyakan soalan berkenaan dengan kita lihat dari segi *presentation* sebentar tadi. Sudah lama, hampir 30 tahun dan bagaimana proses dari segi tuntutan, pembayaran dibuat khusus kepada klinik-klinik ataupun hospital yang menjadi panel dan berapa kadar purata masa yang diambil? Okey, daripada tuntutan dan juga pembayaran.

Misal kata kalau ada staf yang bayar dahulu *then* berapa lama ambil masa *reimburse?* Bagaimana prosedur berkenaan dan adakah terdapat *channel* ataupun mudah hendak dihubungi sekiranya pihak, mana-mana pihak yang terlibat itu ingin membuat aduan sekiranya terdapat kelewatan?

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Chairman*, tambah sedikitlah daripada soalan *Chairman* itu. Puan, *actually, how do you charge your client*?

Puan Fiona Rebecca Limus [CompuMed Services]: *Alright, thank you for the question. So, regarding claims processing. So, claims processing, we have two type of claim processing, what we called cashless claim processing and also reimbursement claim processing.*

So, according to YB, you referring to reimbursement claim. So, generally we take about seven to 14 working days to reimburse back to the member. So, of course what happen is the member will submit their claims to us through the portal and then following that we will process it and then we will forward it to our clients to make payment.

So, remember we said that we are the jam of the sandwich, so many of time of our job is to facilitate. So, if let say we is an insurance company, kita kena proses dahulu selepas itu *submit* kepada *insurance company.* Kalau *insurance company* lambat bayar, respons, jadi kita pun lambatlah tetapi kita ada SLA yang kita perlu patuhi *on both sides. So, that is on the reimbursement, usually about seven to 14 working days.*

Now, in terms of length of time to do claims terpulang kepada *insurance company* masing-masing, ada yang mengatakan 90 hari selepas itu sudah tidak boleh *submit claims*

contoh ya, *corporate companies*-lah *usually. So, they give a timeline* tetapi untuk *insurance company, if I am not mistaken is couple of years.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Pengerusi, *sorry, I am very new, I mean I learn about TPA for the first time, that means like we went to hospital and we come out, let say we pay ourself and then want to claim insurance then we – I mean what I have done recently was that I pass to my insurance agent then the agent compile everything then he will submit to the company. What is that it to do with your side. [Ketawa]*

Puan Fiona Rebecca Limus [CompuMed Services]: *Okay, so there are two type of insurance companies out there. One, that has got their own TPA Function Department and some that – one that doesn't have. For example, AIA, Great Eastern, Prudential, so these three, they are the bigger one, right? So, they have a department that does all the processing and whatever not but there are a smaller insurance companies that doesn't have this kind of department, so they outsource the function to a TPA like us.*

Now, to your case YB, basically you just pass to your agent, actually what your agent has done is they will go to the insurance company, look for the reimbursement form, fill up all the information in there because it's all still manual and then after that they probably ask you to sign or they sign on behalf and then they submit it to the insurance company.

So, when you submitted that to the insurance company, those that have a department they will process it internally. Those who do not have a TPA function they will take – the insurance company will take that claim and pass it to the TPA. Then the TPA will process it and then pass back to the insurance company and then they say, "Ah, okay, betul, I can pay." Then they will make payment to you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa pembesar suara] ...Outsource?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Yes.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, without* ini – *I am so sorry but I think we like to get* Tuan Kamal untuk *present* dahulu baru kita tanya soalan, *to be fair to both* pihak. Ya, terima kasih. So, Yang Berhormat *please keep your question,* kejap lagi baru kita tanya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey.

[Saksi-saksi berbincang sesama sendiri]

Tuan Kamal Aryf Baharuddin [Ketua Pegawai Eksekutif, PMCare Sdn. Bhd.]: *Assalamualaikum warahmatullahi wabarakatuh.* Selamat tengah hari. Terima kasih kerana jemput kami PMCare di Mesyuarat Jawatankuasa Kira-kira Wang Negara (PAC) berhubung peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam di bawah MoF, MOH dan BNM.

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Saya akan mulakan dengan pembentangan mengenai perkenalkan siapa itu PMCARE dan, seperti mana Puan Fiona maklumkan juga tadi, *role* ataupun peranan yang dimainkan oleh PMCARE, dan berdasarkan peranan yang telah kami lakukan, data-data yang telah kami kutip, kami analisa, kita akan kongsikan bersama.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan Kamal, saya tengok ada 60 slaid ini. *Can you make it...*

Tuan Kamal Aryf Baharuddin [PMCare]: Boleh. Saya akan tunjukkan apa yang mustahak nanti.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Alright.* Terima kasih. Sebab benda lebih kurang *je*, kan?

Tuan Kamal Aryf Baharuddin [PMCare]: Ya, betul. *Next slide.* Ini maklumat ringkas mengenai kami. Kami adalah *pioneer* masa— 30 tahun lepas, kami adalah *the disruptor* tapi sekarang ini dah banyak *company* yang berdaftar dengan MOH. Lebih daripada 40— sebelum ini lebih pada 100 tapi yang *serious player* sebenarnya lebih kurang 10 *company* tapi yang masih berdaftar dengan MOH lebih kurang 45 ataupun 46.

Klien-klien kami termasuklah *insurance company* seperti Prudential, Etiqa, Takaful Ikhlas dan sebagainya dan juga syarikat-syarikat korporat termasuklah Shell, EPF, Bank Negara dan sebagainya. Mereka telah, yang mana, memberikan kemudahan kesihatan kepada warga kerja dan juga pesara mereka dan juga kakitangan mereka. Kalau tengok di *slide* itu juga, kebanyakan *group,* kumpulan hospital yang besar juga percaya kepada kami untuk kami menguruskan kemudahan kesihatan mereka juga.

Next slide. Pada tahun lepas, kami telah memproses lebih daripada 4.2 juta *claim* dan telah membuat bayaran kepada *medical provider* sebanyak RM2 bilion. *So*, ini jumlah yang agak besar. Dan juga kadar inflasi yang kami *manage,* kami uruskan, kebanyakannya kurang daripada 10 peratus. Jadi, nanti *slide* seterusnya akan tunjukkan juga.

Next slide. Ini adalah seperti mana yang Puan Fiona *mentioned*, maklumkan tadi, kenapa syarikat-syarikat meng-*outsource*-kan kepada TPA. Kerana mereka tidak mahu bersusah payah memikirkan mengenai soal-soal administratif *overload.* Sebab, mereka lebih mahu fokus kepada *core activity* mereka. Termasuk juga syarikat insurans tadi, kenapa syarikat insurans *outsource* kepada TPA *because their business model if they are relying on the insurance premium to make money, so the cost administration* ini dia *outsource* kepada orang lain, *whoever can be competitive, so we be on panel of the insurance company. So, usually they will select two or three TPA company to be on their panel and then they will check from, based on the efficient level of those company, and then the more they trust, the more they give business to that particular TPAs.*

So, ini adalah, seperti dimaklumkan tadi, kenapa syarikat-syarikat *outsource* kerana mereka kekurangan kepakaran, kemudian kenaikan kos *center* meningkat. Mereka juga tidak

mempunyai peralatan ataupun data untuk menganalisa data-data yang mengenai sakit mereka.

Next slide. Mereka juga kurang mahir mengenai perundangan, *regulatory* ataupun *compliance risk.* Satu lagi, mereka juga sebagai syarikat, mereka bekerja daripada Isnin sampai Jumaat waktu bekerja. Jadi, mereka juga tidak mahu menguruskan sekiranya ada rakan mereka yang sakit pada waktu malam ataupun waktu bercuti. Sebab itu lebih baik mereka *outsource*-kan kepada *company* yang bertugas 24 jam. *So,* TPA, kami bertugas 24 jam.

And then, a lack of apprentice dari aspek pengeluaran. Ini adalah salah satu, *I mean* salah satu daripada cabaran-cabaran yang dihadapi oleh syarikat kenapa mereka *outsource.*

Okay, next slide. Seperti mana itu dimaklumkan oleh Puan Fiona juga— ini TPA, seorang *medical management.* Mana-mana TPA, mereka akan mengatakan mereka ada *medical management, administration services and provider network. The only different is how strong are they, how good or how efficient are they, and then either their panel is big enough or not.*

Okay, next slide. Selain daripada itu, TPA juga perlu menggunakan data untuk membuat analisis untuk mencadangkan apakah solusi kepada cabaran-cabaran yang mereka hadapi.

Okay, next slide. Dan seperti mana-mana TPA lain juga, kami juga memberikan kemudahan aplikasi mobil aplikasi supaya berurusan dengan kami. Jadi, kebanyakan *members,* mereka boleh tahu apakah *coverage,* mereka nak mohon *guarantee letter* ataupun mereka ingin tahu di manakah lokasi kemudahan perubatan, semua boleh— semua di tangan sahaja. *So*, ini agak mudah dan tidak perlu sebenarnya *call our call center*. Tapi, *call center* memang ada 24 jam *and support* untuk *mobile apps* ini juga 24 jam.

Then, sebab itu perkara yang utama kenapa syarikat *outsource* lebih kepada kemudahan kemasukan hospital sebab kalau pergi ke GP, ini *patient* boleh pergi tapi kalau hendak pergi ke hospital, kalau lepas pukul enam, kalau dia tak *outsource* kepada TPA, makna HR sendiri akan uruskan. Jadi, kalau HR dekat syarikat itu tak ada hubungan dengan hospital, jadi agak sukar. Kalau syarikat itu tak ada bank *guarantee* yang mereka letakkan pada hospital, memang agak sukar. Jadi, sebab itulah mereka *outsource.* Untuk kami, dengan sistem data yang kami ada menggunakan AI yang kami ada, kami mampu memberikan— dapat mengeluarkan *guarantee letter* dengan waktu yang cepat, yang pantas.

Next slide. Seperti juga *patient* yang mahu *discharge*, persoalan yang selalu diterima adalah kenapa lambat untuk *discharge. So,* dengan sistem dan AI yang kami ada, kami mampu mengeluarkan *discharge GL* dengan pantas juga.

Okay, next slide. Next slide. Ini kemudahan untuk *tracking*. Ini adalah contoh-contoh. Bila mana kami mengambil alih tugas-tugas ini, syarikat-syarikat mahu mengetahui apakah

kedudukan mereka dari segi kesihatan warga pekerja mereka, berapakah jumlah yang telah dibelanjakan, di manakah mereka membelanjakan tersebut dan apakah usaha-usaha yang boleh dilakukan untuk mengurangkan kenaikan kos ataupun kenaikan inflasi secara mendadak. Jadi, dengan *dashboard* yang kami berikan kepada syarikat-syarikat ini, jadi mereka boleh menilai dan boleh mengakses 24 jam daripada mana-mana juga.

Next slide. Pada waktu yang— okey, ini ada contoh-contoh *report* yang *our partners, our client* termasuklah *insurance company,* korporat, boleh lihat status dan di mana mereka belanjakan dan sebagainya. Jadi, syarikat-syarikat menghargai perkara ini. Dan salah satu pelanggan kami juga adalah Bank Negara. Bank Negara juga menggunakan data-data yang kami berikan untuk kegunaan mereka.

Next slide. Ini hanya— dan setiap kali membuat pembentangan, seperti Puan Fiona maklumkan, sama ada setiap penggal ataupun *every quarter* ataupun setengah tahun, kami akan bentangkan juga laporan yang lebih terperinci, sebab *dashboard* yang sebelum ini diberikan adalah lebih kepada statistik, manakala ini adalah lebih kepada penerangan berdasarkan angka-angka yang kami simpan, gunakan.

Next slide. Baik. Lagi. Okey. *Then, I think this more interesting topic because* kami dipanggil pun untuk membincangkan mengenai kenaikan kos perubatan. Ini adalah *that* yang menunjukkan *as far as a report* yang telah dikeluarkan oleh *few* mengatakan inflasi negara untuk perubatan di Malaysia lebih kurang 15 peratus.

Next slide. Untuk makluman, ini adalah makluman awam yang di mana mengatakan mengapakah, apakah punca-punca kenaikan kos perubatan. *So*, itu, seperti dimaklumkan juga, *prevalence of chronic diseases management, chronic diseases, age-related condition, inactive lifestyle, demand of more in pay benefit* termasuk tuntutan-tuntutan sama ada daripada persatuan kesatuan pekerja dan juga kebanyakan juga *underutilize the executive screening* yang diberikan oleh syarikat.

Menurut data yang kami ada, walaupun syarikat-syarikat memberikan kemudahan *screening* untuk pemeriksaan kesihatan kepada yang berumur lebih daripada 40 tahun, tetapi mana-mana syarikat yang tidak mengenakan syarat sebagai mandatori, hanya 20 peratus pekerja sahaja yang mengambil peluang ini. Ini realitinya.

■1520

Realitinya, ramai pekerja tidak mahu tahu kedudukan status kesihatan mereka, tidak mahu membuat pemeriksaan, walaupun syarikat memberikan *coverage* secara percuma.

Seorang Ahli: Takut.

Tuan Kamal Aryf Baharuddin [PMCare]: Ya, salah satu. *External factors* boleh dilihat di situ, *advancement in medical technology* dan sebagainya. *Then, cost containment initiatives.* Ini adalah kos yang kami lakukan bersama dengan para pelanggan kami dan juga syarikat insurans kami.

Seterusnya, *next slide.* Ini lebih kepada *mechanism process,* bagaimana kami memproses dan apakah parameter yang kami gunakan bila mana kami akan proseskan tuntutan-tuntutan (*claims)* perubatan.

Next slide. Okey, ini kami hanya mahu tunjukkan tiga servis yang utama. Maknanya, *primary care* di *GP clinic. Secondary care* di *specialist and hospitalization, tertiary care.* Ini adalah data-data yang kami ada sejak 2017 tapi nanti kami akan *share* lebih lanjut lagi. *So,* data-data ini menunjukkan peningkatan kos dan juga waktu- kos waktu bila- kos purata- *the average* pada zaman COVID-19 dan sebagainya. *The blue part is actually* inflasi peningkatan setiap tahun.

The next slide. So, slaid seterusnya ini hanya menunjukkan untuk tahun 2023 dan tahun 2024. 2022, 2023, 2024 untuk tiga yang utama tadi. Seperti mana– kos perubatan ini ia akan ada dua unit. Satu, kos perubatan *per visit* dan satu lagi, *number of transaction. So,* kalau jumlah kos meningkat, adakah sebab kos *per visit* itu meningkat ataupun sebab *the number of transaction* yang sebenarnya meningkat? Ini data yang kami ada, kami *share*-kan sejak 2017. *[Merujuk kepada slaid pembentangan]* Untuk ini kita dapati kadar peningkatan untuk GP inflasi sebenarnya tidaklah menakutkan dan ia turun kepada 2022. Kemudian pada 2023, ia naik semula dan kepada kadar lebih kurang 10 peratus. Untuk kami, kami mengetahui kenapa kadarnya lebih meningkat sedikit sebabnya kami telah– dengan kebenaran pelanggan kami. Kalau sebelum ini, bila mana mereka pergi ke *specialist,* mereka akan mendapat konsultasi dan juga untuk ubat. Untuk pertama kali, mereka dibenarkan untuk mendapatkan daripada hospital tetapi ada juga syarikat-syarikat yang mahukan kami berurusan dengan hospital, untuk ubat susulan, dapatkan daripada klinik.

Sebab itu, kita dapat lihat di GP ini seolah-olah tinggi sedikit tetapi sebenarnya kalau tengok balik dengan *specialist* nanti, *the inflation* mereka, kos *is actually lower.* Itu yang kami lakukan. *Specialist care*, inflasi untuk 2023 adalah 2.9 peratus dan untuk 2024 hanya 2.1 peratus sahaja.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *Sorry,* sikit saya nak penjelasan. Jadi maksudnya, selepas *patient* itu dia jumpa dengan *specialist,* membuat konsultasi. Maknanya, dia boleh beli ubat itu di hospital, *government hospital* atau begitu maksudnya?

Tuan Kamal Aryf Baharuddin [PMCare]: Okey, ada syarikat yang membenarkan terus untuk pesakit berurusan dengan *specialist.* Tapi ada juga syarikat-syarikat yang katakan, *"Okey PMCare, boleh tak kita manage kita punya kos, kita kawal kita punya kenaikan kos".* Untuk pertama kali berjumpa dengan *specialist,* dapatkan konsultasi dan ubat-ubat di hospital itu, di tempat yang pertama kali jumpa. Tapi bila buat susulan, lawatan susulan untuk berjumpa dengan *specialist. Specialist* hanya boleh bagi konsultasi tapi ubat dia akan dapatkan daripada klinik. Jadi dengan itu, harganya ataupun di farmasi– dengan itu, harganya lebih murah daripada harga di hospital. Tapi boleh jumpa doktor seperti biasa.

Next slide. Okey, seterusnya adalah untuk *hospitalization.* Sama seperti yang sebelum ini juga. Kenaikan *hospitalization* hanya dilihat suatu COVID-19. Sememangnya- sebab itu banyak yang *test-test* tambahan yang dilakukan dan juga *protection, PPE, all those things. So,* sebab itu sewaktu COVID-19, peningkatan inflasi agak tinggi untuk *hospitalization* tapi sebaiknya, selepas COVID-19, kawalannya agak baik - 7.7. *Then,* untuk tahun 2024 - 0.7 peratus ataupun satu peratus. Jadi, untuk tujuh tahun CAGR *about* 3.5 peratus sahaja, lebih kurang 3.5 peratus sahaja. Ini data-data yang kami ada, yang kami proses untuk pelanggan-pelanggan kami. Jadi, untuk di luar sana, data-data lain yang kami tidak ada, kami tidak boleh beri komen. Kami hanya boleh komen data-data yang kami ada, yang kami proses.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, saya amat terkejut tengok bahawa sebenarnya *the inflation is not high, I mean,* dari segi *hospitalization 0.7 percent. Specialist care, even negative,* ia turun beberapa *percent. So,* apa puncanya- kenapa premium yang dikatakan *medical inflation* itu *15 percent?*

Tuan Kamal Aryf Baharuddin [PMCare]: Okey, yang itu *again* sebab kalau Tuan YB tengok yang *report-report* itu dikeluarkan laporan. Laporan yang dikeluarkan berdasarkan *survey. Survey*- bila mereka buat *survey,* mereka akan tanya semua syarikat yang termasuk juga syarikat-syarikat yang kemudahan kesihatannya agak kecil. Maksudnya- contohnya, dia mungkin juga *survey* kepada kilang-kilang yang kemudahan kesihatan, *entitlement* untuk *outpatient* RM500, contohnya. Untuk *hospitalization,* contohnya RM20,000 seorang. Jadi pada mereka, bila kenaikan sikit, akan ada *effect, because* ia punya *baseline small,* kemungkinan. Tapi saya tak boleh jawab sebab yang buat *survey* itu orang lain. Tapi kami menggunakan data yang sama juga dan *report* yang sama untuk perbandingan dengan data yang kami ada.

Tuan Sim Tze Tzin [Ahli PAC]: Adakah data ini *share* kepada MOH– *you* punya datalah, *share* kepada MOH kah atau *Department of Statistics (DOSM)?*

Tuan Kamal Aryf Baharuddin [PMCare]: Data sebelum ini tidak diminta tapi Bank Negara pada dua minggu lepas memang telah meminta data daripada kami untuk *share.* Jadi, kalau selepas ini, kami boleh tunjuk data secara terperinci. Ini sebab slaid. Kalau nak tunjuk, kita boleh tunjuk terus.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *This one, because this chart* saya rasa ada *yearly medical inflation cost per admission. But, I think the insurance companies argue that, there is an increase of claims under COVID-19.*

Tuan Kamal Aryf Baharuddin [PMCare]: Benar, *yes.* Sebab itu saya maklumkan tadi, bila kos perubatan, ia ada dua faktor. Satu adalah kos per unit, *per visit.* Satu lagi, *the number of claim increase.* Jadi, bila *the number of cases increase, even the unit* tadi jadi– sebab itu, *as far as insurance companies, business model* ia *rely* kepada premium, *loss ratio* dan berapa banyak dia buat *profit.* Okey, *next slide.* Kami juga sedia maklum bila mana– kami mempunyai

16 doktor yang bertugas di syarikat kami. Jadi, bila- doktor-doktor bila membuat pemeriksaan terhadap tuntutan-tuntutan *(claims),* mereka ambil kira juga yang *certain items will not be reflected* dalam *bill. So,* ini yang kita tunjukkan di sini. Contohnya, macam *nursing cost, all those things.*

Jadi kebanyakannya, *this is where that the hospital will put the cross subsidize- part of their cost of doing business.* Jadi, apa yang kami buat adalah kami mengambil kira kos perubatan itu, *rather than* satu item sahaja. Maksudnya, kalau sakit untuk apa dan berdasarkan *benchmark* yang kami ada, kami akan membuat perbandingan.

■1530

So, kalau yang *surgical* bagaimana, yang *non-surgical* bagaimana. Sebab yang seterusnya akan juga tunjukkan benda itu. Okey, *next slide*.

Ini dah *medical study. So*, maknanya saya serahkan pada *our doctor* juga, *our medical director*, Dr. Ainuddin untuk buat penerangan. Sekiranya ada masa, kami juga bersedia untuk tunjukkan lagi data yang lebih selain daripada yang ini. Okey, terima kasih. Boleh saya *pass*-kan kepada Dr. Ainuddin.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tolong kenalkan diri dulu, ya.

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: *Assalamualaikum* dan selamat tengah hari. *So*, saya Dr. Muhammad Ainuddin bin Mohamad Rusli. Saya adalah pegawai perubatan dan juga pengurus di Jabatan Claim di PMCare yang bertugas untuk meneliti *claims* dan juga masalah-masalah perubatan yang dialami oleh ahli-ahli yang bernaung yang diuruskan kemudahan perubatan mereka di PMCare.

Seperti yang dimaklumkan tadi oleh Ketua Pegawai Eksekutif di PMCare dan juga CompuMed, Puan Fiona dan Tuan Kamal tentang apakah tugas-tugas TPA. Antara lain tugas utama ataupun antara servis utama yang kami tawarkan kepada ahli dan juga kepada mereka yang berminat adalah tentang analisa perbelanjaan perubatan tahun ke tahun. Di sini kami sertakan lebih kurang lapan diagnosis dan saya akan jelaskan juga kenapa kami memilih lapan diagnosis ini untuk dibincangkan.

So, lapan diagnosis ini kami bahagikan antara kes-kes yang melibatkan pembedahan dan juga kes-kes yang tidak melibatkan pembedahan. Kenapa lapan diagnosis ini dipilih berbanding diagnosis yang lain adalah kerana lapan diagnosis ini secara puratanya atau majoritinya mereka—sewaktu pesakit datang ke hospital untuk mendapatkan rawatan untuk diagnosis-diagnosis yang dipilih ini, mereka selalunya hanya datang atau mendapatkan rawatan untuk diagnosis ini sahaja dan tidak dikaitkan dengan diagnosis yang lain. Jadi, analisis dan perbandingan yang kita akan buat ini akan lebih tepat satu-persatu berbanding jika ada faktor-faktor lain yang menyebabkan kos-kos perubatan mereka meningkat.

Jadi, diagnosis pertama yang kita akan tunjukkan di sini adalah *tonsillitis* dan saya letakkan *tonsillectomy* kenapa? *So*, kami di PMCARE menguruskan lebih kurang satu juta ahli yang mana kami menguruskan faedah perubatan ataupun lebih kurang tiga persen daripada jumlah populasi di Malaysia. *So*, daripada tahun 2014 hingga 2024, kami membuat analisa untuk 10 tahun ke belakang. Untuk kes-kes *tonsillitis* yang memerlukan *tonsillectomy* iaitu membuang tonsil dan kami dah membuat agregat jumlah mereka duduk di hospital ialah kepada tiga hari.

Kita tengok daripada 2014, median untuk menguruskan kes-kes *tonsillitis* yang memerlukan *tonsillectomy* adalah pada RM7,000 dan kita pergi kepada tahun 2024, jumlah ini dah meningkat kepada RM12,000. Jadi, kita boleh tengok satu persatu di dalam analisis ini. *So*, apakah yang menyumbang kepada bil-bil perubatan ataupun sewaktu pesakit mendapatkan rawatan di hospital selama tiga hari mereka duduk di hospital dan mendapatkan rawatan pembedahan.

Kalau kita tengok kepada slaid yang seterusnya, *so*, ini adalah analisa yang kita buat daripada 2014 hingga 2024. Saya percaya setiap orang mempunyai akses kepada slaid ini untuk melihat dengan lebih jelas. Jadi, kita tengok kepada fi kategori ataupun kategori untuk caj di sebelah kanan slaid. *So*, kita pecahkan kepada pegawai perubatan, radiologi, untuk bilik, untuk *nursing* ataupun kejururawatan, makmal, bilik pembedahan. Kita tengok kepada *anesthetist* dan juga doktor prosedur iaitu merujuk kepada caj konsultan atau caj pegawai pakar perunding yang mana dah ditetapkan oleh kerajaan sejak 2012 dan tidak pernah berubah.

Jadi, kalau kita tengok daripada 2014 sampai ke 2024, kaedah ataupun cara untuk merawat *tonsillitis* dengan *tonsillectomy* hanyalah satu, *which is* dengan pembedahan untuk membuang tonsil. Cuma, mungkin ada teknik-teknik ataupun alatan-alatan baharu yang digunakan dan diperkenalkan. Ini termasuk dalam apa yang kita kenalkan sebagai *technological* atau *medical advancement*.

So, sebarang perkembangan teknologi dalam perubatan adalah untuk kemudahan dan kebaikan pesakit. Antara lain kenapa perkembangan teknologi ini berlaku supaya nombor satu, mengurangkan komplikasi kepada pesakit. Nombor dua, supaya pesakit tidak perlu untuk duduk lebih lama di hospital kerana kadar penyembuhan mereka adalah lebih cepat. Tetapi kita tidak boleh untuk menolak yang perkembangan teknologi ini datang dengan kosnya tersendiri. Itu adalah perkara-perkara yang menyebabkan kenapa tahun ke tahun, kos-kos perubatan ini meningkat.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tapi saya tengok yang *nursing* pun agak meningkat selain daripada *equipment and also medical supply*.

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: Betul. Okey.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *So*, apa *justification* di situ?

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: Dia menunjukkan peningkatan tetapi peningkatan dia tidak sebesar ataupun membawa impak yang signifikan berbanding dengan perkara-perkara yang lainlah, kategori-kategori yang lain.

Tuan Kamal Aryf Baharuddin [PMCare]: *Sorry*, kalau saya boleh tambah. Perbincangan kami dengan pihak hospital memang memaklumkan, *nursing* ini—sebab sejak COVID, kita punya jururawat memang macam itulah, dapat sambutan. Dapat sambutan daripada *Middle East*, dapat sambutan daripada *Singapore*.

Jadi, salah satu hospital di Kuala Lumpur mereka menyatakan dalam masa setahun mereka kena *revise salary* tiga kali. Sebab kalau tidak mereka akan kehilangan jururawat yang mahir. Jadi, *nursing cost* meningkat sebab itu. Kalau tidak memang itu.

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: Tapi—terima kasih Tuan Kamal. Tapi kalau kita tengok di situ dikatakan *the biggest increase year on year noted on medical supply and equipment* bermaksud kadar peningkatan yang paling tinggi direkodkan adalah untuk peralatan perubatan. Jadi, ini dapat kita tunjukkan dalam slaid yang seterusnya.

So, dalam slaid yang seterusnya kita nampak di situ untuk perbelanjaan untuk peralatan perubatan daripada 2014 secara purata perbelanjaannya adalah lebih kurang dalam RM600 atau RM700. Berbanding dengan 2024, ia telah meningkat kepada lebih kepada RM3,000.

Tuan Sim Tze Tzin [Ahli PAC]: Apa maksud *medical supplies* dan apa ini ...

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: *So*, apakah *medical supply*? Apakah yang dalam data kami yang dikatakan sebagai *medical supply* ataupun *equipment*? Ini ialah termasuk kepada peralatan-peralatan digunakan sewaktu pembedahan seperti *scalpel*, *suture* benang untuk jahit ataupun kita namakan *single list item.*

Sebagai contoh untuk kes *tonsillectomy*, kita menggunakan *diathermy* ataupun bahan pemanas untuk membuang tonsil. *So*, kebanyakan hospital swasta sebab perbincangan kita hari ini adalah untuk caj di hospital swasta. Jadi, analisis yang kami berikan adalah analisis yang kami dapat daripada caj-caj daripada hospital swasta.

Jadi, peralatan yang digunakan di hospital swasta ini adalah *single list item.* Ini adalah atas sebab kebersihan dan keselamatan pesakitlah, *hygiene* dan *sterilization*. Jadi, peralatan ini harganya atau kosnya meningkat dari tahun ke tahun. Jadi, kalau kita tengok peralatan ini semua, 80 hingga 90 peratus kita dapat atau segala peralatan yang digunakan di Malaysia, tak kisah di hospital kerajaan ataupun hospital swasta adalah dibawa masuk daripada luar negara. Jadi, kita tidak membuat peralatan perubatan kita sendiri dengan lebih agresif.

Tuan Sim Tze Tzin [Ahli PAC]: *So*, dari segi pendapat—okey, adakah ia termasuk *glove* dan juga....

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: *Glove* adalah antara perkara yang termasuk dalam *medical equipment* dan juga *medical supply* tetapi dia tidak memberi caj atau kesan yang signifikan.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, daripada pendapatan ini, adakah *justified* dengan 51 peratus *increase* ini? *Do you think it's justified*?

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: Untuk kita mengatakan bahawa adakah ini wajar atau tidak? Kita perlu melihat kepada kos yang perlu ditanggung oleh mereka yang membawa masuk. Sebagai contoh kilang-kilang ataupun vendor yang membawa masuk peralatan ini yang daripada luar negara.

Jadi, 10 tahun atau 20 tahun yang dulu, kadar tukaran mata wang mungkin lebih kukuh dan lebih mampan. Tapi tahun ini ataupun 2024, 2025, kewangan Malaysia dari segi pertukaran mata wang asing adalah tidak sebagus yang dulu. Jadi, untuk setiap satu— sebagai contoh jika peralatan dibawa masuk daripada negara Amerika, jadi untuk setiap peningkatan satu dolar US, perubahan yang besar kita nampak berbanding 10 tahun yang lepas.

■1540

Jadi sekiranya kos yang mereka tanggung itu meningkat adalah wajar untuk kita panggil *transfer of cost* atau kos ini ditanggung oleh pihak yang seterusnya lah, yang mendapatkan perkhidmatan.

All right, so contoh diagnosis yang kedua juga adalah diagnosis yang melibatkan pembedahan *which is appendicitis* yang mana rawatannya 99.9 persen adalah melibatkan *appendectomy*. Ini pun sama kalau kita tengok di sini kos untuk merawat *appendicitis* 10 tahun yang dahulu mungkin di hospital swasta mungkin sekitar sepuluh ribu, tapi di tahun 2024, 2025 kosnya adalah lebih kurang RM20,000 ke RM24,000 ribu. Okey pun sama kalau kita tengok kenapa kos ini meningkat, penyumbang utama masih lagi *medical supply* dan *equipment .*

Okey, 10 tahun yang dulu kaedah untuk membuat pembedahan *appendicitis* atau *appendectomy* ini adalah dengan kita panggil *open appendectomy which is* doktor pakar itu melakukan pembedahan dengan membelah perut dengan saiz yang agak besar. Okey*, so* ini mempunyai risikonya tersendiri tapi 10 tahun yang dahulu, ini adalah kaedah yang diterima pakai secara meluas oleh semua pakar. Tetapi 5 tahun kemudian, 2019, 2024, 2025 dengan perkembangan teknologi perubatan, *so* teknik yang diperkenalkan kita panggil *laparoscopy* di mana ataupun dalam bahasa Inggeris nya *keyhole surgery. So* pembedahan *appendicitis* ini dapat dibuat dengan *size incision* yang hanya lebih kurang 5mm, 3mm ke-5mm. Jadi apakah kebaikannya, kadar kesembuhan pesakit adalah lebih cepat.

Okey, *again* seperti yang saya maklumkan tadi, kita tidak boleh menidakkan dengan perkembangan teknologi terdapat kos yang tersendiri, *all right*. Tapi perkembangan teknologi

ini perlu sebab kalau kita tengok kepada *senses* kerajaan di hospital kadar atau diagnosis yang menyebabkan kematian nombor satu adalah penyakit-penyakit yang disebabkan berkaitan dengan jantung, *cardiovascular.* Nombor dua adalah penyakit-penyakit yang disebabkan oleh masalah paru-paru, nombor tiga barulah penyakit-penyakit yang disebabkan oleh virus-virus, contoh HIV atau sebagainya, *all right.*

Tapi kalau kita tengok 30, 40 tahun yang dulu kita selalu dengar oh kenapa orang itu meninggal awal demam panas, kenapa orang tu meninggal *diarrhea.* Itu adalah sebab perkembangan teknologi dalam perubatan ini kita dapat mengawal masalah-masalah yang dulu kita tak dapat nak kawal dan sebagai akibat, kos-kos ini meningkatlah. Tapi kesan baiknya adalah jangka hayat yang lebih panjang berbanding yang dulu, kadar kesihatan yang lebih bagus.

Kalau kita pergi kepada contoh diagnosis yang tidak melibatkan pembedahan. Jadi yang dimaklumkan oleh Puan Fiona tadi apakah diagnosis yang paling banyak atau kita selalu jumpa di hospital kerajaan atau di hospital swasta adalah demam denggi, dan kalau kita rujuk kepada *Code ICD-10 A90*, *so* 99 persen kes demam denggi dirawat tanpa memerlukan apa-apa pembedahanlah. Jadi secara purata kes demam denggi tidak memerlukan pembedahan, okey jadi kita namakan sebagai *non-surgical cases* ataupun *medical cases.*

So, 10 tahun ke belakang sehingga ke 2024 lebih kurang 20,386 kes diuruskan melalui PMCare. Macam saya maklumkan tadi kita uruskan lebih kurang 3% dari total populasi di Malaysia. Kos untuk menguruskan demam denggi 10 tahun yang dulu untuk pesakit yang tinggal di dalam wad lebih kurang tiga hari bermaksud demam denggi yang tiada komplikasi, lebih kurang RM3400 tapi bila kita tengok daripada 2024, kos tu dah meningkat kepada RM5400. Okey, dan kalau kita tengok di sini kenaikan yang paling tinggi adalah di antara tahun 2019 sehingga tahun 2020 lebih kurang 11%.

Okey, jadi 2019, 2020 dan 2021 kita juga kenali sebagai tahun *unnormally* kerana masalah COVID. Jadi proses atau transaksi yang kita terima di hospital swasta adalah jauh lebih rendah berbanding dengan tahun- tahun yang lain. Jadi analisis untuk tiga tahun ini selalunya kita tidak boleh gunakan secara *aggregate* lah. Kita terpaksa kecualikan sebab kalau kita tengok di pihak insurans sekalipun, tiga tahun inilah di mana *claim* insurans adalah sangat-sangat rendah dan di mana hospital mendapat jumlah pesakit yang sangat-sangat rendah jugalah.

So, pun sama kalau kita tengok caj doktor memang tidak pernah berubah daripada 2012 dan caj untuk doktor rawatan demam denggi hanyalah konsultasi ataupun mungkin proses untuk mengambil darah *patient.* Tapi di mana kalau tengok apakah yang majoriti bil untuk demam denggi adalah untuk caj makmal lah sebab untuk pesakit denggi, pesakit perlu diambil darahnya setiap 6 jam untuk kita tengok adakah terdapat perubahan, adakah pesakit

semakin stabil atau pesakit semakin merosot. Jika pesakit semakin merosot perlu ke ICU, jika pesakit dah stabil, jadi kita boleh berfikir untuk *discharge* pesakit.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Nak tanya sedikit fasal carta ini, saya cuba faham carta ini. *Your vertical assist* itu *is on percentage, it's going to be proportionate to 100%* lah tapi sampai 120 and *above* 120 tu kenapa ya? *I try* to understand the carta ni. Macam mana *you based your point on vertical assist* tu *on percentage* tapi *percentage you beyond on hundred* lah? *It's should be max hundred* lah? *I try to understand your* carta ni.

Dr. Muhammad Ainuddin bin Mohamad Rusli [PMCARE]: Ya...

[Ahli-ahli berbincang sesama sendiri]

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *That mean it always percentage kan? That means... [Tidak jelas] Why go beyond hundred? whatever is* ....

Encik Azmi Ramlee [PMCare]: Saya Azmi, Head Data Analytics untuk PMCARE. Bila kami hasilkan carta ni *actually* kami tengok *year on year growth, so they will be a based line year and then over a period of time you will see the growth. So, that 's why sometimes the figure will exceed the 100 percent. Okey, that our best way on how we can present this data.* Kalau kami *break bagi break down another option, it will to give this a break down* dari segi *absolute amount instead of percentage, we give the RM value, then it will be even more messy than this. So that 's why we give this in percentage form and they will be time when it exceeds the based line year, it show use [Tidak jelas] one hundred.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: *What is your based line, what year ?*

Encik Azmi Ramlee [PMCare]: Adli , *I don't quite recall which year* Adli kita guna?

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Tapi kalau *you* guna *whatever year benchmark pun, that means it still the percentage maximum still hundred ?*

Encik Khairul Adli bin Jaafar [PMCare]: *All right, if I may, I'm* Adli, saya dari PMCARE, Data Analitik*. So each claim, let say* kita ada 1,000 *claim*, so setiap *claim* itu memang dia punya *billing group* akan ber *total* kalau kita *agregate* dia akan jadi *100 percent*. Betul, *that' a good catch* tapi kalau kita nak tengok *in a 1,000 claim* kalau kita nak jawab soalan, okey apa yang *typical proportion* ya untuk doktor caj, *then from that 1,000 you have to aggregate that numbers and in this case where* kita menggunakan *median which is the* titik tengah untuk *this number. So that's why* kita ada letak sini satu *remarks* yang setiap *while each individual claims some up to one hundred, the medium proportion across claims may not as medium are calculated independently for each billing group and do not preserve total.*

So we, kita maklum benda ni tidak akan *total up to 100 percent* tapi kita tahu sebab apa, sebab kita cuba untuk *aggregate, let say for example* 1000 *claim* tu, apakah *typical value* yang setiap *billing group* akan, *what is the typical value for that particular billing group*, kalau jawapan saya *make sense.*

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Pada saya *not quite* lah, tapi tak apa,okey, *I think...*

Dr. Muhammad Ainuddin bin Mohamad Rusli [PMCare]: Saya rasa itu memerlukan sesi yang lain sebab analisis, kita bincang kat analisis.

Tuan Ir. Ts. Zahir bin Hassan [Ahli PAC]: Tapi *it cannot, because it just that parameter exactly the same , the number of parameter* sama *unless the number of parameter increase, than I can consider that aggregation* dan sebagainya, tapi *the parameter are all the same. I go for the percentage, its just matter of proportionate,* ok tak pa, boleh *continue ....*

Dr. Muhammad Ainuddin bin Mohamad Rusli [PMCare]: Mungkin itu kita akan bincangkan kemudian sekiranya ada ruang atau masa. Tapi berbalik kepada topik utama hari ini berkenan dengan caj di hospital swasta...

■1550

Jadi, saya berbalik kepada caj makmal untuk pengurusan denggi. Kita akan tengok peningkatan daripada tahun 2014 sehingga 2024 ya. Di sekitar 2014, caj untuk makmal adalah sekitar RM600 tetapi di 2024 cajnya telah meningkat kepada dua kali ganda, RM1,200 okey.

Orang bertanya kenapa makmal pun cajnya bertambah? Jadi untuk setiap ujian makmal dia memerlukan reagen, pun sama, reagen ini didapati daripada luar negara dan tidak banyak reagen untuk menguji ujian darah di Malaysia, dibuat atau dihasilkan oleh makmal-makmal di Malaysia.

Jadi, dengan setiap peningkatan kos di luar negara, kos itu dipindahkan kepada kos vendor ataupun pengusaha di Malaysia, yang mana kos itu perlu diserap dan diagihkan kepada pihak-pihak yang terbabit. Sebagai contoh dalam ini, pesakit yang mendapatkan rawatan di hospital, *right,* okey.

Tetapi kalau kita tengok kepada caj untuk doktor prosedur. Caj ini secara relatifnya tidak berubah dari 2014 dan 2024. Ini kerana macam kita maklumkan tadi, kaedah untuk merawat denggi 2014 hingga 2024 lebih kurang sama. Jadi, akta telah menetapkan doktor pakar yang merawat hospital di hospital swasta hanya boleh berjumpa dengan *patient* untuk memberikan konsultasi di bilik pesakit sebanyak dua kali sahaja.

Setiap konsultasi yang diberikan itu terdapat caj maksimum yang dibenarkan. Jadi, *again* caj ini tidak pernah berubah daripada 2012. Jadi caj, kalau kita tengok daripada analisa ini, secara relatif caj untuk doktor tidak berubah daripada 2014 hingga 2024 tetapi kalau kita – sekali lagi kita berbalik kepada *equipment,* untuk di slaid seterusnya.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Doktor saya tanya sikitlah, *Chairman*. Doktor bersetuju tak kalau Akta Fi ini, *since* 2012 itu di *revise* semula?

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Okey. *So,* untuk penggubalan semula atau perbincangan semula Akta Fi, saya percaya kalau kita bercakap dengan doktor-

doktor pakar atau pihak-pihak hospital, tentulah mereka rasa ini adalah sangat-sangat relevan kerana 2012 hingga 2025, 13 tahun fi ini tidak pernah berubah.

Termasuk juga untuk fi rundingan di klinik ya. Di klinik pula kalau kita tengok DGP daripada tahun 1994 tidak pernah berubah sebab untuk caj di hospital menggunakan Jadual ke-13 tetapi untuk *fee* rundingan di klinik menggunakan Jadual ke-7. Jadual ke-7 ini sejak dari tahun 1994. Jadi caj untuk doktor ataupun caj rundingan mereka di klinik tidak pernah berubah untuk 31 tahun, *yes.*

Puan Teresa Kok Suh Sim [Naib Pengerusi]: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, saya nampak ada sedikit *contradiction* ya antara apa yang dibentangkan. *You* kata *dengue fever* meningkat, apa itu? Apendiks *also* meningkat, tonsil *also* meningkat tetapi apa yang *you present* daripada slaid 27 atau 26. Pada 27 lah *especially. Actually, average cost per admission* tak meningkat banyak.

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: *Okay, alright.*

Tuan Sim Tze Tzin [Ahli PAC]: *Why is that so?*

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: *So,* sebab yang kita maklumkan tadi, kalau kita berbicara tentang purata. Purata tidak banyak perubahan tetapi untuk analisa yang kita buat hari ini kita menggunakan fi median, okey. Tetapi perlu ingat, di slaid, sebagai contoh slaid nombor 35 ya. *So*, terdapat di situ kategori *fee, right. Medical officer, which is* pegawai perubatan, dialisis, caj-caj yang lain, radiologi, *room and board.* Jadi, *medical supply* dan *equipment* menunjukkan peningkatan yang tinggi tahun ke tahun*, right.*

Kalau kita tengok kadar inflasi mereka lebih daripada 50 peratus pun ada. Okey, tetapi kenapa kalau kita tengok kepada data ataupun analisis yang kita tunjukkan di PMCare dan juga di CompuMed sebagai TPA. Kadar inflasi ini 10 *percent* ataupun kurang. Sebab, di mana berlaku peningkatan sebagai contoh *equipment* ataupun *medical supply*, kos-kos ini diserap oleh bahagian-bahagian yang lain.

Sebab itu secara keseluruhannya, kadar inflasi adalah 10 *percent* ataupun kurang tetapi kalau kita – sebab perbincangan kita hari ini adalah caj di hospital swasta. Kita nak kenal pasti di mana ya sebenarnya kadar kenaikan ini berlaku, *right?* Sebab kita perlu kenal pasti kenapa kos meningkat.

Okey, cara untuk kita kenal pasti adalah untuk kita buat analisa dan kita pecahkan setiap *group* untuk caj itu. Kita sudah, di sinilah kita dapat tahu di mana sebenarnya yang memberikan kenaikan tinggi, sebenarnya adalah dari segi *medical supply* dan *equipment.* Selepas kita tahu di mana berlaku peningkatan, kita kena kenal pasti pula kenapa berlaku peningkatan.

So, berlaku peningkatan macam saya terangkan tadi *medical supply* dan *equipment* 89 hingga 90 *percent* dibawa masuk daripada luar negara. *So*, sebarang peningkatan kos

daripada pengeluar di luar negara dipindahkan kepada vendor ataupun pemegang lesen di Malaysia. Jadi perbincangan purata dan median ataupun keseluruhan tidak boleh, tidak akan samalah.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Sedikit, Pengerusi. Okey, soalan saya berkaitan dengan kalau dilihat ada kes peningkatan yang mendadak tadi ya, sama ada – maknanya dari segi surplus dengan servis tadi ya. Bagaimana kaedah fungsi yang disebut *early warning* ini? Maksudnya diberitahu awal kepada *patient* itu ya.

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Okey.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Kalaulah maknanya benda itu sudah pun, sudah, maknanya ada nampaknya penurunan mendadak itu, dari segi kosnya itu. Dari segi mekanisme untuk kita nak...

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Mengawal.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Mengawal dan maksudnya mengawal itu satu. Kedua, prosesnya itu bagaimana nak diberitahu *the patient* dan apa – bagaimana pula rujukan kepada pihak lain untuk dilaporkan ya? Sama ada kepada KKM ke... *[Tidak jelas]* ke? Jadi itu, bagaimana proses itu dibuat oleh TPA itu sendiri?

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: *Alright, okay.* Terima kasih atas soalan. *So*, saya rasa soalan itu membawa kita jauh ke depan, kepada slaid nombor 58. *Right,* okey, sebab analisa yang saya tunjukkan untuk lapan diagnosis tadi untuk menunjukkan, untuk kelapan-lapan diagnosis tadi, kos *driver* kalau saya boleh, adalah disebabkan oleh *medical supply equipment* ya, antara lainnyalah termasuk lah makmal, okey.

So, di sini kita bincangkan apakah *challenges* atau cabaran-cabaran sebagai TPA terutamanya dan juga kalau dari segi dalam negara, KKM dan juga mungkin Jabatan Akauntan atau kerajaan. Apakah halangan-halangan atau cabaran-cabaran berkenaan dengan kenaikan kos kesihatan ya.

So, kalau kita tengok memang dari segi laporan dikeluarkan oleh KKM yang terbaharu adalah sehingga tahun 2023. Berkenaan dengan laporan kesihatan di Malaysia dan juga National Census. Kita tengok *noncommunicable disease* ataupun penyakit-penyakit tidak berjangkit seperti penyakit kencing manis, penyakit darah tinggi, berlaku peningkatan yang sangat mendadak, okey.

Tidak cukup dengan itu, *age of prevalence,* okey. Dahulu penyakit-penyakit jantung ataupun penyakit darah tinggi ini berlaku atas umur 45. Tetapi sejak lima tahun yang lepas, kes-kes ini adalah lebih banyak berlaku di kalangan umur 30 hingga 40, yang mana sangat mudalah. Jadi, Puan Fiona dan Tuan Kamal tadi pun sudah maklumkan apakah sebab-sebab berlaku penyakit-penyakit kronik ini. Gaya hidup yang tidak sihat ya.

Perkara yang kita tidak boleh *again* elakkan adalah kegagalan atau ketidakinginan pesakit untuk mengetahui status kesihatan mereka. Okey, *so,* berbalik kepada soalan yang

ditanyakan tadi. Apakah cara untuk kita mengawal tetapi tidak cukup untuk mengawal, kita kena perlu pastikan yang kaedah untuk mengawal ini juga adalah *sustainable, right?*

So, kaedah untuk mengawal kos perubatan adalah dengan *prevention,* mencegah *alright*, okey. Jadi pencegahan itu tentulah cara untuk mengawal masalah kesihatan atau masalah kos pengurusan kesihatan dari tahun ke tahun. Sebab kalau pesakit itu sudah mendapat apa-apa masalah kesihatan, itu sudah menjadi *seek care* berbanding dengan *medical care* atau *health care* ya.

Jadi, kita perlu fokus kepada *health care.* Jadi, kita perlu – kenapa perkara ini berlaku? Kita tengok pada faktor nombor empat itu, *poor health literacy and prevention*. Jadi, kekurangan kepekaan rakyat di Malaysia tentang kepentingan untuk menjaga kesihatan dan juga mengetahui status kesihatan mereka yang lebih awal.

Kalau kita tengok banyak pesakit di luar sana yang mana mereka mempunyai risiko yang tinggi untuk kes-kes kanser sebagai contohnya, ahli keluarga kanser positif yang banyak, emak, ayah, kakak, abang. Tetapi mereka sendiri takut untuk melakukan ujian saringan untuk mengetahui adakah mereka terdedah kepada risiko kanser

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Perasaan takut itu yang perlu diubah ataupun *behavioral change* ini yang diperlukan untuk kita katakan kaedah untuk mengawal kos perubatan dan juga perbelanjaan perubatan.

Sebab, kalau kita tengok kepada ujian-ujian saringan, tentulah ujian-ujian saringan ini tidak semahal dengan kos-kos rawatan. Kalau kita dapat mengenal pasti risiko-risiko kanser, sebagai contohnya, lebih awal sebelum kanser itu dah menjejak tahap tiga, tahap empat yang mana kita tahu ubat-ubatan kemoterapi ataupun suplemen-suplemen yang perlu diambil oleh pesakit-pesakit yang perlu menjalani rawatan kemoterapi adalah 10, 20, 30 kali ganda lebih tinggi daripada ujian saringan awal, sekiranya ujian saringan awal dapat dilakukan dan mungkin penyakit itu dapat dikesan pada tahap satu, tahap dua yang mana rawatannya adalah jauh lebih murah dan juga lebih definitif, bermaksud pesakit mempunyai peluang yang lebih cerah untuk sembuh sepenuhnya, itu yang lebih bagus. Jadi, ini adalah antara perkara-perkara yang kita perlu terapkan dan didik kepada *member* ataupun rakyat di luar sana berkenaan dengan kepentingan tentang kepekaan kesihatan inilah.

Kalau saya boleh langkau slaid yang lain itu dan pergi kepada *conclusion* ataupun rumusan. Jadi, *the rise in total medical cost of medical supplies equipment seen as the main cost driver.* Kita dah maklumkan tadi, kebanyakan bil ataupun untuk lapan-lapan kes itu kalau kita pergi satu persatu, di mana punca kenaikan ini, kalau kita tengok secara mikro, disebabkan oleh *medical supplies* dan *medical equipment.* Kita dah cakap tadi, kita dah kenal pasti di mana kenaikan, kita kenal pasti kenapa berlaku kenaikan disebabkan ini tidak dibuat di Malaysia, antara lainnyalah.

Juga, kita dah kenal pasti kadar rundingan doktor bukanlah penyebab untuk kenaikan kos ini sebab kadar ini tak berubah 2012 sampai ke sekarang ini. Jadi, *doctor's fee* atau kadar rundingan doktor itu bukanlah penyebab untuk kenaikan kos rawatan di hospital ataupun di klinik di Malaysia, sebab kita katakan tadi, kalau di hospital sejak tahun 2012, di klinik sejak tahun 1994. Lebih lama lagilah.

Kita juga dapat kenal pasti faktor-faktor lain yang menyebabkan kenaikan daripada kos *medical supplies* dan juga *equipment*, tidak ter— apa? Termasuklah *but not limited to relatively weak currency, advancement in medical technology.* Sebagai contoh, kalau 10 tahun dulu kita nak buat *appendicectomy just* memerlukan *scalpel number* 11. *So,* siapa yang dalam perubatan ataupun pembedahan, mereka tahu pisau *number* 11 untuk melakukan pembedahan. Tapi, dengan perkembangan teknologi, kita boleh buat *laparoscopic*. Jadi, set *laparoscopic* itu ada kosnya yang tersendiri. Tapi, apakah kebaikannya? Komplikasi dapat dikurangkan, kadar kesembuhan yang lebih cepat. *So*, ini adalah harga-harga yang perlu dibayar untuk mendapatkan kebaikan yang lebih ya.

Increased use in healthcare services. Pun sama macam yang dimaklumkan tadi. Sepuluh tahun dulu, jumlah hospital dan jumlah klinik di Malaysia tak sebanyak sekarang. Sepuluh tahun yang dulu, jumlah klinik di Malaysia sekitar 6,000 tapi sehingga dua minggu lepas, kita ada lebih kurang 11,612 klinik swasta di Malaysia. Kita ada lebih kurang 280 hospital swasta di Malaysia dan lebih kurang 154 hospital kerajaan di Malaysia.

Jadi, akses kesihatan untuk rakyat Malaysia ini bagus, sangat bagus. Ini adalah satu perkara yang perlu diraikan sebenarnya. Sebab, kita tahu di mana pun rakyat kita berada, akses untuk mendapatkan rawatan itu tidak lebih daripada 20 minit di Semenanjung Malaysia tapi lebih kurang satu jam ke satu jam setengah di Sabah, Sarawak di sesetengah kawasanlah. Jadi, mungkin itu perkara-perkara yang boleh dibincangkan dengan pihak yang lain untuk penambahbaikan dari segi akses kepada kesihatan. Tapi, kita kena maklum yang akses kesihatan di Malaysia adalah sangat-sangat bagus dan ini adalah perkara yang perlu diraikan di samping daripada kos-kos yang mungkin kita perlu runding untuk dapat kawal peningkatannya itu, antara lain. Terima kasih.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih. Saya nampak Kuala Pilah ada nak tanya persoalan. Selepas itu Bayan Baru.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Terima kasih, Yang Berhormat. Pertama sekali, saya lihatlah banyak faktor-faktor penyumbang ini bergantung kepada jenis penyakit. Saya tengok daripada graf ini... *[Merujuk pada paparan di skrin]* Betul ya? Tapi, saya lihat macam ubat-ubatan, kita kata *beyond* kita punya ini *because* banyak *imported* dari luar, kan?

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Betul.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Jadi ubatan, *it falls under pharmacy* lah?

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Betul.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Farmasi ya?

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Ya.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Pasal, ubatan pun menyumbang juga sebagai satu faktor yang besar menaikkan kos.

Dr. Muhammad Ainuddin Mohamad Rusli [PMCare]: Betul.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Lagi satu, Dr., saya *just* nak tanyalah. Mungkin sekarang ini *you are talking about Ministry of Health,* di Kementerian Kesihatan. *They are moving towards leasing,* konsep *leasing. Lease.* Jadi, adakah pandangan doktor ia akan membantu serba sedikit? *You are talking about medical inflation* ini. Dulu kita banyak kita punya *equipment*— contohnya, kan, kesihatan dapat *second highest budget every year.* Tapi banyak ini membeli peralatan, *equipment*. *So*, sekarang ini konsep dah *moving towards leasing.* Saya pun dalam Komiti Kesihatan. Adakah *you* rasa ia akan mengurangkan juga sedikit inflasi? Pasal, kita beli ini dari luar ini memang mahallah. Sekali beli memang mahallah— bilion. Tapi, adakah *you* rasa dengan konsep *leasing* ini, *lease* ini mungkin akan boleh mungkin *reduce our medical inflation in future?*

Tuan Kamal Aryf Baharuddin [PMCare]: Biar saya cuba jawab. Untuk konsep *leasing,* dari segi *cashflow* memang baik. Tetapi sama ada menjawab sama ada kos akan berubah atau tidak, kami pun masih kurang pasti. Sekurang-kurangnya dengan *leasing,* alat akan dapat digunakan— kalau dulu, sebab kita kena beli satu, kos dia RM50,000. Contohnya RM50,000. Dengan *leasing,* mungkin kita bayar RM10,000 sahaja, kita dapat lima alat seterusnya. Cumanya... *[Tidak jelas]* Dengan tempoh yang panjang itu balik macam mana. Jadi, kalau *cost of doing the— cost of financing of the leasing very reasonable, that will be a good way of doing things.*

Cuma, untuk kami beri jawapan, rasanya-rasanya kami tidak ada data, jadi kami tak ada. Cuma, secara prinsipnya, begitu.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ada— saya, saya. Ada maklumat yang kita perolehi bahawa terdapat kos yang tersembunyi yang berlaku akibat prosedur oleh pihak TPA, termasuklah— pelbagai. Maksudnya, digital dan sebagainya. Ada juga audit tuntutan yang berulang.

Okey. Ada tak— adakah pihak PMCare ataupun CompuMed mengakui bahawa sebenarnya beban operasi ini sebenarnya diserap oleh— kos operasi ini sebenarnya diserap oleh klinik dan akhirnya yang kenanya balik kepada pengguna? Maksudnya pada rakyat. Dia ada tak berlaku dalam bentuk— ini *because* pemikiran ya, persepsi— berlakunya *mark up* tidak rasmi dibuat? Ada tak *tendency* itu begitu?

Tuan Kamal Aryf Baharuddin [PMCare]: Okey, saya jawab untuk bagi pihak PMCare ya. Sebab kami mengutamakan data, jadi setiap kali klinik ataupun hospital *submit,* turut ada

dah memang kena *transparent.* Mereka menggunakan portal. Jadi bila data masuk *je*, kami boleh *validate.* Jadi, tidak timbul mengenai klinik atau cuba mengambil kesempatan.

Walau bagaimanapun, kita akui sesetengah bukan sebab klinik tapi pengguna, sebab bila bekerja dengan majikan ini, kadang-kadang dia nak MC *ke* apa. Tetapi, itu kos itu— *the number* kecil, nombornya kecil tetapi orang yang berperangai macam itu pun tak ramai. Jadi, dari situ, kami boleh tahu terus sebab data kami *real time. Patient* yang sama sekejap ini pergi ke sini, dia mungkin tak dapat MC atau*... [Tidak jelas]* Pergi dalam waktu yang sekejap terus pergi klinik lain. Portal itu juga, HR mereka juga tahu. Jadi, mana HR yang *concern,* dia akan buat-buat tanyalah, *"Eh, kenapa tak sihat sampai pergi dua klinik sekali pergi?"* Pekerja itu pun malu sendiri sebab dia dah tahu dah dia dah di-*monitor* oleh HR juga.

Puan Fiona Rebecca Limus [CompuMed Services]: YB, *allow me to add a little bit. Okay. So, with regards to transferring of fee to the members* kan, *so of course* kita sebagai TPA, kita pun— *we have our cost of operating. So, we don't charge the clinic based on the total amount,* contoh. *I think this one I can speak for CompuMed and also for PMCare.*

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So, of course, the clinic who participates or to be our panel, they have to log on to our system. So, in the system, we actually provide a platform for them to have access to our clients. They can submit their claims. Kalau mereka tidak *submit* kepada TPA*,* mereka kena buat sendiri*, submit* kepada *insurance companies, submit* kepada *corporate clients,* macam itu*. So, because we have provided the platform, we call it the cost of doing business to the clinic and* ini kita tidak paksa*. If let say,* klinik itu dia tak nak bayar *the cost of doing business* itu*, it's okey. Then, they don't become part of the panel.* Kalau dia hendak, *then we have an upfront agreement. So,* kita pun sangat *transparent* dengan panel-panel klinik kita*.* Ada juga TPA dekat luar itu dia akan ambil *percentage* daripada *total medical fee. So, of course, this is the different way of TPA doing business* tetapi *I can speak for myself and also for PMCare,* kita tak mengikut peratus *of the medical fee.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *That means,* melalui sistem yang dibangunkan oleh pihak CompuMed dan juga PMCare ini, menunjukkan *you all* boleh menilai sendiri *cost per claim* yang diberikan oleh syarikat ataupun *client*-lah.

Puan Fiona Rebecca Limus [CompuMed Services]: Betul.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh tidak beritahu PAC, apakah margin keuntungan operasi TPA bagi setiap rawatan yang diproses?

Tuan Kamal Aryf Baharuddin [PMCare]: Okey, untuk...

Ir. Ts. Zahir bin Hassan [Ahli PAC]: Sebelum itu hendak sambung soalan. *What is your business model? How do you get your revenue?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Okey, I think this gentlemen from MOH has also asked that question earlier on. How do we charge client? So, we charged*

client on a per member per annum or per member per month basis. So, contoh— ini *just contoh, it's not the real figure. For example, if we charge RM12 per member per year, right? So, each member, we will take RM12 and if they want to— if different client* dia nak bayar tiap-tiap bulan, dia akan bayar seringgit untuk *per individual*, macam itu.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh tidak kongsi dengan PAC, berapa jumlah yang paling murah yang *you* ada, *client you*, yang paling mahal *per annum*?

Puan Fiona Rebecca Limus [CompuMed Services]: Okey*. So, we have what we call tiering* kan? Dia mengikut *total head count. Head count* yang lebih ramai, *then the fee is actually smaller. So, usually* dia *in terms of pricing,* kita pun banyak *combination, because* ada yang ambil *in-patient*, ada yang ambil *out-patient*, ada yang ambil *pre-employment,* ada yang ambil lain-lain punya *service*. *So*, dia terpulang kepada *client,* apa *service* yang dia hendak.

Dr. Muhammad Ainuddin bin Mohamad Rosli [PMCare]: Saya cuma hendak cuba menjawab soalan berkenaan dengan *transfer of cost,* tentang kos operasi. Okey, seperti yang dimaklumkan oleh Puan Fiona, di mana *business* atau *model* itu berlaku adalah dengan klien, ia tidak kisah sama ada klien itu pergi klinik sekali, pergi klinik sepuluh kali atau pergi hospital sekali atau pergi hospital sepuluh kali. Sama ada kos di hospital RM1,000 ataupun kos di hospital RM100,000, kita tidak berlaku perubahan antara caj, nombor satu. Tidak ada caj-caj tambahan atau caj tersembunyi dengan pihak hospital kah, dengan pihak klinik kah.

Jadi, untuk menjawab adakah terdapat atau berlakunya kos-kos tersembunyi dengan pengurusan disebabkan oleh pihak ketiga ataupun TPA itu, saya rasa itu adalah tidak tepat. Apabila kita sudah menerangkan tentang bagaimana TPA beroperasi dan kita membina *model business* itu.

Puan Fiona Rebecca Limus [CompuMed Services]: *As a* TPA, kita hendak *member* kita sihat kerana kalau mereka sihat, mereka tidak akan pergi ke hospital dan *GP clinic* dan kita akan kurang kerja. *So*...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kalau ini nanti, *you* tak ada ini— *you charge* berkurangan, *you* tidak boleh hendak buat *business*.

Tuan Kamal Aryf Baharuddin [PMCare]: Sebab itu fi kami- *retainer fee*. *It is a retainer fee.*

Puan Fiona Rebecca Limus [CompuMed Services]: Dia sudah *fixed.*

Tuan Kamal Aryf Baharuddin [PMCare]: Dia sudah *fixed*.

Puan Fiona Rebecca Limus [CompuMed Sdn. Bhd.]: Dia sudah *fixed.* Contoh, 50,000 orang, *let say we charged RM12, we charge 50,000 times RM12,* itu *fixed*. Dia masuk ke hospital, dia tidak masuk ke hospital, bayaran pun sama. *So, that's why*...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Maksudnya, doa *you all* lebih afdal...

Tuan Kamal Aryf Baharuddin [PMCare]: Sihat.

Puan Fiona Rebecca Limus [CompuMed Services]: Sihat, ya.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Lebih ikhlas, lebih ikhlas.

Puan Fiona Rebecca Limus [CompuMed Services]: *Correct.*

Tuan Kamal Aryf Baharuddin [PMCare]: Ya, betul. Lebih ikhlas.

Puan Fiona Rebecca Limus [CompuMed Services]: Lebih ikhlas, *we want them to be healthy, so that* kita kurang kerja. *[Ketawa]*

Tuan Kamal Aryf Baharuddin [PMCare]: Itu betul, betul.

Puan Fiona Rebecca Limus [CompuMed Services]: *That is why* kita adakan *wellness programme* semua itu kan, supaya mereka sihat.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih Pengerusi.

Ir. Ts. Zahir bin Hassan [Ahli PAC]: *Okey, all these data that you collect, you call it– you sharing with us today. So far, I presume only the insurance companies* yang pakai. *Do you share within the insurance companies or...*

Puan Fiona Rebecca Limus [CompuMed Services]: *Yes, yes.*

Ir. Ts. Zahir bin Hassan [Ahli PAC]: *...You just keep it?*

Puan Fiona Rebecca Limus [CompuMed Services]: *No, no, no. So, it's to the respective— So, maybe we take a step back, one step back. So, because we have been this industry for the last 30 years. To be very honest, our clients i.e. insurance companies, I don't know whether Encik Kamal will agree with me on this, but they have never seen TPA as a worthy partner, because they feel that we are just the backroom processor, right. So, as an insurance company, they have actuaries, they have underwriters, they know a lot more when it comes to risk management.*

But, over the years of 30 years, we have actually been the one that has been collecting a lot of information through the transactions that we have been managing. So, as a result of that, we have people like Azmi who is the Head of Data Analytics in PMCare for example, has been digesting and looking at the data from many-many angles and perspectives. So, today we are very proud to say that we have a lot of information with regards to private healthcare, right.

Tuan Kamal Aryf Baharuddin [PMCare]: *Sorry,* sekiranya saya boleh tambah. Okey, sama ada data dikongsi dengan *insurance companies* sebab kami bekerja— sekiranya kami dilantik untuk akaun ataupun *company* yang diberikan oleh syarikat insurans tersebut. Data-data yang diperlukan oleh mereka, kami akan hantar kepada mereka tetapi sama ada mereka guna atau tidak, kami tidak boleh jawab. Sebab akaun-akaun syarikat insurans, dia yang dapat

klien, dia akan bagi kepada TPA untuk *manage the process, backroom office*. *Okey, back office* dia punya itu- tetapi data-data yang dikata, okey PMCare atau CompuMed, kami mahu *these parameter of data, data field,* kami akan berikan. Cumanya, kami tidak berikan kepada satu *group, because* kami hanya berikan kepada *technically our client, the insurance company appoint.*

Puan Fiona Rebecca Limus[CompuMed Services]: *Owner of the data*.

Tuan Kamal Aryf Baharuddin [PMCare]: *Owner of the data, because ini PDPA also*.

Puan Fiona Rebecca Limus [CompuMed Services]: PDPA *also*. Kalau *for example MOH, like the meeting that we had a couple of weeks ago. They said, 'Oh, will you be able to share with us the data?'. We say, 'Yes, we can.'. But of course,* kita kena *anonymize, generalize and then, we will be able to pass that to* MOH, contoh.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Pengerusi terima kasih. *I think you know every business exist for a reason. So, for TPA, you have your role to play, you become the- what you call?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Facilitator*.

Tuan Sim Tze Tzin [Ahli PAC]: *Facilitator between different-different groups and clients and your patients. Alright. However, I think all businesses will have to be registered. So, I just want to check with you, which ministry actually register, regulate* TPA?

Puan Fiona Rebecca Limus [CompuMed Services]: Okey, *we are like a stateless child. [Ketawa]*

Tuan Kamal Aryf Baharuddin [PMCare]: *TPA* perlu *register* dengan *Ministry of Health. Regulation* ada dalam *the Private Healthcare Facilities and health*...

Puan Fiona Rebecca Limus [CompuMed Services]: *Private Healthcare Facilities and Services Act.*

Tuan Kamal Aryf Baharuddin [PMCare]: Cumanya, itu- *then,* hanya ada satu seksyen sahaja *under* Manage Care Organization (MCO). Cumanya, kami tidak perlu— pada masa ini tidak perlu mendapatkan lesen, berdaftar sahaja tetapi bukannya berlesen.

Puan Fiona Rebecca Limus [CompuMed Services]: *So, we don't have*— untuk *answer your question, YB. We have to register with MOH and when we work with the financial institutions, then we are govern by the Outsourcing Act JPA 31, Outsourcing Act by Bank Negara Malaysia. So, we have to comply to that Outsourcing Act.*

Tuan Kamal Aryf Baharuddin [PMCare]: Maknanya, sekiranya klien kami dari syarikat insurans ataupun *financial institutions,* kami tertakluk kepada akta tersebut sebab syarikat tersebut yang melantik kami.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, kita pun, PAC pun sudah panggil ramai dan memang macam-macam mereka akan kompelin, ini tidak betul. Hospital swasta kata,

insurans tidak betul. Insurans kata, hospital tidak betul. *You know all kind of things. So, we listened a lot.*

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So, one of the things that we listen from especially GP lah, *I think they are – I am sure you also know they are not very happy with TPA. So,* apa yang kita dengar adalah TPA menekan harga mereka*. So, that they actually – they are already like 30 years* tidak – fi mereka tidak dinaikkan, mereka tetap ditekan dengan – sebab *the reality is TPA brings customer to them.*

Okay, I was told about 60 percent of their patients are brought by TPA. So, you have the what you call the power to negotiate and whereas small GPs, individual practice, single practice they don't have that kind of negotiation power. So, they are forced to give in to your pricing. So, some was told, I was told that they are being paid RM12 per consultation fees whereas if they walk in, they can get RM35 but you know, if let's say TPAs walk-in about RM12.

Another thing is that we also heard GP complains is about the annual fees to pay to you guys. Some, you charge them about RM10,000 per year for to being part of your panel. So, these are the things that cost to – added cost to their business. So, can you respond to these complaints please?

Puan Fiona Rebecca Limus [CompuMed Services]: *Okay, so with regards to that RM12 consultation is what we called capping right. So, they will claim that as TPAs, we kept their consultation charges. Is it true? Yes, it is true but that is depending on which TPA is managing, right? I can tell you upfront, CompuMed and perhaps PMCare, we don't cap the consultation fee, right. So, in our system when we're generating you can see some of the GP clinic charging RM35, RM40 and if it is off-office hours for example, midnight rate or whatever not, those rates are definitely higher than the usual rate.*

So, again it depends on which TPA is managing. But you are right, there are some that actually cap the consultation charges. With regard to annual fee to be paid on a yearly basis, that is not correct for CompuMed and also for PMCare. We do not charge an annual fee per se, ya.

Tuan Sim Tze Tzin [Ahli PAC]: *That means that the industry has some people who maybe PMCare and CompuMed doing you know …*

Puan Fiona Rebecca Limus [CompuMed Services]: *Different practices.*

Tuan Sim Tze Tzin [Ahli PAC]: *Different practices maybe having better pay package to the GP but there are some who actually really* apa…

Puan Fiona Rebecca Limus [CompuMed Services]: *So, it's what we call business model right? So, our business model is as what we have shared just now. It's a per member per annum fee, right. But the are some TPAs out there that says the way they sell themselves is they say, "Okay to HR, TPA fee is free", okay. So, then of course as HR,* dia orang sukalah

kan *because TPA fee is free.* Tetapi dunia ini tak ada *free lunch, right? So, where do you think they will make their money from? So, what they do is they will look at the GP clinic and say, okay each transaction I will take 15 percent from the total cost. So, if it is RM100 consultation and medication and all that right, they will take RM15 from the GP clinic. So, there is also another model like that is being practiced.*

Tuan Kamal Aryf Baharuddin [PMCare]: Sekiranya, *sorry* kalau saya boleh tambah. Memang PMCare dan CompuMed – sebab kami pernah hadiri perjumpaan dengan MOH termasuk dengan MyCC. MyCC menyatakan tidak boleh melaksanakan ketetapan *consultation fee* untuk semua klinik dengan satu harga sahaja, ini bercanggah dengan undang-undang. Dengan itu, kami membenarkan klinik menghantar tuntutan konsultasi mengikut waktu seperti mana yang tertera dalam akta. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: *So*, saya punya *point* adalah *as an industry, you need to help regulation – you know, maybe you should form association and self-regulate because I think the issue now is that there is a very big clauses among the GPs against TPA which I think brought – affect your reputation as a group, as a company – as a group lah, so that's why I think it's not government job to regulate everything, it's better that you self-regulate. So, what your – what do you think about that?*

Tuan Kamal Aryf Baharuddin [PMCare]: Terima kasih YB. Ya, benar kami pernah berbincang dengan – sebab kami pun ada persatuan tapi kebanyakan syarikat-syarikat TPA yang begini adalah syarikat-syarikat kita ataupun syarikat-syarikat yang baru mencuba nasib. Sebab syarikat-syarikat yang lama seperti kami yang lebih daripada 20 tahun, klien-klien ataupun *company* kami sudah tahu *business model* macam seperti mana dan juga pengamal-pengamal perubatan, klinik juga suka bekerjasama sebab mereka sendiri akui kemudahan dengan bekerja dengan TPA. Sebab kalau tidak, setiap kali mereka buka klinik, mereka nak kena jadi panel kena *approach* satu-satu ke klien, pergi jumpa HR untuk setiap *company*. Selepas itu pula, tuntutan perlu dihantar kepada setiap *company.* Lepas itu pula *collection* juga perlu diambil daripada setiap *company,* syarikat-syarikat.

Tapi dengan bekerjasama dengan TPA seperti kami yang sudah lama, jadi mereka tahu okey dengan cara mudah, dengan urusan dengan satu *company* TPA, mereka boleh berapa ramai pengguna ataupun ahli daripada syarikat tersebut boleh mendapatkan kemudahan kesihatan di klinik-klinik mereka dan mereka juga berurusan hanya dengan satu TPA sahaja berbanding dengan mereka perlu berurusan dengan banyak syarikat sekiranya seperti dahulu sebelum MCO diadakan, sebelum tahun 1995. *Manage care* ini pun bukannya perkara baru. Di US pun 1965 sudah ada *actually.*

Puan Fiona Rebecca Limus [CompuMed Services]: *We do have an association. We have got the third-party administration association and the chair of this association is under PMCare and we are a member of it.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ramai kah ahli bawah persatuan tersebut?

Puan Fiona Rebecca Limus [CompuMed Services]: Kita ada jemput semua TPA untuk...

Tuan Kamal Aryf Baharuddin [PMCare]: Ya. Itu yang berdaftar di MOH lebih kurang 45 tapi yang berminat untuk berbincang, sembilan atau 10 syarikat. Itu sahaja.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kenapa tak buat *compulsory?*

Tuan Kamal Aryf Baharuddin [PMCare]: Sebab tak boleh *compulsory. [Ketawa]*

Puan Fiona Rebecca Limus [CompuMed Services]: *So, we are happy to be regulated actually. We are happy to be regulated then a lot of things can be above board and more transparent.* Tetapi kita ini *like I said earlier on, first it was Bank Negara then it went to MOH you know? So, we don't have a ministry but at one time, they were considering MITEC [Dicelah]– MITI, ya MITI to regulate us* tapi itu pun tak jadi.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, so* soalan saya adalah *do you want to be regulated and…*

Tuan Kamal Aryf Baharuddin [PMCare]: *[Bercakap tanpa menggunakan pembesar suara] Serious… [Tidak jelas] serious saying, yes.*

Puan Fiona Rebecca Limus [CompuMed Services]: *Yes.*

Tuan Kamal Aryf Baharuddin [PMCare]: *[Bercakap tanpa menggunakan pembesar suara]* Kita mahu kalau ada undang-undang yang*… [Tidak jelas] regulation*.

Puan Fiona Rebecca Limus [CompuMed Services]: *Correct. So, that way …*

Tuan Kamal Aryf Baharuddin [PMCare]: *[Bercakap tanpa menggunakan pembesar suara]* Nanti akan ada yang syarikat-syarikat...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Pakai *mic* yang itu – yang tak… Dr., padam. *Thank you.*

Tuan Kamal Aryf Baharuddin [PMCare]: *Sorry, okay.* Untuk *serious payer* seperti syarikat kami, kami memang mengalu-alukan *regulations specific,* akta yang spesifik sebab sekarang ini aktanya sebagai *subset* kepada *private healthcare facilities act only under* Managed Care.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya nak tambah apa yang dibangkitkan oleh Bayan Baru berkenaan dengan apa yang telah pun dialami oleh GP-GP dan juga rungutan, rintihan yang diberikan. Mungkin tak berlaku pada *big company* PMCare ataupun CompuMed sebab ada yang mereka dapat lewat dia punya bayaran tertangguh sampai berbulan-bulan. Jadi, kalau PAC cadangkan sebab tadi pun kita kata kalau ada di *regulated* lagi baik.

Kalau PAC cadangkan pemakaian kod etika operasi TPA terutama sekali dalam bila tuntutan, hendaklah dibuat contoh, bila dibagi saja, dalam tempoh 15 ke 30 hari kena selesaikan *and then* kalau dalam masa tempoh itu, kalau tak ada alasan munasabah *you* tak boleh tolak, *so you* kena bayar. Adakah pihak TPA bersetuju dengan cadangan?

Tuan Kamal Aryf Baharuddin [PMCare]: Ya, kami pernah berbincang dengan MMA dulu pada tahun 2017 atau 2016. Pada waktu itu, mereka telah mencadangkan supaya TPA ataupun MCO membuat bayaran kepada klinik dalam masa 45 hingga 60 hari paling lewat.

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Sebab kebanyakan rungutan daripada klinik adalah bayaran yang dibuat selepas 90 hari. Kebanyakan klinik TPA yang kecil-kecil membuat bayaran lebih daripada 60 hari dan bukan setakat TPA kecil-kecil dan ada juga syarikat insurans yang besar yang membuat bayaran lebih kepada 90 hari.

Tapi data kami menunjukkan untuk PMCare kami membayar dalam masa 30 hari lebih kurang 60 peratus *[Disampuk]...*

Seorang Ahli: *[Berucap tanpa menggunakan pembesar suara]*

Tuan Kamal Aryf Baharuddin [PMCare]: 90 peratus *sorry,* kami bayar dalam masa 30 hari 90 peratus, 10 peratus dalam masa 45 hingga 60 hari.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Macam mana dengan CompuMed?

Puan Fiona Rebecca Limus [CompuMed Services]: CompuMed sama juga tapi kita, *our percentage* tak setinggi PMCARE. *We made payment for actually 14 days* pun kita bayar. *We have as high as about 60 percent.*

Kerana ini terpulang kepada klien kita. Kalau klien kita ada *established of float fund with us* kita akan bayar, *submit the information, the claim submission from the GP clinic and hospital* terus kita boleh bayar.

Sometimes we even pay as fast as T plus three, T plus five. So, why is it that ada *complaint* mengenai TPA bayar lambat *is because two factors. Number one is that sometimes, let say client* kita, contoh *One* ABC Sdn Bhd. *Then, what happen is we invoice them and then they pay us late. So, if they pay us late, we would also pay the client late right, because our job* bukan macam *insurance company. We don't underwrite risk, right. So, we are only the facilitator. So,* kita kena tunggu bayaran daripada klien sebelum kita boleh bayar. *So, that's one of the factors where payment is going to be slow.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Pengerusi, *straight question, just now you mentioned about some client may send you during odd hours or midnight. Therefore, the charges can be higher. I thought you'll just an outsource entity right, outsource company.*

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: *Not client...*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Why do you need to work at midnight?*

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: *I think,* apa yang Puan Fiona cuba maklumkan tadi adalah berkenaan caj perundingan di luar waktu pejabat *because* kalau kita rujuk kepada *again* Akta Jadual Ketujuh untuk GP atau Jadual Ketiga Belas untuk hospital.

So, caj sebagai contoh, caj untuk rundingan RM10 hingga RM35 sejak tahun 1994, *again* ini bukan ditetapkan oleh TPA tetapi ditetapkan oleh kerajaan. *So,* caj ini adalah untuk sebarang caj perundingan untuk pesakit yang mendapatkan konsultasi atau rawatan di klinik daripada jam 8.00 pagi hingga 6.00 petang. *So,* selepas 6.00 petang mereka dibenarkan untuk caj tambahan 50 peratus.

Sama juga untuk caj rundingan atau caj pembedahan di hospital sekiranya sebagai contoh, untuk pembedahan *appendicectomy,* pakar boleh meletakkan caj RM1,000 sebagai contoh. *So,* sekiranya pembedahan *appendicectomy* itu dilakukan antara jam 8.00 pagi hingga 6.00 petang. *So,* caj maksimum yang dibenarkan oleh pakar itu untuk kenakan ke atas pesakit hanya RM1,000.

Tetapi, selepas jam 6.00 petang ataupun pada hujung minggu hari Sabtu, Ahad atau *public holiday,* di luar waktu pejabat antara lainnya. *So,* caj yang dibenarkan adalah tambahan sehingga 50 peratus. Jadi, berbanding RM1,000 yang dibenarkan tadi sekiranya pembedahan ataupun rawatan atau konsultasi ini diberikan di luar waktu pejabat, mereka dibenarkan untuk caj sehingga RM1,500 sebagai contoh untuk *appendicectomy.*

So, ini ditetapkan oleh kerajaan di dalam akta yang telah diwartakan untuk Jadual Ketiga Belas. Tapi untuk Jadual Ketujuh...

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tapi TPA ini bukan macam *outsourcing company,* maksudnya kalau saya pihak hospital ataupun klinik, saya masih boleh simpan pada keesokan hari baru *claim,* minta TPA untuk buat urusan *payment*-kah atau apa-apa. *So, why do they need to midnight also send cases to you know?*

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: Itu perlu merujuk kepada *provider* atau hospital atau klinik.

Puan Fiona Rebecca Limus [CompuMed Services]: *It also risk mitigation on their part, right. So, when a person comes in in middle of the night holding a medical card and says I've got a medical card let say, right. And then the hospital takes their word for it and admit the patient. It could be that this particular policyholder policy has lapse, right. The next day, if they wait to the next day and they request – issuance for guarantee letter from us. They maybe, when we check in the system and say, this person is already is inactive or don't have not renewed.*

So, which means the risk is on the hospital to bear. So that's why the best practice is of course we always tell our providers request a GL as soon as possible. That's the reason

why we have to provide a 24/7 call centre, to facilitate admission and also to answer to our members.

Encik Azmi Ramlee [PMCare]: Dengan izin saya nak tambah sikit, dalam operasi kami tidak...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Boleh terangkan siapa nama dan daripada mana?

Encik Azmi Ramlee [PMCare]: Saya dah terangkan, nama saya Azmi daripada PMCare, *Head Data Analytics.* Dalam operasi sebuah TPA, ketepatan masa adalah sangat penting. Saya bagi satu senario yang biasa terjadi, pesakit adalah seorang pekerja di sebuah syarikat swasta di mana hari ini adalah hari terakhir dia bekerja dengan syarikat tersebut.

Biasanya hari ini dia akan cuba menggunakan segala faedah perubatan yang dia masih tinggal berbaki. Jikalau proses validasi itu tidak berlaku pada hari ini, cuma di-*submit*-kan *claim*-nya pada atau validasi itu dilakukan pada hari keesokannya, pihak klinik tidak akan mendapat apa-apa pembayaran. Ini kalau daripada segi syarikat insurans ataupun majikan sendiri *they would deny the claim. That's why our company operates 24/7. The demarcation of timing is very critical in our business,* terima kasih.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Sebut pasal soal data, saya nak tanya pasal soal keselamatan. *Since* PMCare dan juga CompuMed memang ada sistem sendiri untuk melihat dan juga untuk *keep track data client,* adakah pihak syarikat TPA ada berkongsi maklum dengan pihak insurans *the data* tersebut? Satu.

Kedua, bagaimana nak mengelakkan ketirisan daripada berlaku? Ketirisan, kebocoran maklumat dan juga data klien daripada jatuh ke pihak yang tidak bertanggungjawab?

Ketiga, saya nak tanya boleh tak macam pihak klien, dia boleh *keep track,* "Oh, aku dah pernah buat tuntutan dekat klinik ini dah lapan kali". *History* pesakit yang bulan berapa dia boleh *check* tak daripada sistem tersebut.

Keempat, kalau berlaku ada kesilapan dari segi data mereka yang ada dalam sistem tersebut, *how to rectify?* Bagaimana mereka nak membuat pembetulan terhadap kesilapan yang berlaku? Itu empat soalan.

Puan Fiona Rebecca Limus [CompuMed Services]: *Okay, first question is do we give data to insurance? Answer is yes, because* kan dah ada *what we call the service level agreement that we sign and in there it's state how, what's sort of an information has to flow between parties*-lah. *So, usually it's two types of data, one is member data and another one is claim data* kerana ini dua *has to be two ways. Yes, we do provide.*

Number two is how to prevent data leak, contoh *right. Data breach for example. That is why Bank Negara implements RMIT (Risk Management Information Technology) policy* yang kita kena ikut, *right.*

So, in that policy it talks about banyak ia punya *requirements and in order to formalize this data security, that's where CompuMed has gone into ISO 27001. Under 27001,* ia ada banyak polisi yang tertera dekat dalam itu *for us to follow to ensure that we protect our data in a formal manner.*

Ketiga, *claim history availability. Yes, PMCare and also CompuMed we do provide what we call claim history. So, today as CompuMed and PMCare member we can log in to our mobile app. As an employee, as a member I* boleh tengok *all my transaction. If I've been in CompuMed* lima tahun, *they can see five years of data, right. So, claim history* semua itu, berapa kali? Siapa? Kalau ada anak yang pergi, isteri yang pergi? *All of these,* memang kita *capture to showcase to the member.*

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If data error, how do we rectify? So, kita kena tengok *who is the source of the data. Now, in this case if the source is the insurance company,* kalau mereka bagi data yang salah, *they have to amend and flow back* kepada kita. *Of course when member,* dia buka dia punya *apps,* dia kata, *"Eh, kenapa I punya pangkat, gred, salah?"* Contoh ya. *So, when they give information like that, they can complaint* kepada kita. Dia kata, *"Eh, you get my grade wrong",* contoh. *That is why we have to flow back to* HR, HR akan tukar *the information and flow back to us again.*

Tuan Kamal Aryf Baharuddin [PMCare]: Sebagai tambahan, seperti maklumkan tadi, memang Bank Negara mengenakan RMiT kepada *financial institution* dengan *insurance company*. Jadi, sekiranya TPA tidak dapat memenuhi keperluan, kriteria yang diperuntukkan oleh Bank Negara, jadi, mereka akan dibuang ataupun tidak dilantik sebagai panel.

Nombor dua tadi, bila data ataupun untuk bertahun-tahun, ini juga sebenarnya lebih kurang menjadi kepada *patient has record as well.* Jadi, member boleh menggunakan *mobile app* untuk tengok rekod mereka sebelum ini. Jadi, *patient has record.* Untuk majikan ataupun klien mereka boleh gunakan – mereka juga mendapat maklumat tersebut. Cumanya, terpulang kepada kriteria yang dikenakan ataupun ditentukan oleh pihak syarikat kepada HR itu sendiri. Setakat mana informasi yang boleh dikongsikan dengan pihak HR dan juga dengan pekerja. Terima kasih.

Encik Azmi Ramlee [PMCare]: Saya juga nak tambah pasal data. Kebanyakan pelanggan kami terutama daripada golongan korporat *actually* akan buat audit kepada sistem IT dan juga pemprosesan kami sendiri. Macam contoh di PMCare boleh kata *we have a revolving door of auditors all the time, coming from our client as well as external parties to test on our security system.*

Apa-apa data yang dikongsikan dengan pihak ketiga memang menjadi keperluan kami untuk *anonymized* dan *aggregate the data.* Tak ada data PDPA yang dikongsi dengan pihak luar.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Pengerusi. Tadi saya – berbalik kepada isu kenaikan harga. Okey, tadi saya tanya tentang *is there different between guarantee letter and also pay per claim?*

Puan Fiona Rebecca Limus [CompuMed Services]: *[Bercakap tanpa menggunakan pembesar suara] We pay and fund.*

Tuan Sim Tze Tzin [Ahli PAC]: *Pay and claim?*

Puan Fiona Rebecca Limus [CompuMed Services]: *Pay and claim, yes.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, *you* said tak ada *because the line by line* item tak ada, *right*? Tak ada ya? Tak ada perubahan, kan? Tak ada perbezaan?

Tuan Kamal Aryf Baharuddin [PMCare]: Ya. Untuk data kepada kami sebenarnya bila *pay and claim* lagi mahal daripada *cashless*. Sebab bila menggunakan *guarantee letter* yang kami keluarkan, kebanyakannya hospital ataupun pengamal perubatan memberikan korporat diskaun sebab mereka *in bulk.* Jadi, itu nombor satu.

Nombor duanya memang – sebab kemudahan dah diberikan secara *guarantee letter.* Jadi, *the number of cases* untuk kami analisis untuk kes-kes yang secara tunai juga tidak banyak. Jadi, untuk kami membuat konklusi lebih lagi agak sukar tapi daripada data yang kami terima, bayaran secara tunai bil di hospital lebih tinggi sebab mereka tidak dapat *enjoy the corporate discount.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, tetapi data yang *you present* itu memang berbeza kerana yang tadi saya ambil contoh pneumonia itulah, empat hari masuk hospital tetapi sebenarnya yang *guarantee letter* itu lebih tinggi. Total kosnya.

Ini bermaksud bahawa mungkin wujud *over diagnosis.* Mungkin wujud *buffet syndrome.* Mungkin wujud pelbagai *claim* yang menyebabkan kenaikan kos itu. Betul tak? *Can you confirm that? Can you comment on this problem?*

Puan Fiona Rebecca Limus [CompuMed]: Dr.?

Dr Muhammad Ainuddin Mohamad Rusli [PMCare]: Okey, kalau saya boleh menjawab soalan.

So, nombor satu, perbandingan antara *pay and claim* ataupun dengan menggunakan surat jaminan. Jadi, contoh yang ditunjukkan tadi kalau *pay and claim* untuk pneumonia, empat hari RM1,699, untuk pesakit yang pergi menggunakan surat jaminan RM7,699, sebagai contoh. Jadi, terdapat perbezaan antara RM6,000. *Right?*

So, nombor satu macam yang dah diterangkan lebih awal oleh Puan Fiona tadi, untuk pesakit yang menggunakan wang sendiri, dia tidak menggunakan *cashless* ataupun tidak menggunakan surat jaminan. Jadi, pesakit dah dimaklumkan lebih awal tentang, *"Ini adalah jumlah yang saya sanggup bayar".* Tuan Kamal pun dah maklumkan tadi sekiranya mereka tidak melakukan sebarang ujian ini, mereka perlu menandatangani *add on risk, "Saya sanggup menerima risiko ini untuk tidak melalui ujian-ujian yang dikatakan".*

Antara punca-punca kenaikan kos kesihatan, kita boleh katakan adalah *defensive medicine*. Apakah yang dimaksudkan sebagai *defensive medicine?* Pesakit menyaman doktor *or* doktor tidak melakukan ujian ini, doktor tidak mengesahkan ini. Kenapa doktor tidak dapat mengenal pasti masalah ini dengan lebih awal. Jadi, itu antara lain yang menyebabkan insurans, kita panggil *indemnity*. Doktor semakin hari, semakin tahun semakin naik. Sebagai doktor juga perlu melindungi diri mereka.

Jadi, itu yang membawa kepada – kita tidak istilahkan sebagai *over servicing* atau *over diagnosis* tapi untuk mencapai kepada diagnosis yang lebih tepat dan jitu, jadi doktor ini melakukan atau meminta untuk dilakukan ujian-ujian yang lebih *detail* yang mana harganya tentulah lebih mahal. Sebagai contoh, untuk *appendix*. *So, appendix* adalah *diagnosis clinical.* Bila katakan *diagnosis clinical* sebenarnya sehingga ke 90 peratus diagnosis untuk mendapat kepada *appendix* itu boleh didapati dengan *history taking* dan juga dengan pemeriksaan klinikal. Tapi ada pesakit-pesakit yang tak puas hati, *"Eh, macam mana doktor boleh missed? You kata you doktor tapi you boleh miss diagnose appendix. Sebenarnya you boleh tak dapat diagnosis appendix".*

So, di sini doktor-doktor, *"Okey, tak apalah".* Untuk melindungi diri dia daripada disaman dan *grievance mechanism* oleh pesakit, *so* dia meminta ultrasound ataupun *CT scan* yang menambah kepada kos. Ini bukan *over servicing* tapi doktor perlu melindungi diri mereka sebagaimana pesakit juga melindungi diri mereka. *So*, adakah ini melanggar etika doktor? Tidak, sebab – melainkan mereka suspek *appendix* tapi buat *CT scan* untuk kepala, *yes*, itu adalah tidak berpatutanlah. Tapi sekiranya dia sama ada adakah ini *appendix* ataupun sekiranya pesakit adalah pesakit perempuan mungkin ini adalah masalah yang berkaitan dengan sistem atau organ perempuan, jadi dia perlu melakukan *CT scan* yang untuk badan, abdomen dan juga pelvis.

Jadi, ini adalah bertepatan dengan praktis. Cumanya adakah 100 persen perlu bergantung kepada pesakit. Jadi, untuk kita katakan atau kita memberi kesalahan, *to shift the blame* kepada doktor, doktorlah punca atau hospitallah punca kos perubatan meningkat sebab kata *over servicing*. Doktor juga mereka cuma melindungi diri mereka dengan mengatakan sekiranya kita tidak melakukan perkara ini, *so*, mungkin ada beberapa perkara lain yang kita *miss*. Jadi, *defensive medicine* itu untuk melindungi doktor adalah perlu. Tapi di mana yang kita katakan sebagai *over servicing* atau *over diagnosis* itu, yang kita perlu teliti supaya menjaga sensitiviti semua pihak.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Pengerusi, ini soalan terakhir saya. Saya nampak bahawa TPA ini kalau you rasa ingin dapat *regulation* nak di *regulated, you are neither here nor there, you know? Because you are not MOH per say* dan *you are very close to insurance also. So, Bank Negara, but Bank Negara also feels that you are not part of it. So, what is your suggestion? Which ministry suppose to be regulating you guys?*

Tuan Kamal Aryf Baharuddin [PMCare]: Kami rasa itu biar pihak yang layak dan mahir fikirkan. Cumanya, kami bersedia untuk di-*regulate* oleh mana-mana kementerian sebab bila kita jalankan kerja dengan betul, *insya-Allah* kita boleh buat kerja dengan betul. Sebab sebelum ini memang dalam Akta *Private Healthcare* memang termasuk dalam MOH. Tapi bila MOH kata mereka tidak mahu menjadi *regulator and then* untuk PMCare*, our business model,* kebanyakan daripada yang kami proses daripada klien kami, kebanyakan klien kami adalah klien yang membayar kos perubatan mereka sendiri, tidak melalui insurans.

■1650

Client-client kami seperti Telekom Malaysia, EPF, Bank Negara, Khazanah, mereka tidak memerlukan insurans, mereka membayar sendiri. Tapi, pada masa yang sama, kami juga berkerjasama dengan insurans seperti Prudential, Takaful Ikhlas. Mereka yang mencari *client,* mereka beri kepada kami untuk kami uruskan bagi pihak mereka.

Puan Fiona Rebecca Limus [CompuMed]: *YB, for me, I feel that we should be governed or managed by MOH. Because the core of matters is still medical, medical, right? And within MOH, they have many departments that we already working with. For example,* Unit Amalan*, right*? *We work very closely with them. And MMC, of course,* ya. *So, they will know what we are doing is right or wrong, right? But, of course, if you look at the biggest business, they are other things which MOH may not be aware of. But that's okay because overall we are about managing the cost of medical, I would say. Healthcare. Thay are the subject matter expert.*

Datuk Wira Mas Ermieyanti [Pengerusi PAC]: *Alright.* Saya rasa tak ada apa lagi soalan yang hendak dikemukakan kepada pihak saksi oleh Ahli Yang Berhormat. Jadi, saya ucapkan ribuan terima kasih kepada Yang Berusaha Puan Fiona Rebecca Limus selaku Ketua Pegawai Eksekutif dan juga delegasi daripada CompuMed Services dan juga Yang Berusaha Tuan Kamal Aryf Baharuddin, Ketua Pegawai Eksekutif dan juga delegasi daripada PMCare ke prosiding PAC pada petang ini. Terima kasih di atas komitmen dan juga penjelasan yang telah diberikan.

Dan kita tangguh kita punya prosiding pada petang ini pada jam 4.52 dan kita bertemu kembali pada hari Ahad— eh, *sorry.* Pada hari Khamis... *[Ketawa]* Ahad lain. Hari Khamis ya, jam 10 pagi. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 4.52 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Isnin, 21 Julai 2025

Bil. 5(n)/2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan Impak kepada kesihatan awam di bawah MOF, MOH & BNM

Malaysian Medical Council (MMC)

(i) Datuk Dr. Mahathar bin Abd Wahab
Ketua Pengarah Kesihatan

(ii) YBrs. Dr. Hirman bin Ismail
Timbalan Pengarah
(Bahagian Perkembangan Perubatan KKM)]

(iii) YBrs. Dr. Mohamed Anas bin Mohamed Hussain
Pegawai Perubatan

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN
PARLIMEN MALAYSIA

ISNIN, 21 JULAI 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Datuk Ali anak Biju [Saratok]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]

Tidak Hadir *(Dengan Maaf)*

YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dr. Hajah Halimah Ali [Kapar]

URUS SETIA

Encik Mohd Sukri bin Busro [Ketua Penolong Setiausaha (Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam (JPA)

Encik Ahmad Azhan bin Mohd Noh [Timbalan Pengarah Kanan (Perkhidmatan)]

Kementerian Kewangan (MOF)

Puan Nadeema binti Kamaruddin [Ketua Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Kawalan Kewangan Strategik dan Korporat)]

HADIR BERSAMA *(samb/-)*

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Puan Norsyahida binti Alias [Penolong Pesuruhjaya (Bahagian Penyiasatan Tatakelola)]
Tuan Premraj a/l Isaac Dawson Martin Victor [Pegawai Penyiasat SPRM (Penolong Kanan Pesuruhjaya) (Bahagian Siasatan, Ibu Pejabat SPRM)]

Jabatan Akauntan Negara (JANM)
Puan Noor Azira binti Abd. Rashid [Akauntan (BPOPA)]
Encik Mohd Taufik bin Hj Ahmad [Akauntan (BPOPA)]

SAKSI

Malaysian Medical Council (MMC)
Datuk Dr. Mahathar bin Abd Wahab [Ketua Pengarah Kesihatan]
YBrs. Dr. Hirman bin Ismail [Timbalan Pengarah (Bahagian Perkembangan Perubatan KKM)]
YBrs. Dr. Mohamed Anas bin Mohamed Hussain [Pegawai Perubatan]
YBrs. Dr. Mohamed Hirman bin Abdullah [Ketua Penolong Pengarah Kanan (Bahagian Perkembangan Perubatan KKM)]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

ISNIN, 21 JULAI 2025

Mesyuarat dimulakan pada pukul 5.03 petang

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
mempengerusikan Mesyuarat]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. *Assalamualaikum warahmatullahi wabarakatuh.* Salam sejahtera dan selamat datang saya ucapkan pada Yang Berhormat Naib Pengerusi PAC, Ahli-ahli Yang Berhormat Ahli PAC Parlimen ke-15, ahli-ahli ex officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen Malaysia.

Yang Berhormat ahli mesyuarat sekalian, pada petang ini PAC Parlimen akan sambung semula prosiding berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan juga Bank Negara Malaysia. Sebagaimana semua sedia maklum, isu ini tidak dilaporkan di bawah Laporan Ketua Audit Negara.

Sehubungan dengan itu, PAC menggunakan punca kuasa di bawah Peraturan Mesyuarat Dewan Rakyat dan juga Arahan Perbendaharaan serta Pekeliling Am Nombor 1 Tahun 2024. Saya juga ingin mengingatkan kepada semua ahli-ahli mesyuarat sekalian bahawa prosiding PAC ini adalah tertakluk kepada Peraturan Mesyuarat 85 sehingga prosiding ini selesai dan juga penyata dibentangkan di Dewan Rakyat.

Yang Berhormat ahli mesyuarat sekalian, hadir di hadapan PAC pada petang ini ialah yang pertamanya, Yang Berbahagia Datuk Dr. Mahathar binti — bin Abd. Wahab, Ketua Pengarah Kesihatan merangkap Pengerusi Majlis Perubatan Malaysia. Yang keduanya, Yang Berusaha Dr. Mohamed Anas bin Mohamed Hussain, *on behalf of the CEO MMC* dan Yang Berusaha Dr. Hirman bin Ismail, Timbalan Pengarah (Bahagian Perkembangan Perubatan KKM). Terima kasih kerana hadir dan juga memberi kerjasama.

Jadi, tanpa membuang masa, marilah kita sama untuk sesi prosiding pada petang ini dan saya difahamkan ada *presentation* dan boleh mulakan *presentation tersebut*. Terima kasih.

[Pembesar suara dimatikan]

Datuk Dr. Mahathar bin Abd Wahab [Ketua Pengarah Kesihatan, Malaysian Medical Council (MMC)]: *Bismillahirahmanirahim. Assalamualaikum warahmatullahi wabarakatuh.* Selamat petang. Salam sejahtera Yang Berbahagia Datuk, Dato', Ahli-ahli Yang Berhormat sekalian.

Jadi, untuk *presentation* berkaitan dengan fungsi Malaysian Medical Council ini secara keseluruhannya, saya menjemput Dr. Anas sebagai menanggung tugas CEO MMC untuk melakukan sedikit pembentangan. Silakan.

Dr. Mohamed Anas bin Mohamed Hussain [Pegawai Perubatan, **Malaysian Medical Council (MMC)]:** Okey. *Bismillahirahmanirahim. Assalamualaikum warahmatullahita'ala wabarakatuh.* Salam sejahtera. Salam Malaysia MADANI. Ahli-ahli Yang Berhormat, Yang Berbahagia Datuk Ketua Pengarah Kesihatan ya. Terima kasih kerana memberi peluang kepada saya untuk pembentangan berkenaan dengan fungsi Majlis Perubatan Malaysia.

So, pertama sekali di hadapan adalah slaid pembentangan dan saya harap ada juga *handout slide* kepada Ahli-ahli Yang Berhormat. *So*, kita mula dengan sedikit sebanyak *corporate information* berkenaan dengan Majlis Perubatan Malaysia ni. MMC ni *established* di bawah Akta Parlimen pada 27 September 1971 dan telah digazet pada 30 September 1971.

Majlis Perubatan telah menjadi Badan Berkanun Persekutuan setelah pindaan kepada Akta Perubatan 1971 yang dilaksanakan pada 2012 di mana Akta Perubatan tersebut telah dikuatkuasa pada 1st July 2017 dan perkara ini juga secara langsung melibatkan *Introduction of the Medical Regulations 2017* lah untuk *replace Medical Regulations 1974* yang lama. *Next slide please.*

So, moto Majlis Perubatan Malaysia *basically* adalah *safeguarding patients and guiding doctors and* misi MMC ini adalah pertama sekali adalah berkenaan dengan untuk memastikan amalan perubatan, etika dan juga pendidikan berada di tahap yang tertinggi untuk *benefit* kepada pesakit dan juga kepada orang awam melalui pentadbiran yang teluslah Akta Perubatan 1971. *Next.*

Fungsi Majlis Perubatan Malaysia adalah termaktub di bawah seksyen 4 Akta Perubatan 1971. *So*, fungsinya dilihat agak *simple*, hanya dua. Satu, adalah untuk mendaftar pengamal perubatan. Yang keduanya adalah untuk mengawal selia amalan perubatan. *So, although this look is very simplified,* tapi *it comes with a very*

heavy responsibility-lah dan untuk lebih menerangkan berkenaan fungsi majlis, termaktub di bawah seksyen 4A di mana *registration* tu adalah merangkumi pendaftaranlah.

Pendaftaran ni merangkumi pendaftaran pengamal perubatan bermulalah setelah tamat program perubatan, dia memulakan program latihan siswazah. Seterusnya, setelah tamat latihan siswazah, mereka akan mendapat pendaftaran penuh. *That means that allows them to become an independent doctor. And then,* di situlah mereka juga perlu memohon amalan perakuan tahunan *(yearly annual practice and certificate)* untuk pengamal perubatan dan *subsequently, if* mereka melanjutkan pengajaran dan pembelajaran ke tahap yang lebih tinggi iaitu pakar, Majlis Perubatan Malaysia juga mendaftar pakar di bawah akta perubatan.

Selain itu, dari segi mengawal selianya adalah dari segi *practice, practice of the medical practitioner* itu sendiri di mana MMC telah mengeluarkan *code of professional conduct* dan juga *good medical practice. This is to guide the doctors to ensure that* amalan mereka jalankan adalah mengikut standard yang ditetapkan dan juga adalah untuk keselamatan pesakit *eventually. Okay, next slide please.*

So, core function tadi seperti yang saya maklumkan ada *registration,* saya dah maklumkan berkenaan dengan pendaftaran *houseman, medical officer* dan juga pakar. Dan juga — selain itu juga Majlis Perubatan Malaysia menyimpan satu daftar di mana daftar ini digunakan bagi orang awam untuk merujuk di laman sesawang MMC sama ada pengamal perubatan tersebut adalah berdaftar. Selanjutnya juga, MMC juga terlibat dalam mendaftar pengamal perubatan daripada luar negara.

So, mereka ini tidak mendapat pendaftaran secara automatik dan sebaliknya perlulah melalui proses *evaluation* oleh Jawatankuasa di bawah MMC dan juga kita melihat sama ada pengamal tersebut ada *experience,* telah berdaftar di luar negara, sama ada pengamal tersebut berada dalam *good standing.* Semua itu akan di-*evaluate* oleh jawatankuasa di bawah Majlis Perubatan Malaysia.

Selain itu juga, fungsi majlis perubatan adalah dengan tertubuhnya satu Jawatankuasa Kelayakan Perubatan *(Medical Qualifying Committee).*

■1710

So, jawatankuasa ini adalah terdiri daripada keanggotaan ahli Majlis dan juga wakil KKM dan wakil universiti. Ini adalah untuk melihat isu-isu sewaktu berlakunya latihan siswazah. Contohnya, masalah kompetensi dan sebagainya dan masalah kesihatan. Satu lagi aspek penting yang dilaksanakan oleh Majlis Perubatan Malaysia adalah melalui *Fitness to Practice Committee* di mana jawatankuasa ini

melihat kes-kes masalah kesihatan mental, masalah-masalah kesihatan fizikal dan juga aspek kompetensi itu sendiri daripada semua lapisan pegawai perubatan.

Satu lagi fungsi penting sebelum ini di mana MMC juga terlibat dalam proses mengakreditasi dan pengiktirafan program-program perubatan tempatan secara kerjasama dengan *Malaysian Qualification Agency*. *So*, di bawah MQA terdapat seksyen 50 di mana menyatakan untuk mengiktiraf dan memberi kredit sebarang program perubatan yang dijalankan di dalam negara perlulah melakukan kerjasama dengan badan profesional. *So*, itu adalah salah satu fungsi Majlis Perubatan.

Seperti yang saya maklumkan juga untuk mengawal selia dari segi etika. Di mana MMC juga berfungsi sebagai satu badan kuasa *judicial* di mana kita melihat aspek-aspek sekiranya terdapat aduan dari segi salah laku etika. *So*, salah laku etika sahaja dan bukan *medical negligence. Medical negligence will go through the civil way*. *So*, ini hanya masalah etika akan perlu dilaporkan kepada MMC dan kita ada prosiding tatatertib untuk *evaluate* sekiranya terdapat salah laku pengamal perubatan.

So, sebarang aduan perlu dibuat secara bertulis kepada Majlis Perubatan sebelum kita melaksanakan prosiding tatatertib dan selainnya adalah memastikan *guidelines, guidelines* atau garis panduan berkenaan dengan perubatan contohnya *telemedicine*, *Artificial Intelligence* (AI) dan juga sebagainya di-*publish* oleh MMC untuk rujukan pengamal perubatan.

So, dari segi keahlian ahli Majlis terdapat sedikit pembetulan. Akta Perubatan telah dikuatkuasakan pada 1 Julai di mana terdapat perubahan dari segi komposisi ahli Majlis. Presidennya adalah secara ex officio Ketua Pengarah Kesihatan dan kita juga ada Ahli-ahli yang dilantik oleh YB Menteri Kesihatan. Komposisinya berubah di sini di mana hanya terdapat lima pengamal perubatan daripada institusi tempatan, tiga pengamal perubatan swasta yang dinamakan oleh Majlis dan tiga pengamal perubatan dari sektor awam. Di mana komposisi telah berubah daripada tiga ke tujuh yang dinamakan oleh Ketua Pengarah Kesihatan.

At the same time, kita juga ada ahli-ahli yang dipilih melalui proses pilihan raya. *So called* pilihan raya. *Voting* oleh pengamal perubatan di mana di sini terdapat 15 pengamal perubatan daripada Semenanjung Malaysia, satu wakil daripada Sabah dan satu wakil daripada Sarawak. *So* secara keseluruhannya ahli Majlis adalah seramai 33 orang.

Okey, secara *overview*-nya Presiden adalah seperti saya maklumkan tadi ex officio Ketua Pengarah Kesihatan yang akan *chair* Majlis Perubatan Malaysia dan di sana kita ada 33 ahli Majlis dan di bawah 33 ahli Majlis tersebut ada sekurang-

kurangnya melebihi 50 ahli Jawatankuasa Induk yang membuat cadangan dan rekomendasi kepada Majlis dan sebarang keputusan Majlis itu disokong oleh *administrative*-nya secara *administrative* oleh Ketua Pegawai Eksekutif yang melaksanakan segala arahan Majlis.

So, execution of decision is done administratively by the secretariat. So, di bawah itu saya *mentioned* tadi berbagai-bagai jawatankuasa. Sebagai contoh, *pre-registration* kalau kita ada Jadual Kedua dalam Akta Perubatan di mana ada senarai kelayakan yang diiktiraf untuk pra siswazah. Sekiranya tidak ada, kita ada satu mekanisme untuk membolehkan mereka masih didaftarkan melalui peperiksaan yang dijalankan. *Examination for Provisional Registration*.

Selain itu, saya maklumkan tadi berkenaan dengan jawatankuasa-jawatankuasa kelayakan, Jawatankuasa Kelayakan Utama (JKP1) yang melihat dari aspek *basic medical degree, full registration* dan seterusnya kita ada Jawatankuasa Penilaian Dua yang melihat kepada proses-proses pendaftaran pakar individu. Selain itu, kita ada *Fitness To Practice Committee,* MQC dan juga yang paling penting kita ada *Medical Education Committee*. *So, this Medical Education Committee looks at standard setting* dari segi *undergraduate, postgraduate, housemanship* dan juga *specialty, sub-specialty* di mana mereka menetapkan standard-standard sebelum sesuatu program itu dapat dijalankan sebagai rujukan.

So, all programs must be based on standard minimum yang ditentukan oleh *Medical Education Committee* dan di situ juga kita ada *Joint Technical Board* di bawah MQA yang melihat untuk meluluskan akreditasi bersama dengan MQA.

The other part is that on disciplinary ethics. Kita ada prosiding tatatertib yang saya maklumkan tadi. Kita ada dua kolum di sini. Satu adalah di bawah akta lama dan satu lagi di bawah akta baharu. *So*, mana-mana aduan yang diterima di bawah akta lama akan melalui proses akta lama. *So*, proses dia sedikit berbeza di mana akta lama bila MMC menerima sebarang aduan, Presiden akan *sanction* kes kepada PIC *and finally, the hearing will be done at the council level. Whereas for the new act,* Presiden tidak sanksi kes, ia akan dibawa kepada Majlis untuk menentukan sama ada *there is a case or not. Basically, the complaint must be against registered medical practitioner, must be indicting and* kita ada *Preliminary Investigation Committee* dan juga *Disciplinary Board*.

So, the process is that kita terima aduan, hantar kepada PIC. PIC *is basically document checking* dan sekiranya ada kes akan dibawa kepada *Disciplinary Board* untuk sebarang keputusan.

So basically, ini adalah komposisi Majlis. Kita ada *Council. We have that various committee seating under the Council*. Kita ada *the secretariat that execute decision of the Council and* kita ada *Chairman of all various committee that reports to the Council*. So, semua *committee*, *committee* ini perlu membawa cadangan kepada Majlis untuk sebarang keputusan.

So, next slide adalah *all the various committee.* Kita ada lebih kurang *45 main committees and* beratus *sub committee* di bawah *Council*. *Is not only the 33 who does the decision making is all guided by the fraternity* di bawah *sub-sub committee* ini yang akan *advise Council in making decision.*

So, the next slide is just to demonstrate journey of a doctor. So, many still confused with the function of Malaysian Medical Council. So basically, MMC is involve particularly in registration of individual doctors. Kita tidak melihat kepada aspek servis. *It's just purely registration and when we say safeguarding patients and guiding doctors* — itunya sebab itu lah adanya standard-standard yang perlu ditetapkan dari segi program-program yang dilaksanakan. *Undergraduate, post graduate* dan sebagainya dan juga melibatkan juga *housemanship training standards* ditentukan oleh MMC *because eventually the product of this program will need to be registered by the MMC and we want to ensure a competent doctor for public safety.*

So, basically this just to demonstrate the overview. So, MMC is basically involve sebelum mereka masuk program perubatan di mana standard ditentukan dan seterusnya as *they move on* bila dah *graduate* jadi *houseman*, jadi *independent doctor, medical officer*, jadi pakar. Semuanya dikawal selia oleh Majlis Perubatan Malaysia. Sekiranya ada masalah kesihatan macam saya *mention* tadi masalah kesihatan fizikal, masalah kompetensi — semuanya akan dirujuk kepada MMC. Begitu juga sekiranya terdapat sebarang aduan salah laku etika dan juga dikawal selia oleh MMC melalui aduan yang dibuat terhadap MMC. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Terima kasih. Ahli-ahli Yang Berhormat ada apa-apa pencerahan? Pertanyaan?

Tuan Sim Tze Tzin [Ahli PAC]: Okey Pengerusi. Terima kasih Pengerusi dan terima kasih Datuk KP kerana dan juga wakil daripada MMC. Saya ingin nak tanya sedikit tentang *a journey of the doctor*. Boleh kah kita tahu bahawa berapa tahun *let say, medical school, public employment, housemanship* — saya bukan doktor lah. Saya pun tak berapa tahu dan sehinggakan dia jadi *specialist* dan lebih kurang kosnya untuk menjadi seorang *as a doctor* lah di Malaysia. Terima kasih.

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Datuk Dr. Mahathar bin Abd Wahab [MMC]: Okey. Terima kasih YB atas soalan tersebut. Jika kita melihat perjalanan seorang doktor. Saya bagi contoh saya. Senang. Jadi nampak depan macam mana. Akhirnya didaftarkan sebagai seorang pegawai perubatan dan seorang pakar.

Jadi untuk tempoh latihan sebagai latihan asas di sekolah perubatan *in a medical school,* secara puratanya lima tahun. Tetapi juga ada sekolah-sekolah perubatan yang ambil masa enam tahun. Jadi, enam tahun di situ. Selepas enam tahun tersebut, selepas berjaya dengan jayanya di sekolah-sekolah perubatan, mereka akan melalui program *housemanship* iaitu dua tahun sekarang ini. Setelah tamatnya program *housemanship* tersebut — semasa program *housemanship* tersebut atau program siswazah, mereka akan mendapat kita panggil *temporary registration* ataupun *probational registration*.

Selepas melengkapi program *housemanship*, mereka akan mendapat pendaftaran penuh. Selepas pendaftaran penuh, mereka akan memasuki bidang-bidang yang berkecenderungan dan selalunya untuk memasuki ke fasa seterusnya, bagi tujuan kepakaran, mereka memerlukan sekurang-kurangnya dua tahun selepas selesai program *housemanship* tersebut.

Jadi untuk *cut short,* lima tahun untuk sekolah perubatan, dua tahun untuk *housemanship*. Sudah tujuh tahun. Dua tahun sebagai MO, sebagai *medical officer*. Selepas dua tahun sebagai *medical officer* dengan keupayaan yang mereka ada, mereka akan memohon untuk memasuki program kepakaran. Program kepakaran asas akan mengambil masa empat tahun kalau mereka dapat melaluinya dengan jayanya. Jadi, kalau kita lihat daripada lima campur empat, sembilan campur lagi empat tahun, secara keseluruhannya 13 tahun baru selesai mereka daripada seorang memasuki sekolah perubatan sehingga berjaya menjadi seorang pakar. Itu kalau tengok secara keseluruhannya.

Tuan Sim Tze Tzin [Ahli PAC]: Agaknya berapa kos untuk menjadi seorang doktor dan sehinggakan kepada seorang pakar? Bukan kos kerajaan. Kos swasta. Individu.

Dr. Hirman bin Ismail [Malaysian Medical Council (MMC)]: Dari aspek kos, kalau kita melihat kepada yuran pengajian bagi mengikuti latihan kepakaran di dalam universiti awam, kos adalah sekitar RM40,000 hingga RM60,000. Mungkin sampai ke RM65,000 untuk tempoh...

Tuan Sim Tze Tzin [Ahli PAC]: Tapi itu *subsidised* kan? Yang saya kata yang tak *subsidised* — yang *actual cost* daripada *medical school*.

Dr. Hirman bin Ismail [MMC]: *Actual cost* kita tak ada *information*. Itu kita boleh *furnish the information,* YB.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, Pengerusi. Saya nak tambah, nak tanya sedikit lagi. Okey, kita tujuan PAC mengadakan prosiding adalah untuk *look into the escalation cost of medical inflation*. Kita tahu bahawa sekarang *medical inflation* itu tinggi. Itu sebab kita nak tengok bagaimana kita bukan — kita tak boleh *stop inflation*. *But at least,* dia tidak menjadi terlalu tinggi. *To moderate the medical inflation*.

Walau bagaimanapun, apabila kita mengadakan prosiding, selalu satu faktor yang dikatakan adalah tentang *the cost of medical* — bukan doktor, sebab doktor *regulated*. Tetapi *about nurses*. Adakah *nurses* ini di bawah MMC juga? Bagaimana seorang *nurse* itu dia punya perjalanan dia? Bagaimana MMC membantu untuk *produce high quality nurse at the same time enough workforce* untuk kita punya industri?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Untuk pelesenan ataupun pengajaran ataupun untuk seorang jururawat bukan di bawah bidang MMC.

Tuan Sim Tze Tzin [Ahli PAC]: Di bawah siapa *nurse*?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Di bawah Lembaga Jururawat sebagai kawal selia. Ia tertakluk kepada institut latihan yang telah menjalankan latihan-latihan tersebut sama ada di institut latihan swasta ataupun awam. Tapi bukan di bawah bidang kuasa MMC.

Tuan Sim Tze Tzin [Ahli PAC]: Kalau boleh saya tambah? Mungkin Dato' Ku dulu lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you, Chairman*. Datuk, saya nak tanya sedikit berhubung dengan — *since MMC became statutory body after the amendments of the Medical Act 1971*. Adakah mereka yang menjadi ahli MMC *the council, the committees, CEO and secretariat and also the Chairman of the Committees*, adalah mereka mendapat elaun dan sebagainya? *Because it is a statutory body not NGO. Thank you*.

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: Terima kasih, YB. *Actually* berkenaan elaun dia hanya akan dapat elaun kehadiran mesyuarat sahaja. Tak ada elaun lain-lain. Hanya kalau hadir mesyuarat baru dapat elaun. *So, just to* maklumkan juga dari segi elaun sebelum ini, elaun Ahli Majlis adalah sebanyak RM500 a*nd they are there for from morning and probably until maghrib. Recently, we have increased the* elaun kehadiran kepada RM1,000. *I think the commitment from Ahli Majlis is very big. They have contributed [Tidak jelas].*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Such a big responsibility.*

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: *Big responsibility yes. But they are not earning anything.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Just a sitting allowance and just RM500.*

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: Elaun mesyuarat sahaja. *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya tabik lah. *Salute*. Lagi satu nak tanya dalam *core function*. Dia di bawah sekali belah kanan itu. *Exercise powers duties based on* MA, MR, CPC, GMP. *These are all doctors,* MA, MR ini? Boleh beri pencerahan tak?

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: Maaf, *actually there is a Medical Act and a Medical Regulation*. *MMC to subsidise the regulation*. MMC keluarkan garis-garis panduan termasuk *Code of Professional Conduct then Good Medical Practice for the practitioners to be guided. Especially in terms of confidentiality* macam mana nak *communicate and what not.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya tanya ini macam *layman*. Bayan Baru pun kata kita bukan pandai sangat bidang ini. Kita selalu *pi* jumpa doktor. Kadang-kadang kita tengok dekat pintu doktor itu, dia tulis Mr. kan? Di UK pun sama juga. Sini pun sama. Apa beza dia Mr. dia dengan — *I know you all doctors by training but*...

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: *So, basically* baru-baru ini pun isu satu adalah Mr. dan Dr. dan penggunaan istilah Dr. dan Mr. *So,* MMC *per se* kita tak boleh nak *regulate* penggunaan Dr. *because* Dr. *is not confined* kepada *medical doctor* sahaja. Ada juga PhD yang mengguna pakai gelaran Dr. *So, it is not reserved for any doctors*. Dari segi *I think in terms of worldwide* kalau Mr. Itu diguna pakai bagi pakar bedah *(surgeon).*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Tambah. Secara *historical, surgeon* ini *they are butchers*. *So, that's why* dia panggil Mr. Tetapi *that's why* kalau YB perasan kadang dia letak Dr. (Mr.) ataupun Mr. (Dr.). Tapi di luar negara kalau *surgeon* dan sebagainya dipanggil Mr. Itu asal *historical*. Tapi merekanya doktor sebagai pengamal perubatan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Doktor itu dia *not butchers* lah? Dia tak potong.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Yes. This one historical* daripada zaman dulu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Interesting*. Terima kasih.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Boleh?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sila.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Terima kasih, Naib Pengerusi. Berbalik kepada prosiding kita untuk melihat kenaikan kos perubatan dan premium insurans ini. Saya ingin bertanya kepada Yang Berbahagia Datuk Ketua Pengarah. Dalam Akta Kemudahan Perkhidmatan Jagaan Kesihatan Swasta 1998 itu. Disebut Yang Berhormat Menteri Kesihatan mempunyai kuasa menetap struktur caj dan yuran hospital swasta. Namun kita lihat dari segi kronologinya kajian *schedule of fee* itu *last* nya 2013. Sudah lebih hampir 10 tahun tidak dibuat semakan. Ada pembentangan 2019 tapi tidak dilaksanakan lagi. Di pihak Datuk sendiri bagaimana? Maknanya, proses ini mungkin agak panjang masa dia. Walaupun ya lah Datuk baru menjawat bulan Mei hari itu.

Mungkin ya lah, maksudnya, apa kekangan di pihak kementerian sendiri dari segi kita kata sebut *schedule of fee* itu sebab kita lihat dalam prosiding-prosiding sebelum ini maknanya bila kita tidak ada penetapan soal kos itu jadi diambil ruang oleh pihak yang ada kepentingan, pihak swasta ini, pihak hospital dan juga insurans itu sendiri. Dia mengenakan caj yang sangat ketara sehingga ada peningkatan sampai 15 peratus dalam laporan itu.

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Jadi, bagaimana Datuk melihat, kementerian sendiri dengan kuasa yang ada di bawah akta itu untuk segera memuktamadkan *schedule of fees* itu? Baik, terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Terima kasih, YB. Soalan itu adalah soalan cepumas sebenarnya. Kita, saya, kami secara jujurnya kalau kita melihat kepada Akta 586 yang di bawah Jadual 13 yang di bawah kawal selia adalah lebih kepada fi perundingan, *free* perundingan, *free* fi perundingan tersebut.

Jadi, dalam kalau kita melihat daripada segi *charged billing* dan sebagainya yang dilaksanakan oleh hospital-hospital swasta, bila seseorang itu — saya pasti *many of us* masuk hospital swasta. Kalau kita melihat kepada *itemised billing* tersebut yang dikemukakan, yang dikeluarkan tersebut, dia ada caj bilik, caj bilik air, caj macam-macamlah dalam itu semua yang dimasukkan dan perkara-perkara tersebut bukan di bawah kawal selia Akta 586 sebenarnya. Itu *[Tidak jelas].*

That's why bila berlaku *escalation cost* di situ, itu yang caj yang diberikan, tetapi pada kadar perundingan tersebut pada pakar-pakar yang melihat dan prosedur-prosedur yang dilakukan yang — contoh dia sebagai seorang pakar bedah. Jika dia membuat sesuatu prosedur, caj untuk prosedur tersebut dia memang tak berubah untuk daripada, semenjak daripada 2013 yang lalulah. Kita pun maklum kalau melihat daripada kos semasa dan inflasi dan sebagainya, sepatutnya kadar tersebut akan meningkat. Tetapi kita pun maklum kalau kita tingkatkan perkara tersebut, dia akan dapat kita panggil implikasi lebih besar kepada apa yang perlu dibayar dari segi *out of pocket as supposed to* daripada insurans dan sebagainya.

Yang caj itu kita — saya rasa semua maklum kita tak ada buat — *even* sampai sekarang pun kita tak ada kita panggil dalam perancangan untuk meningkatkan kadar perundingan tersebut. Tetapi apa yang berlaku sekarang yang kenaikan tersebut, caj-caj lain yang bukan di bawah kawal selia dan ada lebih — saya sebutkan secara jujur, yang caj lain-lain itu bukan di bawah kawalan Akta 586 dan bukan Kementerian Kesihatan yang boleh mengawal perkara tersebut. Itu pun sebenarnya satu perkara yang agak sukar.

Saya rasa YB pun maklum baru-baru ini, saya sebutkan di sini berkaitan dengan yang di luar sana adalah kita panggil permohonan daripada kita punya *general practitioners (GPs)* kita berkaitan dengan untuk menilai semula kadar perundingan yang RM10 ke RM35 yang sudah hampir 30 tahun yang tidak di-*review*. Jadi, sebenarnya untuk kita — kita pun maklum sebagai contoh, sebagai contoh ya, sebagai contoh, kalau kita tingkatkan kadar minimum tersebut, implikasinya adalah pada kita punya rakyat, daripada *out of pocket* yang mereka boleh bayar untuk mendapatkan perundingan tersebut.

Jadi, *that's why* untuk membuat keputusan sedemikian pun, kita perlu mengangkat, kita perlu kaji dengan lebih mendalam dan mendapatkan kita panggil input daripada pelbagai pihak dan seterusnya, mengangkat ke Kabinet untuk membuat keputusan. Jadi, itu yang kita risaukan sebenarnya.

Dari kos semasa, kami di pihak Kementerian Kesihatan Malaysia, dari segi kawalan itu yang apa yang di bawah bidang kami, memang kami cuba — bukan kami cuba, memang tak pernah dinaikkan pun untuk sekian lama. Macam YB lah, bayar RM1 kan, dan rakan-rakan. Yang kena bayar sekarang RM1, kita memang takkan usik yang itu sebab kita tahu isu-isu semasa. Tetapi kalau kita berbalik kepada soalan YB tadi, kos-kos yang menaik itu adalah bukan di bawah kawal selia kami.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Sedikit soalan tambahan. Jadi, adakah Yang Berbahagia Datuk setuju bahawa Akta 586 ini ada nampak ada kelonggaran sedikit...

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ya,

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: ...Ya dan perlu ada penambahbaikan yang maksudnya di-*review* oleh pihak maknanya kementerian sendirilah untuk mungkin di apa itu, ditambah lagi item-item penting untuk nak mengelakkan apa yang sedang berlaku itu. Maksudnya, sebagai kawalan kepada kos-kos itu maknanya dapat disenarai dengan penuh ya dan tidak ada celahan oleh pihak ada kepentingan ini untuk dia nak elak daripada dia kena tindakan dan sebagainya. Adakah Datuk bersetuju dengan mungkin pindaan maksud saya, kepada akta ini sendiri?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ya, ya, ya, ya. Yang — betul Yang Berhormat. Ini dari segi skop Akta 586 itu, pihak kami perlu berbincang semula untuk memastikan komponen-komponen mana yang perlu ditambah baik terutamanya daripada melihat dari segi aspek peningkatan kos terhadap apa ini, untuk mendapatkan rawatan dan sebagainya. YB cakap itu perkara yang memang kita sedang usahakan. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, berdasarkan apa yang dicadangkan, yang dibangkitkan oleh YB Sik, adakah kerajaan akan *look into* DRG untuk mengawal kos atau akan mengkaji *HSS (hospital supplies and services)* yang tadi item-item yang tidak terkawal itu? Apakah hala tuju kerajaan? Nak kawal *hospital supplies and services* atau *go to* DRG? Sebab DRG ini dia mengambil masa dan HSS itu mungkin akan ditingkatkan lagi. Jadi, apa — ini adalah satu dilemalah. Minta pandangan Datuk.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Buat masa ini YB, kita melihat kepada aspek DRG. Saya rasa semua — *DRG is Diagnostic-Related Groups*-lah, itu maksud dia. Dengan adanya konsep DRG ini, beberapa negara telah guna pakai, jadi ia meletakkan nilai ataupun pakej perawatan yang sesuatu intervensi dilakukan. Secara terbaiknya untuk makluman YB semua, pihak Kementerian Kesihatan Malaysia sekarang sedang mengusahakan kita panggil penggunaan DRG.

Ada dua kaedah. Pertama, DRG — kajian-kajian DRG yang dijalankan di hospital-hospital awam, di hospital kerajaan dan sebagainya. Pada masa yang sama, kita menggalakkan penggunaan DRG di hospital-hospital swasta.

Untuk makluman YB juga, ada beberapa hospital swasta yang besar telah pun mengguna pakai aplikasi DRG supaya ia lebih telus dan dari segi kawalan harga

adalah lebih kita panggil bertepatan dari segi nilai yang diberikan terhadap sesuatu prosedur atau intervensi ataupun perawatan yang diberikan.

Tetapi pada masa yang sama, YB juga — memang tepat sekali. Untuk membangun sesuatu DRG bukan perlu dalam masa sekelip mata, ia mengambil masa. *Thats why* mengikut daripada perancangan yang kita telah letakkan dengan menggunakan kaedah DRG ini, kita melihat daripada tahun 2027 baru kita dapat menggunakan kita panggil DRG tersebut kita panggil DRG Kebangsaan *(National DRGs).* Bila adanya *National DRGs* ini, syarikat-syarikat ataupun hospital-hospital swasta dan sebagainya jika mereka ingin menetapkan sesuatu bayaran dan sebagainya untuk sesuatu intervensi, dia ada satu sandaran. Sandaran tersebut meletakkan nilai kepada prosedur tersebut. Itu adalah lebih baik.

Untuk yang perkara kedua yang kawalan terhadap harga dan sebagainya untuk perkara-perkara lain, saya mohon maaf, saya tidak boleh respons kepada perkara tersebutlah. Sebab kawalan harga dan sebagainya dari segi bukan di bawah — untuk perkara-perkara tersebut bukan di bawah kawalan Kementerian Kesihatan Malaysia. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Kubang Pasu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Timbalan Pengerusi. Saya nak tanya sikit lagi Datuk ya, ini nak tanya pandangan Datuk sebagai *Chairman MMC*. Mengenai *national health insurance*, saya difahamkan, *correct me if I am wrong, only Malaysia* dengan North Korea yang tak mengamalkan *national health insurance*. *All other countries are having the national health insurance.* Apa pandangan Datuk? Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Soalan kepada KP yang baru tujuh minggu jadi KP. *[Ketawa]* Saya rasa terima kasihlah bagi soalan tersebut pada saya ya. Sebenarnya bila kita melihat kepada pembiayaan untuk sistem kesihatan, *I think* asasnya adalah pembiayaan kepada sistem kesihatan.

Kita sebenarnya satu negara yang amat bersyukur sebenarnya, untuk sekian lama pembiayaan sistem kesihatan kita *actually* sebahagian besarnya adalah daripada kerajaan menggunakan konsep *prepaid, prepaid*. Kita pun maklum dalam sekarang ini, kita punya *out of pocket which is* yang kena bayar sendiri pun agak tinggi juga, dah hampir sama 30 peratus *if I am not mistaken*.

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Jadi, untuk jangka masa panjang memang tidak akan membebankan kepada rakyat. Jadi, itulah salah satunya jika kita melihat daripada untuk jangkauan masa hadapan dari segi hala tuju sistem kesihatan negara satu sistem *prepaid* perlu

diaplikasikan sama ada dia kita panggil *national health insurance* ataupun *social health insurance* dan berbagai-bagai lagi ada di luar sana kita tidak boleh saja — minta maaf ya, *copy* dalam izin, *copy and paste* sebab negara kita mempunyai sistem perubatan tersendiri dan dari segi *sosiodemografi* pun berbeza-beza, keupayaan rakyat pun berbeza-beza.

Tetapi, apa-apa pun yang lebih penting pada kita sekarang ini adalah memastikan sebagai satu — untuk membuat peruntukan dana pembiayaan tersebut, kita mempunyai satu dana pembiayaan yang bersifat *robust* dari segi bagaimana dana tersebut dapat dihasilkan. Itulah sebabnya salah satu perkara yang kita cuba usahakan adalah untuk satu bentuk *revenue* yang boleh diletakkan kepada dana tersebut untuk kita guna pakai bagi sistem kesihatan kita. Sebab kalau kita menggunakan — *national insurance* ada pelbagai. Sebagai contoh, kalau di-*pooling* punya itu, kalau kita panggil dia ada *earmarked tax,* sya ingat ada *tax*, *tax* tertentu khas untuk kesihatan. Tetapi di negara kita *actually general taxation certain amount been given* dan sebagainya.

Jadi, agak sukar untuk — sebab jika kita melihat daripada aspek dana pembiayaan ini adalah agak kompleks sekali sebenarnya. Bukan — *it's not as simple that* sebagai contoh di luar sana, okey, tak apa dia kata, kenapa susah sangat? Naikkan saja caj RM10. Sekarang bayar RM1 naikkan ke RM20 ke RM50. Sebenarnya dengan berbuat sedemikian pun implikasi lebih besar. Sebenarnya, jika kita menggunakan kaedah sedemikian, *actually, out of pocket* daripada orang yang membayar itu adalah lebih. Kita tidak mahu yang itu. Apa yang kita mahukan pembiayaan, dana tersebut datang daripada mana.

Buat masa ini Yang Berhormat, saya boleh sambung sama ada *social health insurance* ataupun *national health insurance,* semua itu adalah opsyen-opsyen yang sedia adalah. Kita pun masih belum membuat keputusan bagaimana kita akan menggunakan kaedah ini sebab salah satu asas untuk mendapat dana tersebut kita perlu faham apakah kos sebenar kita untuk menjalankan perkhidmatan kesihatan di negara ini. Itu pun satu perkara yang kajian, yang sebagaimana soalan Yang Berhormat tadi berkaitan dengan hala tuju DRG kebangsaan. Itulah sebagai asas untuk perkara tersebut.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Soalan tambahan Datuk, sikit saja. Saya ambil contoh Indonesia, dia orang ada laksanakan *national health insurance*. Dia — penduduk ataupun rakyat kena bayar RM120 sebulan, duit kitalah. Dan kalau rakyat yang tidak mampu, kerajaan akan *make the payment. And then,* orang yang lebih kaya juga diberikan opsyen, dia tambah

bayaran *then* dapat *different service compared to ordinary* rakyatlah tetapi dia punya premium itu lebih tinggi ya. Apa pandangan Datuk?

Dr. Hirman bin Ismail [KKM]: *I think* perkara tersebut merupakan antara opsyenlah yang telah — yang pernah kita bincangkan dalam kita membuat perancangan tentang apakah bentuk pembiayaan kesihatan yang paling sesuai untuk diamalkan di Malaysia pada masa akan datang. Sebagaimana yang Datuk KP cakap, *a national health insurance or social health insurance are the two main models that we have discussed before* dan antara perkara yang telah kita pertimbangkan adalah berkenaan dengan pembiayaan ataupun premium insurans tersebut berdasarkan kepada status sosioekonomi rakyat. Maknanya rakyat yang mempunyai kapasiti ataupun kemampuan yang lebih mungkin akan membayar yang lebihlah berbanding dengan rakyat yang mungkin kurang berkemampuan.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Saya nak tambah dekat sini Yang Berhormat, kalau dibenarkan ada satu kita panggil topik yang disebut sebagai *health financing for legislators.* Yang ini adalah satu artikel yang ditulis oleh World Bank Group*.* Dan dalam artikel ini telah menyenaraikan negara-negara yang menggunakan kaedah-kaedah sedemikian tetapi asasnya adalah kita meletakkan kita panggil *universal health coverage.* Saya tiada halangan untuk *share this article* kepada semua Yang Berhormat untuk tengok betapa kompleksnya bila kita bercakap berkaitan dengan dana pembiayaan dan sebagainya.

Dan dalam artikel ini juga meletakkan negara-negara yang menggunakan *social health insurance, national health insurance* untuk sekian lama dan apakah implikasi kepada negara-negara tersebut. Saya tiada halangan, saya boleh *share* artikel ini kepada Yang Berhormat semua untuk dihadamkan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Datuk. Minta *share*-kan.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ya, baik.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: Kalau ikut nafsu saya nak tanya soalan tetapi *outside* MMC lah tetapi oleh kerana kitanya — Datuk dijemput di sini sebagai *from* MMC juga, jadi saya *confined*-kan soalan dalam konteks MMC.

Referring to your slides, berkenaan *your core function, bullet point number 4* itu, *"To evaluate/monitor houseman training and performance under Medical Qualifying Committee." From my observation or from my experience* sendirilah — bukan *myself,* anak ya, *generally doctors in the houseman* punya *two years* punya *period* itu, *they have undergone* macam budak baru masuk *boarding school* kena *ragging*.

To the extent that I remind my daughters, careful-lah *because of the peer, test* dan sebagainya, jadual dia dan sebagainya itu, *to me, it may affect the level of service by that two years period of the houseman. Because they have undergone* dan sebagainya itu *and* macam *— if I may use the word*-lah macam *ragging, then to the extent that, it may affect the quality of service* yang *houseman* bagi. *So, how does MMC see this situation? Okay*. *That is the first question.*

Second question, the last bullet point itu fasal *mental health*-lah ini. *If it is — out of the Malaysian total is 30 percent, as got mental health* punya *problems. I think among doctors could be more. I have — MMC look into this issue. That means mental health among doctors because they are the frontliners to people* yang sakit. Jadi, kalau orang yang sakit rawat orang yang sakit, *the repercussion or the effect would be double or triple*-lah. Jadi, *that two questions.* Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Terima kasih Yang Berhormat. Soalan memang bernas sekalilah. Pertama, berkaitan dengan *"ragging"* ya, *"ragging"* saya pun kena *ragging* juga 30 tahun yang lepaslah. Jadi — tetapi *that's my time*-lah kan.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: Tetapi...

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Saya nak bagi senario semasalah ya, senario yang berlaku. Kita tahu generasi sekarang tidak sama dengan generasi saya ataupun generasi masa kita muda-muda dululah kan. Saya bagi tahu pengalaman saya dulu ya sebelum saya cakap fasal *ragging* tadi itu ya.

Semasa zaman saya dulu, *housemanship* saya melaporkan diri di satu hospital, *houseman* ada empat orang dan wad pun ada empat. Satu wad lebih kurang dalam pesakit antara 30 ke 40 pesakit, satu wad. Jadi, satu *houseman* jaga satu wad, satu. Dan jika kita *oncall*, kita akan — selepas pukul 5 kita akan jaga — saya akan jaga empat-empat wad. Jadi, bayangkan empat wad itu ada 100 — empat kali empatlah, 150 pesakitlah. Itu zaman sayalah dulu, zaman macam itulah ya. Tahun awal 1990an, pertengahan 1990an. Jadi, satu.

Ini adalah satu sebenarnya pada saya dulu kenapa ialah kita kena terima tak cukup doktor dan sebagainya, satu. Kedua, kita meletakkan program *housemanship* itu adalah satu program yang kita panggil yang akan membina asas masa depan mereka sebagai seorang pengamal perubatan. Saya cakap macam ini ramai kepada *houseman, houseman.* Saya bagi tahu, bila — *during housemanship training* itu, seolah-olah kita ingin menyuburkan akar tunjang, asal dia. Kalau akar tunjang kita subur, *insya-Allah,* pokok itu kena taufan pun dia tak tumbang. Jika akar tunjang kita

tidak subur, asas dia itu di situ dan kemudian itu sebagai seorang pengamal perubatan dia akan menjadi masalah di kemudian hari. Itu satulah.

■1750

Itu adalah fungsinya. Jadi, dalam tempoh semasa program *housemanship* tersebut dan seterusnya peringkat awal sebagai seorang pegawai perubatan adalah tempoh masa penting untuk pegawai-pegawai perubatan atau pengamal-pengamal perubatan untuk kita panggil membina asas-asas, *the building block* untuk masa depan mereka. Itu satu. Apa maksud di situ? Dalam tempoh inilah yang kita perlu membina asas kompetensi kita untuk melakukan perawatan kepada seorang pesakit. Jadi asasnya, dalam tempoh tersebut, cuba belajar sebanyak mungkin, cuba mahir sebanyak mungkin sebagai satu asas yang kukuh untuk pergi lebih jauh.

Adakah kita bersetuju dengan buli, *ragging?* Tidak. Sebab pengalaman sebagai seorang — membangunnya seorang doktor itu, kemahiran mereka itu bersandarkan kepada program *apprenticeship*. Jadi seorang *houseman*, seorang MO, dia ada — dia ikut siapa. Cikgu dia mana. Macam kita mengaji Quran itu, mengaji kitab itu ber-*talaqqi* dengan siapa, siapa guru dia. Itulah program bagaimana kita membina asas kemahiran tersebut. Satu. Jadi, jika kita tidak dapat membina kemahiran tersebut dan kemudian hari akan sukar.

Jika kita melihat kepada apa yang berlaku sekarang, itu sebab saya beritahu banyak kali. Dalam program *housemanship* tersebut, bila sahaja selesai mendapat ijazah di sekolah perubatan, apa yang lebih penting, mereka menggunakan keupayaan apa yang di belajar di sekolah perubatan tersebut untuk menterjemahkan semasa peringkat *housemanship* tersebut. Dia macam kita belajar kebanyakan dia teori dan sedikit praktikal, tetapi *houseman* tersebut *is actually the actual practical*. Kalau kita gagal di situ, *the consequences later on* akan lebih besar.

Jadi, adakah dengan membenarkan mereka bekerja 60 jam seminggu itu dipanggil *ragging?* Saya sukar nak jawab perkara tersebut sebenarnya. Pada saya, ini adalah tempoh penting untuk mereka membina kemahiran mereka. Tetapi, adakah kita benarkan mereka dibuli sampai tak sempat makan, tak sempat pergi buang air, tak sempat nak solat dan sebagainya? Perkara tersebut kalau benar-benar berlaku, maklumkan kepada kita. Kita tiada masalah untuk menangani perkara tersebut — punca sebab asasnya ketika itu kita melihat kepada garis panduan *housemanship* tersebut. Asasnya adalah untuk mereka membina kemahiran mereka. Itu satu lah.

Yang kedua berkaitan dengan isu *mental health*. Betul. Saya latar belakang saya sebelum saya jadi KP, hampir 30 tahun bekerja di bidang perubatan

kecemasan. Mungkin YB maklum lah, jabatan cemas ini semua orang datang cemas, kan? Semua orang sakit dan sebagainya. Semua orang nak cepat. Jadi, boleh bayangkan tekanan mental kepada saya inilah dan rakan-rakan saya di sana. Memang betul, isu kita panggil isu mental ataupun mental punya isu adalah memang besar, memang ada.

Sebenarnya pun kita dah ada kajian di peringkat tempatan berkaitan dengan perkara ini melibatkan *housemanship*, melibatkan pegawai-pegawai perubatan dan juga pakar-pakar. Kita amat risau sebenarnya, ia nya semakin meningkat. *I think* asas perkara yang sama. Saya rasa YB pun tahu jawapan dia kenapa isu kesihatan mental berlaku. Sebab kita dalam sekarang ini, dalam tempoh *vicious cycle*. Apa *vicious cycle* yang berlaku? Kita kekurangan pakar, kita kekurangan pegawai perubatan, kita kekurangan *nurses*, kita kekurangan *allied health personnel* dan sebagainya.

Bila itu berlaku, kerja yang lebih banyak perlu dilaksanakan. *Our nurses have to do double shift, at least* satu atau dua hari seminggu. Doktor kami, macam saya dulu sebagai seorang pakar kena buat *on-call* sampai enam, tujuh, lapan kali sebulan. *So, this is because the vicious cycle because of the* kekurangan pakar dan kekurangan doktor. Jadi, untuk menangani perkara tersebut, bukan sekadar kita boleh bantu dengan *dollar and cents*. Tidak.

Sekarang ini perspektif KKM sekarang yang kita usahakan lebih melihat kepada remunerasi dari segi aspek kebajikan. Saya rasa lebih penting. Mereka— *because we are human being and they are frontliners. I know very well because I was there and I'm still there. That I know very well.* Bukan sebab *dollar and cents*. Ia adalah isu kebajikan, isu kebersamaan, isu *me time* bersama keluarga dan sebagainya. Jadi, kalau kita untuk menangani isu dari segi *mental health* tersebut, kita perlu tangani daripada aspek tersebut.

That's why baru-baru ini YB pun maklum semasa kita mendapat pengecualian 40 jam untuk dua waktu bekerja syif untuk jururawat. Sebenarnya dia lebih kepada satu moral untuk meningkatkan semangat mereka. Sebab itu sebenarnya daripada kita — contoh, kita naikkan insentif mereka, naikkan duit mereka. Itu sebenarnya dengan kita memberi pengecualian sedemikian, semangat mereka akan lebih baik, moral akan lebih. Inilah sebenarnya faktor-faktor yang kita perlu tangani sebenarnya.

Jadi asasnya di sini sekarang, apa yang kita perlu tangani adalah isu kekurangan tenaga kerja di Kementerian Kesihatan Malaysia. Itu yang kita perlu tangani dan saya pasti YB semua akan menyokong kami lah jika kami ada letak

sebarang permohonan dan sebagainya untuk membantu dari segi aspek perkara-perkara tersebut. Bukan sekadar untuk meningkatkan bilangan pegawai-pegawai perubatan, pakar-pakar dan sebagainya, tetapi juga insentif-insentif lain. Itu sahaja saya boleh respons pada YB tadi.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: YB Pengerusi ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, sila.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk, saya nak membawa kepada perkara yang bersangkut-paut apa yang disebutkan oleh Datuk Dr. tadi tentang kekurangan tenaga doktor, pakar, *nurses* sekalipun ya. Kita menghadapi satu cabaran yang amat besar. Dalam masa yang sama, dalam *news* baru-baru ini, doktor-doktor kita mendapat tawaran daripada Singapura dengan gaji yang berganda lebih besar daripada Malaysia.

Tetapi apa yang saya tak faham ialah kenapa — kita tahu kita berhadapan dengan masalah kekurangan doktor, nisbah pesakit dengan doktor kita masih melebar, tetapi kita meletakkan doktor kita itu dalam kontrak. Kontrak ini bila-bila masa mereka boleh berhenti dan boleh pergi kerja tempat lain dan nampaknya macam kita tak mengiktiraf mereka ini sebagai satu golongan tenaga kerja yang amat penting bagi negara. Lepas itu, kadang-kadang kita kata "*Kita dah cukup doktor*". Ada dengar. Saya — *I'm wondering* macam mana kita punya *manpower planning* dalam negara kita khususnya dalam bidang kesihatan ini Dr.? *You just be honest to us, what exactly happen?*

Dia kata macam itu selalu. Kita kata, "*Oh okey, pakar komputer tak cukup*" Okey, masuk lah banyak buat komputer. Lepas itu, keluar tak ada kerja. Lepas itu pula, lepas, lepas itu tak cukup lagi. Jadi, kita — saya tak faham di mana silap dan salahnya kita punya *manpower planning* ini untuk negara kita khususnya dalam perubatan. Terima kasih Datuk.

Dr. Hirman bin Ismail [MMC]: Terima kasih Yang Berhormat. Pada awalnya, mengapa sistem kontak diwujudkan, *I think almost like more than 10 years ago* adalah kerana — 2016 ya, kerana pada ketika itu kerajaan sukar untuk mewujudkan perjawatan baharu khususnya untuk *houseman* lah atau pegawai perubatan siswazah. Jadi, mungkin ada sebab-sebab tertentu ketika itu kenapa *government* atau kerajaan sukar untuk mewujudkan perjawatan baharu. Mungkin ada kaitan dengan kos, skim pencen dan sebagainya.

Jadi, untuk — pada ketika itu, mungkin masa menunggu untuk seseorang graduan perubatan untuk masuk ke dalam sistem mungkin mengambil masa yang

lama. Jadi, sebagai respons kepada situasi tersebut, kerajaan ketika itu mewujudkan sistem kontrak dengan niat adalah untuk mengurangkan waktu menunggu bagi graduan perubatan dan ia ternyata *workable* lah, maknanya berkesan dari segi mengurangkan masa menunggu tersebut. Daripada beberapa bulan, mungkin ketika ini untuk mendapatkan penempatan bagi *houseman* mungkin ambil masa hanya dalam tempoh dua bulan sahaja lah. Jadi, saya rasa mungkin KP boleh sambung tentang hala tuju.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: YB, soalan YB itu memang baik sekali lah, memang tepat sekali lah. Jadi, sebenarnya kita perlu jujur lah dalam aspek ini.

■1800

Sebenarnya semasa tahun 2014, 2015 dan sebagainya, pada tempoh tersebut, bilangan *houseman* yang dikeluarkan di negara ini adalah amat besar sekali dan ya. *[Dicelah]*

Seorang Ahli*:* *[Berucap tanpa menggunakan pembesar suara]* 6,000.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Diambil 6,000 lebih setahun. Jadi, itulah sebabnya antara perkara-perkara untuk mereka memasuki pasaran diletakkan isu kontrak tersebut. Saya boleh sebutkan di sini sebenarnya saya masih ingat lagi apa yang pernah dimaklumkan kepada kita pada masa tersebut itulah sepatutnya satu tempoh kita panggil interim. Interim. Interim tersebut. Jadi, pejam celik, pejam celik interim itu dah 10 tahun dah sebenarnya interim.

Pada masa yang sama moratorium juga telah dibuat kepada sekolah-sekolah perubatan, betul ya untuk -— mereka tidak meningkatkan bilangan, ada kuota yang diberikan untuk mereka tidak meningkatkan bilangan *intake*, bilangan *school,* satu, dua *intake*, ada kuota-kuota tertentu dan sebagainya. Moratorium tersebut baru sahaja di *has been lifted* baru-baru ini.

Buat masa ini YB, untuk tahun 2024 dan dua tahun sebelum ini dan setahun sebelumnya, setahun adalah lebih kurang dalam 3,000 lebih pegawai-pegawai perubatan ataupun yang keluar daripada sekolah perubatan untuk memasuki pasaran. Saya bersetuju sebenarnya untuk keterjaminan sebagai seorang — dahlah kita belajar lama, lepas itu masuk *houseman* pula, masa itulah kita nak membina keluarga dan sebagainya, lepas itu dengan adanya kontrak tersebut, tidak ada satu jaminan untuk masa hadapan mereka. Nak ambil *bank loan* untuk beli rumah pun tidak boleh, kan. Saya tahu sangat perkara tersebut.

Itulah sebabnya sekarang apa yang kita laksanakan sekarang kita akan cuba mengurangkan tempoh kontrak tersebut yang sekarang ini *up to seven years*,

kalaupun tujuh, kalau campur empat kalau mereka menyambung belajar kepada 13 tahun kepada kurang daripada tiga tahun. Maksud, kita nak *revert back* kepada apa yang berlaku sebelum ini lantikan awal tersebut tempoh percubaan antara satu ke tiga tahun dan seterusnya diserap di dalam perjawatan.

Tetapi untuk perkara tersebut dilaksanakan, perlu ada perwujudan jawatan-jawatan pegawai perubatan di Kementerian Kesihatan Malaysia berdasarkan kepada keperluan sebenar. Jadi, saya terus terang boleh menyatakan di sini sebenarnya perjawatan-perjawatan kita yang dah ada di Kementerian Kesihatan Malaysia sekarang terutamanya fasiliti-fasiliti yang sedia ada bilangan perjawatan tersebut tidak memenuhi keperluan sebenar, satu.

Pihak agensi pusat mewujudkan perjawatan-perjawatan untuk pegawai perubatan bagi fasiliti-fasiliti baharu yang dibangunkan. Contoh, Hospital Pasir Gudang itu baru bina dia datang sekali dengan jawatan. Ataupun fasiliti-fasiliti lama yang membuat bangunan baharu dan kita dapat jawatan. Tetapi fasiliti-fasiliti lama yang tanpa sebarang bentuk perwujudan jawatan agak sukar, satu.

Kita juga untuk tiga tahun kebelakangan ini, tahun 2025, 2024 dan 2023 setiap tahun kita telah mendapat kelulusan daripada Kabinet untuk mewujudkan 1,500 jawatan pegawai perubatan yang baharu. Kabinet juga telah pun meluluskan sejumlah 800 jawatan pakar setiap tahun. Yang itu tidak ada *ending* dia, *every year* akan ada 800. Bila saya — dengan adanya perwujudan jawatan-jawatan ini secara berterusan, yang pegawai perubatan dan pakar perubatan, kita akan — kita boleh mengurangkan tempoh masa kontrak tersebut dan yang terbaiknya kita balik, balik kepada sistem asal di mana mereka boleh diserap terus selepas selesai *housemanship*. Itu sebenarnya hala tuju yang kita mahukan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Sikit sahaja tambahan kepada soalan tadi itu. Berapa nisbah yang sebaiknya untuk berapa orang pesakit dengan satu doktor? Sekarang ini apa yang patutnya? Sebab saya *dok* tengok 2014, 2015 kononnya kita ada lambakan doktor, saya tidak percaya sebab kita mesti ada unjuran, kan?

Setahun berapa tambahan pesakit-pesakit terutama sekali sekarang ini banyak penyakit-penyakit yang tidak pernah wujud sebelum ini, penyakit mental dan sebagainya dan sehinggakan bila sampai satu ketika *suddenly* kita tidak cukup doktor. Kita dah cakap universiti semua *you stop producing too many doctors,* 5,000, 6,000 kepada 3,000. Baru ini pun di Johor masuk akhbar bahawa mereka menghadapi masalah tidak cukup doktor di hospital di Johor. Sila, Datuk. Terima kasih.

Dr. Hirman bin Ismail [MMC]: Jadi, bila kita membuat unjuran dari segi bilangan doktor diperlukan di dalam negara, kita melihat kepada *population based projection*. Jadi, sasaran kita adalah kalau kita tengok negara maju kebanyakan dia bilangan doktor adalah tiga doktor bagi setiap 1,000 populasi. Malah ada negara yang lebih daripada itulah mungkin ada *3.3, 3.5* dan sebagainya. Tapi kita meletakkan sasaran kita dan kita telah *inform* kepada Kabinet bahawa pada tahun 2025, *target* kita adalah *2.5* doktor bagi setiap 1,000 penduduk dan untuk pada tahun 2030 sebab kita buat sasaran itu secara berperingkat, kita tak nak meletakkan sesuatu sasaran yang terlalu tinggi menyebabkan mungkin kerajaan tidak mampu untuk mencapai tahap tersebut.

Jadi, pada tahun 2030 kita telah mencadangkan kepada kerajaan bahawa bilangan doktor adalah sepatutnya tiga doktor untuk setiap 1,000 penduduk. Kita punya jumlah sekarang adalah lebih kurang *2.3 to 2.4* doktor bagi setiap 1,000 penduduklah. Jadi, itu merupakan sandaran ataupun *guideline* bagaimana kita menentukan bilangan doktor tersebut.

Daripada jumlah doktor yang kita *project* atau kita unjurkan dalam negara, sepatutnya *70 percent* ataupun 70 peratus perlu berada dalam sistem kesihatan awam, *public sector*. Kenapa 70 peratus? Kerana kebanyakan *workload*, beban kerja sektor kesihatan di dalam negara kita ini 70 peratus adalah ditanggung oleh sektor awam, bukan sektor swasta. Sektor swasta hanya 30 peratus. Jadi, secara amnya 70 peratus unjuran doktor ataupun anggota kesihatan yang kita buat itu 70 peratus perlu berada dalam sektor awam.

Cumanya kalau kita tengok bilangan pakar contohnya pakar, khususnya pakar-pakar yang kritikal dia tidak *70/30,* mungkin *50/50* ataupun mungkin ada lagi teruk maknanya ada bidang *60 percent* di *private, 40 percent* di *public sector*.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih, Datuk *and doctor.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, Pengerusi. Okey, tadi Datuk KP kata sememangnya tidak cukup doktor pakar *and we are facing a problem with you know* dalam sistem kitalah ya. Jadi, *thanks for being honest with us* dan kita perlu mencari penyelesaian.

Walau bagaimanapun Datuk, saya ingin membangkitkan *sometimes* kita, Malaysia melahirkan ramai *good doctors and then they* — tapi mereka ramai yang *practice overseas* ya, banyak, ramai. Ada yang melalui JPA lepas itu *graduate,* kekal di sana dan tidak balik. Ada yang di-*sponsored* oleh *father and mother*, "fama".

"Fama" scholarship hantar ke luar negara *but* lepas itu tidak balik. Tetapi ada yang nak balik sebenarnya dan *they're actually funded by our owned Malaysians money.* Tetapi mereka tidak dapat kelulusan daripada MMC, okey.

MMC, saya tidak pasti sistemnya tetapi saya nak *quote* satu kes yang diadukan *personally* kepada saya adalah dia praktis di Singapura, dia *graduate* di UK, okey. Praktis di *Leeds*, di hospital *in Leeds* lepas itu dia pergi ke Singapura dia praktis *as a surgeon* dekat hospital Singapura sebab dia nak balik ke Malaysia kerana dia nak anak mereka mempelajari bahasa Melayu dan juga nak dalam keadaan Malaysia ini. Nak hantar balik, nak balik.

■1810

Satu keluarga nak balik tapi apabila dia minta daripada MMC, *reject.* Okey. *So,* kes ini *very* sakit hati sebab lepas *reject,* dia beberapa kali dia *appeal,* masih *reject* dan akhirnya, dia *give up.* Dia kata *no point* sebab dia — anaknya makin besar dan akhirnya dia *naturalised* jadi Singaporean. Sebab dia tak boleh tunggulah. Dia kerana — *so I think we lost one good surgeon because of the system.*

So, saya nak minta pandangan Datuk dan juga MMC, apakah caranya untuk mempercepatkan atau apa prosedurnya untuk memberi *our specialist to come back and serve.* Dan, apakah kekangan sehinggakan kes-kes macam ni berlaku? Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Sebelum saya memohon Dr. Hirman ataupun Dr. Anas jawab, bukan YB saja sakit hati. Saya pun sakit hati juga. Jadi, kita tahu ada isu berkaitan dengan doktor-doktor daripada luar negara untuk kembali bertugas di Malaysia dan diletakkan MMC tersebut adalah satu badan yang membuat pendaftaran dan sebagainya.

Okey, saya mohon Dr. Hirman — inilah sebab antara satu sebab mengapa kita buat pindaan kepada Akta Perubatan yang baru kita kuat kuasa pada 1 Julai. Mungkin Dr. Hirman boleh terangkan. Silakan.

Dr. Hirman bin Ismail [MMC]: Okey. Terima kasih Yang Berhormat. Saya rasa kes tersebut saya tak tahu *detail* tentang kes tersebut tapi saya menjangkakan mungkin kes tersebut adalah kes yang mana pengamal tersebut mempunyai kelulusan kepakaran yang tidak tersenarai sebagai kelulusan kepakaran yang diiktiraf di bawah Majlis Perubatan Malaysia. Dululah. *This is my suspicion*-lah. Okey.

Jadi, mungkin disebabkan peruntukan Akta Perubatan sebelum ini menyebabkan satu bentuk kekangan mungkin tidak dapat mendaftarkan pegawai pengamal tersebut sebagai pakar. Jadi, selepas kita membuat pindaan Akta Perubatan (Pindaan) 2024, kita telah mewujudkan satu *clause* khas yang mana

sekiranya pengamal tersebut mempunyai kelulusan yang tidak tersenarai dalam Jadual Keempat — Jadual Keempat ni merupakan satu jadual yang kita wujudkan dalam akta tersebut yang menyenaraikan semua *qualification, local* dan juga *overseas qualification*. Dan, sebagaimana kita tahu dekat luar sana banyak jenis *qualification* yang mungkin tidak tersenarai di bawah senarai MMC tersebut.

Jadi, walaupun seorang pengamal tersebut tidak mempunyai kelulusan yang tersenarai dalam Jadual Keempat, pengamal tersebut masih boleh dipertimbangkan untuk didaftarkan di bawah MMC, di bawah seksyen 14B(2). Jadi, akta tersebut baru sahaja dikuatkuasakan pada 1 Julai. Jadi, kita dalam proses untuk memperhalusi proses tersebut. Jadi, *the guideline should be out soon*-lah untuk kita menangani isu-isu sebagaimana yang telah dibangkitkan oleh Yang Berhormat tadi.

Tuan Ahmad Tarmizi bin Sulaiman [Sik]: Ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Oh, Sik. Okey. Selepas itu, Betong.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Oh, okey. Ya. Saya nak bertanya berbalik kepada isu yang kita sedang bincangkan ini iaitu kenaikan kos perubatan ini.

Dalam prosiding sebelum ini, ada yang ditimbulkan iaitu terdapat amalan *overtreatment* ataupun *upcoding* di hospital swasta ini ya, yang menyebabkan caj yang dituntut itu melebihi yang kadar biasalah ya. Dalam Akta Perubatan 1971 atau 1950 itu, yang MMC tu, disebut adalah salah satunya mengawal etika profesional dan amalan pengamal perubatan ya.

Jadi, dalam akta ini bagaimana *mechanisme* atau kaedah yang digunakan oleh MMC sebagai satu pemantauan ataupun audit etika yang dilaksanakan secara praktisnya kepada pengamal-pengamal perubatan ini? Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Terima kasih soalan tersebut YB. Soalan yang baik sekali. Sebarang ataupun *any* — sebarang pengamal-pengamal perubatan yang melakukan rawatan tidak menuruti keperluan perawatan tersebut dan menyebabkan *overcharging* dan sebagainya, mereka boleh melaporkan terus kepada MMC untuk tindakan dan memungkinkan pelanggaran kepada *Code of Professional Conduct.* Itu jelas. Boleh buat pelaporan dan di pihak MMC, akan ada satu jawatankuasa penyiasatan jika aduan tersebut naik dan jawatankuasa penyiasatan tersebut akan menilai aduan tersebut secara fakta.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Dalam tempoh mungkin untuk beberapa tahun ini, adakah ada kes-kes yang dirujuk oleh MMC seperti ini?

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: YB, kita belum ada terima aduan yang sedemikian. Tak pernah. *Overcharging* tak pernah ada.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Tapi kami tiada halangan untuk ini *because* pada asasnya, kalau mereka membuat satu perawatan yang tidak sepatutnya, itu salah satu bentuk pelanggaran etika.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Okey, terima kasih Pengerusi. Saya menyusul isu kekurangan doktor tadi. Ia memang terkait dengan kewujudan jawatan daripada jabatan — daripada JPA, *right?*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *[Bercakap tanpa menggunakan pembesar suara]* Ya.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Ataupun *human resource*-lah.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *[Tidak jelas]*

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Ia nya jawatan yang tetap dan berpencen. Apakah sekiranya jawatan kalau kita nak tawarkan pegawai perubatan ini mengikut jawatan berasaskan caruman. Dia bukan tetap dan berpencenlah *you know. So,* mungkin satu yang fleksibel. Satu hari nanti mungkin kalau ada tawaran di pihak swasta yang baik, dia boleh keluar dan berkhidmat di hospital swasta dan dia akan tidak rugi dari segi dia punya caruman tadi.

Dan, sekiranya dia nak balik kepada kerajaan lagi, contohnya satu hari nanti sebagai seorang *specialist* dengan sekiranya kerajaan ada mewujudkan jawatan yang berasaskan caruman, jadi dia fleksibel. Apakah pandangan Datuk Pengarah sama ada ia nya dapat mempercepatkan ambilan *you know,* doktor-doktor tu ke dalam sistem perubatan?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Terima kasih YB atas soalan tersebut. Lantikan yang — sebarang lantikan tetap, lantikan apabila ditawarkan lantikan tetap selepas *I think* setahun atau dua tahun lantikan tetap dilaksanakan, pegawai akan di...

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: *[Bercakap tanpa menggunakan pembesar suara]* Diberi opsyen.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: ...Diberi opsyen, diberi pilihan sama ada untuk mengambil opsyen pilihan berpencen ataupun opsyen caruman KWSP sebenarnya. Opsyen tu memang dah sedia ada sekarang. Macam sebelah *ni [Merujuk kepada Dr. Mohamed Anas bin Mohamed Hussain]*, dia caruman KWSP sebenarnya. Saya *ni* tetap berpencenlah. Yang ini pun pencen jugalah *[Merujuk kepada Dr. Hirman bin Ismail].*

Jadi, opsyen tu memang sedia ada tapi asasnya, perlu ada jawatan tetap. Kalau kontrak, tidak sebegitu. Itu sebab yang bagi tahu tadi, saya bagi tahu pada awal tadi, kita kalau boleh kita nak memendekkan sebagaimana sistem sedia ada sebelum ini – satu ke tiga tahun tempoh percubaan dan seterusnya diserap ke jawatan tetap.

Selepas jawatan tetap tersebut, mereka boleh sama ada memilih opsyen kita panggil caruman ataupun tetap. Dan, jika pun mereka — contoh, pegawai membuat keputusan untuk keluar daripada meletak jawatan atau keluar daripada sistem perkhidmatan awam, dan mereka ke luar negara ataupun pergi *private.* Dan, pada satu ketika mereka mungkin berubah fikiran untuk masuk balik ke dalam sistem perkhidmatan awam, sekarang pun memang ada kita panggil laluan untuk mereka untuk memohon semula untuk masuk balik dalam sistem perkhidmatan awam. Memang laluan tu memang sedia ada, sudah sedia ada.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Adnan bin Abu Hassan [Kuala Pilah]: Kuala Pilah. Terima kasih, terima kasih Timbalan Pengerusi. Yang Berbahagia Datuk KP. Yang Berbahagia Datuk, sebenarnya kita PAC ni telah memanggil ramailah dan banyak pihaklah *stakeholders* yang terlibat dalam isu kenaikan harga insurans ini.

Dan, saya lihat daripada beberapa saksi atau *stakeholders* yang kita panggil ini, saya boleh buat kesimpulan bahawa 70 peratus, contohnya daripada *billings*. Saya balik, balik kepada kita punya tajuk ni. 70 peratus daripada caj yang dikenakan kepada pesakit itu sebenarnya datang daripada perkara lain yang di luar caj melibatkan servis diberikan oleh doktor tersebut. Okey.

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Jadi, saya lihat banyak kepada *medical supplies* contohnyalah, *70 percent* daripada *findings* kita dapatlah. Jadi, saya ingin bertanya kepada Yang Berbahagia Datuk, adakah Yang Berbahagia Datuk bersetujulah, bersetuju? Saya ingin mohon pandangan sahaja. Mungkin kita boleh buat satu usul juga di pihak PAC agar semua perkara yang melibatkan *billing* ini, caj kepada pesakit ini diletakkan di bawah MMC. Seperti mana Bar Council meletakkan semua perkara melibatkan peguam di bawah Bar Council termasuklah sehingga ke dia punya *scale professional fee* dia, remunerasi *(remuneration)* semuanya diletakkan di bawah Bar Council dan ia bercakap tentang diskaun, contohnyalah.

Fasal saya lihat tadi dan saya bersetuju dengan Yang Berbahagia Datuk bahawa saya nak tanya tadi tetapi soalannya telah ditanya oleh jawatankuasa yang

lain iaitu ada tidak aduan berkaitan dengan *over charge* ini dan apakah tindakan. Saya lihat tadi mungkin daripada seperti tadi Yang Berbahagia Datuk tadi, Datuk pun sebenarnya MMC sendiri pun terikat tangannya. Bukan semuanya MMC boleh masuk. Contoh tadi, saya dengar ucapan Yang Berbahagia Datuk tadi yang melibatkan mungkin hospital swasta apa semua ini, kita pun tidak boleh masuk, contohnya. Betulkan saya kalau saya silap.

Jadi, benda-benda macam itulah yang saya rasa — fasal tajuk kita ini ialah tajuk macam mana kita nak *address* isu kenaikan ini, harga-harga caj kepada pesakit ini yang melambung tinggi inilah. Ini saya hanya memohon pandangan dengan Datuk atau mungkin kita dipihak PAC ini boleh membantu dalam konteks tersebutlah.

Lagi satu Yang Berbahagia Datuk, ini mungkin di luar sedikit tentang tadilah, tentang sumber manusia. Tahun ini dan tahun-tahun sebelum ini kita lihat pengambilan *medical student* jatuh, turun. Jadi, risau juga kita takut korelasi perkara ini berlaku oleh sebab mungkin *parents* pun sudah tidak yakin lagi untuk meminta anak mereka mengambil jurusan inilah, jurusan ini. Jadi, untuk kita nak *compare apple to apple,* kita doktor di Malaysia bersamaan dengan di Singapore dan tempat lain memang tidak boleh pun. Tetapi, saya bersetuju dengan Yang Berbahagia Datuk tadi seorang yang berpengalaman pun dalam ini, sebelum menjadi Ketua Pengarah ini, dalam perubatan ini. Mungkin kita boleh melihat tadi tentang untuk *create* keadaan yang lebih selesa bagi doktor ini untuk tetap di kerajaan.

Sekarang ini, kita tengok betul mungkin *intake* ramai tetapi dalam pada masa yang sama, ramai yang juga memohon seperti *teachers* sekarang ini, memohon untuk bersara awal. Di pihak doktor pula saya lihat, dalam gred 54, 56 selalunya *normally* mereka ini adalah doktor pakar, selalunya. Bila mereka mungkin digerakkan ke tempat lain mereka ada pilihan. Mereka berhentilah. *Afterall*, dah dapat pencen pun. Tetapi yang sedihnya dalam gred 54 dan 56 ini Yang Berbahagia Datuk, mereka sudah seperti Yang Berbahagia Datuk juga, sudah boleh mengajar *young medical doctors*. Itu yang menyedihkan kita lah. Bagi saya itu satu kehilangan besar bila mereka keluar daripada perkhidmatan awam kita.

Lagi satu Yang Berbahagia Datuk, dah bukan senang nak jumpa Ketua Pengarah yang baru ini kan. Saya tahu Datuk pun sibuk. Contohnya tadi, saya mungkin untuk sentuh di sini tentang sumber kekurangan jawatan-jawatan pekerja kesihatan ini. Di Kuala Pilah contohnya, kita *will be getting a new block* tambahan di Hospital Tuanku Najihah *next year. Last week*, saya buat lawatan kerja. *Alhamdulillah* Datuk, cantik. Memang cantik. Ada enam bilik bedah. Saya khuatir nanti bila saya tanya Pengarah, *staffing* saya tanya. Dia risau, dia cakap. Dia risau.

Jadi, saya pun lagi risaulah. Dahulu orang Kuala Pilah nak bangunan tambahan fasal *'berjimpit'*. Orang Negeri Sembilan kata *'berjimpit'* lah, *cramp*.

Sekarang ini pula dah isu dah ada bangunan tambahan besok, *nurses* tak cukup, *doctors* begitu juga, bilik bedah ada enam. Mungkin akan *operate* dua sahaja. Akhirnya, empat rosak. Ini bahaya. Bukan saya tengok, saya tanya tentang *costing* pun mahal bilik bedah ini. Jadi itulah Yang Berbahagia Datuk. Mungkin Datuk pun *aware* perkara ini tetapi saya ambil kesempatan inilah untuk *highlight*-kan sikit, terlanjur dah jumpa Yang Berbahagia Datuk ini. Terima kasih Yang Berbahagia Datuk.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Untuk kawalan caj itu. Untuk MMC, saya rasa ─ *personal opinion* sebagai Yang Dipertua MMC, dia agak terkeluar daripada skop sebenarnya MMC tersebut. Tetapi, apa yang kita boleh laksanakan — dia melibatkan kementerian lain. Saya tak pasti sama ada PAC dah panggil kementerian lain berkaitan dengan kawalan harga dan sebagainya. Jadi yang untuk...

Dato' Adnan bin Abu Hassan [Ahli PAC]: Yang Berbahagia Datuk, sebenarnya saya yang kita risau ini banyak yang kita panggil dah ini. Ya lah, kalau di konteks biasanya kita boleh cakap *profiteering*. Kita boleh cakap.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ya.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Kita boleh *address* isu-isu itu. Tetapi, dalam konteks *medical* ini, tak boleh, siapa kita nak apa kan mereka. Jadi, itu saya tengok tidak ada parti, tidak ada *body*, agensi yang mungkin boleh letakkan isu ini di bawah mereka. Jadi, sebab itu saya cadanglah tadi kepada Datuk kalau mungkin ia nya *suitable*-lah. Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Salah satu perkara yang mungkin kita boleh bincang dekat kementerian di bawah Akta 586 sebenarnya. Itu adalah — saya rasa adalah lebih sesuai untuk kawalan kawal selia dan sebagainya caj-caj tersebut. Itu pun dalam peringkat perbincangan sebenarnya untuk perkara tersebut berkaitan dengan — tetapi bukan bawah MMC lah ya YB.

Kedua berkaitan dengan sumber manusia. Saya — bukan sayalah, kami bersetuju dengan pandangan tersebut. Itulah sebabnya bila gred sekarang ini gred U14. Dahulu U56. Sekarang gred 14, gred 15. Gred 15 sama dengan 56. Gred 56 ini hanya akan dapat kepada pakar-pakar sahaja dan kita pun maklum. *In fact,* untuk pergi ke peringkat seterusnya gred khas dan sebagainya *there's where the bottleneck is. I think* YB maklum perkara tersebut. Kita pun maklum mereka di gred U15 atau gred 56 pun adalah memang dah tahap pakar perunding dan sebagainya.

Itulah sebabnya, salah satu perkara yang kita melihat sekarang apakah kita panggil fleksibiliti-fleksibiliti lain yang kita — bukan sekadar *welfare* sahaja, apakah peluang-peluang lain yang kita boleh berikan kepada mereka untuk mereka lebih selesa ataupun untuk mereka berada di dalam kementerian.

Satu lagi yang disebutkan dengan pertukaran tadi. Ini pun macam mana saya nak jawab ya? *[Ketawa]* Bila kita melaksanakan pertukaran. Sekarang ini yang berlaku kalau kita lihat dari segi pertukaran atas memberi alasan pertukaran yang menyebabkan mereka meletak jawatan. Bukan kebanyakan daripada gred 56 ini. Dia adalah daripada gred awalan gred 44 yang semasa mereka selepas penempatan semula untuk mendapat lawatan tetap dan mereka diberi pilihan dan sebagainya. Satu, dua, tiga macam baru-baru ini dan kita — *I think* YB pun maklum kekangan. Ada tiga negeri lah di Malaysia ini yang amat besar daripada jurang nisbah doktor dan keperluan.

Of course, Sarawak, Sabah, Johor sebenarnya. Jadi, jika kita letak mereka di negeri-negeri ini. Inilah gred, gred-gred inilah yang akan meletak jawatan sebenarnya. Ha itu. Jadi, saya rasa YB pun maklum kalau kita nak hantar semua ke Lembah Klang, ke Negeri Sembilan, ke Melaka, jadi rakan kita, pesakit kita dekat Sabah, Sarawak dekat Johor ini macam mana pula? Saya orang Johor. Jadi, kita pun salah satu sebab punca kekangan di situ adalah bila kita letak pun — sekarang ini kalau boleh nak duduk hospital sebelah rumah macam itu atau seberang jalan. Saya bagi contoh, saya bagi contoh. Contoh pakar, saya terlibat dalam penempatan pakar-pakar perubatan kecemasan sebelum ini. Kita dah bagi penempatan di Hospital Ampang, tak nak. Nak pergi Hospital Klang.

Jadi, saya kata ini dah Lembah Klang. Nak macam mana lagi kan? Itu saya bagi contoh. Contoh kedua, saya bagi tahu juga *houseman* saya, dua orang. Saya ingat lagi *houseman* ini masa saya Ketua Jabatan Kecemasan. Bagus dua-dua ini. Perempuan. Cekap dan sebagainya. Dia bila habis sahaja latihan *housemanship*, dia jumpa saya, *"Bos saya nak floating dekat Jabatan Kecemasan boleh kah?"* Saya cakap, *"Bolehlah tak ada masalah." "Boleh tak sokong?"* Saya kata, *"Saya sokong."* Hantar.

Tetapi, pada masa tersebut kekurangan bukan dekat Jabatan Kecemasan, masa tersebutlah, di Jabatan Perubatan. Jadi, bila Jawatankuasa Penempatan Hospital letak dia dekat Jabatan Perubatan, dua minggu itu dia datang jumpa saya, *"Bos nak bagi tahu kami dah letak jawatan."* Saya cakap, *"Kenapa? Sebab tak dapat masuk ED."* Itulah generasi yang kita hadapi sekarang, YB. Itulah generasinya.

Saya masa itu bila saya dengar saya kata atas *that very simple reason, you* letak jawatan. Walhal, sama ada pada peringkat awal tersebut untuk menjadi seorang pengamal perubatan yang berjaya bidang perubatan, bidang pembedahan, bidang kecemasan, bidang *O&G*, pediatrik itu semua adalah asas-asas untuk mereka membina kemahiran mereka empat, lima tahun akan datang tetapi sebaliknya berlaku.

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Ini lah yang kita hadapi sekarang. Macam saya beritahu tadi. Kalau kita membenarkan ia berlaku, kita akan dapat *half-baked doctors in the future*. Itu pun kita perlu seimbangkan sebenarnya. *These are* — saya bagi contoh-contoh sedemikian berkaitan sumber manusia.

Akhir sekali berkaitan dengan — saya tahu hospital bangunan blok baharu itu sebab saya terlibat dalam *design*. Jabatan Kecemasan yang baharu dekat situ. Memang cantik. Memang kita bila datang bangunan baharu akan datang dengan perjawatan tetapi selepas ada perjawatan, selalunya pengoperasian adalah secara berfasa. Sebagaimana kita laksanakan di Hospital Pasir Gudang. Dia secara berfasa mengikut kepada peningkatan sumber manusia dan juga peralatan struktur sedia ada.

Untuk makluman YB semua, apabila sesuatu bangunan baharu itu telah siap hospital dan sebagainya, KPI kita adalah untuk mengoperasinya dalam tempoh sebulan. Tapi selalunya kita tidak boleh operasi sepenuhnya dalam tempoh sebulan terus 100 peratus sebab dalam tempoh tersebut juga ada isu-isu peralatan dan sebagainya yang perlu diselia, *testing* dan sebagainya, satu. Kedua, bilangan sumber manusia yang ada itu tidak mencukupi. *That's why* selalu berfasa. Kalau kita bagi contoh Hospital Pasir Gudang, dalam tempoh perancangan dari segi permulaan operasi hingga beroperasi sepenuhnya 100 peratus adalah tempoh antara enam ke 12 bulan. Jadi secara berfasa disebabkan sumber manusia.

Nanti YB semua maklum kenapa perkara tersebut berlaku. Walaupun kita ada jawatan di negara kita sekarang ini adalah untuk *nurses, for example*. Sebagai jururawat sebagai contoh. Bilangan *production* ataupun yang keluar daripada sekolah-sekolah jururawat adalah amat rendah berbanding kepada keperluan negara. Itu lah menyebabkan *the mismatch.* Apa yang KKM telah laksanakan, KKM telah *ramp up* balik dari segi pengambilan bilangan jururawat di KKM dan pada masa yang sama di institusi awam-swasta yang lain untuk memenuhi keperluan negara.

Bukan sahaja situasi ini untuk makluman YB bukan berlaku sahaja di hospital kerajaan tetapi di hospital swasta. Sebagai contoh di KPJ Group pun *they have*

problem. Dia ada KPJ punya *universities* yang dilatih untuk jururawat, jururawat mereka pun lari pergi *Singapore*, pergi *Middle East* juga. Sama sahaja sebenarnya.

Isu yang kita hadapi di negara ini bukan di negara kita juga, di negara — saya *train* dulu dekat United Kingdom pun isu yang sama juga. *Train*, lari pergi sana. Sekarang sebagai contoh jururawat dua destinasi utama di *Middle East* dan kedua adalah *Singapore* sebenarnya. Bukan sahaja jururawat daripada kerajaan tetapi juga daripada swasta. KPJ Group dan sebagainya. Mereka pun *suffer* juga sebenarnya *actually*.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, saya rasa yang topik ini ramai berminat. Okey, saya hanya nak tanya satu soalan berkenaan dengan ini. Saya tak pernah tanya okey. *[Ketawa]*

What is the basic pay, gaji permulaan bagi seorang doktor selepas *housemanship and also* jururawat (*nurse*) selepas semua *training* dia. Apakah gaji *the first month? What is the basic pay?*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Secara puratanya untuk pegawai perubatan adalah RM4,500 sebulan. Untuk *nurses, I think* campur elaun RM2,000 lebih sikit. RM2,300 macam itu, RM2,400. Saya tak tahu secara terperincinya. Saya kena rujuk perkara tersebut tapi itu secara puratanya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey yang saya baca ialah baru-baru ini semua jururawat dikatakan ikut *nine to five or* lapan jam satu hari punya *schedule*. Tak ada dipaksa untuk buat *overtime* lah. Doktor juga sama, kan?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Maksud YB tak dipaksa? Saya tak faham. *[Dicelah] 42 hours* — jadi macam ini. Pengecualian yang diberikan kepada lima skim terutamanya kepada lima skim tersebut iaitu skim pegawai perubatan. Pegawai perubatan termasuk pegawai perubatan dan pakar. Skim jururawat. Tiga skim jururawat masyarakat. Keempat, skim penolong pegawai perubatan. Kelima adalah pembantu perawatan kesihatan (PPK). Kelima-lima skim ini mereka mengekalkan waktu bekerja syif sedia ada iaitu secara puratanya 42 jam seminggu berbanding dengan sebagaimana diletakkan di bawah SSPA iaitu secara puratanya 45 jam seminggu. Itu yang pengecualian. Kita bersyukur pengecualian tersebut dilaksanakan sebab *this is a moral booster for those important schemes*.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Doktor? Macam mana doktor? Sama juga?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Sama. Untuk bekerja syif. Doktor yang bekerja syif. Pengecualian itu adalah *just mainly* untuk yang bekerja syif. Untuk doktor-doktor bekerja syif ini hampir kebanyakannya adalah doktor-doktor

yang bekerja di jabatan kecemasan, tempat saya dulu bekerja. Kita perlu faham bila kita meletakkan seorang pegawai itu di hospital untuk bekerja syif, apa asasnya di situ. Maksud dia di situ keperluan dari segi intensiti fokus adalah untuk 24 jam.

Macam bekerja di jabatan kecemasan ini dia tak ada *peak hour*. Dia tak ada *peak and off-peak. Every hour is a peak hour*. Dia bukan *nine to five peak, after that* dia tak ada. Jabatan kecemasan *every hours is a peak hours* sebenarnya. Itu lah yang saya lalui 30 tahun sebelum jadi KP. Sekarang ini *every day, every hours is peak for me now.* Depan YB semua pun *peak hours for me also*. *[Ketawa]*

Jadi bila kita berada di dalam situasi sebegini, fokus kita perlu tidak boleh sampai 12 jam, 24 jam. Itu sebab kita bekerja syif. *They are actually shorter duration and then actually* kita dapat fokus lebih baik. Tetapi asasnya bila kita meletakkan waktu bekerja syif tersebut, untuk sesuatu bekerja syif itu berjaya dengan sepenuhnya, *we must have a critical mass in order to make sure it's a single shift all the time*. Maksud dia dalam seminggu itu semua orang dapat satu *single shift*. Tetapi disebabkan situasi kekurangan sumber manusia daripada jururawat dan doktor, satu atau dua kali seminggu mereka perlu buat *double shifts*. Itu apa yang kita gusarkan sebenarnya. *That's why we need to break the vicious cycle* dari segi kekurangan sumber manusia untuk kita pastikan mereka tidak bekerja *double shifts* dan sebagainya. Itu pun kita ada untuk *double shifts* pun kita tak benarkan contoh lepas kerja malam, sambung pagi. Perkara-perkara macam itu dibuat di peringkat operasi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Boleh saya tahu berapa Ahli Yang Berhormat mahu tanya soalan? Sik, Bayan Baru, Shah Alam, Saratok. *[Ketawa]* Empat ya? *Confirm* ya? Siapa dulu?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Tambah berkenaan gaji tadi dengan lebih tepat. Untuk gaji permulaan seorang jururawat gred U5 ataupun U29 asas. Kalau dicampurkan gaji pokok bersama dengan imbuhan-imbuhan adalah RM2,884 sebulan. Bagi gred 41— ini adalah untuk *houseman*. Untuk pegawai perubatan gred 43 iaitu pegawai perubatan selepas *housemanship,* gaji yang mereka dapat sebulan adalah RM5,411. Tidak termasuk elaun tugas atas panggilan. Bagi *houseman which is* yang masuk pada gred 41 ataupun U9, gaji mereka pada permulaan adalah RM4,547. Gaji permulaan. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, Saratok.

Datuk Ali anak Biju [Ahli PAC]: Terima kasih Timbalan Pengerusi. Terima kasih di atas penerangan yang panjang lebar yang telah diberikan oleh daripada orang yang betul-betul saya rasa fahamkan keadaan *medical* kita, MMC ini. Saya dari Sarawak. Saya tertarik dengan masalah kekurangan doktor yang nak berkhidmat

di Sarawak ini. Salah satu masalah ialah saya tengok sebab kemudahan klinik ataupun hospital di Sarawak itu memang dia tidak mencukupi.

■1840

Jadi, secara tidak langsungnya, doktor yang dari luar Sarawak memang tidak mahu bekerja sana. Kuarters tak ada, kuarters yang ada itu pun dah usang. Macam di tempat saya sendiri, dua tahun nak cari doktor siapa yang nak tinggal dekat — yang nak bekerja di situ, tapi tak ada sebab tak ada kuarters. Nak sewa kuarters, rumah orang kampung manalah boleh, ini doktor.

Jadi, kebajikan mereka saya rasa memang perlu kita tanganilah dengan gaji yang tak seberapa tadi itu. Memang saya rasa gaji mereka, doktor ini memang tak cukup sebab inflasi yang ada sekarang dengan kerja yang sangat *stress*. Memang kerja 24 jam sebenarnya kalau doktor ini. Saya dulu, *daddy* saya, *uncle* saya menasihati saya jangan ambil kerja sebagai doktor sebab dia cakap *stress, you* tak ada masa depan, *you* tak ada masa dengan keluarga. Syukur jugalah saya tak ambil. *[Ketawa]*

Jadi, salah satu daripada isu tersebut adalah doktor kita mungkin dan sekarang ini trend dia mereka akan pergi ke luar negara, *Singapore*, dengan *nurse*, kalau kita tak tambahkan kebajikan dan gaji mereka. Kalau kita nak tambahkan lagi, dia akan menaikkan harga insurans kita. Jadi, ini macam *chicken and egg problem* ini. Tapi *personally speaking*, saya rasa gaji doktor kita memang tak cukup. Saya tak rasalah kalau naik sikit itu dia akan menaikkan insurans tersebut. Tapi, apakah pandangan MMC? Adakah trend doktor dan *nurses* kita yang lari ke luar negara ini untuk '*greener pastures'* ini akan bertambah? Sebab kalau bertambah, kita memang menghadapi masalah. Ramai kawan-kawan saya di hospital kerajaan, memang mereka cita-cita utama merekalah bila saya nak kalau — *chance* untuk kerja di luar negara. Itulah, adakah trend ini akan bertambah? Apakah kesan dia kalau dia bertambah?

Satu lagi ialah di Sarawak ini, adakah, apakah cadangan daripada MMC untuk mengatasi masalah kekurangan doktor yang nak berkhidmat di Sarawak? Tambahkan anak Sarawak sendiri jadi doktor, salah satu daripada cadangan sayalah. Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Saya kena jawab bukan atas *hat KP*, atas *hat MMC*, MMC tak ada kuasa benda ini. Saya akan jawab atas KP lah *na*. Pertama, berkaitan dengan prasarana, betul memang saya setuju, memang kami setuju. Itu sebab sekarang ini dalam pelan pembangunan untuk fasiliti-fasiliti kesihatan terutamanya di Sabah dan Sarawak, ia juga melibatkan pelan

pembangunan kuarters. Memang itulah dia untuk makluman YB lah. Satu. Memang itu salah satu, baru sahaja mesyuarat pembangunan baru-baru ini pun perkara yang sebegini diutarakan. Sebab salah satu perkara sebagai contoh Hospital Kota Marudu...

Datuk Ali anak Biju [Ahli PAC]: Kota Marudu.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: ...Kota Marudu, Kota Marudu. Saya ke sana beberapa tahun lepas, kuartersnya memang uzur sekali. Jadi, ***that's why*** dalam Pelan Pembangunan Kota Marudu, hospital-hospital sedemikian memang kita meletakkan kuarters dan sebagainya. Tapi bukan kuarters sahaja ya YB, kita juga melihat daripada aspek bilik-bilik *on call*, bilik rehat semasa tugas atau panggilan dan sebagainya.

Yang kedua adalah berkaitan dengan saya rasa YB pun maklum, kerajaan insentif — Kerajaan Negeri Sarawak telah pun memberi insentif tambahan kepada pegawai-pegawai perubatan yang ingin bertugas di sana. Bukan sekadar daripada Elaun Wilayah, tetapi juga ada elaun-elaun lain yang diberikan oleh Kerajaan Negeri Sarawak. Pihak kerajaan, pihak KKM amat berterima kasihlah atas perkara tersebut dan kita mengharapkan negeri-negeri lain mungkin atau mengusahakan perkara yang sama. Kita dimaklumkan juga, negeri Sarawak juga selepas 10 tahun dan sebagainya juga diberikan — minta maaf bercakaplah, 'kewarganegaraan negeri Sarawak' dan sebagainya. Saya rasa insentif sebegitu.

Datuk Ali anak Biju [Ahli PAC]: *Welcome to Sarawak.*

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ya. *[Ketawa]* Trendnya dari segi, dari segi *attrition* ataupun yang ke luar negara ataupun berpindah ke *private* dan sebagainya. Kalau kita lihat trend untuk jururawat untuk tiga tahun lepas, kita amat merunsingkan, amat merunsingkan. Itu sebab di pihak kementerian, kita cuba, bukan cubalah. Kita, sebagai contoh yang 42 jam yang baru-baru ini, itulah antara perkara-perkara yang kita perlu lihat, kita perlu kaji selain daripada insentif-insentif lain yang kita boleh berikan kepada petugas-petugas kesihatan kita. Jadi, sebab kalau kita tidak ataupun memastikan ia *plateau* dan kesan kepada negara adalah lebih besar. Di situlah. *You* nak tambah lagi? *[Merujuk kepada seorang pegawai]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya Bayan Baru mahu berucap, bahas? Tanya cepat. *[Ketawa] [Dicelah]* Ya, ya. Dia mahu pergi bahas.

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry. Sorry,* saya *cut queue* sekejap*.* Ada tambahan?

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ada tambahan. Untuk pendaftaran untuk Sarawak pun dia punya *special rate*, dia tak sama dengan Semenanjung. Itu dari MMC lah.

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: Ya YB, *just to inform* berkenaan Sarawak, pendaftaran pun kita buat laluan khas untuk Sarawak ya, di mana *especially* pengamal-pengamal perubatan (MO). *MO especially foreigners*, kalau dekat Semenanjung ini tak boleh kerja dekat klinik-klinik swasta, klinik-klinik kerajaan, tak boleh kerja. *But for* Sarawak, MMC telah memberi kelonggaran ya, *especially* — dekat Sarawak kita boleh benarkan untuk bekerja *especially* — *especially in remote areas* lah, *private clinics* dan sebagainya yang memerlukan dan juga di *government to allow* mereka berkhidmat di Sarawak termasuklah pakar-pakar. Ada laluan yang lebih fleksibellah untuk membenarkan. MMC tengah dalam proses adakan satu laluan yang lebih fleksibel untuk membawa balik lebih ramai pakar-pakar untuk berkhidmat di Sarawaklah *especially the remote areas. So,* ini telah — perbincangan telah diadakan juga dengan Prof. Sim ya...

Datuk Dr. Mahathar bin Abd Wahab [MMC]: *Deputy Premier.*

Dr. Mohamed Anas bin Mohamed Hussain [MMC]: *Deputy Premier* untuk menjalankan *exercise* inilah *to ensure that.* Macam sedia maklum tadi, *the job* dari segi pengisian kekosongan itu adalah banyak di Sarawak. *So, we are trying to open up to allow more flexibility in terms of registration* lah di Sarawak.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Terima kasih. Ya, tanya.

Tuan Sim Tze Tzin [Ahli PAC]: Okey Pengerusi, terima kasih kerana bagi laluan. Saya nak bahas, jadi saya kena minta laluan dulu. KP, saya harap *you* terus pakai *you* punya topi KP. Sebab bukan senang nak dapat Ketua Pengarah Kesihatan ke PAC. Jadi, kita nak tanya sedikit soalan.

I think when you become a KP, you automatically look at the bigger picture dan kita — *I think what we are facing after COVID is medical security*. Saya nampak bahawa GP adalah benteng utama untuk *medical security* negaralah sebab *I think the GP* seperti *rightly pointed out by I think* Dato' Ku adalah tentang *GP's fees* yang terlalu rendah dan hanya RM10. Saya harap selepas prosiding, kami pun faham tentang keperluan untuk meningkatkan fi untuk GP. Kalau tidak, dia akan menjadi masalah kepada negara.

Saya rasa pembangkang di sini tak akan bantahlah di sini, ahli pembangkang. *No*, tak ada. Setuju ah? *[Dicelah] Okay, very good. So,* kita haraplah boleh dipertimbangkan. Tapi pembangkang di dalam Dewan saya tak pasti. *[Ketawa]* Kita

kena pastikan Sik dan Kubang Pasu mainkan peranan. Okey, *no, just jokes aside, but I think* kita perlu lihat tentang isu ini.

Kedua dari segi *medical security*. Kita, negara kita terlalu bergantung kepada pengimportan ubat-ubatan dan juga mesin-mesin, *medical devices* daripada luar negara. Sebenarnya dari segi perubatan, kita ada dan perlu dipertingkatkan. *Medical devices* pun ada, *industry medical devices*, contohnya di *Penang* kita ada. Tapi, mereka menghadapi masalah untuk *penetrate* dan jual kepada hospital kerajaan.

Jadi, saya telah berusaha dengan KKM, sebelum itu dengan Timbalan KSU, Dr. — Dato' Sri... *[Dicelah]* Norazman, ya. Tetapi, masih tidak berjaya. Dia ada isu-isu tertentu dari segi perolehan, dari segi dia kena melalui orang tengah atau sebagainya. Jadi, saya rasa adalah perlu *look into this, so that we have* — mereka ini berjaya untuk jual kepada luar negara, *the devices, but it's not being sold to KKM*. Selalunya mereka hanya katakan *they actually* — mereka sudah ada *business* di luar negara dan mereka hanya kata — tapi, dia punya *customer* dia akan tanya, *"Do you sell to your own country?".*

■1850

Dia tak boleh jawab sebab kalau Malaysia pun tak beli maka dia punya *customer* di luar negara dia akan nampak waswaslah dari segi itu. Jadi, saya rasa perlu ada perubahan dari segi *procurement*, dari segi *cut away all this* orang tengah *because there are some* orang tengah yang *block* tentang isu ini sebab mereka nak jual *brand name, branded* dan akhirnya dia merugikan *medical security* negara. Terima kasih.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Terima kasih Yang Berhormat. Saya meminta Dr. Hirman untuk respons. Dia *in charged of* perolehan sebelum ini.

Dr. Mohamed Hirman bin Abdullah [MMC]: Terima kasih Datuk KP. *For information of PAC Council, actually* untuk sebarang *procurement* di Kementerian Kesihatan Malaysia apabila melibatkan membeli barangan import, kita ada jawatankuasa ditubuhkan di peringkat kementerianlah iaitu jawatankuasa barang import yang masih lagi berkuat kuasa di mana semua perolehan membeli barang import perlu mendapatkan kebenaran daripada KKM dan juga MOF.

So, jika ada produk yang dalam senarai kita yang dibuat ataupun di-*manufacture* dalam negara, maka kelulusan tak akan diberi. Mereka mesti beli produk buatan Malaysialah. *So, for example* macam kalaulah kita membeli produk macam *for example nitrile gloves, all these* ada *local manufacturer* yang banyak, *so* memang kita — memang hospital kalau dia mohon untuk beli barang import memang sebenarnya tak dibenarkanlah. Mereka perlu beli barang buatan tempatanlah.

And most of our central purchasing in our APPL Programme, kebanyakannya *actually* kita beli banyak daripada barangan buatan tempatan *but — especially for consumables. So,* benda-benda macam *for example like gloves, gauze, these are the things* yang kita memang beli daripada pembuat tempatanlah yang mana yang telah mendapat kelulusan *Medical Device Authority.* Seperti mana yang kita tahu MMC *is in charged of regulatory of the professional body, Medical Device Authority (MDA)* dia *in charged of regulatory or* pendaftaran alat perubatan. *So,* bila mendapat MDA *approval* bermaksud KKM — PTJ di KKM ataupun di peringkat pusat kita boleh melakukan perolehanlah.

Tetapi, *there are still some equipments* yang masih lagi kita tak *manufacture locally*-lah. Saya ingat tahun lepas saya berada di sini untuk menjawab tentang isu ventilator Pharmaniaga. *One example*-lah Pharmaniaga punya ventilator memang kita tak ada — *for* ventilator *itself* kita tak ada *local manufacturer*-lah. *So,* yang itu memang kita terpaksa beli daripada barangan import. *Even simple things like* macam *patient monitor, BP set, we are still waiting for if there is any local manufacturer*-lah yang *manufacture. So, we hope that in the future there are more local manufacturer* yang akan bagi harga yang lebih kompetitiflah *and also better service*-lah.

Tetapi, dari segi aspek *consumable* saya rasa KKM banyaklah dapat daripada — banyak buat perolehan daripada barangan buatan tempatan. *So far, that is the* kawalanlah yang dibuatlah di peringkat KKM. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Sik.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ya, ya. Saya — soalan saya yang *last* ini ya. Ini di luar tajuk dan kita cuma ada kaitan dengan KKMlah ya. Saya sangat hargai kehadiran Datuk KP.

Saya menerima memorandum daripada pegawai kontrak pegawai psikologi atau kaunseling KKM. Mereka telah diberitahu maknanya *contract for service* (CFS) itu akan tamat pada Ogos 2025 yang melibatkan 200 pegawai yang dilantik secara CFS ini lebih kurang lima tahun yang lalu. Jadi, mereka masih — maknanya menunggu bagaimana status perjawatan mereka ini selepas Ogos nanti apabila dimaklumkan Kementerian Kewangan sedang menghentikan bajet kepada KKM itu sendiri ya.

Jadi, mereka ingin tahu apa statusnya selepas mereka — saya katakan berhempas-pulas membantu KKMlah, membantu rakyatlah khususnya ketika pandemik hari itu menguruskan masalah pesakit-pesakit yang ada masalah mentallah di klinik-klinik, di — maksud saya di Sik lah ya. Setahun lebih 1,000 kes menurut kepada pegawai psikologi ini, mereka hanya diberi dalam tempoh kontrak

itu gaji tetap — secara pukal RM2,250 sebulan, tidak ada caruman KWSP dan PERKESO dan pekerja yang sangat bebanlah.

Jadi — cuma, dari segi status mereka ini adakah selepas — setelah habis Ogos ini adakah perjawatan itu sudah tidak ada ataupun ada pelan tambahan oleh KKM sendiri untuk juga keperluan pegawai ini perlu ada di klinik kesihatan ataupun di pejabat kesihatan daerah di seluruh negara yang melibatkan 200 orang ini? Terima kasih Datuk ya.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Yang Berhormat, saya mohon maaf. Kami mohon maaf, kami tak boleh respons perkara tersebut sebab ia — bukan bermaksud apa, saya tak ada data berkaitan perkara tersebut. Tetapi, apa-apa pun kalau mereka itu adalah pegawai psikologi klinikal — tadi pegawai psikologi klinikal ke yang dimaksudkan tadi ke? Dia psikologi dia ada banyak...

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Psikologi (Kaunseling).

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Kaunseling dia ada kaunseling klinikal, satu kaunseling *general*.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Kaunseling *general*.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Ha, *general*. Saya mohon maaf sebab yang ini adalah di — kalau kaunseling *general* ini dia panggil — gunasama kan, dia bukan sahaja di KKM *[Suara tidak jelas kerana pembesar suara terhalang oleh tangan]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Mereka ditempatkan di ..

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Di hospital-hospital.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Tak, tak. Di pejabat kesihatan daerah.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Kesihatan daerah.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Sebab — dan mereka dirujuk oleh hospital daerah dan juga klinik-klinik desa kepada pegawai inilah.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Okey.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Oleh doktor-doktor yang bertugas ini.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Saya mohon maaf saya tak boleh respons. Saya tak ada maklumat berkaitan perkara tersebut. Tetapi, kita boleh buat semakan dengan satu bahagian dipanggil Bahagian Kesihatan Bersekutu KKM

tentang perkara tersebut. Kalau perlu kita boleh bagi respons kemudian berkaitan perkara tersebut.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] [Tidak jelas]* nanti memorandum dia orang itu untuk rujukan.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Boleh, boleh. Boleh tak ada masalah.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ada lagi? Tak ada ya.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Last, last, last.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Last* Shah Alam.

Tuan Haji Azli bin Yusof [Ahli PAC]: Tunggu lama. *Last* tetapi pendek saja Datuk sebab ramai tadi pun hampir sama juga soalan yang daripada rakan-rakan. Cuma, saya — pertama sekali saya nak berikan satu penghargaanlah kepada petugas kesihatan dan juga kementerian dan juga MMClah.

Dulu, orang selalu kata Hospital Tengku Ampuan Rahimah itu servis teruklah, macam-macam semua, kan? Dan Hospital Shah Alam itu *is a benchmark*-lah, *a few years* dulu. Maknanya, semua orang puas hati, seronok pergi dan sebagainya. Sekarang ini Hospital Shah Alam pun dah jadi macam Tengku Ampuan Rahimah juga.

I can understand because yalah, *patient* makin ramai dan kawasan dah tak ada dan sebagainya. *So,* macam *emergency* pun dah terpaksa duduk tiga hari baru dapat masuk wad dan sebagainya. Kemudian, wad kelas satu pun dah tak ada, semua dah *convert* jadi wad biasa.

So, I can understand. And then, manpower, the frustration, jadi bila dah ramai, *frustation* di kalangan *nurses*, doktor pun saya boleh fahamlah semua itu. Dan saya percaya kalau mereka ini ada pilihan nak pergi ke Singapore ke pergi Saudi, dia orang pergi dia orang akan pergi tetapi mungkin tak ada *because that also require a certain qualification*-lah, kan? Nak pergi ke luar negara itu.

Jadi — dan *gladly* Datuk dah sebut tentang masalah ini telah pun dikenal pasti dan sebagainya dan ada mungkin inisiatif-inisiatif yang akan dilakukan terutamanya berkenaan dengan menjadikan petugas kesihatan sekarang ini dihargai. Mereka sekarang ini merasakan mereka tak dihargai. Sebab itu dia rasa macam *not only because of the monetary reward* nak pergi keluar tetapi *because of that* tetapi *gladfully* Dr. kata sudah dikenal pasti dan akan ada inisiatif-inisiatif yang tertentu.

And then you mentioned about kalau ada permohonan-permohonan tadi, *so* kalaulah mungkin boleh dikongsikan kepada kita apakah antaranya yang mungkin — permohonan yang mungkin boleh dipertimbangkan oleh kalau kita sebagai *policymaker* dan seumpamanya. *One or two* kita boleh binalah sikit naratif itu di kalangan *all these politicians*-lah. Kalau boleh dikongsikan. Terima kasih Datuk.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Terima kasih Yang Berhormat atas soalan yang baik tersebut. Saya ini sebagai seorang *clinician. Clinician* ini maksud dia doktor yang merawat pesakit. Saya dilatih untuk berterus-terang. Kalau putih, putih. Kalau hitam, hitam. Dia tak ada kelabu asaplah. Itu satulah.

■1900

Jadi, jika kita — jadi, apa pun yang saya akan beritahu kepada pesakit adalah sesuatu perkara yang saya pasti atau tidak pasti. Contoh dia, kalau saya bagi rawatan kepada pesakit, saya beritahu, "*Okey, kita akan cuba ubat ini. Keadaan pesakit-pesakit ini, kita cuba ubat ini. Selepas 48 jam, kalau makin teruk, kita tukar ubat dan kemungkinan untuk ubat ini berjaya mungkin 60-70 peratus*". Saya akan cakap macam itu kepada pesakit saya. Jadi, apa maksud di situ, satu perkara yang bila saya pasti ataupun kami pasti, kami akan beritahu. Jadi, kalau perkara-perkara yang kami belum pasti, saya kalau — saya rasa saya terpaksa tidak beritahu sebab nanti ia nya akan di — merupakan satu jaminan yang kita tak boleh jamin.

Tetapi, YB semua, memang sebenarnya kita semenjak daripada hari pertama saya jadi KP, saya dah maklumkan kepada Tan Sri KSN, KPPA, *even* YB Menteri sendiri. Saya kata, "*Untuk kita bergerak ke hadapan, untuk reform kita punya health system in this country, cabaran utama kita adalah sumber manusia*". Saya kata, "*Kalau kita tak tangani isu sumber manusia, tak usah sebutlah fasal reform*". Itu sebab daripada hari pertama lagi kita telah melihat daripada apakah perkara yang kita boleh perbaiki. Bukan sahaja dari segi insentif kewangan, tetapi apa yang lebih penting adalah kebajikan mereka.

Saya rasa *actually there's a lot of work actually behind the scene on this aspect*, perkara-perkara yang berkaitan dengan perkara-perkara ini. Jadi, saya mohon maaflah kita — saya tak boleh sebut perkara-perkara tersebut. Kalau sebut nanti jadi satu, yang ini dia kata, "*Tengok, dulu dah cakap tetapi tak boleh buat*". Tetapi, saya rasa YB pun maklum untuk kita melaksanakan perkara-perkara sedemikian bukan mudah. Apa yang kita perlu adalah data-data, fakta-fakta yang jelas untuk kita menjustifikasikan perkara-perkara tersebut. Saya berhenti dekat situlah dululah YB. Saya mohon maaf ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Boleh. Ya. Terima kasih. Bagi pihak PAC, saya ingin berterima kasih kepada Yang Berbahagia Datuk Dr. Mahathir bin Abdul Wahab.

Datuk Dr. Mahathar bin Abd Wahab [MMC]: Mahathar. Mahathir tak ada kena mengena...*[Ketawa]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, minta maaf. Mahathar, Ketua Pengarah Kesihatan merangkap Pengerusi Majlis Perubatan Malaysia dan juga Yang Berusaha Dr. Mohamed Anas dan juga Dr. Hirman kerana sudi datang memberi penerangan kepada PAC. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 7.03 malam]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Khamis, 14 Ogos 2025

Bil 5(o) / 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan dan Caj Hospital Swasta serta Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

Kementerian Kesihatan Malaysia (KKM)

(i) YBhg. Dato' Sri Zahrul Hakim bin Abdullah
Timbalan Ketua Setiausaha (Kewangan)

(ii) YBrs. Dr. Yap Wei Aun
Ketua Pegawai Eksekutif, Pejabat Transformasi Kesihatan

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 14 OGOS 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Puan Vivian Wong Shir Yee [Sandakan]

Tidak Hadir *(Dengan Maaf)*

YB. Tuan Syahredzan bin Johan [Bangi]

URUS SETIA

Mohd Sukri bin Busro [Ketua Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara)]
Puan Farah binti Mohamed Rafiee [Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Puan Ilyani binti Md Razak [Ketua Penolong Pengarah (Perkhidmatan)]

Kementerian Kewangan Malaysia (MOF)
Puan Noni Salmina binti Abu [Ketua Penolong Seksyen KKID (Bahagian Pelaburan Strategik)]

Kementerian Ekonomi (KE)
Puan Noor Diana binti Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]

Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) (Bahagian Perkhidmatan Sosial)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Encik Chang Ching [Ketua Sektor Intra Agensi (Bahagian Siasatan)]
Puan Sharimah binti Mat Zin [Penguasa Kanan]
Encik Rosli bin Abdul Ghani [Penguasa]

Jabatan Akauntan Negara (JAN)
Encik Mohd Taufik bin Haji Ahmad [Ketua Penolong Pengarah Kanan, Unit Perakaunan Aset dan Inventori Persekutuan (UPAIP) (Bahagian Perkhidmatan Operasi dan Agensi)]

SAKSI

Kementerian Kesihatan Malaysia (KKM)
YBhg. Dato' Sri Zahrul Hakim bin Abdullah [Timbalan Ketua Setiausaha (Kewangan)]
YBrs. Dr. Yap Wei Aun [Ketua Pegawai Eksekutif, Pejabat Transformasi Kesihatan]
YBrs. Dr. Dinash Aravind a/l Radhakrishnan [Ketua Penolong Pengarah Kanan, Pejabat Transformasi Kesihatan]
YBrs. Dr. Ahmed Ibrahem bin Mohd Azaman [Ketua Penolong Pengarah Kanan, Pejabat Transformasi Kesihatan]
YBrs. Dr. Kurudeven a/l Tamil Chelvan [Pegawai Pergigian, Pejabat Transformasi Kesihatan]
YBrs. Dr. Mohd Radzi Hamzah [Pegawai Perubatan, Pejabat Transformasi Kesihatan]
YBrs. Dr. Maheshwara Rao a/l Appannan [Pengarah, Bahagian Kesihatan Digital]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

KHAMIS, 14 OGOS 2025

Mesyuarat dimulakan pada pukul 12.02 tengah hari

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
mempengerusikan Mesyuarat]

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Assalamualaikum warahmatullahi wabarakatuh* dan salam sejahtera. Selamat tengah hari Ahli Yang Berhormat, Ahli PAC Parlimen Ke-15, ahli-ahli ex-officio daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen.

Yang Berhormat, Ahli Mesyuarat sekalian, hari ini PAC Parlimen akan menyambung semula prosiding berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, KKM dan juga Bank Negara Malaysia.

Sebagaimana semua sedia maklum, isu ini tidak dilaporkan dalam Laporan Ketua Audit Negara dan sebab itu PAC menggunakan punca kuasa di bawah Peraturan Mesyuarat di bawah Arahan Perbendaharaan dan juga di bawah Pekeliling Am No.1. Yang Berhormat, Ahli Mesyuarat sekalian, hari in hadir di hadapan PAC dalam prosiding pada hari ini adalah Yang Berbahagia Dato' Sri Zahrul Hakim bin Abdullah, Timbalan Ketua Setiausaha Kewangan, Yang Berusaha Dr. Yap Wei Aun, Ketua Pegawai Eksekutif Pejabat Transformasi Kesihatan, Yang Berusaha Dr. Dinash Aravind a/l Radhakrishnan, Ketua Penolong Setiausaha Pejabat Transformasi Kesihatan, Yang Berusaha Dr. Ahemad Ibrahem bin Mohd Azaman, Ketua Penolong Setiausaha Pejabat Transformasi Kesihatan dan juga ahli-ahli delegasi daripada KKM.

Terima kasih saya ucapkan kepada semua di atas kehadiran di hadapan PAC bagi memberikan penjelasan pada hari ini. Untuk makluman semua, KKM telah dipanggil pada 24 Februari 2025 dan ini merupakan kali kedua KKM dipanggil bagi prosiding isu yang sama dan sebanyak tiga kali penjadualan semula telah pun kita lakukan bagi mendapatkan komitmen KSU untuk hadir dalam prosiding ini.

Surat panggilan mesyuarat Bilangan 5.0 Tahun 2025 telah dikeluarkan sebanyak tiga kali iaitu pada 9 Jun, 22 Julai dan — walau bagaimanapun, 13 Ogos pada semalam petang, kita telah dimaklumkan bahawa KSU tidak dapat hadir mesyuarat pada hari ini dan saya sekali lagi ingin tegaskan di sini bahawa tanggungjawab KSU adalah juga tertakluk kepada seksyen 5(3)(d) Pekeliling Am No.1 Tahun 2024 Organisasi Kementerian-kementerian dan PAC amat kecewa tentang perkara ini.

Baik, ini adalah isu rakyat. Isu yang kita tuntut untuk Pegawai Pengawal untuk berada dalam prosiding ini untuk memberikan gambaran jelas dan juga memberikan maklum balas kepada PAC. Kehadiran Pegawai Pengawal adalah dituntut, jadi apabila tiga kali dan tarikh hari ini, saya menurut tarikh kelapangan daripada Dato' KSU. Tapi bila Dato' KSU tak dapat hadir atas alasan jumpa KSN, saya minta maaf, kami pun ada juga tuntutan-tuntutan lain, Ahli Parlimen pun ada tuntutan-tuntutan lain. Tapi bila tak dapat ini, kita agak kecewa pada hari ini.

Jadi, tanpa membuang masa, saya dengan ini menjemput Yang Berbahagia Dato' Sri Zahrul Hakim bin Abdullah untuk memulakan pembentangan. Terima kasih.

Dato' Sri Zahrul Hakim bin Abdullah [Timbalan Ketua Setiausaha (Kewangan) Kementerian Kesihatan]: *Bismillahirahmanirahim*. *Assalamualaikum warahmatullahi taala wabarakatuh* dan salam sejahtera, salam Malaysia MADANI. *[Membaca sepotong doa]*

Terima kasih Yang Berhormat Datuk Wira Pengerusi Jawatankuasa Kira-kira Awam Negara dan Ahli-ahli PAC, serta rakan-rakan ex-officio perkhidmatan awam dan juga pegawai-pegawai kanan dari Kementerian Kesihatan Malaysia kerana kami diberikan peluang untuk hadir di hadapan PAC pada kali ini, kali yang kedua bertujuan untuk memberikan penjelasan lanjut berkaitan dengan isu berkait peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impaknya terhadap kesihatan awam.

Ini adalah siri kedua melibatkan KKM, selepas 24 Februari yang lalu dan kami di KKM mengambil maklum berkaitan dengan kekesalan dan kekecewaan yang dimaklumkan oleh Pengerusi Datuk Wira sebentar tadi. *Insya-Allah* saya akan sampaikan mesej ini kepada Dato' Sri KSU KKM tentang pentingnya beliau sebagai Pegawai Pengawal untuk hadir di hadapan PAC memberikan penjelasan dan saya akan maklumkan kepada Dato' KSU untuk prosiding yang akan datang tentang keperluan untuk menghadiri sesi bersama dengan PAC.

Untuk makluman Datuk Wira Pengerusi dan Ahli-ahli PAC sekalian, isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impaknya terhadap kesihatan awam melibatkan pelbagai pihak yang berkepentingan bukan

sahaja di peringkat Kementerian Kesihatan Malaysia, bahkan tentunya melibatkan juga Kementerian Kewangan dan Bank Negara Malaysia (BNM). KKM sangat komited dan memandang serius berkaitan dengan isu ini kerana ia memberikan impak yang langsung kepada kemampuan rakyat bagi mendapatkan rawatan dan keberlanjutan daripada sistem kesihatan negara sedia ada.

Jika harga perkhidmatan penjagaan kesihatan di sektor swasta terlalu tinggi, kita khuatir rakyat akan lebih bergantung kepada fasiliti kesihatan kerajaan di mana ini tentunya akan memberikan tekanan terhadap fasiliti-fasiliti sedia ada dan juga para petugas kesihatan.

Untuk makluman Datuk Wira Pengerusi serta Ahli-ahli PAC, pada 25 Jun 2025 yang lalu, satu jawatankuasa bersama peringkat Menteri telah dibentuk berkait dengan kos penjagaan kesihatan swasta yang dipengerusikan bersama oleh Menteri Kewangan II dan Menteri Kesihatan Malaysia.

Ini adalah merupakan salah satu daripada inisiatif di bawah strategi *reset* bagi menangani inflasi kos perubatan yang semakin meningkat. Jadi, untuk tengah hari ini Datuk Wira Pengerusi, KKM akan bersama-sama saya ialah Dr. Yap Wei Aun, Ketua Pegawai Eksekutif Pejabat Transformasi Kesihatan dan Dr. Dinash Aravind daripada Pejabat Transformasi Kesihatan dan kami akan membentangkan laporan berkaitan dengan status terkini berhubung dengan isu yang dibangkitkan oleh PAC.

Saya dengan izin mohon kebenaran untuk menjemput Dr. Yap Wei Aun untuk meneruskan dengan sesi pembentangan taklimat. Terima kasih Yang Berhormat.

Dr. Yap Wei Aun [Ketua Pegawai Eksekutif (Pejabat Transformasi Kesihatan) Kementerian Kesihatan]: Salam sejahtera Yang Berhormat Pengerusi Jawatankuasa Kira-kira Wang Negara (PAC) Datuk Wira Mas Ermieyati dan Yang Berhormat Ahli Jawatankuasa Kira-kira Wang Negara (PAC) yang lain.

■1210

Dalam mesyuarat prosiding PAC bersama KKM terakhir pada 24 Februari 2025, Kementerian Kesihatan telah memberi penerangan tentang beberapa perkara.

Pertama, punca inflasi perubatan swasta termasuk punca yang munasabah seperti perkembangan teknologi perubatan, penuaan, kos input seperti gaji yang meningkat dan sebagainya serta dengan punca inflasi yang sesuai untuk intervensi termasuk bahaya moral iaitu sindrom major bufet, tokokan harga yang berlebihan dan kekurangan persaingan untuk membekal opsyen mudah mampu dan penggunaan kaedah pembayaran fi untuk perkhidmatan atau *fee-for-service*.

Kedua, pengawalan harga perubatan swasta secara menyeluruh daripada pembendungan harga seunit sahaja bagi setiap item kepada satu pendekatan yang menyeluruh seperti DRG.

Ketiga, strategi seluruh negara untuk membendung inflasi perubatan di mana bukan sahaja satu strategi oleh satu kementerian atau satu agensi tetapi beberapa strategi seluruh negara yang melibatkan beberapa kementerian dan agensi meskipun sektor swasta juga diperlukan.

Inflasi adalah satu isu yang kompleks dengan punca yang munasabah dan punca yang sesuai untuk intervensi. Penyelesaian yang tergesa-gesa yang membawa kesan yang tidak diingini atau *unintended consequences* patut dielak. Transformasi kepada pendekatan pembendungan harga yang menyeluruh adalah diperlukan termasuk transformasi struktur daripada *fee-for-service* kepada DRG secara berfasa.

Matlamat pembentangan pada hari ini adalah untuk memaklumkan kemajuan pelaksanaan strategi seluruh negara ini. Izinkan saya untuk menggunakan dwi-bahasa disebabkan kegunaan istilah teknikal.

Seperti mana yang dimaklumkan, kerajaan mengambil agak serius cabaran inflasi perubatan sektor swasta dan telah mengarahkan pembentukan jawatankuasa bersama peringkat Menteri mengenai kos penjagaan kesihatan swasta ataupun JBMKKS. Struktur tadbir urus JBMKKS adalah seperti berikut.

Jawatankuasa bersama peringkat Menteri yang dipengerusikan bersama oleh Yang Berhormat Menteri Kewangan II dan Yang Berhormat Menteri Kesihatan. Keahlian jawatankuasa ini terdiri daripada Gabenor Bank Negara serta dengan pengurusan tertinggi Kementerian Kewangan dan Kementerian Kesihatan. Jawatankuasa ini disokong oleh satu jawatankuasa pemandu yang dipengerusikan bersama di peringkat Bank Negara Malaysia dan Kementerian Kesihatan dan suatu majlis perundingan yang terdiri daripada pemegang kepentingan daripada sektor swasta, universiti dan NGO turut disertakan.

Beberapa kumpulan kerja juga boleh dibentuk dan telah dibentuk untuk membantu dalam kerja JBMKKS ini. Mesyuarat pertama seperti yang dimaklumkan telah diadakan pada 24 Jun 2025. Boleh saya terus kepada bahasa Inggeris tentang terma rujukan jawatankuasa ini.

Terma rujukan jawatankuasa ini adalah *to ensure timely and effective implementation and monitoring of immediate measures to address rising private healthcare cost, to foster long-term collaboration and consensus among stakeholders and relevant ministries, government agencies and private sector representatives in the private healthcare ecosystem and to support the development of a private healthcare ecosystem that is effective, sustainable and affordable in line with value-based healthcare services.*

And it lists the three different hearts of this JBMKKS. The first is the ministerial level Joint Ministerial Committee which provide strategic direction and decisions, an oversight on the implementation of RESET. RESET is the name of the framework for implementation which I will elaborate on later. Facilitate communication and coordination among key industry stakeholders and government bodies and to update the Cabinet and public on progress.

The Steering Committee on the other hand is to oversee the implementation and monitoring of initiatives, make recommendations on the implementation of the Joint Ministerial Committee and to convene and consult the Consultative Council members as and when necessary, in the development and implementation of the initiatives.

The Consultative Council is to represent the members of respective organisations and to provide inputs into the development and implementation of the initiatives and facilitate the implementation of the initiatives amongst the members of respective organisations.

This slide lists down some of the key members of the — the permanent members of Consultative Council which include members representing private hospitals, private healthcare professionals, private insurance and takaful providers as well as other stakeholders who are quite critical representing the interest of consumers and also, we have representatives from expert such as academia.

I will skip these two slides because they just elaborating on some of the more dof the etails of their background and the diagnosis and also on the purpose of this JBMKKS which I think we have already explained. Let me go straight to some of important slides and I'll go slowly on this because I think it's quite critical.

The first thing to notice is that this is the whole-of-nation approach. This RESET framework. Dia bukan sahaja satu inisiatif daripada satu kementerian atau satu agensi atau satu pemegang kepentingan tetapi adalah satu strategi secara menyeluruh untuk menangani ini secara pendekatan seluruh negara.

The first part of the strategy is R, to revamp MHIT which is basically a transformation of the private healthcare insurance and takaful products. This is really quite an ambitious reform. You can see that there we plan to develop a base MHIT product to support value-based healthcare services. Incorporating global best practices in the design on encouraging for example wellness, prevention, primary care as well sustainable payment models which is one of the key things which I will describe more later on under DRGs. And also, there's a desire to have life course coverage (liputan kitaran hidup) *so that it is fairer for people across all stages of life.*

When they join when they are young and healthy and if they commit to this product, this product should commit to them even past post-retirement.

Also, we need a pathway, actuarially sound pathway for including people with pre-existing condition such as diabetes into this coverage. On the right-hand side on number 10, we see there it's also quite important to create a simple framework for people, for consumers to make informed choices when they select a private health insurance coverage options.

Going to strategy E, which is to enhance price transparency. The overall game of this is to provide more information for consumers to make informed choices. You'll notice that they also includes number two, pre-existing initiatives on the paparan harga p*harmaceuticals for private clinics and private hospitals which are already on-going. But it also includes things to clarify some of the confusion regarding let's say medical price inflation numbers where different sources co-different values. But we also want to come out with a standardised methodology for that.*

You will see also number four, five and 11 of the strategy E, that we do hope to review some of the legislation, particularly at Act 586 to support initiatives both for price transparency as well as to support the development of DRGs. Leading to the publication of price ranges for common healthcare services, so that people and consumers and the rakyat *can make inform choices about where is it going to be expensive or cheaper to get private healthcare. In this number 11 definitely requires some form of a standardised framework collecting this information.*

Moving on to strategy S, strengthening the digital health ecosystem. I just want to acknowledge also my colleagues from the rest of ministry from divisions who are here also to help to support and provide answers as need be to including the digital health division and I think from perubatan *side. [Dicelah] We have Dr. Mahesh from* Bahagian Kesihatan Digital *and also we have colleagues from* Bahagian Amalan Perubatan *as well.*

So the whole game aim of strategy S, is to leverage and to just come out to the stand of technology where we do not need to duplicate tests and scans even though a patient go across different hospitals in a private sector. And this is just a technological element of allowing this interruptibility to happen. So, people can share with the patients consent and agreement information recording their little scans and lab results. So that the relevant to inflation is that we do not need to duplicate unnecessary tests just because a person is going to different facilities.

Strategy E, is really intervention to work on the supply side, to expand cost-effective options and release two. So not only Rakan KKM which provides a mid-tier premium economy services much more affordable than five to six star private

hospitals. But we also want just generally expand the role of non-profit hospitals. I think some of you may be aware of them such Tung Shin, Lam Wah Ee, Assunta, et cetera.

The most critical actually from Ministry of Health's perspective is also to get DRGs going and that's under last strategy T, transform provider payment mechanisms.

■1220

This is — sorry to use such mechanical terms but a provider payment mechanism includes things like how we pay a hospital or clinic for the services they provide. And the existing paradigm is fee-for-service, we add up the bill, add up the number of drugs used, the amount times spent and that fee-for-service but we want to change towards DRGs. Other options are capitation, et cetera.

And we want to do so in a phased manner. The phase implementation of diagnosis-related groups. Not — it's not like the perfect solution with absolutely no problems at all but it is certainly better than the existing fee-for-service provider payment mechanism. Also, just want to clarify that — please don't confuse. This private sector DRG with the national DRG initiative, is also focused particularly on the public sector which is a long-standing initiative which is also ongoing at the same time.

Now, very often in the public sector, when we mention all these initiatives at the private sector, I'm sure you may also get feedback from a constituency. What about the public sector is basically this government is heading towards just private sector. So, I just want to clarify that these private sector initiatives are a response to the issues of inflation in the private sector and we do need to transform the private sector.

But, ongoing with this private sector initiatives or how put it maybe Malay, walaupun KKM sedang giat mengusahakan strategi RESET di sektor swasta bersama kementerian dan agensi lain, transformasi perkhidmatan penjagaan kesihatan sektor awam masih adalah tumpuan kita dan inisiatif untuk memperbaiki sektor swasta ke arah perkhidmatan penjagaan kesihatan berasaskan nilai, ini bukannya penswastaan sektor awam. *So, just because you see the news that we are announcing things like JBMKKS and we are intervening to correct problems in the private sector to address inflation, it does not mean that, that is all the reforms there are but there are certainly a lot of public sector reforms.*

Ongoing. Last slide — and I do apologise that this slide is a bit on the technical side but I believe that you all would be very curious to know what is going on in terms of DRGs. So, allow me to just provide a brief overview on this. On the top, you see

private sector. So, that's a keyword. So, it's not referring to the national DRG intervention which pertains to KKM hospitals, MINDEF hospitals and a public university's hospital as well.

But, it's a private sector initiative and the other important things — I'm sorry that the formatting is not clear but it says the private sector DRG implementation strategy via base Medical Health Insurance and Takaful (MHIT). So, this private sector DRG implementation is very much linked to that initial thing on top in this slide, where you see the development of this base product — base MHIT product, number one. So, number one and number nine, if you like, are linked to each other. They mutually enable each other.

It's important because a base MHIT being a standardised product with a common benefits package and a common provider network provides that standardised platform for which we can put on a DRG. If we just put DRGs in a fragmented system where there are different benefits, different hospitals, different rules, different ways of paying, it will be a leave it more complicated.

So, let me just also go to the blue box for this, what are DRGs and this is just a very simple definition. I'm sure professors may come up with a more complicated definition but I just want you to think of something simple. So, these are care episodes. So, things like a hospitalisation but not just one of, but just think of it as not just the initial hospitalisation, you may know that you need to go for some test before and some follow-up after. So, just a care episode, classified into resource comparable resource.

That means the amount of resources in terms of staff, time, drugs and otherwise. A comparable clinical group. So, you have to make some sense in terms of the clinical diagnosis and what's going on. And payments are made by a predetermined fixed amount for each of these groups and we typically adjust also for severity. So, if you do appendicitis and a perfectly well and teenager versus doing it in an 80-year-old who has diabetes and obesity, is kind of a different thing in terms of its resource comparability.

On the top right, why are we doing DRGs? The big picture is we want to head towards fairly based healthcare. Fairly based healthcare emphasises health outcomes over expenditure. Not just doing a lot of things like ordering a lot of tests or giving a lot of drugs, emphasises the outcome, people's improved health status, if you like. It's a transition away from inflationary fee-for-service payments, increasing efficiency which I think is critical for cost inflation, a reducing the length of stay, predictable and comparable pricing as well. So, it's easy to bill for it.

To get this private sector DRG going, we just need three elements, three key elements and I've enlisted there as one, two and three. The first one is a DRG grouper. A grouper is like the system which says that this sort of diagnosis and these sorts of procedures goes into group A. Another sort of diagnosis goes into a group B or C. and their 100, if not 1,000 of groups potentially depending on the grouper. And in between like appendicitis, that might be one, for example.

And overall strategy is to adopt an existing grouper. They are both open-source groupers available as well as groupers which a ministry already has developed. As I mentioned, there is a long-standing national DRG initiative. And then subsequently to validated based on real private sector data. So, you know whether it works or not and whether it needs a bit of adaptation to local practice, particularly.

But, DRG groupers, if you look on right-hand side, require continuous refinement. The reason why is because healthcare is dynamic. Technologies improved. 20 years ago, your treatment options for cancer are limited. 20 years from now, things are going to be very different as well. So, it moves with technological improvement. It also moves with the way doctors and nurses practice medicine. And it also changes based on the epidemiology of diseases. The spectrums of disease are changing. So, we do need — it does need to be a dynamic system.

Number two is how we get the price rates. So, once you assign something to a group, how much do you actually reimburse for that? So, for this one, we want to really align in terms of standard with all existing national DRG initiatives. I won't bore you but this includes things like coding standards and testing all the variables. I'm sorry if I'm going too technical here but also bailing information.

And then, to collect pricing data using a variety of strategies, both voluntary. You may be aware and I think you've talked to the private sector as well. They have given us their commitment that they are willing to share this data. The reason why they are willing to share this data is because it is in their interest to do so. They do not want to reimbursement rates to be based on synthetic or data which may not be actually correct. So, I think it's in their interest to give the right data.

But, nevertheless, we are also working on other strategies at the same time, including exploring the changes to 8-5, 8-6 to support the mandatory collection of certain price information, as well as working through insurers and takaful operators to get similar information. But, just like the groupers on top, the price also requires continuous refinement as practices change. And, so this is a dynamic process and we want it to be such as such.

You also realise that collecting this information is not only useful for determine the price rates for the DRGs. it's also useful for providing more price transparency for

the rakyat *and consumers and even institutions of purchase, such as insurers, to know which are more expensive or cheaper hospitals. You may recall that in February 1, the hot topic is why is it that people who pay based on insurance seem to have a higher bill than people who pay out of pocket in cash. So, now we want to get more information, so we can answer such questions more definitively.*

Number three is we need a payment mandate. How do we agree or how do we enforce, like if you like the payment based on DRGs? We proposed to link it to the base MHIT product. So, this will most likely be in the form of a contracting process. There is still a lot of ongoing work which is already in progress to explore the legal regulatory and another contracting issues related to that, as well as the development of appropriate systems to support the data collection, validation, all these pricing rates, staff. So, all this is ongoing.

And, now, I guess you also want to ask when we are going to implement DRGs. So, because the DRGs and MHIT asas *are linked to each other, so the timeline for DRG implementation and MHIT* asas, *if you like, basically synchronise for that. Approximately sometime next year. And, we plan to phase it in, in phases if you like. Why is this so and how do we do this? Let me just try to explain it in as simple a way as I can. As I mentioned that the DRG groupers you can have 100 if not 1,000 of groups. Some of them will be very obscure conditions and we may not have enough information to say it should be definitely — priced as X ringgit or Y ringgit.*

But there are also if you talk to people, the common conditions for going to hospitals, typically, if we've something to do is gastroenteritis and this can be very, very common. So, we want to start with the most common conditions and we want to progressively shift from the fee-for-service bill in stages towards the DRG bill. So, it's like essentially, we do not need to just go from one day overnight from paying 100 percent based on fee-for-service to which is an itemised bill to 100 percent based on DRG alone.

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It's possible to blend in the payments and progressively change that ratio over time so that this will not disrupt the market too much. But nevertheless, we'll start beginning to exert the pressure on hospitals to benefit from efficiency and process improvements and it also disincentivise already at the stage unnecessary— let say, in antibiotic prescribing or unnecessary tests or procedures being done because it already exerts that little pressure on it. So, that's how it happens in phases.

So, I just wanted to pause here because I wanted to give you all that sense of where we are. If I just…

Puan Vivian Wong Shir Yee [Ahli PAC]: *Datuk Wira Pengerusi, one question. Can I ask how long was the timeline, this timeline? The implementation timeline. Started when?*

Dr. Yap Wei Aun [KKM]: *Yes.*

Puan Vivian Wong Shir Yee [Ahli PAC]: *Right now, it still ongoing, right?*

Dr. Yap Wei Aun [KKM]: *Yes, it's ongoing.*

Puan Vivian Wong Shir Yee [Ahli PAC]: *So, it started when? Like how long and how long is your prediction on this entire?*

Dr. Yap Wei Aun [KKM]: *Is your question when we started?*

Puan Vivian Wong Shir Yee [Ahli PAC]: *Yes.*

Dr. Yap Wei Aun [KKM]: *I think even when we first met in February, we've already doing the groundwork to figure out the methodologies and talking to stakeholders, talking to people about what needs to be done. So, I think it's really— I mean, PMX announced it in December, right? That he wanted DRGs implemented. So, as executive we are obliged to really accelerate our implementation of that. So, it certainly started some time back.*

Puan Vivian Wong Shir Yee [Ahli PAC]: *This year? February this year? [Berucap tanpa menggunakan pembesar suara]*

Dr. Yap Wei Aun [KKM]: *The thinking has— DRGs as a national project, it's been ongoing for a long time. Even the idea of linking it to this is even precedes the PM's announcement. So, it just we have been thinking and trying to do the due diligence to figure out how we can get this going in the private sector for a long time already.*

But the benefit actually is because of the push on the political side. Because in many countries, they may feel like, "Why we do we want to rock the boat?" The different stakeholders. But now with the clear leadership from the political side to say that it is really important to address inflation, I think stakeholders are very much more align. So, I think you all should be appreciated, you all should give yourself a pat on the back for really pushing this issue.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat, kalau boleh saya tambah berkaitan dengan *timeline* untuk inisiatif swasta ini. Sebagaimana yang dimaklumkan, jawatankuasa bersama berkaitan dengan— jawatankuasa bersama yang ditubuhkan pada 25 Jun yang lalu, melibatkan KKM bersama Kementerian Kewangan dan Bank Negara Malaysia dan kita telah mengadakan mesyuarat yang pertama. Matlamatnya ialah untuk menangani inflasi perubatan swasta secara menyeluruh, holistik dan mengukuhkan keseimbangan antara sektor awam dan swasta.

Dari segi *timeline*, kita memang ada gerak kerja untuk mengadakan mesyuarat lebih *frequent* dengan Kementerian Kewangan dan juga Bank Negara Malaysia. Ada beberapa inisiatif yang telah pun dimulakan. Contohnya, berkaitan dengan Rakan KKM, telah pun ditubuhkan pada bulan Jun yang lalu dan berdasarkan kepada perancangan Rakan KKM Sdn. Bhd., kita akan mengeluarkan *first patient* pada Disember tahun ini.

Inisiatif-inisiatif lain juga sedang dalam pelaksanaan termasuk sebagaimana yang Dr. Yap Wei Aun sebutkan tadi, *revamp on* MHIT. Ini sedang dibangunkan bersama Bank Negara untuk pelan asas takaful mampu milik. Juga berkaitan dengan pemaparan kos rawatan secara telus melibatkan hospital-hospital swasta.

Di peringkat KKM juga kami sedang giat melaksanakan *digital health ecosystem* yang lebih mapan menggunakan sistem rekod kesihatan digital, teleperubatan dan *interpretability data* melibatkan fasiliti-fasiliti kesihatan di bawah KKM. Akan diperluaskan juga di peringkat swasta. Jadi, ini adalah merupakan antara perancangan di peringkat KKM yang kami bekerjasama rapat dengan Bank Negara Malaysia dan Kementerian Kewangan melalui jawatankuasa bersama yang telah pun dimulakan pada 25 Jun yang lalu.

Jadi, kalau Yang Berhormat mohon dari segi *timeline* ataupun *readiness* untuk kita melaksanakan, sebenarnya telah pun berlangsung dan kita memang ada perancangan. Tahun hadapan kita akan pastikan semua inisiatif yang kita bincangkan di dalam jawatankuasa ini akan dapat dilaksanakan secara keseluruhan.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Datuk TKSU, kita tengok mesyuarat kali pertama JBMKKS ini diadakan pada 24 Jun. *Announcement* berlakunya kenaikan insurans sebanyak *spiked* 70 peratus adalah pada *somewhere* tahun lepas, dalam 5 Disember, tapi sebelum itu dah ada dah. Dah ada *rumors* dan sebagainya.

Pada tahun ini awal tahun, dah ramai dah rakyat Malaysia yang terpaksa menghentikan polisi mereka. Tidakkah itu memberikan kesan kepada kesihatan negara apabila mereka tidak lagi dapat rawatan di hospital swasta, tetapi sebaliknya mereka akan terus pergi ke hospital awam?

Soalan saya, kenapa ambil masa yang lama— enam bulan di waktu kala rakyat Malaysia dah ramai *surrender the policy*? Tadi saya dengar lah doktor ada beritahu membuat persiapan dan sebagainya, tetapi apakah justifikasi mesyuarat JBMKKS ini diadakan pada bulan Jun?

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat Datuk Wira, berkaitan dengan kawal selia insurans. Sebagaimana yang kita sedia maklum, ini adalah di bawah Bank Negara Malaysia. Jadi, kita perlu libatkan semua *stakeholders*

yang terlibat dengan sistem penjagaan kesihatan dan tentunya Bank Negara Malaysia boleh *intervene* berkaitan dengan kenaikan tahunan premium yang ditetapkan oleh syarikat-syarikat insurans.

Jadi, ada perbincangan telah diadakan bersama dengan Bank Negara Malaysia dan Kementerian Kewangan. Enam bulan sejak Februari 2025 yang lalu, memang ada perbincangan telah dibuat dan hasilnya ialah jawatankuasa bersama sebagaimana yang saya maklumkan tadi diwujudkan dan telah pun mengadakan mesyuarat yang pertama pada 24 atau 25 Jun yang lalu.

Jadi, memang dia melibatkan *whole of nation* punya *approach*. Bukan hanya KKM sahaja, tetapi KKM mengambil tanggungjawab untuk memastikan semua pihak yang berkepentingan dapat duduk dan berbincang untuk mengatasi isu berkaitan dengan kenaikan kos penjagaan kesihatan swasta ini. Mungkin Dr. Yap boleh tambah.

Dr. Yap Wei Aun [KKM]: *Maybe if I just add briefly. If you look at the RESET framework in even this one, just to mention that some of these initiatives were— we began even way before JBMKKS was formed. So, for example, I can't remember the exact date for MHIT product but we have been discussing with MKII since the middle of last year already and discussing with EPF as well and even with Bank Negara in subsequent meeting some time last year.*

It just that putting it all together in a coherent framework is for public messaging is what happened more recently in June. But another example is in number two, the paparan harga*. [Merujuk kepada slaid pembentangan] These, all long standing initiatives because you are correct to say that— I think the government was well aware of the inflation issues. So, we'd already started beginning initiatives suggested.*

So, I think it's incorrect to say that we did— that the government did nothing until June 24th and then only started addressing inflation. It's not correct to say that. Many of these initiatives precedes that.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, sikit fasal paparan harga. *Price display. So, when you get all the information, inputs from the ground, what establishment where you getting it from? Is it only the* hospital swasta *or what? Because now you are de-stabling the whole GP system.*

Dr. Yap Wei Aun [KKM]: *So, I think there's two initiatives which are slightly different. The first one is initiatives number two which is* paparan harga. *So, this is the one where we are telling the GP's and private hospitals to* papar harga. *That's one.*

But what we are talking about in terms of data collection is more on the private hospitals side to get systematic information and billing information so that it can support the generation of the DRG pricelist as well as ultimately some kind of price transparency dashboard so that people can compare different hospitals et cetera in the systematic manner.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry, the hospitals is a different entity? You pay lots to the hospital if you go to the hospital. But if you go to a GP, that one is* ciput *only and that's the primary care. Hospital is secondary care. So, that's what we— that's what the GPs and now the primary care system is getting angry with KKM because they are not the one who's causing this health inflation.*

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And even your health insurance, how do you cater? *or how, why is it that you disturbing the primary healthcare system where the real issue is about health insurance is, the hospital bills right*? *And we are talking about the — what do you call it*? TPA ke PTA? TPA eh? TPA, *the third party* kan?

So, that is the big issue now. Right now circulating.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat Kapar, untuk maklum, isu berkaitan dengan pemaparan harga ubat ini, harga ubat yang Yang Berhormat maksudkan untuk GPs, sebenarnya telah pun diluluskan di bawah Akta 723.

Akta 723 ini kawal selia dia adalah di bawah KPDN. Kita ambil maklum tujuan untuk pemaparan harga ubat ini adalah untuk ketelusan harga dan bagi memperkasakan pengguna supaya mereka boleh membuat perbandingan harga yang lebih telus dan pengguna boleh membuat pilihan dan elakan daripada caj-caj yang tersembunyi ataupun yang tidak munasabah.

Kita memang mengadakan libat urus dengan GPs serta KPDN berkaitan dengan Akta 723 ini yang telah dikuatkuasakan pada 1 Mei 2025. Dalam masa yang sama juga, KKM sedang mengkaji untuk meminda Jadual 7 di bawah Akta 586, yang ini juga adalah dalam proses dan akan dibawa kepada Jemaah Menteri.

Jadi, memang ada tindakanlah di peringkat KKM Yang Berhormat.

Dr. Hajah Halimah Ali [Ahli PAC]: Minta maaf Datuk Pengerusi, saya nak mewakili suara GP yang dekat luar sana.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Ya. Saya faham. Daripada Perlis sampai ke Sabah. *[Dicelah]*

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Apa-apa pun, Kapar sahaja doktor dalam ini. *So*, kita tak boleh bagi halangan.

Dr. Hajah Halimah Ali [Ahli PAC]: Sebab mereka akan apa, dekat kamilah. *What is a percentage of the cost you are talking about*? Okey, *you are talking about GPs, manipulating the price* sampai dia gila-gila punya harga*. How much is that out of the* semua yang di-*complain* pasal *health inflation* ini?

Makna, masalah pasal kos yang mendadak naik. *So*, yang di GP punya apa? Dia macam ini, orang pergi ke GP, orang nak pergi ke farmasi atau kedai ubat, kedai *sensei*, kan. Kenapa orang pergi ke GP? Kenapa orang pergi jumpa doktor?

Kalau *you all* tengok you punya akta, *I can't remember* dia punya akta, dah 35 tahun yang tak *revise* lagi kan, RM15. Kita orang doktor ini belajar dia bukan macam doktor jaga kayu, ke besi ke apa tahu. Kalau *you* tak cukup tidur, tak cukup apa, *you* ketuk macam mana pun, orang tak mati. Tapi macam doktor ini, gila-gila belajar, termasuklah jururawat dan sebagainya, kalau dia tak cukup tidur, tak cukup apa — *how do you* ini?

So, now the doctors are very-very upset because kerajaan seolah-olah melihatkan doktor ini macam apa ini — kedai jual bendalah. *Because Panadol* pun orang jual kan dekat kedai biasa. *So, you don't have to see a doctor to get a Panadol* ke, ubat apa ke, tampal-tampal segala plaster ke apa.

So, why do you see a doctor? *So*, kalau you suruh KPDN — KPDNK eh? Untuk apa ini nak papar, *then* dia yang akan menentukan yang ini tak boleh, ini tak boleh, *you are equating a GP premise* seperti kedai motor, kedai ali, kedai apa benda.

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]* Restoran, restoran.

Dr. Hajah Halimah Ali [Ahli PAC]: *So*, ini, kalau *consultation fees for the doctors* RM15. Kalau orang jumpa kosmetik nak buat *facial-facial* rasa lagi mahal kut kan? *You, see*? *And then is not* apa *— risking the lives*? *So why are you bullying the GPs*? *That is what the GP asking me and ask the government.*

Because it's not the same. Because — nak letak apa itu? *Yes*, kita faham. *You* tak nak orang apa, ini kan harga, yang ini *Panadol* dia jual RM500 agaknya *ler*. Yang ini, RM5 ke apa kan. *You don't want that to happen. But, you have to see the context. Where are you putting the doctors*?

Dah lah dia lari daripada KKM kerana *of your system, your contract, your* apa benda itu. Bukan sebab dia nak keluar daripada kerajaan. Tapi, mana pergi lagi? Dia pergilah yang jadi GP ini. Lepas itu, ramai yang dah tutup. *You all understand* tak? Yang sewa nak naik, itu nak naik, api nak naik, air nak naik, kapas pun nak naik harga.

So, I think you have to have a look at the real context and the real apa itu*. So don't — not the hospital, don't equate GPs as the* hospital swasta. Itu *totally different*

thing. And your health insurance doesn't cover GP, ye ke? Ada ke? Bayan Baru, *you* bayar dia boleh pergi GP ke? Tak kan? *Even* dia apa — hospital dia pun, *you have to be admitted* kan? Nak pakai insurans itu. *It's not just a daily* jumpa dua tiga jam begitu *je*?

Sorry apa — *so that* itu baru dengar sikit *je*. Dengar yang lebih dekat luar sana, lagi teruk *you all*.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Tak apa Yang Berhormat Kapar. Kami faham sentimen di luar berkaitan dengan isu bantahan daripada GPs berkaitan dengan penggunaan Akta 723.

Cuma, dari segi kuat kuasa penggunaan akta itu adalah di bawah KPDN, KKM di peringkat Kementerian Kesihatan, kita memberikan *support* teknikal dan menjalankan pemeriksaan lapangan juga. Mungkin Dr. Yap boleh maklumkan berkaitan dengan status terkini berkaitan dengan paparan harga ubat.

Dr. Yap Wei Aun [KKM]*: I think, just generally speaking, I think we really definitely appreciate the role of primary healthcare. So, I think just to reaffirm that. And, if you look at it objectively, it's written in item number 1(b) on top, enhance primary care service is part of patient pathway and gatekeeping.*

So, I think you immediately ask, do we plan to consider the role of GPs in this MHTI asas*. So, I think in the presentation you can see that certainly not just the role of GPs but even prevention is being considered.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Please proof it by actions, not just the wordings. Thank you*, Dr. Yap.

Dr. Yap Wei Aun [KKM]: Okey.

Tuan Sim Tze Tzin [Bayan Baru]: Datuk Wira Pengerusi, terima kasih. Terlebih dahulu, saya ingin mengucapkan tahniah dan terima kasihlah kepada KKM dan juga Bank Negara *for coming out with this whole of nation approach.*

To be honest, apabila kita memulakan isu ini dan menerima bantahan daripada rakyat, saya sendiri tak pernah — tidak, *we didn't expect that kind of comprehensive approach*-lah *from the government. I think you have done a lot of work. And I want to congratulate that. Because* apabila PAC buat prosiding pun, apabila kita jumpa satu *group*, mereka kata, *"Oh minggu depan kita akan jumpa KKM."* Ada group yang lain, dia kata, *"Oh, the next week, or earlier week already met KKM and Bank Negara."*

Means that, you guys are working-lah. Okey. *I want to say, I want to give a pat on your back as well. Alright*, saya ingin memulakan dengan isu pertama iaitu inflasi. *I think, the crucks of a problem* adalah inflasi. Di mana, tidak ada orang yang boleh memberi data yang betul-betul *what is amount of inflation*. Sebab, data KKM

pun ada. *It's very low*. Data DOSM pun ada, *quite low*, tapi *data from one survey which everyone use it as their justification* untuk naikkan insurans. Itu adalah dalam satu *survey I forgot what — it's a survey*.

Tapi akhirnya *insurance company take advantage* untuk menggunakan data tersebut dan menaikkan insurans sebanyak 70 peratus sehingga *as high as 216 percent. So*, inilah isunya. Saya rasa *number one*, saya rasa KKM dan juga Bank Negara kena ada satu *consent* — satu sistem untuk *collect* data yang boleh menunjukkan *real* data dan kita *stop all this kind of nonsense by the insurance company*. Okey, itu saya rasa nombor satu.

Tapi, kerana Kapar pun sudah masuk isu GP, saya pun nak masuk isu GP juga. *I think, we all know GPs is very important and this is a fund* — dia punya benteng pertama dan *we cannot let it fail* dan *to be honest* saya setuju dengan Kapar, bahawa *pricing* sekarang memang tidak adil kepada GP. Itu sebab berlakunya *cross subsidy*, menggunakan ubat-ubatan untuk *cross subsidy* operasi dia.

They have to pay their nurse. They have to pay their workers dan *pay the rent as well as their own money. They cannot survive* dengan RM15 itu.

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So, I want to say that actually KKM failed to convince NACCOL untuk tukar pendapat, untuk menaikkan harga GP. Tapi itu pun saya pun nak *blame the political side because the opposition were use this to play up the issue.* Kalau bolehlah Kapar dengan rakan-rakan semua komited *to say* setuju naikkan harga GP. *I think this thing would not happen.*

Maksudnya, *we will have price transparency.* Tapi *as a compromise*, saya rasa KPDN *maybe it is not the time to enforce that kind of cross subsidy* kerana sememangnya itu adalah *cross subsidy* yang perlu dilakukan. *I think I start with these two. May be need some comment* daripada KKM.

Dr. Yap Wei Aun [KKM]: Terima kasih YB Bayan Baru. Bagi perkara yang pertama mengenai cara untuk mengukur kadar inflasi perubatan, ini memang adalah antara satu inisiatif nombor tiga dalam strategi ini. *To establish a mechanism to consistently produce, monitor and publish key medical inflation measures.*

Kumpulan kerja ini sebenarnya melibatkan DOSM dan Bank Negara *as the key agencies.* Kementerian Kesihatan *we can attend but we are not the key person for the generation of inflation measurement*-lah. *So*, kumpulan kerja ini memang sedang bekerja dan yang saya faham daripada Bank Negara – *I don't know Bank Negara wants to say anything* — yang *technical support* pun didapati daripada Bank Dunia dan sebagainya dan perunding yang lain.

So, this one is certainly in progress. Maybe if I give some — I hope you are not bored with technical answers but healthcare is quite complicated for the measurement of inflations because if you have let's say an egg. 100 years ago, an egg is and egg. 100 years later it's still going to be an egg.

So, you can compare one item and the price change. With healthcare for the services, the basket is different. The way we treated appendicitis 100 years ago and now is different. It is not just that the equipment that you use 100 years ago, you just cost it up and add this ancient, anesthetic drug and ancient equipment and just see what the price of it is now and the cost of the doctor.

The way we treat appendicitis has changed completely. So, even the kind of inputs used are different. So, that makes it more complex. And then the change in the pattern of diseases also change. Maybe in the past more people had TB but may be now more people have heart attacks. So, when you are looking at the overall healcare cost which is what insurance maybe more concerned about.

Even the kind of diseases have changed. Nowadays people want to preemptively check for cancer at the early stage. So, that means additional diagnostic procedure colonoscopy, et cetera. So, even the volume has changed. So, that's why is not so easy to just say we just — that's why it's a little bit more technically challenging and requires a little bit more kumpulan kerja *to sort it out. So, just to give you that technical background on that.*

On the GPs, I think you summarised it very well, YB Bayan Baru. At the technical level as a ministry, we have already given our inputs and it has risen to essentially the political level. Because on one hand you have two different groups here. You have GPs and I think YB Kapar and YB Bayan Baru, you have given the technical justification why primary care is so important because it's the first protocol, important for prevention, important in primary care. Really we need to kukuhkan itu. *But at the same there's another group stakeholder which is the patients. Are they wiling to pay more?*

Balancing the interests of these two parties is beyond the ministry's technical ability to say that, "Okay, we must favour group A versus group B or group B versus group A". It is a political level at this point now.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Kami di peringkat NACCOL Yang Berhormat, kita ada beberapa perbincangan di Jawatankuasa NACCOL berkaitan dengan pemaparan harga ubat. Dan memang KKM ada banyak siri *engagements,* libat urus bersama dengan GPs dan dalaman sendiri pun kita ada buat beberapa siri bengkel dan ada beberapa set harga yang telah kita cadangkan.

Tetapi bila kita bawa ke NACCOL, ada dua pandangan, dua sekolah yang berbeza yang kita perlu *work* balik dan lihat semula. Sebab nak menetapkan harga lantai dan harga siling yang munasabah yang boleh memenuhi kehendak kedua-dua pihak iaitu GPs dan juga penggunalah.

Jadi, kalau kita set harga terlampau tinggi mungkin akan menjadi bantahan. Tapi kalau kita letak rendah sangat sebagaimana Yang Berhormat Kapar sebutkan, harga tersebut tak pernah di-*revised* sejak tahun 1982. Jadi, yang ini yang kita *consider*, nak dapatkan *win-win situation* melibatkan kedua-dua pihak iaitu GPs dan juga pengguna.

Tuan Sim Tze Tzin [Ahli PAC]: Saya nak cadangkan, kalau *next time you* berjaya *set the ceiling or* harga lantai, dia naik mengikut *inflation*-lah, *you know. You don't have to go back to 1982, 40 — I think I was* — saya pun belum masuk sekolah lagi.

So, I think it should be, you know you follow kalau *two percent inflation every year, you* naikkan *two percent every year.* Kalau tidak *we have to wait another 40 years to revise. I think that is not fair.* Mungkin diletakkan dalam Akta 7...

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: 723. 586. 586.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, kalau boleh Datuk Wira Pengerusi, dengan isu DRG. Saya nak tanya, sekarang DRG itu di-*rolled out* untuk *private hospital*. Adakah DRG akan untuk hospital kerajaan juga?

Dr. Yap Wei Aun [KKM]: *Okay, what is the objective of DRGs? For the public sector, one of the key purposes of DRGs — is so that there's a little bit more clarity in moving away from aligned item budget system where just say, okay we just give it based on the number of doctors you have, the numbers of beds you have and we just think of number of patients.*

If you base it on this, they'll say, "But my hospital is a busy hospital and we are located in a place where the prevalent of diabetes is very high." In other words, our case mix is very different. So, even though we get 100 patients, you get 100 patients, our patients require more resources. So, in order for a government or payment authority to decide, how much is appropriate allocation of funds to particular hospital? They need a case mix adjustment. So, they use DRGs for those kind of allocation purposes.

They can also use it as shadow budget or to check the performance of a hospital. So, for example they will say like, "Okay, based on our DRG simulation, you should be requiring 'X' million ringgit but your current allocation is 'X' plus three, compared to another hospital which is 'X' minus three". So, why is one hospital

apparently more efficient than another? Let's go and explore in other words, let's to performance management.

So, the purposes in the public sector can be quite different. Where's in the private sector, I think the key points that I brought out earlier on, number one they want some certainty on the prices. So, they don't want to have the system where we are going to pay for appendicitis for example and we don't know how much we are going to pay until the bill comes to us. So, they want some price certainty.

The other is you want to have payment system which is not based on trying to encourage the provider to add as many items into the bill, to do as many drugs as many procedures but you want them to just get the same health outcome with a modest amount of resources and that's value-based healthcare. You want incentivise efficiency, you want to reduce length of stay, in order words you want to cost-contain and reduce inflation.

So, the purposes are different in both sectors. So, I think we certainly would want the benefits of DRGs to be accrued for both sectors. But based on the political push, it is quite clear that the immediate need, the rintihan rakyat *is cost of living issues for the middle class in the private sector and from a technical perspective, why don't we leverage this challenge as an opportunity to lift up our neighbours including fairly advanced neighbours to implement this payment mechanism and go straight to best practices globally for this.*

Tuan Sim Tze Tzin [Ahli PAC]: *Sorry*, saya cuma nak tambah sedikit *and I will end my first round*-lah. *Okay, the issue with DRG is I think eventually* mengikut *Health White Paper,* memang kerajaan ingin melaksanakan *universal payment system*-lah untuk *even private* dan juga kerajaan.

Jadi, adalah lebih baik kita *roll out together* supaya — *so that the government side you can also discipline yourself to cut cost because government hospital also have cost escalation, I'm sure. There's also a lot of wastages. So, it is the best that you do it together, so that both sides are all disciplined. I think that the spirit must be fair to everyone. So that the whole country have a very comprehensive DRG system. That's my point. Thank you.*

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Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, nak tanya — mungkin Dr. Yap dengan TKSU lah *kut*. Okey. Bila nak di-*implement*-kan *or is it already in your planning* di mana *doctors just give prescription and only the pharmacist can give medicines.* Saya nak *explain* begini. *I was a medical student in a system whereby doctors just diagnose, treat, prescribe and then you'll get a piece of paper, you* cari ubat di farmasi. *I was trained that way. But that was not in Malaysia.*

Okay. *So, we are talking about* Malaysia, negaraku. *Whereby* kita punya sistem di sini ialah tempat GPs, tempat nak ambil *prescription is usually* lah dekat-dekat pekan, kan? *And then, pharmacy is not as available. Your system here is very different from where I graduated. I graduated in Australia. So, I'm quite familiar with that kind of system*.

Tetapi bila kita pergi dekat makcik, dekat *uncle* Mutu apa semuanya, dia pergi jumpa doktor itu, dia dah sakit-sakit ini, jalan dah sakit-sakit, dah itu motor pula dia tak berapa elok, jalan pula berlubang *and all that*. Dah sakit itu tiba-tiba doktor kata, *"Uncle, you kena cari beli ubat sana. Saya bagi you kertas you pergi cari apa dekat apa." Uncle* itu tak tahu nak beli dekat mana. *And then, our pharmacies — because* sekarang bila masuk politik je tak masuk ke dalam klinik lah, tak bagi ubat orang, bagi orang sihat je. *Not all medicines are in a pharmacy*. Dia kena cari tempat lain, kena tempat lain, kena tempat lain, kena tempat lain.

And then, okay. I nak ini kan *your client*, *okay. Your client. My client* jugalah *as* wakil rakyat kan. Okey. Dia ini darah tinggi naik, apa naik, semua-semua naiklah. Bila saya tengok rekod dia, *this is public service* punya apa kan, empat bulan dah *the last appointment* dia pergi. Saya kata kenapa ini — kenapa tidak makan ubat ini? Berapa lama ini nak habis ubat lambat ini. Dia kata saya nak jimat ubat. Hari ini saya makan ubat darah tinggi, besok saya makan ubat kencing manis, lusa saya makan — kenapa kata? Sebab saya tidak ada duit nak pergi hospital ya, hospital kerajaan ini. *I'm talking about* hospital kerajaan. sebab saya tidak ada orang nak bawa, anak tidak bawa. Saya naik teksi RM18 pergi, balik RM18, RM36 dia kata. *That's a public service* ya. Belum pergi dekat *job doctors and not talking about the private* — apa pergi *doctors and then you go to the pharmacy* lagi, lain apa.

So, our system is — Malaysian system is very simple. You pergi tempat doktor itu, *you* menangislah, mengata ke apalah, *you* tak boleh tidur apa bendalah, cucu tak balik apa semua-semua, *everything under the sun. And then,* lepas itu *you get all the treatment,* balik rumah, habis, tidur. *That's all. And you want to change that? Huh, not overnight* tahu? *You can't change just like that. So, I want to know how far is it now in your*— apa itu ini. *You nak implement ke*, *you* nak kuat kuasa *ke*, *whatever*.

Dr. Yap Wei Aun [KKM]: *I think the term is dispensing separation. So, I'm also trained in a system where there is dispensing separation. Maybe I just give some technical background. Why do people push for dispensing separation? Because they want to remove the incentive that a doctor would prescribe or a prescriber would influence that prescribing because it is part of their business model. So, that's the technical rationale for dispensing separation.*

Certainly, in Malaysia, the points that you have brought up for dispensing separation is an issues which has been discussed for years and years and years ya. This is not a new issue and I did mention— we don't have a pharmacy representative here today. So, I don't know the exact status of it. But, my understanding — I hope I'm not wrong, so we have to double check this with the pharmacy's side. But my impression is that actually they want to mitigate this perverse incentive of depending on a pharmaceutical for your business model through the paparan harga.

So, I think this is — so, these are sounds like initiatives really to think or voice the acuan Malaysia *way of addressing the perverse incentives but something which works in a Malaysian context lah.*

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat, *dispensing separation* ini kalau kita tengok dari segi isu kos klinik swasta ini biasa sebahagian daripada pendapatannya ialah daripada penjualan ubat. Jadi, kalau kita laksanakan — mungkin akan naikkan kos konsultasi dan kita kena akui juga untuk akses di kawasan-kawasan luar bandar, banyak kawasan luar bandar yang tidak ada — kekurangan farmasi. Jadi, kalau kita buat pengasingan penuh, mungkin akan sukarkan pesakit untuk mendapatkan ubat-ubat dengan segera.

Tetapi, sebenarnya perkara ini telah di-*debate* sebagaimana Dr. Yap sebutkan di KKM dengan banyak pihak. Kita juga ada *engagement* dengan persatuan farmasi untuk pasaran pengasingan sepenuhnya untuk sektor swasta. Namun, terdapat bantahan daripada persatuan dan juga persatuan perubatan. Kita masih lagi buat *engagement* Yang Berhormat.

Dr. Hajah Halimah Ali [Ahli PAC]: Kalau boleh GPs itu kan, *you all* ambil *sample* daripada mana? *Is it just within your areas ke,* daripada mana? *You* kena cari ya, *very remote,* Sabah, Sarawak ini, *you know,* pedalaman, yang banyak orang miskin B40 dan sebagainya *or is it just your Lembah Klang areas*?

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Datuk Wira Pengerusi. Saya ada beberapa persoalan di sini. Pertama, saya nak tanya mengenai *the — which one minister or committee ya establish for the whole-of-nation approach to address medical insurance issues? We go back to that. That is the main issue.*

So far, this meeting only been held once ya, 24th June 2025. I know it's not easy to call for a meeting, having so many people to be involved from different ministries as well. Setakat ni apa kemajuan yang telah dicapai? Sebab *first time* Jun, lepas itu dah tak ada lagi, *before that,* tak ada lah. *So, I think this is a very important* jawatankuasa *and* saya tahniahlah — nak ucap tahniah kepada Kementerian

Kesihatan sebab menubuhkan komiti ini. Tetapi, *we have to expedite, we have to speed it up because the issue is so serious for the country.*

Soalan saya tadi ialah pertama, *what is the progress so far? That's number one. Number two,* mengenai DRG ataupun kumpulan berkaitan diagnosis ya. Ini kita berharap ia akan dapat mengurangkan kos perubatan hospital-hospital swasta. Menteri Kesihatan pada bulan April ada membuat kenyataan bahawa sistem DRG Kebangsaan ini dijangka akan dilaksanakan tahun ini dengan sebagai *pilot project* terhadap penyakit ringan.

Saya nak minta pencerahanlah daripada pihak Kementerian Kesihatan *what is the progress so far. Progress* ini nak kena tahu. Kalau tidak kita pun tak tahu apa terjadi dan sebagainya. Dalam *meeting* ini kita boleh tahu apa *the progress* dia. *What is the progress so far and* adakah dia mengikut perancangan ataupun dia terkebelakang ya?

Number three, the last one. Saya nak tanya dia bersangkutan juga dengan kos perubatan, *national health insurance* ya. Adakah Kementerian Kesihatan bercadang merancang untuk melaksanakan *national health insurance?* Negara seperti Indonesia dah ada *national insurance. So,* minta diberi penjelasan, pencerahan tentang tiga perkara tadi. Terima kasih.

Dr. Yap Wei Aun [KKM]: *Thank you for your question. Yes, it is true that the minister-level committee has met once in June 24th but that's a former meeting. I think the ministers also confer with each other frequently as to the top management in as a* ahli.

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But if you see the structure, there's not just one minister level committee. There's at least…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I know you have the Steering Committee*, bawah.

Dr. Yap Wei Aun [KKM]: *Steering Committee…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *And consultative group.*

Dr. Yap Wei Aun [KKM]: *…and the Consultative Committee and…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But at the end you need to have the* jawatankuasa induk *checked by the Minister because this is a whole nation approach* yang *involve many ministries.*

Dr. Yap Wei Aun [KKM]: *Yes. So, they provide the strategic direction and then all the implementation, execution*, libat urus *happens very frequently. If I could give example on the intensity of the engagement, maybe I just give the example*

from— maybe in just my calendar, we have discussion on DRG this morning and this afternoon is on MHIT. That just my calendar alone. Tomorrow is also continuation Steering Committee, a day before is a discussing internally on the DRGs with my top management. The day before is also related with JBMKKS.

So, in other words, even for just one person, we are having meetings with DDA and the team so often that we've becoming best friends forever. So, and if you talk to the other stakeholders as YB Bayan Baru mentioned, it is the meetings are so frequent that even with the prior stakeholders they are, they are getting too busy.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I'm not asking you all to have so often meeting.*

Dr. Yap Wei Aun [KKM]: *It's because of the intensity of the…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I just want to know the progress.*

Dr. Yap Wei Aun [KKM]: *...because of the intensity of the engagement. So…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The meeting sometimes it doesn't give you any good results. Too much meeting, you don't have time to think and analyse. So, but we want to know is the progress whether it is progress as planned.*

Dr. Yap Wei Aun [KKM]: *Yes. So, I mean the tangible thing is that— for example, for MHIT* asas, *they've already hired* pakar perunding *to work together with Bank Negara and the rest of the agency on this. We are pushing ahead with the DRG implementation, exploring the legal reviews. So, I think probably it's a little bit like an iceberg. There's a lot of baseline technical work and reviews which need to be done which don't get seen. People will just see what happens once it's implemented. So, it' like— it is not like building a road where people— you start cutting the trees, people see, "Oh, there's progress".*

It's different when it comes to policy especially structural change. There's a lot of work which goes behind the scene which is under— like the iceberg underneath the sea before you get to see the hasil daripada itu. *So, I think that's one.*

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: DRG?

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: DRG pelaksanaan tahap berperingkat, Yang Berhormat. Kalau ikutkan, kita jangka untuk DRG 2027 *onwards*. DRG.

Cuma, saya nak respons berkaitan dengan produk asas takaful insurans. Memang kita ada banyak jawatankuasa di peringkat KKM bersama dengan Bank Negara, EPF, MoF dan sebagainya serta pemain-pemain luar, tetapi dari segi *target*

kita memang kalau dapat, kita nak lancarkan pada akhir tahun ini iaitu produk asas MHIT ini, mampu milik ini pada Disember 2025. Kita nak rancang— kalau mengikut perancangan KKM ialah kalau dapat pelaksanaan penuh produk MHIT ini dapat dilaksanakan sepenuhnya pada akhir tahun 2026.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya difahamkan dia akan dilancarkan di *Cyberjaya Hospital. Is it correct?*

Dr. Yap Wei Aun [KKM]: *Are you referring to DRGs?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: DRG. Di *Cyberjaya Hospital.*

Dr. Yap Wei Aun [KKM]: *So…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That is what I was informed.*

Dr. Yap Wei Aun [KKM]: *Maybe the way to see is that there's a national DRG. I think they've their own timeline and then there's the private DRG linked to the base MHIT and the timeline is linked to the launch of the base MHIT. So, it is not hospital by hospital kind of launch for the DRGs.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *National Health Insurance? [Ketawa]*

Dr. Yap Wei Aun [KKM]: *National Health Insurance. If you look at the Health White Paper, Health White Paper involved a lot of stakeholder engagement with experts and engagement on the ground. And, health financing is one of the critical things that they were exploring because it's key.*

Despite all these engagements, what they managed to come out with is not a definite saying that we are going for— to carry on with general taxation system or even a commitment saying we are going to NHI or SHI. The reason for this reflects the fact that there is lack of consensus on the ground as to where we want to head.

The simple reason is because a national health insurance or social health insurance system is a mandatory contribution system from formal labor. In other words, as you all's MPs, will you feel comfortable signing into a law requiring everybody who is working formal labor force to have in their paychecks "sumbangan SOCSO", "sumbangan EIS", EPF, LHDN *and then a mandatory health contribution?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But why Indonesia, I think Singapore also can implement this.*

Dr. Yap Wei Aun [KKM]: *I'll get there. Okay. So, that's what NHI or SHI system is. When we consulted the experts, just two or three of them, closed door. The views are extreme. On one hand, we have the expert A which says, "You do NHI,*

SHI, just like Indonesia, all your problems are solved". On the other hand, another person says, "Do NHI, SHI, your government will collapse". It's as extreme as that.

So, we can't just depend on perceptions. We need data. And therefore, you're asking me on Indonesia. So, for Indonesia, when they introduced the JKN in 2014, what we see is, "Is there an increase in expenditure from NHI to SHI as a total part of their health expenditure?" Surprisingly as a proportion, that did not increase. The part which actually increased, if you check WHO National Health Accounts for Indonesia is the government tax funded incentives to cover the poor and the informal labor force. That really expanded dramatically.

So ironically for Indonesia, even the headlines say, "We are introducing NHI, SHI", the key push for the funding is the government subsidies to support those who are poor and those who are the informal sector. So, one good thing is that for Indonesia they expanded the coverage which is a great thing. But don't forget that Malaysia throughout existing general taxation system already achieved that decades ago.

Then the next question is, "Is Indonesia system more sustainable?" If you just check the news, you'll find that for the last several years since JKN was initiated…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But Indonesia is not the only country implementing this. There are some other countries as well.*

Dr. Yap Wei Aun [KKM]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Some are developed countries.*

Dr. Yap Wei Aun [KKM]: *Maybe you just allow me to finish. So, if you look at the news, every year there has been a deficit or most years has been a deficit for BPJS requiring the government to bail it out and I think more recently the person in charge of BPJS announced that by 2026, they are not even sure it's going to be sustainable.*

The reason why is because like Indonesia, Malaysia has a high proportion of informal labor force. The typical countries which are associated with NHI and SHI would be— for example is Germany, a very advance country which has a very solid formal labor force, able to contribute to assist NHI, SHI.

But even globally speaking, when you look at NHI and SHI countries, the question of how do you cover it in a context where people is increasingly aging— just like us where they are poor people, who is going to cover them? And so even for those countries, they are going towards a more of a planned system.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The poor people will cover by the government.*

Dr. Yap Wei Aun [KKM]: *Exactly, exactly. So, if we are thinking of a system where NHI, SHI is going to absolve the government of the need to pay for healthcare for the people, that's a wrong approach. So, what we are trying to propose actually which is mentioned in my SPC, as well also mentioned in RMK13 is a middle of the ground approach rather than just going to extremely saying "Okay, we are suddenly going to push the burden completely on the formal labor to fund it".*

Can we actually form a national health fund which collects together various public sources of funding from the government, perhaps from state, perhaps from zakat, perhaps from Baitulmal, perhaps from various different sources, put it together in national health fund? If there is political will, even to mandate an additional contribution from the formal labor force, let's put it in as well and more importantly, shift away from a form of payment which is not going to incentivize efficiency but to actually go towards a means of payment which emphasize accountability for health coverage and health outcomes delivered.

So, that's basically what we're hoping to deliver through the Dana Kesihatan Nasional. *I think as Members of Parliaments, probably in the coming years, God willing, these will be things you have to debate and raise a wave. But we wanted two sidestep the need to have this first step of saying—*

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First thing is we just ask for money and mandate it. We need to fix a lot of things. And then, you also ask about the status pelaksanaan *because you know things take a while for institution and capacity to be build.*

So, in the first phase of our national health financing transformation, we want to create ways small stepping stones where we can create the push and the importance for creating different institution and capacity need to support a modernize health financing system regardless of whether we are going to continue to depend wholly on general taxation or whether we are going to bring in some this mandatory contributions.

So, that's in a nutshell, where we are trying to had in terms of the health financing system.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you* Dr. *It's a matter of determining what is the right modal*-lah. *Thank you*.

Dr. Yap Wei Aun [KKM]: *It is quite critical in — I think this agenda will raise up the political agenda as countries naturally become more advance and more edge. And we are seeing that here. So, I think that's just to highlight to you all. All the healthcare issue is going to come more and more. So, just so you all know. It's also*

to say, I can't think of any country which is not struggling with thinking how their fund their age care and their healthcare.

So, let's not also have unreasonable expectation that with just one paper suddenly we jump to have five percent of GDP allocated health just because we passed one paper. It's really not as simple as that ya.

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Terima kasih Datuk Wira Pengerusi. Kita — *when we have this kind of discussion, one of the issue that we found is that the hospital are — private hospital, although it is under the purview of KKM, but KKM have no so called 'no bite' to regulate them.*

And one of the issue that we found is that the excessive charges over testing, you know, all sort of things. So, actually, private hospital is for profit. And we understand that. And they use the opportunity to make up their margin.

Tetapi kerajaan tidak mempunyai sebarang kuasa untuk *to rein in this kind of excessive profiteering. Sometimes*-lah, I *would not say excessive profiteering, but they still have a lot of profit. Okey. So,* soalan saya adalah, adakah kerajaan mempunyai kuasa atau ingin *regulate private hospitals in term of their charges*, ya, *while we wait for DRG, yes.*

Tetapi, *at this point*, masih ada banyak lagi cara mereka untuk membuat keuntungan. Minta komen. Terima kasih.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat Bayan Baru, untuk hospital swasta di Malaysia ini, sebenarnya dia dikawal selia oleh KKM di bawah Akta 586 atau Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998. Akta ini telah pun kuat kuasa Mei 2006 di bawah kawalan KKM iaitu Bahagian Kawalan Amalan Perubatan Swasta.

Kita ada satu bahagian, dipanggil CKAPS, untuk kawal selia dan memastikan hospital serta kemudahan kesihatan swasta mematuhi piawaian keselamatan, kualiti perkhidmatan dan etika profesional. Isu yang berbangkit oleh Yang Berhormat tadi, berkaitan dengan isu kos yang ditetapkan oleh pihak swasta.

Pada masa kini, ada beberapa perkembangan, di mana cadangan untuk meminda Akta 586 ini untuk menyokong pelaksanaan strategi RESET yang kita bincangkan pada tengah hari ini sedang berjalan di mana melalui pindaan Akta 586 tersebut, kita akan dapat *outcome* untuk kawal selia mengawal inflasi kesihatan swasta termasuk kemungkinan memperluaskan kawalan kepada inisiatif-inisiatif baru seperti DRG dan ketelusan harga yang dikenakan oleh pihak swasta.

Kita, CKPAS memang ambil perhatian dan pindaan Akta 586 ini sedang dalam tindakan KKM dan kita jangka kita akan dapat bawa ke Kabinet dalam suku

keempat 2025 ini. Kemudian, kita mungkin dapat *outcome*-nya berdasarkan kepada RESET yang kita bincangkan pada tengah hari ini.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, saya tanya soalan ini, sebab CKAPS ini dia kawalan kualiti keselamatan dan juga mutu. Kualiti *healthcare*. Tetapi, dia tidak kawal dari segi *business*. Yang masalahnya, adalah *business practice* oleh sesetengah syarikat atau hospital yang mengejar keuntungan.

Saya rasa itu adalah isu yang harus diperhatikan sebab untuk negara lain, contohnya di Korea. Mereka tidak membiarkan hospital swasta untuk *list* dalam pasaran saham. Pasaran saham, dia punya *problem* adalah dia setiap suku dia kena *show the investor how much they make.* Itu sebab dia memberi tekanan kepada syarikat untuk teruskan *all kind of this profit.*

Tekanan itu *translate* kepada hospital dan setiap hospital itu dia kena *deliver that kind of margin*. Okey. Jadi, isunya adalah kita walaupun KKM dia teknikal, komiti teknikal. Dia kawal mutu, dia kawal dia punya standard, *da–da–da* tapi dari segi *business* itu tak ada orang kawal. Okey, yang menyebabkan hari ini, kita mempunyai masalah ini, di mana hospital mengejar keuntungan.

Saya kata, *we know that private hospital they are for profit, but we don't want is just excessive. There has to be a complaint mechanism*, supaya kerajaan boleh masuk *and say* okey *this is excessive*. Okey. *Then*, kita boleh ada — *and maybe the government must*, *let say for example,* kalau dia nak *list* dekat *stock market*, dia nak dapatkan dana untuk membina hospital baru. *No problem*.

Tetapi mungkin dia punya — dia kena ada *rules*, dia kena rujuk kepada Bank Negara *for certain guidelines*, okey. Contohnya, oh okey, dia punya *profit must come back to the hospital*. *It cannot be everything goes to the shareholders. That kind of certain rules that I think* Bank Negara *must look into*.

Itu cadangan saya.

Dr. Yap Wei Aun [KKM]: *I think we will be very happy to conveying your suggestion to the relevant government agencies, including* Bank Negara. *Generally speaking, I don't think* Kementerian Kesihatan *will look at the business operating, profitability model of any company*.

I don't think we really even have the act to do so, and I am not even sure if it's appropriate for Health Ministry to be doing so. But, certainly under this JBMKKS, we are happy to convey your views. Ya.

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Isu yang kedua saya nak bangkitkan adalah tentang, sekarang kita *on the way to become to regulate on this MHIT, based MHIT,* transisi lah. *According to your timeline is end of 2026 to roll-out.* Okey. *The*

Bank Negara, dia sebenarnya, dia *limit*-kan *the what do you call, the 10 percent hike until 2026* juga.

Jadi, saya haraplah sempat *roll-out based MHIT. But, if you delay, I think I hope that,* KKM *and also convey to* Bank Negara, *no more hike by the private until at based MHIT is being roll-out because three years of 10 percent hike is actually 50 percent compound rate. Is actually 50 percent hike.*

So, to them, you know, it is already quite a high inflation to the consumer, the insurance policy holder is already, some of them already gave up on their policy holders. So, there is not justification. I think we should convince the insurance company to wait until based MHIT roll-out for further hike. Maybe that's another point I want to — I hope KKM *can bring it up to* ini, Bank Negara.

Dr. Yap Wei Aun [KKM]: *Yes, we can convey to the relevant agencies.*

Tuan Sim Tze Tzin [Ahli PAC]: Okey, *last point I want to rise is* KKM juga *you also have your own cost to contain.* Sebab, *inflation* dia *hit everyone* dan antara yang kita faham adalah *there's a lot of wastages, that's a lot of wastages in* KKM. *But, one thing that I got recently from the industry player* adalah dari segi *procurement of your drugs.*

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Basically, there are three ways of procurement drugs from KKM. First is that you open tender. Second, you go through the Pharmaniaga channel to procure drugs and then the third one is sistem anak angkat.

Sekarang, apa yang kita dapati bahawa adalah KKM sekarang *the open tender at the procurement side,* dia tidak telus. *It used to be very transparent. Companies put in their bid, they show the price, who got the tender,* habis cerita. *Everyone the industry players play by the same rules.* Tetapi sekarang, apabila dia *submit* dia punya harga, tak tahu syarikat A, B, C dapat. A, B *and* C dapat. Kalau katakan syarikat A dapat, harganya tidak dipaparkan juga.

So, it is very not transparent. So, the industry players are saying we are trying to bid for lower price, so that you reduce your cost. It will reduce the inflation. But if you don't paparkan *all these* harga dan tidak tahu siapa syarikat dapat juga, *I think that is not fair on the market side*-lah. *So, I hope that kementerian look into your system, get the stakeholders to do a transparent procurement.*

Another thing is that, they always complaint is that once they put in procurement, it waited nine months. After nine months, may be you said 10 million boxes. Tetapi apabila dipanggil, *you only order two million boxes.*

So, for them they cannot plan their process because they cannot wait nine months. Nine months the prices changes. Another thing is that they plan bulk

purchase of 10 million boxes tetapi akhirnya KKM hanya beli dua juta*, two million boxes. There's also things that doesn't — there's a confident — because for international companies they want the government to be transparent, to stick to the rules, follow the rule of laws or else they don't have that kind of confidence in the market. So, I think KKM should do this.*

Another issue that they bring up is about anak angkat. Anak angkat *is to help local companies build up the capacity, so that we can secure medical security. Help certain companies to survive, so that they can become big and one day they can stand on its own.* Tetapi sekarang, kriteria untuk jadi anak angkat itu orang tak tahu.

Ada sesetengah syarikat dia nak jadi anak angkat tapi dia tak tahu kenapa syarikat A, B, C yang kena dipilih bukan D, E, F yang kena dipilih. Dan, kalau syarikat Z yang nak masuk, jadi anak angkat mereka pun tak tahu macam mana caranya.

Then, baru-baru ini mereka pun kompelin tentang ada syarikat daripada UAE pula yang menjadi anak angkat. Bukan syarikat tempatan. Walaupun mereka masuk bina kilang di sini tetapi yang dapat adalah syarikat daripada luar negara.

So, there's no consistency or very transparent rules on the anak angkat. *So, may be I will get some comment from the KKM please.* Terima kasih.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat, kita ambil maklum berkaitan dengan isu yang dibangkitkan oleh Yang Berhormat. Memang dalam agenda reformasi kesihatan, salah satu aspek yang diberikan penekanan di KKM ialah berkaitan dengan perolehan khususnya melibatkan *pharmaceutical*. Kita memang sekarang ini ke arah untuk menggalakkan lebih banyak *local manufacturers* dan membuka peluang kepada pengilang-pengilang tempatan. Isu yang sering kali dibangkit di luar adalah berkaitan dengan dakwaan kartel dan monopoli berkaitan dengan perolehan-perolehan perubatan termasuk *pharmaceutical.*

Jadi, di peringkat KKM, Yang Berhormat Menteri Kesihatan sendiri telah pun mengarahkan untuk kita *explore* ataupun meneroka pasaran-pasaran baru di luar negara bagi produk-produk *phermaceutical* yang mungkin generik bukan *originator*. Daripada negara-negara ketiga, negara lain contohnya, Turkiye, Iran dan sebagainya. Ini sedang dalam peringkat tindakan oleh Bahagian Perkhidmatan Farmasi KKM.

Berkaitan dengan isu Skim Anak Angkat untuk *approve*, kami panggil di KKM ialah sebagai konsep Skim Angkat. Ini memang telah lama dilaksanakan. Tujuannya ialah untuk memastikan tak ada — kita dapat main konsep *mentor-mentee*-lah untuk memastikan rantaian itu tak terputus dan kita akan lebih buka peluang lebih banyak lagi untuk Skim Anak Angkat dipanggil ABBL ini.

Pada masa hadapan melibatkan pembekal-pembekal tempatan juga. Jadi, juga dalam tindakan peringkat KKM dan memang ada dalam agenda reformasi kesihatan yang sedang dilaksanakan oleh KKM, Yang Berhormat.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara]* YB Sik.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Terima kasih Yang Berhormat Datuk Wira Pengerusi. Berbalik kepada *committee* yang digerakkan ini. Salah satu perkara tadi ada sebut dalam Perkara 11 seingat silap saya. Soal *mechanism* untuk *data sharing* yang — *establish standards and mechanisms for data collection on private healthcare cost.*

Kelmarin kami ada prosiding bersama dengan Malaysia Reinsurance. Antara perkara yang kami bangkitkan adalah bagaimana *mechanism* ataupun proses pengumpulan data-data pesakit, kos itu sendiri yang sekarang ini maknanya tidak ada satu *data collection* dan kerana masing-masing mereka menyatakan ini adalah kami yang sangat *privacy.*

Dalam *committee* ini maksudnya sudah pasti *ke* perlu ada satu yang kita katakan *mechanism* itu sebagai kolaborasi dan konsensus jangka panjang untuk pastikan data-data ini dapat, maknanya di-*collect* dan pihak-pihak yang maknanya yang keutamaannya itu termasuklah hospital swasta dan juga syarikat insurans itu.

Walaupun mungkin ada konsensus itu tetapi kalau tidak ada satu peraturan, mungkin kita akan ada cabaran dan halangan dalam data proses itu. Jadi, bagaimana maknanya dalam peringkat *Steering Committee* melihat perkara ini kerana itu antara cabaran terbesar kita nak proses dari segi nak capai matlamat dalam *committee* ini.

Juga sudah pastilah ketidak tentuan ataupun kekurangan data bersepadu ini, pelan-pelan kita ke depan itu akan sangat sukar termasuk yang kita nak *sign* DRG itu sendiri, mesti ada data. Jadi, bagaimana perkara ini dilihat dengan serius oleh pihak MOH ini sendiri? Terima kasih.

Dr. Yap Wei Aun [KKM]: Terima kasih Yang Berhormat. Saya rasa YB *very, very clear with* apakah yang masalah yang dihadapi. *So, the whole strategy* yang berbentuk E itu adalah mengenai data dan informasi. Strategi ini bukan sahaja satu tapi ada beberapa.

Dalam strategi keempat, kita lihat keperluan untuk menggunakan dari segi perundangan, dari segi kawal selia untuk mendapatkan maklumat ini daripada industri secara berpiawai supaya dia boleh digunakan dalam sistem maklumat, ICT dan sebagainya bukan persendirian atau tidak ada standard dan sebagainya.

On top of that, kita juga sedang berbincang untuk mendapat maklumat itu dengan lebih cepat secara sukarela. *So*, perbincangan ini terus *direct* dengan hospital swasta sedang dijalankan.

Ketiga, kita juga mahu memanfaatkan insurans dengan takaful operator yang sedia ada yang juga mendapat maklumat kerana *it's also in their best interest to share the data with us.*

Keempat *is also* dari segi *contracting*. Bila kita melaksanakan MHIT, kita akan dapatkan maklumat sebagai satu pembeli strategiklah tentang maklumat ini. Standard-standard — *if you see the next slide* juga dalam perkara ini yang hijau di tengah-tengah kiri itu, memang untuk mendapat piawaian dari segi peng-*coding, diagnose* dan *procedures*, semua ini adalah antara perkara yang amat-amat penting, bukan sahaja maklumat klinikal tetapi maklumat bil dan sebagainya.

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All these are under consideration lah*. So, I think you are absolutely right. These are critical necessities that we need to work through. It's not so easy. You know,* kita tak boleh *just like tomorrow we just get it done,* tak boleh. Kita kena ada libat urus, kita ada menentukan *standard* piawaian yang kalis masa hadapan. *So, we don't have to find a — next year, oh, we should do it — have done it differently. So, I think basically you've got all the key points and just to say that it is indeed one of the critical parts of the RESET strategy.*

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *last kut* ya. Nak tanya *about your* Rakan KKM itulah *kut*. *I just want to have a clearer picture of what it is and what does it means. What's the implication and implication to the* orang biasalah kan. *Ini for the able to pay,* kan yang Rakan KKM *is* yang buat apa? Boleh bayar.

Kalau saya nak *share* sikitlah, *to give you some context* ya, *what I'm concern*. Saya ada seorang — ada abang angkat. Umur dia sekarang umur 75 tahun. Dia ada *heart attack and* dia ada buat apalah angioplasti *and all that because* dia ada insurans, *so* dia pergi *private* lah. *It's done and he's quite okay*.

Last year, menantu dia, penjawat awam, 48 tahun nak buat angiogram, belum apa-apa lagi. Dia penjawat awam, dia kena *toe the line. The day that* dia nak buat *investigation* itu, dia meninggal sebab dia tak sempat. *So*, orang lain kena lebih — lebih awal. *What I'm worried about is* saya difahamkan — *that's why I need clarification from you*. Kita ini — *why you were suggesting this, I think if I'm* — inilah kalau betul dia punya apalah ya, maknanya kita tak cukup doktor pakar, kan? *So*, ramai yang *queue* daripada merata-rata tempatlah kan. *So*, dia ikut dia punya inilah *a turn*.

Tetapi, yang difahamkan — *this is what the people are telling me.* Orang yang boleh bayar, *you can go faster*. *You can* potong *line*. *[Dicelah]* Potong *queue* ya. Potong *queue* itu kan. *So, he gets first*. Walaupun *you* punya tahap itu tadi, *your seriousness not as bad. So, the worry is* kalau tadi penjawat awam ini, 48 tahun dia boleh meninggal *due — because* sekarang ini 30 tahun mana ada sakit jantung kan. *So*, dia boleh apa *and* abang dia — eh bukan, bapa mertua dia 75 tahun *because* dia pergi swasta *and* dia cepat kan, *diagnose* cepat, *treat* cepat, dia boleh *survive*. *So*, macam mana *you* apa ini? *What's the story actually*?

Dr. Yap Wei Aun [KKM]: Terima kasih Yang Berhormat *and very to hear about that story*. Kami memang ada *prepare* beberapa slaid pembentangan tentang Rakan KKM kerana ini adalah soalan ramalan yang dijangkakanlah. *I think the first thing is a… [Dicelah] I think the first thing* untuk memaklumkan adalah bahawa terdapat banyak *misinformation* di kalangan *social media* dan sebagainya. Sumber maklumat yang paling benar saya rasa adalah daripada *microsite* daripada KKM, *rakankkm.moh.gov.my.* Jadi, *I think it's best to refer to the reliable resources. You just imagine after pandemic, all the information about healthcare is totally — when you just rely on social media where there is our vaccine, Rakan KKM, all so much misinformation* lah.

Jadi, *I think the importance in this DNH, especially in the health sector to be very careful in weighing the sources of information. It's really, really critical. So, anyway, let me share some slides from Rakan KKM and I see some people* sudah mula makan. Silakan *because that's a few slides on this. So*, antara — ya, *I'll be as brief as possible*.

So, I think you already highlight antara cabaran yang utama yang semasa di ke arah retensi tenaga kerja kesihatan bukan sahaja pakar tetapi juga jururawat. *And then the number is roughly 400 specialists resigned from KKM last year in 2024. It's very serious, is more than one day.* Jika kita tidak mengatasi masalah ini, *how do we cover all these people who are coming in as your* 'menantu', *for example, and many other people? What's the point of saying that we have just one system and we — a lot of people, are even able to see a doctor because they have left to go to the private sector. So, retention of* tenaga kerja kesihatan *is a very, very, very critical issue. It's really quite bad right now.*

Inflasi perubatan sektor swasta, *I think just your — I don't have to convince you all this is the key issue why you all even convening that I think it's also obvious that there's* kurang dana kesihatan. *So, keep on is that Rakan KKM is actually a solution. It's in response to one of these many challenges that we have. So, I think*

— when you think of Rakan KKM, just think of the headlines. It is actually created for the public benefit. Unlike what you are hearing in social media and everything.

So, it's a partnership and that is what is called Rakan *and it's a whole-of-government partnership which is designed to actually to preserve and to advance the public interest* (kepentingan awam). *How so? With five things. One is* untuk meningkatkan siling terutamanya bagi golongan M40 dengan perkhidmatan pilihan ekonomi premium *yang* mampu milik *especially important* dalam konteks inflasi perubatan yang tinggi, yang ini. *Especially important when you are ageing and you all may also have parents who you may have to cover their healthcare costs and you may feel a little bit sad if you have to send them to a public hospital only. You may feel an obligation to send them to a private facility but it could be unaffordable but here, this is an intermediate option for you.*

Number two is to menambahkan pendapatan petugas penjagaan kesihatan bagi mengekalkan mereka dalam sistem penjagaan kesihatan awam untuk memberi manfaat kepada semua pesakit. *So, if we lose our doctors and nurses, who's going to benefit it*?

Number three, untuk meningkatkan lantai terutamanya bagi B40 melalui subsidi silang dan peningkatan pelaburan dalam sistem penjagaan kesihatan awam. *This is where* Rakan KKM *is different from the preexisting initiatives such as full-paying patients. That actually, we are going to collect more than just the cost, so we generate some additional revenue which can then be used to improve things for the public patient, including optimising capacity.*

Number four is basically in conflict of inflation to have a benchmark competitor.

Number five is really to say that because this is a sustainable initiative, a financially sustainable initiative. We do not need to pump, pump money from the government budgets to expand it. We can just go to a GLIC who and just so they can fund the expenditure of it. And that means our government budget can be focused on things for the existing B40, for example. But, of course, the GLIC will just aspect a profit return. I mean, this is for example, if you have members. Of course, you'll expect them to have appropriate returns.

It's also structured for the public benefit. Rakan KKM distrukturkan untuk manfaat awam. *On the left, you see that we want to preserve the existing system* dengan kadar fi yang rendah, yang dapat dikekalkan. *So, the existing public coverage that people get is going to be there. You are also very concerned about people who may have a more severe condition and need to be seen more urgently.* Bagi kes

kecemasan, dia akan diutamakan mengikut keperluan klinikal, bukan kebolehan untuk berbayar.

On the right-hand side, Rakan KKM *is a* pilihan tambahan. *I think that's important to say again and again. We are not forcing everyone to suddenly become fee-paying. We are telling people if you want this added option, not as a replacement of the existing public system but as an added option. You can get this* perkhidmatan ekonomi premium dengan pilihan doktor, keselesaan tambahan, privasi yang lebih, *and this applies only to elective cases and we plan to just charge more affordable payment for this*.

Dr. Hajah Halimah Ali [Ahli PAC]: *Sorry Dr. Tan, to interrupt you. But, where is it done? The ward, the clinic, is it the public hospital or is it a totally* hospital swasta?

Dr. Yap Wei Aun [KKM]: *No, it is as you see that diagram, it is basically side by side with the government facility. So, for example, we are making use of wards and other facilities where there's not enough staff. I mentioned beforehand, we have a huge problem with* retensi tenaga kerja kesihatan. *If you read the news when we open the new Hospital Pasir Gudang, what's a limiting factor? Is it infrastructure? The limiting factor right now in the* kementerian *is actually staff, all right. So, we want to make use of untapped capacity in the public sector. So, that means…*

Dr. Hajah Halimah Ali [Ahli PAC]: *It is a public — the answer is a public hospital, premise? Right?*

Dr. Yap Wei Aun [KKM]: *Betul*.

Dr. Hajah Halimah Ali [Ahli PAC]: Ya, *okay*.

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Dr. Yap Wei Aun [KKM]: *Yes, yes.*

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Ya, *private hospital.*

Dr. Hajah Halimah Ali [Ahli PAC]: Okey.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Betul, Yang Berhormat. Berfasa. *So,* kita mula dengan empat hospital dahulu untuk tahun ini. Kita jangka *fourth quarter,* melibatkan *Cyberjaya Hospital, Putrajaya Hospital, Serdang Hospital* dan juga Institut Kanser Negara (IKN) dan akan diperluaskan untuk hospital-hospital utama yang lain pada tahun 2026.

Dr. Yap Wei Aun [KKM]: *Yeah, I think it is important to know it's a public initiative because the* hasil pendapatan, *besides going towards the cost of operations, will be used for the public benefit* dari segi subsidi silang kepada *the B40 and also to pay back the GLIC. So that, basically the* peluasan Rakan KKM tidak memerlukan bajet kerajaan *which can again be used for other things.*

I think it is also very, very critical to know that this is an improvement of pre-existing initiatives such as full-paying patient which was started in 2007. So, full-paying patients which has been going from 2007 is probably the one which you most associate with queue jump paying. The purpose of it is untuk mengekalkan pakar, hanya. Okey.

But for Rakan KKM, besides mengekalkan pakar, *we want it also to* menambahkan dana untuk semua pesakit melalui subsidi silang. *The critical point of change is to think that full-paying patient is a zero-sum game because you are running this service with the existing budget. Rakan KKM is not a zero-sum game because you can charge the cost plus and retain it to improve things for all patients. So, therefore you can see why it's an improvement of the existing unequal initiatives.*

So, we can menawarkan pilihan perkhidmatan penjagaan kesihatan tambahan mampu milik *as a benchmark competitor*. *I think that benchmark competition, I think that's something which is quite clear for this— in this inflation context. You also may not be aware that under full-paying patient*, hanya pakar yang akan dibayar. *But under Rakan KKM, when a patient is seen and needs to go for operation, the scrub nurses are also paid. All the other relevant people who are providing the care are also paid. Isn't that a fairer improvement of the existing status quo?*

And then, from the rakyat's *perspectives, it's quite important to know that FPP is a zero-sum game. When it's run, when the foreigners use it, people who can pay use it, it is at the expense of the same resources use to serve them. Whereas Rakan KKM, they are paying fully for that and more, and that more is used to improve things for other people.*

There's also another initiative called flexi hours which allows our doctors, our specialists to work in a private hospital during office hours, one day a week. You may not see this happening because it's not so visible. But doesn't that— YB Kapar, doesn't that worry you about your 48, your own menantu? *When— now the existing initiatives allow a* hospital— pakar *to be going to private sector one day a week. That's the existing initiatives.*

Whereas with this one, the profit doesn't just go to the pemegang saham. *YB Bayan Baru, you are very concerned about why is it only the shareholders which are benefitting. But with Rakan KKM, the benefit is that the specialist who want to serve in this don't have to commute across to another part of town. They can serve right there in the same public hospital, providing continuous clinical leadership to the team. If there's a problem in the ward, they can find their* pakar. *And the profit from this go*

to the public purpose. So, I think that's a very critical difference. That's why it's very important to discern what actually is correct or not correct from social media.

Also, we find that many, many countries do something which is similar to Rakan KKM. This includes fairly advanced, fairly rich countries such as France. You may know France has its logo about being very egalitarian. Many egalitarian countries, you see that UK there which with NHS, have a system which is similar to this.

The equity issue is not seen as a problem in many of this because of the mitigation and because of its ultimate benefit to the public purpose. Even our neighbors, both down South, both North, do something similar. Even within Malaysia is also unique that there's something along this line to retain people.

So, finally I think it's also important to know that this is a quite a popular initiative among our doctors. But we have to also realise that our doctors don't like to self-promoted. They don't want to just say, "We want this because it makes us richer". But the silent majority want them. Three-quarters; amat sangat berminat, sangat berminat, *or* berminat *to serve in this because they know it's not just to benefit them. Even the nurses and the whole team get the benefit. The profit maybe can be used to upgrade things like getting more equipment for the department. So, they can practice their craft for the public benefit in the best possible way with the most interesting cases which you only find in the public sector.*

So, it's quite a— I think the people who actually understands this initiative are quite keen on this. So, I think from the political perspectives, we just want to emphasise a few key messages. The first one is the reassurance that akses kepada perkhidmatan kesihatan awam yang sedia ada dilindungi dengan kadar fi rendah untuk semua akan dikekalkan. Iltizam Rakan KKM hanya memberi pilihan tambahan. *It's an added option*, bukan *pengganti. For those who want it and for elective cases only to address the inflation issue so that you have the alternative.*

Kes kecemasan diutamakan mengikut kepentingan klinikal. Rakan KKM memberi peluang sukarela. *So, they will say, "Oh, doctors are already too busy. Why do we force them to work Rakan KKM?" Nobody said we are forcing any of our doctors or nurses to do so. It is an option for them. Many of them serve doing locums outside and the benefits accrued to private hospital.*

But now there's a chance for them to do so within our facilities, to retain them and to also retain the revenues for our purposes. But you may say to me the nurses are very busy. Even private hospitals don't have enough nurses. Where will we get them? It's very simple. Some of the JPA rules make our nurses and doctors retired

at the stage when they actually at their peak, when they have been trained and very skilled for 20, 30 years working operating theater.

And then, just because of a rule, they have to force and be retired. Many of them want to continue to work in the public sector if they had the opportunity. This gives them the chance to do so, to make use of their skills, the amount of hour that they wish to serve.

And I think another third important point on the equity issue is that this is an improvement on those existing initiative like full-paying patient and flexi hours. Because those initiatives are zero-sum games where's this one uses the added revenue for the benefit of non Rakan KKM patients as well. This initiative is not so unique that it is least conceived of and we are the only country in the whole wide world which would think of something as unusual as this. It is very, very common.

So, key message, it is diwujudkan demi kepentingan awam *and* bukannya satu inisiatif penswastaan atau mengarah ke penswastaan. *I hope that's clear here. So that you all are also able to explain to your constituencies that, "Yes, this is a bit like the pandemic", you know. People are saying like, "Oh, we don't want COVID-19 vaccine. It going to cost all this problems, et cetera" and all the crazy misinformation. So, I think— I hope this gives you all the tools to explain to them what the facts are. Thank you.*

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Dr. Yap, nanti berikan pada sekretariat slaid ini sebab kita tak ada, untuk kita masukkan dalam kita punya laporan nanti. YB Betong, lepas itu saya bagi pada YB Sik.

Dato Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Terima kasih Datuk Wira Pengerusi. Mengenai DRG ini, nanti apabila ia nya di-*implement* ataupun dilaksanakan di masa yang akan datang. Saya melihat beberapa isu. Antaranya ialah dari segi *compliance,* dari segi *transparency* dan juga isu *manipulation* ataupun *upcoding* oleh *private providers* ini.

So, in my opinion, there must be independent oversight body that will monitor all these compliances and they to ensure transparency in this DRG across the, you know, application of this DRG across the private sector and also to ensure there is no— or to prevent manipulation by these private sectors. So, what is your opinion at that? Thank you.

Dr. Yap Wei Aun [KKM]: Terima kasih Yang Berhormat. Perkara ini juga adalah perkara yang amat penting. Dalam beberapa bulan ini kami sudah membuat beberapa libat urus bukan sahaja dengan perunding di Malaysia, tetapi juga untuk memahami apakah *best practice* dekat negara jiran dan sebagainya.

■1400

Kita ada bertemu dengan — ada mesyuarat dekat Filipina, dengan Thailand dan sebagainya. Antara yang *best practice* yang kita dapati adalah bahawa DRG ini dilaksanakan oleh sesuatu badan *quasi-governmental*. Jadi, dalam masa ini kita sedang memperincikan kebaikan dan keperluan untuk menggunakan satu struktur tadbir urus seperti begitu supaya dia boleh dilaksanakan secara telus tanpa faktor-faktor *influence* daripada pihak swasta dari ITO dan hospital tetapi boleh dilaksanakan oleh satu badan yang *quasi-governmental* yang mementingkan kepentingan awamlah. *So*, sedang ditelitikan.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Ya, ini termasuk dalam Jawatankuasa Menteri Bersama Yang Berhormat, yang kita bincang tadi RESET adalah satu agendalah di mana kita akan lihat *progress* pelaksanaan DRG untuk penjagaan kesihatan swasta.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Pengerusi, soalan *last* ya. Okey, mungkin soalan saya ini tidak sangat merujuk kepada perbincangan kita. Tapi masih berkait dengan dasar polisi KKM-lah ya. Isu sedang berlegar bila timbul satu *statement* daripada SPA, (Suruhanjaya Perkhidmatan Awam) jururawat akan diambil daripada Indonesia.

Jadi, di kalangan MP-MP pun banyak berbincanglah apa sebenarnya situasi itu ya. Jadi, saya ya lah, pihak Menteri sudah jawab bahawa belum ada lagi perbincangan khusus dengan KKM sendiri. Tapi, bila dilontar sendiri oleh SPA itu agak nampak serius dari segi maknanya tenaga kerja jururawat kita ini ya. Jadi, apa yang mungkin sudah ada *stand* di pihak KKM sendiri ya dalam masa kita nak selesaikan masalah kekurangan jururawat itu maksudnya nak mengurangkan *ratio* kalau disebut.

Kalau di Johor itu 1:10 ya. Satu jururawat 10 pesakit. Walaupun standard itu mungkin 1:5 atau 1:8. Jadi, mungkin saya ingat dalam mungkin dalam *join committee* ini adakah sudah itu dalam perbincangan? Ataupun dari segi hala tuju sebenarnyalah kerana ini saya nampak akan ada — walaupun ada *pro and con*-nya itu, tapi dari segi rakyat sendiri dia akan nampak ini satu benda yang sangat pelik dan ketika mana kita kata, *"Ah Indonesia, takkanlah semua nak ambil dia."* Nak ambil sawit pun orang Indonesia, takkan ini nak merawat anak kita di wad pun orang Indonesia juga.

Ini mungkin ada akan ada masalah dari segi apa nama nasionalisme kita lah ya. Itu mungkin sudah ada *stand* di pihak KKM sendirilah. Ini soalan *last* saya Pengerusi ya. Baik. Terima kasih.

Dato' Sri Zahrul Hakim bin Abdullah [KKM]: Yang Berhormat Sik, memang kita akui di peringkat KKM, isu kekurangan jururawat ini adalah satu isu yang serius. Di KKM, kita telah menubuhkan *taskforce* sumber manusia bukan sahaja untuk

Pegawai Perubatan tetapi juga melibatkan juga jururawat dan kita dapati memang data yang menunjukkan bahawa kita kekurangan lebih 8,000 ke 9,000 jururawat pada masa kini.

Jadi, apa yang berlaku ialah apabila sesuatu fasiliti hospital dibuka, dari segi operasi terpaksa dilaksanakan secara berperingkat kerana bekalan ataupun jururawat yang ada perlu dilatih untuk tempoh dua atau tiga tahun sebelum mereka *graduate* dan boleh diletakkan. Tetapi jumlah yang *graduate* setahun lebih kurang dalam 1,500. Jadi, masih ada lagi defisit untuk skim jururawat.

Di peringkat *taskforce*, kita melihat beberapa opsyen untuk mengatasi isu kekurangan jururawat. Salah satu opsyen yang disebutkan oleh Yang Berhormat itu memang benar, kita ada lihat juga cadangan untuk mengambil jururawat luar, khususnya daripada Indonesia, India yang pernah dilaksanakan di KKM tetapi dia masih di peringkat awal dan kita ada sekurang-kurangnya lima atau enam opsyen, yang sedang diteliti dan akan di bawa kepada Jemaah Menteri untuk isu kekurangan jururawat.

Termasuklah untuk melantik semula jururawat-jururawat yang telah pun bersara sebagai Skim Kontrak sebagaimana Pegawai Perubatan Pakar dan opsyen-opsyen ini sedang diteliti. Cuma isu yang berbangkit ini telah dijawab oleh Yang Berhormat Menteri di luar, dua hari lepas dan peringkat KKM, kita akan teruskan dengan sesi opsyen-opsyen yang kita cadangkan ini untuk dibawa ke Jemaah Menteri untuk dapatkan pandangan Jemaah Menteri-lah.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *I think* saya *last*-lah. Tadi, saya nak tanya tentang *quasi-government organization* untuk *manage* DRG kan? Adakah keperluan untuk setup *private healthcare commission*? Sebab, kalau kita tengok *based* MHIT pun, dia perlukan sesuatu *quasi-government although it should be private.*

Pendirian saya, *as personally, I feel that private insurance should be privately run because it should be based on market, it should be you know* — yang kalau kita masuk kepada kerajaan, dia akan menjadi kebajikan dan *one care* dan sebagainya. Dia tidak akan berjaya kerana dia kerajaan.

Jadi, kalau ada satu *quasi organization that is very independent,* bukan kerajaan *then* dia akan *make it work*-lah, *DRG dan based MHIT*. Jadi, soalan saya adalah kita akan *setup private healthcare commission*? Okey, itu soalan satu.

Soalan kedua adalah adakah *based* MHIT, adakah KKM akan cadangkan *based MHIT* itu *cover* juga GP? Sebab, kalau kita oleh *cover the primary healthcare, enlarge the cake, so that you know, more people will buy that kind of healthcare*

insurance and then, the first screening should be at the GP, not immediately go to hospital.

Akhir sekali saya nak ucapkan terima kasihlah kepada KKM sekali lagi, *you know to work very hard on this. I hope that we will be successful. I think this is the only window that we — that's only one or two years window for us to be very successful. I think, if we can do this, I think everyone of us can be very proud of our success*-lah. *So, hopefully everyone will work hard on towards this*-lah.

Terima kasih banyak.

Dr. Yap Wei Aun [KKM]: *I think for a private healthcare commission*, kami boleh menelitilah perkara ini dalam JBMKKS. Memang ada model dekat beberapa negara, tapi kita kena tengok secara mendalam apakah sebenarnya yang dilaksanakan oleh entiti tersebut dan apakah kaitan dia dengan sistem Malaysia *and to see the relevant*-lah.

Jadi, kita boleh meneliti. Dari segi perkara kedua, tentang *involvement of a* kesihatan *premier* dalam MHIT*. Let me just say, with a caveat*-lah, *we are at the design stage.* Jadi, saya boleh memberi *idea but not a commitment yet. So, I will explain as such*. Memang *it is clearly within our radar on the importance of wellness, prevention, primary care to put that into the mix.*

However, if we put it, if you think from actuaries' perspective, they will say okey, but, insurance you are covering rare, unpredictable, catastrophic events. If you want to add-on thing which are expected expenditure that's usually not the clear function of insurance. But then, we also can give another argument, we can say. But what if with this addition of the gate keeping function, the prevention, some of the shift of the utilization from hospital to primary care, saves money.

Then, they will think, boleh dipertimbangkan. *So now, we are at the stage where, we understand conceptually. Of course it is important to this, but also understand if we add, add, add, the premium also add, add, add. So, where is the right balance*? *So, we are currently at the design stage where all these very important considerations are being discuss at the technical level and trying to be figure it out.*

That's why this is not something we can just snap of fingers, we just do tomorrow. Boleh buat. *It requires very careful thought and consideration and technical design and expert inputs for all this design elements. But that's for the MHIT part. Let me also put on the table another addition option, which we have not really discuss in public.*

So, I am just discussion more as a brainstorming with you all because I see that you are very keen to make sure that we are following best practices. You hear from previous countries, you hear from the crowd, they are many-many ideas.

■1410

So, another of the ideas and the brainstorming that we also find is what about in the private sector right now? Private companies don't they cover primary healthcare? Is there a way we can nudge the system to be more focused on health outcomes, improving the care of diabetics, people with obesity. So that we can reduce their healthcare, their hospitalisation need and their premature mortality and their healthcare cost and their productivity? I think there's a very strong care for this.

So, I think to in addition to just insurance function, where you are trying to get average cost, we are also want to shift private healthcare even towards thinking more on broader value-based healthcare paradigm. So, all these if you say brainstorming-wise, certainly we are aware of these ideas, aware of these opportunities but these requires a lot of technical thought, a lot of deliberation and a lot of libat uruslah*.*

So, certainly these ideas are on the table. I can't really give as a commitment but just to say that certainly the ideas and the technical rationale is understood-lah*.*

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Terima kasih. Saya rasa semua dah tanya soalan. Cuma saya nak menarik balik perhatian pada *page* 3 yang mana ada *working group* yang terakhir *communication* dan juga *stakeholder engagement.*

Jadi, usaha oleh pihak KKM ini kita lihat baik, bagus dan *of course* akan ambil masa yang agak panjang dan juga komitmen yang banyak. Sebab itu kami mengharapkan di PAC supaya ada *team* yang dedikasi yang boleh — sebab kita nak menangani isu ini bukan hanya pada *certain, certain* waktu, ia sepanjang masa.

Sebagaimana yang telah disentuh oleh YB Bayan Baru tadi dia kata pembangkang akan mengisukan isu-isu ini, tak. Sekiranya ada *the right engagement* yang dilakukan oleh pihak kerajaan, saya yakin dan percaya *even* pembangkang juga akan menyokong inisiatif yang baik oleh pihak kerajaan.

Sebab itu saya mengharapkan supaya sesi libat urus dan juga komunikasi yang baik. Bukan hanya untuk di KKM tetapi apabila dalam jawatankuasa kerjasama itu dapat ditekankan tentang apa juga inisiatif yang dilakukan haruslah sampai suara itu ataupun kerja itu di akar umbi. Itu saja. Jadi, untuk itu ...

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *last, last.*

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Oh, *last question.* Saya baru nak *wrap up.*

Dr. Hajah Halimah Ali [Ahli PAC]: Sebab saya belum puas hati apa yang Dr. Yap sebut itu tadi. *When you talk about primary healthcare,* cuba tengok Singapore. Singapore. *You can't go to the hospital, private hospital or whatever hospital unless you go to the GP first. So,* GP kata perlu pergi hospital, *then, only go*. Di Malaysia, *I*

don't know whether we ever got law or not, regulation ke tidak. *You* masuk terus pergi hospital. *You want to see the specialist* terus, *that one thing.*

Yang keduanya itu tadi, *about the insurance,* kan? Dia bila dah teruk, dah masuk hospital *and all that* baru dia *qualified to get insurance coverage. So,* dalam apa ini, *for the primary care* punya ini, *it's not just* kena *screening*, ada *cancer marker* ke tak, apa ke tidak *but it's also* — dia jatuh katakan. *Is that covered by the insurance?* Dia jatuh tapi tak patah, *so*, tak payah masuk hospital. *So, is it covered or not? That's the kind of cost.*

The people at large have got to catered for especially dengan *the economy* apa sekarang ini, *vulnerability* sekarang ini. *So, that's the kind of thing yang you* kena tengok. *You talk about whole-nation, so it's got to be holistic. Look at the health issues.*

Dr. Yap Wei Aun [KKM]: Yang Berhormat, *I think certainly* dari segi teknikal, *as you can see in 1(b),* kami memang sudah memahami keperluan untuk *gatekeeping by* GP dan faedah daripada GP.

So, at the technical level, when we are in the design stage, your idea certainly sudah diserap. *We just hope that we can get it through once we discuss with all the other relevant like the cost of it, the cost of premium* dan sebagainyalah.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Terima kasih atas jawapan Dr. Yap dan semuanya. Sekali lagi daripada pihak PAC kita mengucapkan ribuan terima kasih kepada Yang Berbahagia Dato' Sri Zahrul Hakim bin Abdullah, TKSU Kewangan, Yang Berusaha Dr. Yap Wei Aun, Yang Berusaha Dr. Dinash Aravind a/l Radhakrishnan, Yang Berusaha Dr. Ahmed Ibrahem bin Mohd Azam dan semua ahli delegasi daripada pihak KKM.

Terima kasih di atas kerja keras anda. Di pihak PAC kita amat menghargai dan kita harapkan apa juga masalah isu kesihatan di negara kita ini dapat diatasi dengan baik dan berjalan dengan lancar dan kami menyokong apa juga agenda yang terbaik untuk negara. Jadi, untuk itu kita tangguhkan prosiding kita pada jam 2.15 petang dan untuk Ahli PAC dan semua ex officio, petang ini kita sambung semula jam tiga petang. Terima kasih.

[Mesyuarat tamat pada pukul 2.15 petang]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Khamis, 19 Jun 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan dan Caj Hospital Swasta serta Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

i) **Life Insurance Association of Malaysia (LIAM)**
Tuan Mark Steven O'dell
Ketua Pegawai Eksekutif

ii) **Allianz Malaysia Berhad**
Tuan Zakri Mohd Khir
Pengerusi

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PAC BIL. 5(P) 2025

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 19 JUN 2025

AHLI-AHLI JAWATANKUASA

Hadir

YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Tuan Ts. Zahir bin Hasan [Wangsa Maju]

Tidak Hadir *(Dengan Maaf)*

YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Datuk Ali anak Biju [Saratok]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]

URUS SETIA

Encik Mohd Sukri bin Busro [Ketua Penolong Setiausaha, Seksyen Jawatankuasa Kira-kira Wang Negara (Bahagian Pengurusan Dewan Rakyat), Parlimen Malaysia]

Encik Mohamad Tarmizi Bin Ahmad [Penasihat Undang-undang I, Parlimen Malaysia)]

Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan, Seksyen Jawatankuasa Kira-kira Wang Negara (Bahagian Pengurusan Dewan Rakyat), Parlimen Malaysia]

Puan Siti Noor Akmar Binti Zulkafli [Juruaudit, Seksyen Jawatankuasa Kira-kira Wang Negara (Bahagian Pengurusan Dewan Rakyat), Parlimen Malaysia]

Encik Muhammad Zydil Iman Bin Zulkefli [Juruaudit, Seksyen Jawatankuasa Kira-kira Wang Negara (Bahagian Pengurusan Dewan Rakyat), Parlimen Malaysia]

Puan Farah Binti Mohamed Rafiee (Penolong Setiausaha, Seksyen Jawatankuasa Kira-kira Wang Negara (Bahagian Pengurusan Dewan Rakyat), Parlimen Malaysia]

HADIR BERSAMA

Kementerian Ekonomi (KE)
YBrs. Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah 1 (Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah Bahagian Perkhidmatan Sosial (Bahagian Perkhidmatan Sosial)]

Jabatan Perkhidmatan Awam (JPA)
Encik Aznirul Fariz bin Alwi [Ketua Penolong Pengarah (Bahagian Perkhidmatan JPA)]

Kementerian Kewangan Malaysia (MOF)
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Bahagian Kawalan Kewangan Strategik dan Korporat)]
Encik Abdillah bin Azizudin [Ketua Penolong Setiausaha (Bahagian Pelaburan Strategik)]
Puan Joy Hii Mei Xin [Ahli Sekretariat GEAR-uP (Pejabat Ketua Setiausaha Perbendaharaan)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Pkpj. Premraj a/l Isaac Dawson Martin Victor [Pegawai Penyiasat (Bahagian Siasatan)]
Puan Norsyahida binti Alias [Penolong Pesuruhjaya (Bahagian Penyiasatan Tatakelola)]

Jabatan Akauntan Negara (JANM)
Encik Mohd Taufik bin Haji Ahmad [Akauntan (BPOPA)]

SAKSI

Allianz Malaysia Berhad
Tuan Zakri Mohd Khir [Pengerusi]

Life Insurance Association of Malaysia (LIAM)
Tuan Mark Steven O'dell [Ketua Pegawai Eksekutif]
Puan Rashidah binti Abdul Rashid [Pegawai Perhubungan Awam]

Allianz General Insurance Company (M) Berhad
Dr. Muhammed bin Abdul Khalid [Pengerusi]
Tuan Wang Wee Keong [Ketua Pegawai Eksekutif]

Allianz Life Insurance Malaysia
Tuan Charles Ong [Ketua Pegawai Eksekutif]

AIA Berhad
Tuan Heng Zee Wang [Ketua Pegawai Penjagaan Kesihatan]

Great Eastern Life Assurance (M) Berhad
Tuan Loke Chang Yueh [Ketua Pegawai Kewangan]

Prudential Assurance Malaysia Berhad
Puan Manisha Keyal [Ketua Pegawai Penjagaan Kesihatan]

Persatuan Takaful Malaysia (MTA)
Tuan Wan Saifulrizal Wan Ismail [Pengerusi]

Persatuan Insurans Am Malaysia (PIAM)
Tuan Ng Kok Kheng [Pengerusi]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PAC BIL. 5(P) 2025

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 19 JUN 2025

Mesyuarat dimulakan pada pukul 10.04 pagi

[Yang Berhormat Datuk Wira Mas Ermieyati binti Samsudin
mempengerusikan Mesyuarat]

[Masalah teknikal]

[Audio tidak dapat dimainkan]

[Audio mula dapat dimainkan pada minit 6.41]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: ...Dr. Muhammed bin Abdul Khalid, Pengerusi, Allianz General Insurance Company (M) Berhad; Yang Berusaha Tuan Charles Ong, Ketua Pegawai Eksekutif, Allianz Life Insurance Malaysia; Yang Berusaha Tuan Wang Wee Keong, Ketua Pegawai Eksekutif, Allianz General Insurance Company (M) Berhad; Yang Berusaha Puan Manisha Keyal, Ketua Pegawai Penjagaan Kesihatan, Prudential Assurance Malaysia Berhad; Yang Berusaha Tuan Wan Saifulrizal Wan Ismail, Pengerusi, Persatuan Takaful Malaysia (MTA) dan semua delegasi yang turut hadir pada hari ini.

Terima kasih, saya dan juga bagi pihak PAC kepada semua kerana sudi hadir dan memberikan komitmen untuk sama-sama memberikan penjelasan kepada PAC pada hari ini. Sebelum saya menjemput saksi untuk memulakan pembentangan, saya nak maklumkan kepada semua ahli-ahli mesyuarat bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 dan Peraturan Mesyuarat 85 sehinggalah prosiding ini selesai dan juga laporan dibentangkan di Dewan Rakyat.

Jadi, pada pagi ini saya difahamkan PAC terdapat dua pembentangan iaitu daripada pihak LIAM dan juga Allianz Malaysia Berhad. Jadi sebelum kita mulakan prosiding, saya maklumkan bahawa pada hari ini Parlimen akan mengadakan latihan kebakaran dan ini juga mungkin akan memberikan gangguan sedikit kepada perjalanan mesyuarat kita pada pagi ini.

Jadi kita akan maklum bilakah waktu tersebut. Saya kira dalam beberapa minit lagi. Tapi tak apa kita teruskan sahaja. Tanpa membuang masa saya dengan

ini menjemput Yang Berusaha Tuan Mark O'dell untuk memulakan pembentangan. Dipersilakan.

Tuan Mark Steven O'dell [Life Insurance Association of Malaysia (LIAM)]: *Thank you and good morning. First of all, I want to say appreciate again your indulgence in my giving my presentation in English. What I have is — I'll first cover if you recall last session, there were 12 things that the industry or the regulator or together with industry that we were working on, I'll give you an update on that and then I would outline nine things that the industry is committed to do in terms of reform. In between we'll have some illustrations, of some of the challenges faced by the insurance companies and takaful operators.*

So first — next slide — I'll just get right into it. Last time we talked about point one, was appointing an independent consultant, paid by the insurers and hospitals to analyse and recommend stakeholder action to reduce claims inflation. The work is in progress to appoint a consultant to develop the basic MHIT product and secondary outcome from this initiative will be to understand what other jurisdictions have done in this area of reducing claims inflation.

So, we will no longer be looking at hiring another independent consultant. They consult and is working on a basic plan. We will be able to draw from the experience of other jurisdictions from that initiative.

■1010

Number two, intermeasures. Offer assistance to customers at risk of losing financial protection due to their inability to cope with the repricing, also to strengthen sales and disclosure practices and to improve communication and transparency around repricing. BNM interim are in place. We're following their measures. New disclosure format showing the impact of seven and ten percent inflation on premiums over 20 years for improved transparency — that will begin in September. What that means is that every new customer will be shown an illustration, it will show the impact of seven and ten percent of inflation on their premiums. So, they will actually see the impact and the increases that not necessarily they would expect because from what we've seen is that claims inflation can be quite volatile. But it's just a couple of reference points for them to — the understanding that premiums will rise.

Three is policy copayments. The Bank Negara regulation launched last year required — insurers to illustrate copayment plans next to a non-copayment plan. In a recent survey of LIAM members, the take-up rate ranges from 11 and 99 percent of new sales. The 11 percent is a bit of an outlier. Most insures are over 50 percent are now — their are new plans come with at least deductible. There is one point we

want to make here is that the co-share plans with deductible and co-insurance are voluntary. So, they can still buy a 100 percent plan. We would like to see a move to mandatory co-insurance. Singapore and Indonesia have done so. That's one of the asks that will continue to put on the table with Bank Negara. Just want to note that for the committee.

Encourage incentives — incentivise healthy lifestyle. So, 50 percent of LIAM members now offer some form of incentive like a no-claim bonus, wellness incentive or claims-based pricing. LIAM is also going to run a two-year wellness literacy campaign to educate the public on numerous issues around health.

Five, establish industry-wide claims database for better claims analysis and reducing abuse. Greater transparency by publishing the average cost of common procedures and treatment across private hospitals as well as an annual medical cost inflation publication. To update you the database is up and running. Right now, we are still just validating important numbers. We expect to publish inflation rate in Q3 for the last several years.

[Penggera kebakaran berbunyi]

Oops, a little technical problem. Everyone has a hardcopy. You don't have it? Okay.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *We have it in our screens.*

Tuan Mark Steven O'dell: *Oh okay, okay. So, I'll continue. So, I was saying that the publishing of the inflation rate in Q3, publishing of common cost of procedures across all private hospitals by end of 2025. This will increase transparency and aide policyholders in making informed healthcare decisions.*

What we need is some support from MOH; update the clinical guide, audit practices for medical necessity, publishing of the costs of common procedures, diagnostic tests et cetera. We see a lot of abuses by providers. There's one example that we want to show you at this point. It has to do with scoping. I'll just give a little context. Many people go for scoping. I have, maybe you have, for screening. That is generally not covered under a medical insurance plan. But if the — as a consequences of the screening, if there is something found like a polyp then you can claim. So, it really depends on what the outcome of the scoping. Also, when you're treating for a condition, you usually don't need an upper and a lower. You might need one or the other depending on your condition. With that, I just turn it over to my colleagues Zee Wang to talk a little bit about some of the challenges that we face in this area.

Tuan Heng Zee Wang [Ketua Pegawai Penjagaan Kesihatan, AIA Berhad]: *Thanks Mark. A very good morning to the members of the PAC. As what Mark has mentioned, I want to take this opportunity to share some of the sample data that we have and some of the challenges that the industry actually face. So, if you look at this example of a gastro case. We look at a sample of hospitals, which has got a lot of gastroenteritis. We look at the variation in the practice and we compare data cross to other hospitals in the similar — in the region. We compared the cost of the upper scope (OGTS) they call it so and the lower scope which is colonoscopy as well as a combined scope.*

So, what is interesting to see over here is the ratio of combined scope that's prescribed. That means— and these are all outpatients cases. If you got either stomach discomfort, you know what are the percentage of times that you have to go through both upper and lower scope at the same time. It's quite interesting to see that at least in the insured experience at a particular hospital is in the range of 65 percent of our customers being subjected to both upper and lower scopes. This kind of like in line with the average in Klang Valley. These are only insured samples set we see. But if you were to compare this with twelve international best practice, typically, the need to do combined scope may range from 10 to 20 percent. Maybe in the insured case may go up to 30 percent, taking into accounts some wastages.

But over here, don't know whether this is the Malaysian stats, we see a staggering 60 over percent in prescribed upper and lower scopes. Hence there is a big question on what is medically necessary and how do we enforce or to call a check about this practice.

[Sistem penggera kebakaran diaktifkan]

[Simulasi latihan kebakaran di Dewan Rakyat sedang berjalan]

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Boleh tak cakap kuat sedikit suara?

Tuan Heng Zee Wang [AIA Berhad]: Ya, boleh. *That's what we observed in terms of prescription of combined scopes. Then we look at the cases with gastric polypectomy. What this is is, you know the percentage of transfat of polyps removed from scopes finding. Again, in the samples that we see over here, we see on average 21 percent cases with gastric polypectomy. Again, if we were to compare with — just to confirm this I actually did a quick check on a ChatGPT. The so-called best practices range could be one to three percent. In the insured case maybe two to six percent, double the rates.*

It is quite interesting that ChatGPT actually says red flags if you see anything that's more than 10 percent. That actually is a very big red flag for [Tidak jelas], I mean in this case you look at 21 percent. HB samples is what basically is effectively what you do the polypectomy and then that polyps you go send for lab tests. Two to three is probably a good average. But it's the cases that is reported normal. We look at this samples. We see some cases where there's polypectomy being done but a big percentage like Dr. G here, 60 percent is reported normal. Again, that's a question whether this is like actually necessary. But it is quite interesting to see that say Dr. A who did a lot of cases. All the cases are reported abnormal. Despite only 10 percent, 14 percent of these cases gone through polypectomy. So, we are fully reliant on the what doctors write as a finding. Hence there's really a question of like how do we kind of like check medical necessity and what is the audit procedure, what's the reporting procedures in terms of quality.

■1020

Tuan Mark Steven O'Dell [LIAM]: *Okey, thank you Zee Wang. So, you see we face many pressures on whether it's medically necessary or not. We're not always in a very good position to challenge the medical necessity and procedure.*

Moving on to six, develop a basic long term sustainable medical product together with BNM. Actually, I can say that it's together with BNM, MOF, MOH and EPF and the industry. This is ongoing with consultantants — we had a selection of the consultants, hasn't been announced yet, but we have decided on the consultant to work with on this project and we hope to have a pre-project meeting next week and there is a three-month development phase with the product followed by feedback and focus groups and then pilot and rollout in 2026. So, this is meant to be a basic plan and the coverage will be less but will be adequate and the premiums are expected to be less than what we see commonly being sold today.

So, here is just to note that — and we get a lot of feedback from customers who said rate increases due to age is not medical repricing. I know it can be a little bit contentious but most policies if not all policies in Malaysia are sold by age-rated bases which is quite common around the world. There has been a lot talk about community-rating which for all age groups. This is why you have one rate to all age groups but generally we believe that we need to have a very large base either mandatory coverage or the vast majority of coverage taking up by the population. That way, you can capture both young and healthy life and as well as the older and less healthy life.

If you have a small base like right now, maybe this whole industry is about 8 million customers have individual medical insurance. That's about 24 percent of the population and so it seems to be a bit challenging to move to community rating with that penetration rate. But there's been a lot of talk and a lot of expectation on this basic plan.

Next slide, seven. We've asked for exemption of group insurance for the eight percent SST to encourage more employers to take up. Currently there are four million employees that get covers to group and many of those members of B40. Customs has said no to our request. We still hope to raise this issue. We need some support. Don't know whether this could be more than a recommendation, but you know, SST does not apply to individual insurance but it does apply the group insurance. And so, you know we'd like to see that to be equalized in order to promote greater penetration in the group insurance market.

Number eight, insurers to consider develop suitable and streamlined repricing framework. This is to reduce increase shock by spreading out the impact of larger increases and this is an area that is often misunderstood by the public when a company maybe proposing a 40 percent increase, it isn't 40 percent per year. It maybe 40 percent that is meant to cover two years, three years, four years and companies currently there is no consistency as to how often a company will reprice. But what we've learned is that — and it obvious that it may be more agreeable if you will or acceptable by the public if we have smaller but more frequent increases instead of you know, a large increase every few year.

Number nine, providers and TPAs to align better regarding cost and consumption healthcare services. Cost containment measures must be adopted by providers. The insurance and takaful industry they support the adoption of DRG. It was talked about yesterday at the Bank Negara symposium. Diagnostics Belated Group repricing just as a reminder it's where — it's really complex package pricing where the hospital has agreed to take a fixed amount for certain procedures including you know, the complexities and comorbidities There's a DRG committee even formed. Some of us including myself are on the committee but one of the disappointing things in the first meeting was that the committee is focusing on the public side first. Public teaching and military hospitals and that won't be rolled out until 2027 and so we're — they only work on the private side after that and the private option is not planned to be compulsory. And so, we see this as you know, a missed opportunity if we don't, if we can't look to introduce DRGs in the private side sooner.

So, we need support. ITOs are very concerned with the progress and the ambition of the project and we'd like to appeal to MOH who's of course not in the

room but to MOH to expedite. We have discussions ongoing to expedite development and transition to this effective payment mechanism.

Ten, was work with MOH to require the use of generic drugs and control pricing of all drugs. APHM's own report states that 48 percent of private hospital profits come from pharmacy. We're going to show you in just a minute a little bit about the difference in pricing between private hospitals and retail pharmacies. Where we are right now is observing the impact of the pricing transparency regulation that went into effect in May but we need strong oversight on generic usage. As example, Singapore MOH publishes the list of [Tidak jelas] drugs covered by MediShield and so right now I turn it back to Zee Wang to show you some price comparison between retail pharmacy and private hospitals.

Tuan Heng Zee Wang [AIA Berhad]: *Thanks, Mark. So, we're here again, you know, we gained some sample data to show what we observe in you know, in insurance bill. Typically, you know if we go to retail pharmacies, we see the price of a tablet of Panadol for example cost around 40 cents on average but the price that you have to pay in private hospitals. [Merujuk kepada slaid pembentangan] So, the dots represent different hospitals across — and it could range from 59 cents to RM1.52. So, if we just take the average of 40 cent compares to 93 cents, that's more than doubled the cost that we have to pay at private hospitals. It's quite interesting that yesterday, Sasana Symposium organized with Bank Negara talked about rising cost where you know — YB. Datuk Seri Dzul was on the panel together with Prof. Dato' Dr. Adeeba. Dr. Adeeba actually mentioned that — actually question about the reason for this that they've got to pay like RM20 a box for per pax.*

The next example is a very typical antibiotic widely used, Ceftriaxone, you know. The Rocephin is actually the branded version and then we have a lot of other very, very similar generic version. This actually general so-called potential misconception of generic as inferior drugs. So, you know in pharma terms, a generic actually used the exact molecule or chemical make-up of the drugs. So, they are technically the same. So, right here we can see the price differences for originals there can range for RM103 from one hospital to RM217 to the other hospital. They charge the most. Even generic used, the price ranges can go from RM24.79 to RM109, which actually cost more than the originals in some hospital. So, this huge price variation is a very strong indication when there is no control in price or when there is no reasonable set up of price. This is a consequence that we are seeing today.

It's good that we see the drug price publication starting today. I think, one step further that we can take to make it easy for customers because today there's still a

very long list of drugs that not easy for consumers to find. If there's an agregator put somewhere that customers can easily have access to, then we make the transparency works even better. Thank you

■1030

Tuan Mark Steven O'dell [LIAM]: *Okay, thank you Zee Wang. Moving on to 11. We request if private hospital to freeze costs for the same period that insurers and takaful operators are asked to cap premiums. They have publicly said no. We need support because while insurers have implemented BNM interim, APHM has publicly refused to do anything in terms of the cost. They seem to be continuing as business as usual. We need appropriate form of regulation at private hospital care, regarded as essential services.*

As now, I'm going to go back to Zee Wang and he's going to show you several slides that illustrate private hospital, price increases this year as well as some other billing behaviour that we deal with that leads to a higher cost.

Tuan Heng Zee Wang [AIA Berhad]: *Thanks Mark. So, again in the brief [Tidak jelas]. these first four months alone you know, we've actually observed on our medical bills, more than 3,000 unit line items, price has actually increased. So, here is the sample of hospitals that've got 32 items, price increased. Quite a few items are related to drugs. For example, the first item has increased more than two times, two and half times. Interesting to hear like last year when the price increased, we say the Ringgit had weakened significantly and some of this cost has increased. But this year, actually the Ringgit has actually strengthened quite a fair bit but yet we have seen some of this been translated.*

Second item on GTP load. This is like orthopaedic, you know, pillow and you can see again with a significant price increase and we look across the board it's not only drug price increase. But item three like probe cover, ThermoScan, is actually this is the thermometer that you out in the ear and that plastic cover costs RM3. So again, that question — put question on what is, you know, what is reasonable charges on all these items. Where we see today that the price increase appears to be fully at the discretion of the provider, you know, without any control, it's like that.

And then, you look further if we were to say not only that item price can increase, there can also be new item being added into the bills. So, here's one of the examples. You know, most of the time the customer would pay for room and board when you know they are hospitalized. But it's very not uncommon to see you know in the bill, things like clinical waste disposal, bedsheet being charged, pillow case being charged. So, this is similar to you checking into a hotel, you pay for the room,

for the hotel but you know you have to pay a separate cost for sleeping on the pillow and the bedsheet and also throwing rubbish.

So, next slide you know is another one. So, every single item in the room being used, for example, some of you who may had visited friends or had experience of being in hospital you know, the beeping item at the side of the bed. We call the bedside monitor. The usage of it, in this example is RM158 and then there's a whole other layering of charges. Somebody come in to read the blood pressure every four hours. The central team monitoring, just in case, that costs RM172. Somebody come and take a reading of the vital sign is RM49 and then additional pulse oximeter is RM94. That, you know it's per time used or per day used and if three days, you have to pay for three times. Likewise, the thermometer being used as well. So, all these very clear layered charges that's added you know to the room and board.

Next, you know this is another example of operating theatre. You know we pay for the operating. The usage of the operating theatre by hours. So, in this case it's one and a half hours RM800 per hour. But on top of that, there's a line item called operating theatre table, which cost RM1,000. That means you pay for the operating theatre but if you want to sleep on the operating theatre bed you have got to pay RM1,000 for sleeping on the bed.

Next slide, so this is another very good example of unbundled charges. So, very typically when you're hospitalised there are SOPs to put what we call the IV drips on the hand. We're actually being charged for nursing fee and again it's not untypical because of the comment that nursing fee has increased. So, this is a very good example that you pay for that and then you pay for the blood taking then you pay for putting in the needle then you pay for pulling out the needle and then you pay for stuff like putting the alcohol swab on this. So, each of every one of the items is costed differently.

So, hence you know these are the kind of challenges that the industry is actually facing. So, for us you know we need to serve our customer within a very short period of time that they're in hospital, approving them for the claims and wanting them to go home fast you know to rest and recover. Within that time we need to go through the 100 of lines in the bills to find items like that. The worse thing is if the insurer decided not to pay for these items, these items will be have to be paid out-of-pocket by the consumers or by the customers because they have already consumed this item while they're in the hospital.

So, as a result that what we often hear as complaint is that you know we pay insurance premium for many years. This is the first time I used it and I have got to pay for a lot of things or quite a lot of things are not covered. That is a very common

complaint that we often hear. So, that's the challenges that you know we face as an industry here.

Tuan Mark Steven O'dell [LIAM]: *Okey, thank you Zee Wang. Just about wrapping up for the first section, Rakan KKM. I think you may be familiar it's an initiative MOH to utilise part of their hospitals for what they call premium economy and charge for those services. The benchmarking I've heard from them would be around you know 70 percent of the cost of the private hospitals. So, they hope to use a diagnostic group pricing as well. And the industry is supportive. From what I've been told by the doctor who is running the programme that they hope to launch five hospitals in Klang Valley by Q3 and ultimately would have 43 government hospitals around the country will have a wing that will be providing really similar services to a private hospital. Our only concern here, we'd like them to move faster.*

As we have to finally wrap it up, you know we need an all-of-nation approach to this. We don't see a lot of changes at the hospital's side. There is a lot of initiatives that are ongoing on the insurance and regulatory side. I would like to then just finish with the summary of the reform initiatives that we have agreed or are undertaking. There are nine of them and categorised them into the thrusts that Bank Negara earlier had issued five thrusts. Now — they've rearranged it. Now, they call it RESET, so they just rearranged to the thrust but they're the same as in what they covered.

So, Thrust 1 greater price transparency, publish annually the claims costs, inflation rate. Dated to be targeted it Q3. This is of concern we always get is that there is no authority for what is the claims inflation. So, here we are hoping to be able to educate the public on the cost of care and the cost of claims or the rate of inflation on claims, each year. Next bullet is publish the costs of common procedures across all private hospitals. We hope to do that before the end 2025. We have a work group formed for that together with publishing cost of drugs. These will facilitate the implementation of reasonable and customary charges.

This is another area that we face. Even though the policy may often cover as charged there is another provision that says up to the reasonable customary fee. But there is no authority for a reasonable customary fee and so each insurer left on their own to negotiate those with the hospital. We are hoping that this would provide some benchmarking of the cost across to the private hospitals sector.

■1040

As was alluded to with Zee Wang with the slides, we need to strengthen the regulatory oversight over… [Masalah teknikal – tiada rakaman hilang] ...private hospitals.

Thrust 2, improve provider payment mechanisms. Implement Diagnostic-Related Group pricing to replace fee-for-service. This will promote greater provider efficiencies, and the support we need there is we need a more ambitious plan and expedite development of this DRGs. In my own desktop research, the Scandinavia countries, I read report from Boston Consulting that it takes about three years, two to three years on average to implement some form of Diagnostic-Related Group pricing.

Thrust 3, development of basic MHIT product that is more affordable and sustainable, collaborating together with other ministries and EPF. Target pilot and implementation is next year. Review planned design to reduce unnecessary admissions and tests to drive right diagnosis and treatment at the right setting. More plans to offer, no-claim bonus or discounts and wellness incentives. Rationalizing and tiering networks or providers or doctors. This is ongoing.

Thrust 4, support Rakan KKM and the introduction of DRG-based claims payment. Finally, it's not written here but we're working together with BNM reviewing insurance data on managing closed blocks of business and whether greater pooling would be beneficial to policyholders. So, with that, I end my presentation Madam Chair.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Thank you Mr. Mark. So, without — I think we can proceed to another presentation before we proceed with the questions. So,* saya ingin memanggil pembentangan kedua daripada pihak Allianz. Terima kasih.

Tuan Zakri Mohd Khir [Pengerusi, Allianz Malaysia Berhad]: Terima kasih Puan Pengerusi. Terima kasih.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Mungkin boleh kenalkan diri.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Ya, nama saya Zakri. Saya daripada Allianz. Saya empat slaid saja. Saya cuma hendak memberi susulan kepada mesyuarat kita bulan sebelas ini. Inilah *update* yang kita boleh bagi kepada PAC tentang langkah-langkah yang kita buat untuk menyokong reformasi kesihatanlah.

Pertama sekali — slaid ya. Pelaksanaan penuh langkah interim BNM. BNM sendiri beritahu pihak BNM mengetengahkan, *impose interim measure* dalam isu kenaikan harga polisi insurans kesihatan. So, dengan — salah satunya, pelarasan premium berperingkat, penangguhan pelarasan premium bagi warga emas, penguatkuasaan semula polisi luput tanpa perlunya pengunderaitan. Maknanya kita tak tanya soalanlah bila dia luput ya, kita aktifkan balik.

Juga, kita memperkenalkan pilihan produk mampu milik bagi pelanggan yang terkesan. Kita *introduce plan deductible*, produk-produk baharu seperti Mark cakap tadi, cirikan *co-payment* dengan *no-claim discounts*. Ketiga, pembendungan kos, kolaborasi dengan hospital swastalah. Maknanya kita jumpa dengan semua hospital dan kita bincang dengan dia tentang struktur kos yang untuk mengawal inflasi perubatan.

Slaid kedua. Dari segi khidmat pelanggan, pertama sekali tujuan kami memastikan perlindungan berterusan. Makna dia, tak ada *dropout*-lah ataupun kita kurangkan peluputan. Langkah-langkah yang kita menyokong pelanggan, satu, *dedicated hotline*. Dia apa-apa keperluan dan pertanyaan dibantu. Latihan dan penglibatan agen. Insurans di Malaysia ini dijual oleh agen. *So* makna dia, *first contact* dia selalunya dengan agen. *So*, kita seharusnya melatih agen untuk boleh menerangkan apa-apa perubahan fasal polisi-polisi termasuklah harga dan struktur polisi. Kita memang dari segi selepas bulan sebelas ini, kita *intensify training* kepada agen untuk boleh menjawab kepada pengguna-pengguna yang beli insurans. Ada satu contohnya, kalau kita ikut aduan pelanggan 2024, 14. Dan setakat ini dalam tahun ini ada 30. Kalau kita tengok carta sebelah kanan itu, bilangan pertanyaan mula-mula pada hujung tahun lepas memang tinggi dan sekarang dah *start* menurun. Makna dia, ada lebih banyak kefahaman antara apa yang berlaku dari segi penyelarasan premium dari segi *consumer market*.

Slaid ketiga, impak pelarasan premium. Ini sebagai contoh dari segi pengalaman Allianz, yang kekal dengan produk yang dilaraskan termasuk pelarasan berperingkat, polisi dikuatkuasakan semula, 60 peratus; bertukar kepada produk mampu milik, 30 peratus; peluputan biasa, maknanya *[Tidak jelas]*, memang dalam setiap tahun ada lapan dan sembilan peratus, tak kiralah bukan fasal premium, tapi memang ada peratusan dia, itu masih lagi ada; dan hanya dua peratus kes peluputan disebabkan oleh pelarasan premium. Makna dia walaupun ada, tapi taklah sebesar yang kita jangkakan.

Di sebelah kanan, 90 peratus pelanggan yang terkesan kekal mendapat perlindungan secara berterusan. Itu yang satu orang kata, contoh yang baik. Lagi satu, pelan perubatan baharu diperkenalkan dengan ciri-ciri *co-payment five percent* atau *co-insurance* 15 peratus. Ini saya rasa semua syarikat insurans kena buatlah. Oleh kerana itu, kami boleh pulihlah dari segi *growth* ataupun pertumbuhan Allianz, seperti premium Allianz, kepada enam peratus lebih berbanding dengan tahun lepas.

Slaid terakhir, ini pembendungan kos. *Basically,* kita duduk dengan hospital swasta dan kita bincang. Bincang, bincang, bincang, bincang dan kita *line by line* minta dia turunkan harga seperti mana macam dalam contoh ini, pembendungan 11

peratus bilangan tuntutan kes ringan dan elektif macam jangkitan pernafasan, gastrik, cirit-birit, denggi dan *cervical fibroid — I mean, sorry,* fibroid rahim. *Then*, kita bincang dia dengan harga berpatutan. So, benda ini kita bincang dengan hospital satu persatu ya, *phase-to-phase* punya *discussion* dan dari puratanya nampak berkesan. Makna dia, kita dapat membendungkan kos dan bolehlah katakan adalah margin untuk kami. Tapi, kawalan inflasi jangka masa panjang ini perlukan *structural change*. Kita masih lagi *kicking the can down the road*. Apa yang kita buat sekarang, hanya *temporary.*

So, minta-minta PAC inilah yang boleh *discuss* balik dengan kerajaan, macam mana kita buat satu struktur jangka masa panjang untuk *to allow people to buy insurance in the long-term basis. We cannot continue this kicking the can down the road. Whatever discussion we have with the hospitals are temporarily. I think our colleague over there has mentioned, they still try to increase costs where they can. Like the unbundling, you can see they try as much as possible to recoup that cost.*

So, hospital are — everything is cost. What you do is they're trying to transfer the fixed costs to somebody else. In this case, examples shown that if they don't transfer to the insurance company, they transfer to the patient directly, but they are transferring. So, this is something that perhaps the PAC can help. Itu sahaja slaid saya. Boleh kemukakan soalan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. *Before I give to Seputeh*, terima kasih ya kepada pihak Allianz di atas pembentangan itu tadi. *My question to Mr. Mark, from our previous proceeding, we were told there is the decrease of number the new policy. Can you clarify on that statement. Is it true?*

Tuan Mark Steven O'dell [LIAM]: *In the number of new policies, I have some numbers here that show that the number of covered insurance actually had a slight decrease in 2024 from 2023. 2023, the years prior to that were all increases but there was a slight increase in 2024.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *How about the I mean, the first quarter or second quarter or…*

Tuan Mark Steven O'dell [LIAM]: *I don't have the data, sorry, 2025.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, the slightly decreased, can you provide us with the information?*

Tuan Mark Steven O'dell [LIAM]: *I can.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Later on, maybe later on.*

Tuan Mark Steven O'dell [LIAM]: Ya.

■1050

Also, I can comment that the 2025 claims inflation rate seems to be tapering down and this may support the notion that what we're seeing is post-COVID-19 sort of pent-up demand where all the elective surgeries were put off during COVID-19 and then we see them coming in 2022, 2023 and 2024.

Q1 at least for LIAM companies, I know the gross volume of claims was up only five percent, which is probably the slowest growth that we've seen in many years.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, Mr. Mark. In your presentation, LIAM proposed a co-payment and also co-insurance mechanism to curb the overutilisation.*

Tuan Mark Steven O'dell [LIAM]: *Yes.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *So, don't you agree that such mechanism will effectively shift the financial burden to the policyholders especially the vulnerable B40 and also M40 who I mean, these groups are actually who are struggling with the inflation. Can you explain more on this?*

Tuan Mark Steven O'dell [LIAM]: *Yes, sure. Of course, we have to balance the amount of co-payment whether it be the deductible co-insurance with the ability of the insured to bear those co-payments, right?*

Now, usually they are paying that could be several thousands per year or some other numbers anyway. Material number for their medical insurance. So, usually the co-payments, almost always actually the co-payments are capped. So there is a, I say RM500 deductible and maybe five percent of the next RM5,000 or five percent of the next RM10,000 might cap that the total cost, let's say RM750 or a RM1,000 per hospitalisation.

Generally, we feel that for an insured person who has undertaken to buy and pay premiums, that this should not present an undue burden for the majority of the population.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Isn't a system abuse better tackled through strict provider audit and through clinical governance rather than penalising a patient?*

Tuan Mark Steven O'dell [LIAM]: *Certainly, that would be helpful. Yes, it would be helpful. We can actually approach that through diagnostic-related group pricing, right? Where it's agreed upfront what the total cost is and the provider has to actually make do with that the total cost or the more efficient they are, the more margin they can make.*

The less efficient they are, the less margin they'll make. But the cost are fixed, then that maybe also another approach to this as you mentioned.

Tuan Heng Zee Wang [AIA Berhad]: *So, maybe allow me to add to Mark's points. So first, I think you know the question on whether the co-insurance or co-pay will burden the B40 and M40. So, I think it's important to clarify that the setup of Malaysian private healthcare today is not meant for B40.*

The cost base itself is very difficult to be provided or to be covered or covering the B40. I think that the biggest concern that we have now is actually the M40. With the escalation in medical cost, maybe we are looking at the B60 now rather than — because the income has not actually grown as fast as the medical cost. Hence, the bottom of the M40 may no longer be able to afford medical insurance.

But the question is a five percent co-pay, would that reduce the wastages? I showed you the example of cases where you really have to ask whether these are medically necessary. And we say if you don't say a lot and say, look, typically wastages, depending on the countries will range from 20 percent to 30 percent, which means all the insurance premium, all the medical cost can be 20 to 30 percent cheaper if everyone becomes more responsible.

Customer asks more questions. Doctor would actually ask more questions whether patients can afford. This is exactly like what Mark had said in the first quarter this year. We actually observe there is so much noise going on. With so much pressure, so much concern going on in the first quarter of it this year with medical cost inflation across the board even in our conversation with the hospitals of why the claims have gone down so much.

The general comment is first we see patient becoming a lot more cautious. They go to GP first, they don't need to walk in the hospital directly. So, without co-payment they will go in the hospital directly for example.

Second, the doctors also become more cautious. So, we see our outpatients go up a lot in the first quarter. It's really because there's also pressure to say, "Look, if I am being audited, you're going to have questions. Then it's difficult to explain.

So, all these are positive behaviours that we need to encourage by having certain mechanism to encourage these types of positive behaviours across the board to make healthcare cost more sustainable.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tuan Pengerusi. *I want to ask number one is that just now you say the patient shouldn't go to the hospital directly if you have small thing. Small issue with the health. Actually, I can tell you that over the years, I have been just going straight to the pharmacies. They are equally good and prescribe whatever medicine that I need. That's one.*

Number two is that can the insurance companies consider about NCD? You know the accidents in car insurance NCD, so that the small scratches here and there we don't claim insurance, we pay ourselves until when there is big issue then only we claim. So, if you all can consider that, that also would make your clients to be more conscious when they want to claim the medical insurance.

Okay, the third thing is like yesterday, we had a proceeding, we met with APHM, right? The Alliance of the Private Hospitals. So, they all complained that the insurance companies forced them to give discounts even up to 25 percent and they said that really eat into their cost until that they have no choice but to increase the cost and so on.

So, can you all consider — can LIAM consider to ask all your members not to demand discount especially up to 25 percent from the private hospitals so that we know — I think when we are having series of proceedings on this cost and now the Cabinet also say they want to set up a special committee to handle the private healthcare, costs and inflations. If the insurance companies alliance can also stop demanding for big discounts from private hospitals, I think this also can help to reduce the healthcare cost.

Tuan Mark Steven O'dell [LIAM]: *Maybe I'll tackle your question about no-claim discount (NCD). More and more companies are offering it now. More than 50 percent of the members, at least LIAM offer some form of either wellness benefits for no claims or no-claim discount or what's called premium-based — sorry, claims-based pricing where they immediately give you a discount and then the premium may go up if you utilise your plan for next year. You can go back down again once you don't utilise your plan for that year. That's called claim-based pricing.*

So, you see more and more of that and I expect we'll see more coming out in the future. It's interesting with the discounts because that is the biggest complaint I think from the private hospitals, that insurance and takaful operators keep asking for discounts.

It's one is the only leverage that insurers have with the hospital. But even despite those discounts, big hospital groups like IHH and KPJ, they are making margin of 20 percent to 25 percent and that's even despite the discounts that they are complaining about. So, I have a hard time feeling empathetic with the situation. They are making good profit.

Tuan Heng Zee Wang [AIA Berhad]: *So, maybe allow me to supplement Mark's comment. So, on the first point on NCDs. So, today NCD works very well for motor. Actually, in motor you also have what they calle excess. So, the first RM300 maybe you still have to pay this. No difference from co-pay.*

In terms of NCD, it works better for insurance because the repair of the car typically cost maybe RM1,000 something like if you have small knocks and all of those. So, the premium could be RM3,000 and then you say you get 50 percent discount and then if it is like a few hundreds and then people happy to pay for it.

Now, there is a difference today because the insurance premium in Malaysia for medical is still quite cheap compared to the medical cost. Every hospitalisation cost is about RM10,000 to RM12,000 today but your premium could be RM3,000. So, even if you get half of the discount, it still would not deter somebody going to the hospital because the hospital bill is RM10,000 versus like RM1,500. So, you definitely won't pay the RM10,000 yourself.

■1100

So, there is very, very few — in fact, there's no case that we can see today that you can go into hospital with a cost of RM1,500. So, the impact of a no-claim bonus will be very, very limited in terms of changing the behaviour in medical for now because of the premium is still low.

On the second point of a hospital discount, as I shared earlier, actually the discount is very ineffective today. Personally, you know I see from our own experience for our company. It's because every time we see there's a discount being negotiated, the price was actually being passed through in the increase because there's no control. As I indicated, yes, you know true enough for this quarter, maybe a lot of the insurer, because of interim measure, has gone to the provider to request for discounts. But we also see that, look you know the price actually already almost immediately moved up.

Now, I can speak on maybe for my company or maybe on behalf the industry that, look, if the private hospital says that, "Look, insurance asked for discount". If it says, "Look, we are happy to remove the 10, 20 percent discount", will the price come down by 10-20 percent? Will the provider be committed to say, "Look, if insurance don't ask for discount, the price of the cost will come down". That means they will adjust all the price to come down. Will that happen? For example.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Tuan Pengerusi, saya nak masuk campurlah dari segi Allianz*. YB, why should there be a discount in the first instance? They should be charging fair pricing and clearly there's evidence to show that they have not being doing that. There are many issues, the hospital are private institutions, some are listed. You know, they buy a piece of machinery, they want to recover that piece of machinery in six years and make six times profit from that particular machinery. This is what happening in — us. So, we are asking for fair*

pricing, we are not asking for discount. So, why you call it discount? Because we realised that they are charging us more than what they should be charging, and this is the reality. So, let's stop talking about discount, we want fair pricing. We want fair pricing. Publish your price, we can see.

Use the DRG that will show more clarity in respect to procedures — cost of procedure. Why don't we do this? But they come to you and say, "Oh insurance companies are whacking us, asking for a discount." It's not discount, we are asking for fair pricing. So, this is the reality.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *That means, in your view, the private hospitals maybe per patient they make more than 30 percent of the profit. That's why you demand, you know they give the insurance companies clients a 25 percent discount. So that they make less profit. I mean, is that how you view?*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *I think YB, they are making more than 30 percent. Okay, you buy a lithotripter machine, for example. It's a tank that you put to diagnose, to break up your stones in your kidney. So, let's say it's a USD1 million, for example. The hospital will want six times that amount, they want six times that. So, they put everybody to utilisation. So, the only way to recoup, to get that six percent is to charge higher. So, it's not fair pricing. The way they behave as well in terms of utilisation of the machine. They buy a new machine, "Oh, we have to utilise". They send an email to all of the doctors, "Please utilise this machine as much as possible", and this is what's happening. So, fair pricing, over-utilisation, trying to recoup back their fixed cost is basically causing the prices to go up. I'm not throwing them under the bus. They are behaving like any other private entity, they want to make money.*

But a certain landing page has to come. We have to get to a point of fair pricing. What is fair?

Tuan Heng Zee Wang [AIA Berhad]: *So YB, just to add, it's not about questioning whether hospital make how much margin or who makes so much. So, as an insurer we're responsible you know for the fair chargers, we are payor. So, we are responsible for fair charges for our customers, for our patients and that the consequence of that is basically the increase in premium right? And the worst thing is if one person over-utilise or if one person being overcharged, is the nine others who is actually in the insurance pool that will have to pay for? That's the whole concept of insurance right? Like each one pay USD1 and if somebody — something happens to somebody, he takes the USD10. If the person decided to take USD20 when he needs, then everyone has to pay USD2, that's the most simple, basic*

fundamental of pooling of risk in insurance. So, our job is to make sure that we pay a fair price.

Hence Mark just now talked about the need of a reasonable and customary price. DRG is aimed to address that but DRG will take a very, very long time and that's where our concern is. Hence our question is; in the meantime, are we able to say why one hospital charged RM5,000 for an MRI? Why another hospital charged RM3,000 for MRI? Why another hospital charged RM1,500 for MRI? Why do we need to use MRI of a certain accuracy of a high definition for a mild symptom cases, for example. So, all these are what we call medical wastages. Just like the scopes, it's not about wanting a discount for the scopes. Actually, we don't need the discount if you say, "Look, upper lower scope is done sparingly and it's not 65 percent upper lower scope but it's 20 percent". The whole cost will come down and there's no need for discount on that because it's used in appropriate manner.

Puan Manisha Keyal [Ketua Pegawai Penjagaan Kesihatan, Prudential Assurance Malaysia Berhad]: *Sorry, just to add a little — maybe unclear. I think I love the fact that yesterday when we attended …*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Can you introduce yourself? You are from?*

Puan Manisha Keyal [Prudential Assurance Malaysia Berhad]: *Manisha, Prudential. We are talking about reset. I think the point lies in the fact that we all need to have regulated pricing, which I appreciate. If you go back to the history, the regulator as an independent body for the insurance companies regulate the increase in the premium. They look at the cost that the company is paying, they look at the premium they are collecting and then allow the products to be priced accordingly, which is great as a governance. A similar governance on how the private hospitalisation's cost can increase, what's the parameter to increase the cost, how can we rationalise that, is really the ask.*

The ask is really the governance, the ask is not to say that it is less or it is more and why it is more and why it is less. The ask is can we look at some kind of a governance to say how can the private hospitalisation cost going forward can increase hospital by hospital, group by group, under which category. So, they'd be all together have a same amount of transparency and governance. That's really the summary of the ask.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *We are in proceeding number 15 today, right? On this issue? And we are still hearing the same phenomena. That phenomena is the insurance sector says that the private hospital has got 20 to 25 percent profit. Yesterday, we had session with — proceeding with Association of*

Private Hospitals, they said otherwise. Okay, and this phenomena has been — we have been hearing it until today's proceeding.

Now, putting that aside, I think that is one thing that we need to address. But putting that aside, just like to understand the industry first, the insurance industry first. You've got three bodies here, you got the LIAM, you got the takaful, you got the PIAM. Okay, why do you need three bodies in the first place? I'm just — not on the subject matter, I'm just trying to understand your setup first before I go into the subject matter.

Tuan Mark Steven O'dell [LIAM]: Ya, *I think it's a — there are two things here. It's not a matter of need the three but we have three very distinct types of a business, right? PIAM writing general insurance but they can also do medical; LIAM writing life insurance but we can also do medical; and then you have MTA doing takaful but they can also do medical. So, that's why you see the three of us here today. The market breaks up — about 70 percent of the business is from LIAM, about 20 percent is from MTA, and about 10 percent is from PIAM. So, there's no one medical insurance body.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, okay, after saying that, that means at the same time, previous proceeding it's mentioned that on the health side, you are not making much as compared with the other sector?*

Tuan Mark Steven O'dell [LIAM]: *That's right.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *It's still true until now? For all the three organizations or associations?*

Tuan Mark Steven O'dell [LIAM]: *I can quote from LIAM numbers and I also have some numbers from Bank Negara, which you'll probably see later. In 2024, our combined insurance loss RM245 million from medical insurance and 2023 the loss is worth RM327 million.*

■1110

Those were just from LIAM members cause I can survey my members and I can get that kind of data. But I suspect that the situation is not much different for MTA and PIAM but I don't have those numbers.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, with that fact on the table, all three associations still feel that you're going to proceed or expand further, or progress further on the health sector. Or you are still expecting to the growth rate there or are you strategizing accordingly to cater for that losses or whatever numbers that you share with.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Yang Berhormat YB*. I take this one.* YB, sebenarnya kita ada tiga persatuan di sini fasal undang-undang.

Akta itu memang lain. Kita ada akta *Islamic Financial Services Act* dengan Akta *Financial and Services Act*. Makna dia, bahagian takaful dia punya *regulation* dia lain daripada bahagian konvensional. Dalam akta-akta itu pun dia memisahkan insurans nyawa, insurans am, takaful keluarga dengan takaful am.

Oleh sebab itu, pembentukan *market* itu memang macam inilah. Lepas itu dalam itu lagi kita kalau macam insurans nyawa dia jual polisi *long term*, panjang seumur hidup. Takaful ada yang setengah buat *long term* dan takaful am dia buat yang pendek supaya *general insurance*. Dia buat insurans kesihatan setahun-setahun. Bentuk polisi *long term* dengan bentuk polisi setahun, setahun ada berbeza. Ini bukan nak cakap salah orang tapi memang hakikat dia. *Market* itu memang macam itu fasal kita memang dibentuk dari segi pelaksanaan undang-undang. Dari segi *structure* Bank Negara.

Dari segi *profit,* memang. Antara semua *profit,* kalau macam kita Allianz *profit health insurance* paling rendah, masih lagi tiga peratus daripada polisi. 60 peratus datang daripada insurans am, 37 peratus datang daripada insurans nyawa dan hanya tiga peratus datang daripada insurans kesihatan. Itu memang tak ubah. Dari dulu sampai sekarang. Sama sahaja.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So what's the strategic move? Five, ten years down the road in terms of the health sector*-lah *from your members, from all the three associations. Are you expecting growth? How do you move forward? That means with three percent is it sufficient?*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *So — maybe you can check again but for us yes because as long as — for health insurance we don't expect to make much money. It's quite improbable that you will make a lot of money. But it is important as the insurance company to provide —* kita kena jual insurans. Kalau tak, orang tak beli kan. *So,* kita kena buat. Kita kena jual. *We have to sell. So, our hope is as long we don't lose too much money on health insurance, we are okay.*

So, the reality now is if I take ourselves back twelve months ago, all of us went to Bank Negara. We are losing a lot of money in health insurance. We submitted all our rating to Bank Negara and Bank Negara agreed. Tapi, it resulted in perhaps in an increase of 40 percent. Then, the market jumped. Then Bank Negara asked us, cannot, go back 10 percent, 10 percent, 10 percent. Remember? This was what happened. So, because every single thing that we do in terms of rating we have to send to Bank Negara.

Another point YB Teresa, there's no regulator looking at the hospitals. When they price, they price. For us there is Bank Negara. Every single of our price goes to Bank Negara and they will scrutinise and they use fair pricing in their adoption of the

model to check whether our price is fair. That means we meet the minimum requirement of pay and claims. We have a little bit of margin and that's it. That's what basically they approve.

So, kita kalau masa hadapan akan *continue* macam ini, insurans kesihatan tetap akan kecil. Kalaupun buat duit pun sikit sahaja. Tak banyak.

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *So, your — the industry is prepared to continuously be in this situation or you have strategies to increase your percentage of profit from this sector?*

Tuan Wan Saifulrizal Wan Ismail [Pengerusi, Persatuan Takaful Malaysia (MTA)]: *Assalamualaikum warahmatullahi wabarakatuh and* selamat pagi. Ahli jawatankuasa, untuk persoalan itu kalau kita tengok *medical* punya insurans ataupun *family takaful* daripada *life insurance* dengan MTA kebanyakannya adalah *guaranteed renewable*. *So, basically* bila kita dah ambil *customer* itu kita kena *renew* dia sampai bila-bila. Kita tak boleh *terminate*.

So, kita dah ada beberapa juta orang *customers* dalam buku tersebut. Kalau kita tak *continue* untuk *write new business*, buku yang kita ada itu semua akan kira dalam bahasa insurans panggil *ageing*. Bila *ageing* kos dia akan lagi meningkat. Jadi, nak macam mana pun kita terpaksa kena ambil *customers* baharu untuk kita nak *average*-kan, untuk kita *help* tampungkan *the cost. So, for most of us, we actually have, short of better words*, *we have to continue on with the current book that we have and we can't get out from it.*

Tuan Mark Steven O'dell [LIAM]: *Maybe I just add a little bit as well. I used to run companies as well. You know the shareholders of course the industry cannot sustain material losses ongoing indefinitely. We hope that through the some of the initiatives that we've outlined earlier, that will get us to a better place. But that's still we have to face reality that we're not going to be getting big margins from medical insurance.*

But the benefit to us, to the industry is that our clients want, the rakyat *wants medical insurance. This is also seen as a way to build more clients and that can open the door for sales of other products. I won't stay it's a loss leader but it's a semi-demand product that our customers want. We feel that we need to fill that need.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Coming back to the slides number 11. You shared with us.*

Tuan Mark Steven O'dell [LIAM]: *Okay, the appendix. Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Yes. This is for a Hospital Y. This I presume this is a private hospital. Correct?*

Tuan Mark Steven O'dell [LIAM]: *Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Do you have the breakdown for the public hospital?*

Tuan Mark Steven O'dell [LIAM]: *No, we don't have that data. Sorry, we don't have that data.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *You don't have it at all?*

Tuan Mark Steven O'dell [LIAM]: *No. I am not even sure they have that data.*

YBrs. Tuan Wan Saifulrizal Wan Ismail [MTA]: *Because generally I mean most of our customers don't go to the public.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *I know. I realised that. I am just wondering whether you have that.*

Tuan Mark Steven O'dell [LIAM]: *No, we don't.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Because I think...*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara] University Hospital? University Hospital?*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Other public hospitals because I think MOH also don't have this…*

Tuan Mark Steven O'dell [LIAM]: *I think so too.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Yes, that's why I am asking if you have it.*

Tuan Mark Steven O'dell [LIAM]: *[Ketawa] We don't have it.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Alright. Then my next question is when you prepare the premium for your clients, you take into consideration of their health condition.*

Tuan Mark Steven O'dell [LIAM]: *Yes.*

Tuan Ts. Zahir bin Hasan [Ahli PAC]: *Some policies, you close one eye you said okay you just take a ballpark figure with certain assumption then you give a certain amount of premium. But some of your policies I think you have pre-condition, medical condition of that clients before you determine the premium. Right?*

Now that is understandable but I am just wondering whether you have any plan to include in your assessment or in your parameters of determining your premium cost, lifestyles. For example those who smoke, those who take vape, do you give penalty points or do you take that as part of their parameters to determine your premium? That means their lifestyle. If for example I don't know this one could be micro. If somebody can prove that they exercise every day — for example, lifestyle — they don't take sugar, they don't smoke, they don't take vape. Do you have that

kind of approach where you take all these into consideration before you determine the rate of the cost of the premium?

Because that would positively encourage people to take insurances. While — I mean convincing the insurance company. Okay I have got a healthy lifestyle. You give a certain incentive for such situation. Rather than you penalize your potential client for you have diabetes, you have already high blood et cetera. Thank you.

Tuan Wan Saifulrizal Wan Ismail [MTA]: Untuk jawab soalan itu, memang untuk insurans dengan takaful bila segi kita caj premium dia. Merokok, alkohol, BMI, semua dia ambil kira dalam pengiraan premium tersebut.

■1120

Sebab kita ambil kira faktor-faktor, *the factors* yang kita boleh *objectively determine because whether you smoke or not, when you submit your claim,* kita akan tahu *if you declare you are a non-smoker but then you submit your claim you have indication of a smoker, it's easy to check. But there are other lifestyles* yang lebih susah untuk *determine*. Contohnya, *like exercise everyday* ataupun — memang kita ada *smart watch* dan sebagainya tetapi keberkesanannya dengan objektiviti untuk kita *determine* sama ada orang itu *exercise everyday*-kah, makan *healthy*-kah lebih susah untuk kita *determine*-kan. *So,* bila kita *price*, kita ambil kira faktor-faktor yang objektif sahaja, yang kita boleh buktikan sama ada orang ini betul sihat ataupun tak sihat.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: YB, kita dalam insurans ini, ada dalam syarikat-syarikat insurans, dia perkenalkan polisi diabetes. Makna dia *Type 2, Type 1* boleh lagi ambil tapi *you* kena jaga. *High BMI, hypertension*. Ada produk-produk ini tetapi orang tak beli. Walaupun kita terima orang yang sendirinya ada penyakit tapi dia tak beli. Mungkin saya rasa boleh katakan *struggle*-lah nak jual produk-produk ini. *So,* bukan tak ada, ada tetapi hakikat dia, orang ramai ini tak beli. Ini yang masalah ini.

So, benda-benda macam merokok semua memang ada tetapi dia ada dia punya ada faktor-faktor, had dia, lepas itu kita kena serah — kita tak boleh *load* terlampau tinggi sangat fasal bila kita hantar ke Bank Negara, dia akan tengok. Bank Negara *applies fair pricing* juga, dia *also* masa dia bagi kebenaran kepada kita untuk caj polisi, dia akan tengok produk-produk kami. *So*, memang ada *checks and balances* sikitlah tapi insentif itu ada tapi orang tak *interested*.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih, Puan Pengerusi*. I think, I have a lot of questions*-lah. Ada 11 soalan tapi *I think to be fair, we split*-lah ya.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ya, bagilah orang lain juga.

Tuan Sim Tze Tzin [Ahli PAC]: *I ask the first three questions* dulu. Okey, terima kasih *for all the insurance and also LIAM, PIAM and Takaful to come back the second time. I think this is a big issue that I think needs further deliberation. That's why we call for a second round. Alright, yesterday, Bank Negara already announced the RESET initiative. I'm sure you guys were there and over the past few months, you have also been, you know, talking to them. So, my first question is do you think the RESET will work or not? In your opinion. And what are the pitfalls? What can go wrong about that RESET plan?* Terima kasih.

Tuan Mark Steven O'Dell [LIAM]: *Maybe I'll take this first. I think if it is executed as designed, I think it will have an impact. But you know, there is a lot of variables. Number one is, let's take the basic plan. There is no guarantee yet, you know, that we can design a basic plan that is affordable and adequate. So, this is what we are going to be working through with the consultant in the next three months and that is attractive, you know? So, it's a big challenge but it also a big variable. And things like DRG is another one that we think is something that will make a big difference. But we need the will of MOH to actually make it mandatory in order for it to have its greatest effect. So, I think the short of it is if implemented as outlined, I think it will make a difference. The devil is in the implementation.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *YB, just a perspective of an individual company. The RESET is good but like Mark said, are people going to buy? Even if you make it cheap, will they buy? This is the other issue. We really don't know. We have done in the past, if you remember, I think EPF came out with* i-Lindung, *was it? And what happened? No take-up, right? Ya, very low take-up. So, we are talking about human behaviour, we are talking about restructuring the medical, there's a lot of factors.*

So, we say we will do it, we'll try and we'll see how far we can actually go with this particular aspect but don't expect the 100 percent, it will be somewhere in between. Hopefully higher than what we have previously experienced but we cannot control human behaviour. Like I said, we come out with Type 1, with all this diabetes policy, if you got hypertension, you can still buy a policy. No take-up. People — not that they don't want to take up; they don't want to follow the regime. They said, "Oh got regime? I don't want", you know? So, it depends also on human behaviour as well.

Tuan Heng Zee Wang [AIA Berhad]: *So, YB. Sim, maybe just to supplement, I think you know, question on we said that we were all there yesterday. I think what*

Mark shared earlier the 13 items, if you were to regroup them, it all fall under the RESET, different buckets of RESET. Like for the example the first one on the revamp MHIT, Mark talked about the base plan. This is actually currently you know going on. The second one on enhanced price transparency. We spoke a lot about price transparency and procedure transparency and cost transparency. That one is very essential. So, this will work if you really take a whole-of-nation approach like everyone has to participate in making this possible.

Why we are so concerned today is because Bank Negara actually announced yesterday to say interim measure is a plaster, it's a temporary fix, hence we bring down the price. But if we see the price at the other side continue to go up, it's not sustainable and hence that's why it's very important for everyone to say, look, this is what we can do you know, to control the cost. Right? It's not about making profits, who makes more profits. It's about reducing the wastage, you know? Medical resources are very valuable. The public side have insufficient amount of screenings and you know, but yet in the private side you know, we use this excessively. Maybe you can use the spare capacity to support some of the shortfall we have in the government's facility and at the right price which is what you know Datuk Seri Dzul talked about funneling some of the B40 patients, at the right price, to the private hospital.

So, this really requires everyone working together. One side, insurance or Bank Negara work alone. It's insufficient, I have got to say, coming out from yesterday's session, we are quite worried that it becomes quite clear that there's no appetite to introduce any form of regulations or control. If there isn't any regulation or control on private healthcare, which we now deem as essential, then the transparency part becomes very important. The benchmarking part becomes very important. The audit on what's medically necessary is becoming very, very critical because today, that is not part of the scope. As far as we understand the hospitals, maybe they do their own audit. We are not aware that KKM actually do medical-necessary or appropriate audit on private healthcare, for example.

Tuan Sim Tze Tzin [Ahli PAC]: *Okey, thank you for the first question. I think the basic issue that this proceeding started is basically how — about medical inflation. So, we have been asking everyone, all sessions, what is the true medical inflation? Alright. Because what we know that the 15 percent that is often quoted is actually through a survey. Alright? It's a company that surveyed East Asia, South East Asia* dan sebagainya. *So, we have been trying to determine and I think nobody has a certain answer what is the real inflation. So, we asked APHM, what is the real inflation? They told us they also don't know but from their record, it's about six*

percent. Alright, six to seven percent. And we asked third party administrator (TPA). This is more what you called, data-centric.

They came out with actually less than two percent per-case basis. Per-case basis, the inflation from the claims is actually like less than two percent. So, we can — and then we have DOSM. DOSM came out with 1.7 percent, alright. So, what we can say is that the medical inflation is not per-case basis, it's not outrageous per se but the issue is the pent-up demand like what Mark just now said. A lot of pent-up demand that add to the case, add to the inflation. That's why it is more than five, six percent or 1.7 percent.

■1130

Then, the problem — the issue if with that is that, even if you have pent-up demand and it will plateau. Now, you have seen that the cases have gone down, or actually not going up anymore like what Mark has testified just now. So, the issue is because during the COVID-19 time, there was no claim actually, there was less claim because everyone is about COVID-19, COVID-19, COVID-19. They delayed their treatment, they do the treatment now so it goes up. But now I think after seeing all the doctors have done, now it has plateaued.

So, I had a problem here. Because let's say even if this is 15 percent, even if it is — which I don't think so but the insurance is charging a premium high of 50 to 70 percent. I don't think it's justified, okay. I think is un — is excessive. So, I want to put up to the insurance industry. If you put up a 70 percent and you actually kill off a lot of your customers. Customers don't want to join you, don't want to buy up new insurance because to them it's unaffordable.

To me, I feel that, why should I have been paying — if let's say the 15 percent inflation, why should I have been paying 70 percent hike?. So, I think the industry must reform yourself because I don't see here your presentation how you are going to reform yourself. Can I get some comments, please?

Tuan Mark Steven O'dell [LIAM]: *Ya YB. The numbers that you are quoting, right, the 40 percent, the 50 percent, those are multiple years. There are not an annual increase. Is not like it's going to be increasing 40 percent a year, this year, next year, etc etera and it's usually meant to be — try to be adequate for a certain period going forward. So, the companies make assumptions on what inflation may be and they use that in their pricing and that is what you get, a one-time 40 percent that may last the company three years, say for example, before they have to revise again.*

But the other factor too is that, during COVID-19, companies were asked to defer adjustments at all. So, some of the adjustments came out in 2023 and 2024, the payments hadn't be adjusted since pre-COVID and so there was a bit of catch-up in some cases. And while the number of admissions were down during COVID-19, the number of claims were down less so. And I just quote some of the numbers you asked about inflation numbers. I have some unaudited numbers if I may. There are not audited yet but there from our medical database. The average medical claims inflation rates from 2020 to 2024 were seven percent, seven percent.

Now, there — it spiked in 2022 and 2023 where we saw the recurring, you know, that resurgence right over elective procedures to 33 percent in 2022 and 17 percent in 2023. 2024, has come down to 9.8. So, we're seeing it decreasing because we're seeing the frequency levelling off and the cost of care while the last few years had been up a modest two to four percent, the average cost of care. The average cost of the hospital admission has gone up 50 percent in the last six years, 50 percent. So, there are — it's a bit of a mixed bag and I can't speak specifically for any company you know but the majority of rate increases that were proposed say in 2024 were less than 20 percent. But there were outliers that were is high is you quoted earlier 40 to 70 percent and I can't speak to the necessity of that, but we are seeing claims cost coming down. But the average from 2020 to 2024 was — the CAGR was seven percent.

Tuan Sim Tze Tzin [Ahli PAC]: *Ya.*

Tuan Heng Zee Wang [AIA Berhad]: *So, just to supplement that. You know YB, I think on the first point on medical, as Mark said look the 40 maybe 70 is potentially the aftermath of the COVID-19. Some complain may have to catch up five years or three years plus another two years project forward so that's like five percent. So, five years of inflation, even if you take like 10 percent, you compound to that kind of quantum.*

So, you know you asked a question on what is the industry doing. As proposed by Mark earlier on in the pipe, there are two big things, you know, that the industry needs to do. One is to, instead of moving to like you know irregular periodic repricing and this is what Bank Negara has also effectively done in the interim measure is to do something more regular and but smaller quantum and hence the shock to the consumer would be much less.

Second is to also make this transparent and upfront as what this is proposed under point two. In fact, you know come September, you know that will be a new rule for insurers to what we call illustrate in a medical premium inflation. So, it would be like some percent inflation and say, look, if your premium wants to increase in seven

percent each year over the next 20 years, how much you need to pay. And then there is another rate at 10 percent. Of course, it's an illustration, it may be high, maybe lower.

So, hence it is great awareness to the customers to understand that, look you know, medical inflation is here to stay. All of us to be responsible. Cut down wastages, so that you know hopefully it doesn't increase at the rate that impacts affordability.

Tuan Sim Tze Tzin [Ahli PAC]: *I want to quote a few examples that people complained to us. The insurance medical* inflation *[Tidak jelas] are hiked. It's as high as 180 percent, 183 to be exact. To me, that is totally unjustified, okay. Because the inflation rate, like what you say seven percent per year, how do you justify even if you say delay repricing three years or five years? How do you justify 183 percent? It's totally outrageous.*

So, that is why the problem to us after we investigate more and more deeper, is actually your product, that's the problem. You have a closed pool. The pool is dying, okay. Smaller product, different kind of product. You started a product 1980s, a lot of young people bought — sorry, let's say 1990s, a lot of young people bought. But after that, you move on to another new product. So, that old product, as it ages now 2024, 2025, they become old, they know young people come in, then that pool is dying and because those people are retiring, retired. Now they go hospital, so you charge them a 180 percent hike. I think this is unsustainable and I think the problem is that insurance companies' product is designed that way and you keep on creating new pools. The pool, the old pool died and you don't have a cross-subsidy mechanism.

Then I think it is unfair to those people who are loyal to you for 30 years and when retire, when they're being — they need insurance most, they're punished. And then the bigger problem is that — that is why the people out there are saying insurance is only to insure healthy people. When they are unhealthy, you try to keep them out from this system. They give up, they give up this — they surrender the policy.

I think that gives the insurance industry a bad name. To me personally, I think insurance is a very important industry. It is a very important to healthcare and I have never denied and I have never what do you call — and I always think that insurance is very important to our society to protect. So, the issue is, can you guys reform yourself? Because I don't see any slides reforming yourself here. Thank you.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *YB, let me just — first of all, what you are describing is actually a requirement by the regulator. Because when they see, they regulate us by risk-based capital. So, risk-based capital is where your portfolio is weak, you have to put more capital. When you have to put more capital,*

therefore your premium has to go up or you have to restructure. This is a formula that is not created by us but it's created by the regulation of this particular industry.

So, what you describe, yes, from this point is actually quite fair but it's a very capitalistic approach towards how we deal with financial institutions, banks and insurance companies. We ask the bank. If their loans go bad, they get penalised like us. So, when our particular cohort gets — ages and more claims, we ask to do something. Otherwise, we have to put more capital to sustain that particular cohort.

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So, the automatic response to that will be an increase in premium. I am not saying it's good or bad. I am just explaining to you this is how the mechanism works.

So, if you ask us to reform this, certain reform would have to be done into the risk-based capital framework of the country, which then has to be back to Bank Negara. Because at this present moment, anything we are not allowed to cross-subsidise. I am speaking for the whole industry, right, Saiful? We are not allowed cross-subsidise. You have to put money whenever there is a deficiency in your portfolio.

*So, we are not allowed to cross-subsidise even if we want to. I belong to an age where there were no RBC, because I started 40 years ago. Those days, great old days, we just charged flat premium, okay-*lah *we take some losses here, we can subsidise there.*

Now, we cannot do that under the risk-based capital regime. I am not throwing Bank Negara under the bus. This is happening all over the world, okay. Because actually, capital has got to do with risk. It's the most scientific way of looking at risk.

So please, we're not trying to criticise Bank Negara, but it is a system also that it is a very capitalistic system that actually promotes that kind of particular behaviour. Capitalism promotes profit margin. So, when you have a financial model based on that, you will displace people and this is exactly what are you described this now, sir.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, I…*

Tuan Ng Kok Kheng [Pengerusi, Persatuan Insurans Am Malaysia (PIAM)]: *Yes, sorry. If I may add, I think you're only talking about the reform. I think because we are regulated by Bank Negara, so the whole thing that we have to do as what Encik Zakri have said, will have to be followed.*

But if you are particularly now looking at the medical side, I think what we are doing here today is also trying to reform it in how we can. Come out with the product that can be affordable to a much more broader part of the consumers and then also

lift up to the insurance company themselves to also — because as a company, I don't know how we can reform if we are already operating under such governance unless the law itself were to change to make sure that we reform. I think this is an approach because of this recent issue that came out, right? I mean even with the pent-up demand coming up. This is what we are doing.

So, I think there are few committees that has been working on in coming out with the basic product and so on. That should be a part of the product reform to address certain issues that we have.

Presently, I think Bank Negara, what they have done in imposing on all of us is to hold back on the price increases. That's going to go on for three years. So, that would probably provide a bit of relief.

Hopefully within that time, we are able to come out with much better solution. Also, I want to emphasise that I think the solution cannot be just focus on the insurance industry because at the end of the day, we are to operate within regulation and make sure that the companies are all also strong to continue.

We cannot have companies operating and if they are getting in trouble, they also affect consumers because the consumers then will have a company who's no longer around and where do they get their insurance cover and claims from, right? So, that is the purpose of regulation, to make sure that we continue to be strong and well-governed.

Even under this medical pricing, we are also under governance, under regulation to see how we price it. I think the broader issue also is that the — as everybody have said, but one area I thought that maybe, as a whole. You see, I am also involved — I am from PIAM and motor insurance is a big part of what the industry is doing. Presently we are also facing increasing cost as well and also because there's also increase in rate of accidents. We feel that there is a lot of work that we need to do as well.

One of the things is that how do we reduce accident rate. So, if you want to reduce accident rate on motor vehicles or on drivers, I think it's more than just making sure that our roads are well done, traffic lights and so on, but it is people's driving behaviour.

We are not addressing sometimes the fundamental, that people's driving behaviour and where do we start improving people's driving behaviour is probably at the schools. I still remember when I was a young boy in school, we are taught how to cross the road properly, how to drive, how to signal and so on. I am really not sure whether that's done today.

I think similarly if you look at medical, it's about what? It is about whether we are able to live healthy and where do we start it from? So, we are also not addressing some of this, I think. So, if you don't, we are just looking at what the consequence is going to be.

I am really hoping that we do not go the way of the United States. Because everybody in the United States is really free capitalist, even insurance companies, they can price, they can charge, they can reject claims. It's a lot, a lot more. Its not what we do here, but over there it's so different and it's even blatant. You've heard of stories as well, how consumers are even reacting to that. By picking a gun and claimed a CEO as well.

So, we hope you don't go that way. But apart from what we are trying to do, I think we are trying to reform it by a certain way of coming out with the product that can suit — but the hospitals also have to play their part. I think the government on the health side there have to really maybe be — just how Bank Negara does it on us, right? I think something may have to be done there because otherwise, if you regulate one side, the other side is not regulated that well or — so for me it's not addressing the entire issues.

Tuan Mark Steven O'dell [LIAM]: *YB, YB, can you go the slide five? I think there are number of things that — sorry, my slide is next one. Next one. Yes, right. [Merujuk kepada slaid pembentangan]*

There are really five areas here that I would put in the bucket of reform. One is under transparency, the first two bullet points there. Thrust 2, implement diagnostic-related group pricing, I think it is a reform. Initiative on the Thrust 3, developing of basic MHIT plan more affordable and sustainable, also a reform item.

Just below that, review plan design to reduce unnecessary admissions. I just gave you the example. Somebody going into an emergency room for an acute but not serious conditions. Maybe able to be treated and then sent home, but often times they are admitted. They are admitted, why? Because by being admitted, they can make a claim. So, this is a design flaw. We need to come out with a better design product to encourage the right behaviour.

Finally, as you mentioned, BNM is reviewing with insurers data on the managing of closed blocks on whether greater pooling would be beneficial for all. So, to me, I put those in the bucket of reform.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, yes. I think these are good, you know. We are trying to push everyone to do something, okay. Of course, private hospitals will say the wrong is from the insurance. Insurance will say the, you know, hospitals*

are wrong. Everyone will blame the government is wrong, all right? So, I think that's given. Finger-pointing, that is when there are some issues.

However, this is why we call for a second meeting. The second meeting is that what are you going to do? Okay. What are you going to do to reform your problem? I think the biggest problem now we know for the first time that this thing called risk-based capital framework. Okay, and risk-based capital framework is causing this problem because you have to make sure every pool — some pools are very small now.

That is why there is a case of 183 percent. I cannot take it, you know. It's unjustified totally, impossible to have a 183 percent hike. Even me personally, got a 50 percent hike. And it is, I believe that pool is quite big, okay. But I got a 50 percent hike. I think it is not justified at all. You see?

So, I think the problem now is that insurance company if you don't do something about yourself, you're going to lose a lot of customers because people are very aware now. They are price-sensitive, they already see, they already know. If you don't do something, I am sorry, you may have a tough business environment. To be honest, medical insurance is your first — you told me just now, that it is your first, your product to open it up, so that you open up for other businesses. So, you need medical insurance to attract people to start buying. Okay?

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So, the way I see is that cross-subsidy is justified because you are making money from so-called investment-linked. You have other riders; from medical insurance you go to life insurance. You go to general insurance et cetera. I think certain subsidy is — no business is forever making money. Cross subsidy happens everywhere, alright? So, I think I hope the insurance companies here, a lot of CEOs here, to rethink about it.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: YB.

Tuan Sim Tze Tzin [Ahli PAC]: Ya.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *I'd like to interject. We cannot cross-subsidise. The regime doesn't allow us to cross-subsidise.*

Tuan Sim Tze Tzin [Ahli PAC]: *Talk to Bank Negara.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berha]: *[Ketawa]*

Tuan Sim Tze Tzin [Ahli PAC]: *Because I think your business is affected by this issue and you have talk to Bank Negara to reform this framework. Maybe if this — we don't have to follow whatever capitalist America is doing if the Americans using*

the risk-based capital framework. Why do we need to do that in Malaysia? We don't have to follow everything.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *I cannot answer that question. Many of us have spoken to Bank Negara about this and it's a no-go. The RBC is here to stay and for a lot of good reasons as well because they're looking at bigger picture; the health, the insurance claim system, systemic risk and stuff like that. So, everybody is looking from a different angle. So, the compromise is what we require. It's a thus far I would say it is not achievable with the RBC.*

Tuan Sim Tze Tzin [Ahli PAC]: *How about you merge your pools? Because your pools are, you know, there are too many pools and your pools are, some of the pools are dying and it's not fair to the people who loyal to you for 30 years.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *Tuan Wan is a better authority on this subject.*

Tuan Wan Saifulrizal Wan Ismail [MTA]: *Okay. I guess YB if I may. I think the issue of cross-subsidy, we just have to be very careful of what we design and how what we wish for as well because cross-subsidy is also implying that certain parties are paying more in order to help another party.*

So, let's take two simple examples on what, how cross-subsidy may have unintended consequences. So, let's say you take life versus health, right. If your life cross-subsidise your health pool and people who are purely buying life potentially will now need to pay at higher cost even if they don't use health. Then the question is it fair for them?

If you look at young versus old — let's start on the issues of a closed book itself. I mean, yes, closed book generally has older customers but in order to cross-subsidise that means you are bringing the younger pool and in order for the younger pool to cross subsidise that means you charging — you're intentionally charging, over charging the younger pool in order to help the older age. So, the question also is it fair for the younger ones to actually pay more than what the actual cost is?

So, the cross-subsidy has this element of unintended consequences, which yes, we can do it in the short term but the law of equilibrium is it will have to adjust itself. The cost has to be borne by somebody else whose probably not utilising it.

Tuan Sim Tze Tzin [Ahli PAC]: *How do you justify 183 percent hike?*

Tuan Wan Saifulrizal Wan Ismail [MTA]: *I mean I can't speak on behalf of the company that does a 183 percent hike. But I mean I am just talking from the concept perspective that we have to be very careful in terms of asking for that cross-subsidy to happen because it will have a broader implication on the dynamics.*

Tuan Sim Tze Tzin [Ahli PAC]: *The broader implications is that people lost trust in insurance company if you don't reform yourself. I don't have a — I am not running insurance business. I am throwing up back to you. Maybe it's a cross-subsidy from your shareholders, alright. I don't run insurance. You guys have to figure it out. Alright, thank you for the first round of questions.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, so your next round will come later. [Ketawa] Very long first round. But I'm very patient because you have a lot of points to say. Thank you, Datuk Wira Chairman. But I just want to go through some of your recommendations. I think overall this is a positive step after the second round you come over here, you come out with some of these recommendations. We hope that some of these recommendations will be accepted by relevant parties. That is the most important.*

Page three number four, you mentioned about the update — 50 percent of the LIAM insurance now offer some form of incentives like no-claim bonus like automotive, wellness incentives, and claims based on pricing. My first question is, is this something new for you offer this no-claim bonus like automobile insurance or you have been doing this for sometimes?

Tuan Mark Steven O'dell [LIAM]: *It's a growing trend that more companies are doing it. They were — if you go back five or ten years and you wouldn't see much of it at all but in recent years it is something I can say is relatively new.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, this will go on? Will — the number will increase more than 50 percent?*

Tuan Mark Steven O'dell [LIAM]: *I believe so. I believe so.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I fully understand and appreciate about what you said earlier regarding your profit. An average of three percent, I presume your profit before tax. This is not a big profit but for the fact that your members are prepared to give no-claim bonus. That means this is something positive. I presume — I don't know. I don't want to say the word 'cross-subsidy', your other insurances beside the health insurance are making good money, right?*

The other thing you mentioned about wellness incentives. What kind of incentives you are giving to the people who took your insurance as wellness incentives?

Tuan Mark Steven O'dell [LIAM]: *Yeah, I am not in the position to comment in detail but basically what we mean is for those who are not claiming, their companies have programs that provide either discounts or subsidies or for check-ups, for screening, for other wellness, for vaccinations, different things that they offer to incentivise a healthier lifestyle.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I don't know whether we have figures in terms of the number of people who…*

Tuan Mark Steven O'dell [LIAM]: *Who utilise it?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *The total number and versus the claim. The total income. Take one company as an example and the total claim. How much is the difference? Because I remember I am quite fortunate in the sense I don't really buy insurance but I am okay until today.*

Before I was on the board of one of the companies in Kedah. Ten years I was insured but I never claimed even once because I don't get hospitalised. Whenever I get sick, I just go to clinic then get medicine then it's okay. So, ten years the insurance companies make money from me through this company that I am sitting on the board.

I presume that maybe many more people like me. I am sure. I don't know about Seputeh. Have you been hospitalised? I have never been. You never been right? You've been buying insurance, right?

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You are not fortunate. I am fortunate. I don't buy insurance. Or the company bought for me. So, I don't quite really — not that I don't believe them. I'm quite really convinced that three percent is the average profit before tax, I presume, by the insurance companies. Forgive me if I am wrong. That is one.*

Another thing is you plan to give incentives for people who have been loyal to you for many years, they never claimed. After five years they never claimed you give certain incentives to encourage them to be with you, to stay loyal to you. That is another question.

Another one is — I will not be as long as YB Sim because he is a person very totally in this thing. We are just supporting this thing. Page four. This is regarding exempt group insurance from eight percent SST.

I think is not fair just to do it for the group insurance. I think should be for the individuals as well. To get exemption from the government from SST, people in B40 for example, you know that exemption is a big amount for them. Eight percent now compared to six percent before. Is there a plan to even ask for the…

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Tuan Mark Steven O'dell [LIAM]: YB, *so for the individual...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Not group, individual.*

Tuan Mark Steven O'dell [LIAM]: Ya, *for individual insurance, it's already exempted. So, we want to level the playing field by asking for an exemption for group insurance.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *But, why not for individual as well?*

Tuan Mark Steven O'dell [LIAM]: *No, individual is already exempt from...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Oh, you've already got?*

Tuan Mark Steven O'dell [LIAM]: Ya, *already, already.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Sorry, I don't know much because I don't buy insurance. Okay, that's okay.*

Then, on page five, request — on number 11. Request private hospitals to freeze cost for the same period that insurance takaful operators are asked to kept premium increases. What is the response from private hospital or private...

Tuan Mark Steven O'dell [LIAM]: *Sorry, which one? 10? Number 10?*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Number 11.*

Tuan Mark Steven O'dell [LIAM]: *11. Oh, the responses were quite public, there was an article published where they said no.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *They said no?*

Tuan Mark Steven O'dell [LIAM]: *They said no.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, they are — they not..*

Tuan Mark Steven O'dell [LIAM]: *And I think it's evidence to Zee Wang was showing the increases. Just in this year, in one hospital, there were 300,000 line items that the — right? Yup, yup.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Tuan Mark Steven O'dell [LIAM]: *Over hospitals. Yup and the — so, the price increases continue on their side.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, the next one is on page 12. Charging behavior. No control of charged item. This is a quite a big issue that we also asked from the private hospital about this issue. Like disposable gloves, they charge much more, you know, compared to the price is like the whole box of the glove, was just one pair they charged; and many other item as well. Their response was — you see, when they have to claim from insurance, this kind of thing cannot be included. Right? Then, they have you know things like cost or expenditure for the cleaners, for nurses and many other people, security, work in hospital. Right? It's not included in the cost that they sent to insurance. That's why*

they have tried to charge exorbitant amount some of the item. Maybe you can respond on that first.

Tuan Mark Steven O'dell [LIAM]: *Sure. I think they are talking about that in reference to most plan designs have a room and board limit. And so, the common complaint from the hospital is that because they room and board limit, let's say RM250 but the cost for them to operate their room and board services is higher than RM250. So, that they try to make up forward in other ways right? Right? So, there are two thing I just comment there. One is there is nothing that prevents them from charging the patient the actual cost of the room and board and the policy then would pay up to the limit and the patient may pay the difference. But that's not ideal. The other thing is when I was talking to some colleagues about this the other day is so let's say you move the room and board into 'as charged' like any other hospital item, we have no confidence that we'll see a reduction in some of the other cost.*

If we had a commitment, you know that the cost of this incidentals or the — we call it hospital services and supplies would go down and they could claim the actual cost of room and board, I think the industry will be open to that. But right now we have no confidence that would happen.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, the next one and the last one on page 14 Mark.*

Tuan Mark Steven O'dell [LIAM]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Regarding a [Tidak jelas] charging behaviour, OT and labs services and charges, while it may include some other things as well, MRI and all that. You see, I don't really know what is the lifespan of these equipment or machines.*

Tuan Mark Steven O'dell [LIAM]: *Alright.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *They have to be different machine, maybe the lifespan is different and therefore their time of the depreciation is different. Building maybe depreciation in 20 years and so on. Therefore, after you finish all those it's fully depreciated. Come out with just a book value and I don't understand why they have to charge this kind of amount. I presume they make money from this even after the machine cost is only RM1 book value. What's your opinion on this?*

Tuan Mark Steven O'dell [LIAM]: Ya, *I think it's really what we call unbundling or a layering of charges. I mean you know they could just as easily have increased the operating theatre cost by the hour and include the bed right? Instead, they separated out for reasons are not clear to me. But, ya, this is a common practise, not just to say operating theaters but in many other areas.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Do these items go into the claim they make to the insurance company?*

Tuan Mark Steven O'dell [LIAM]: *Yes.*

Tuan Heng Zee Wang [AIA Berhad]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *They do?*

Tuan Mark Steven O'dell [LIAM]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You never questioned?*

Tuan Mark Steven O'dell [LIAM]: *I'd have to ask my claims colleagues. [Ketawa]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You never questioned. [Ketawa]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Even the price of the pulse oximeter is stated there, it's RM94.80. Actually, we can just buy. I mean around RM30...*

Tuan Mark Steven O'dell [LIAM]: Ya, ya, ya. *True, true, true.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Exactly right? You can buy three oximeter.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This is where you can play the role.*

Tuan Mark Steven O'dell [LIAM]: Ya, ya, ya.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *This is very ridiculous, the price.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *You can ask them. What does it mean?*

Tuan Mark Steven O'dell [LIAM]: *So, the question is what do we do about it right? I don't know...*

Tuan Heng Zee Wang [AIA Berhad]: *So, maybe I can suplement. You know YB, that's exactly the kind of question that we ask. And like you said, the reason is look they're going to cover for the cleaners and everything else. So, did this — this is where it really boils down to transparency and what we call reasonable and customary charge. All of us are private entity, we are here to make money, that's reality and all of us incur cost to make money. We as insurance, we pay for cleaners, we pay for everything as well. So, we've got to find a way to cover those by improving efficiency and you know doing automation et cetera right and the same is expected from everyone. If there's a party that can very conveniently pass — any efficiency...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I fully agree. I mean this is where you make money. But you cannot make too much money at expense of those you, know, unfortunate people.*

Tuan Heng Zee Wang [AIA Berhad]: *Exactly, exactly, exactly.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Right?*

Tuan Heng Zee Wang [AIA Berhad]: *So, from where...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Because the high increase in the insurance premium.*

Tuan Heng Zee Wang [AIA Berhad]: We understand...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I think insurance companies, LIAM have a role to play.*

Tuan Heng Zee Wang [AIA Berhad]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *To ask them, why you charge this much? I know this machine only last 10-20 years lifespan. I thought 10 years so they all fully paid. Why you still charging this kind of amount?*

Tuan Heng Zee Wang [AIA Berhad]: *So, YB, for your information...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *And you are the one who's going to pay, you decide, "No. We are going to pay this amount". Can you do that?*

Tuan Heng Zee Wang [AIA Berhad]: Ya. *So, YB, for your information, we have actually unpanelled this hospital for this unreasonable charges. So, for more, we understand why they actually do this. Apparently there could be some benchmarking that the providers done on themselves. So, they want to compare on other hospital, my operating theater is cheaper and all those and hence there are these other layers that is not compared. That could be one of the reasons why this thing...*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I want to give you one example, which I know personally from one specialist doctor. This is a scanning for cancer. They went to one private hospital, this private hospital doesn't have this machine and expertise. They sent to another hospital. The total charge is RM5,000 and the first hospital charge is RM3,000. They make money from that RM3,000, from the RM5,000. It really happened. So, I think it's high time we must really look into this. And I think there are — if you really resolve this issue, it can help a lot to reduce the cost of health insurance and the cost of medical. I think this area you must look. So many other examples, this is just one of the examples. I — my nephew is a doctor specialist in some hospital though I know this exactly happens. Thank you. I think that's all for the time being. Thank you.*

Tuan Ng Kok Kheng [PIAM]: *I don't know whether there's something I should dare to talk about or suggest. You know, if you go to book a room in the hotel right and you just pay for the room rate and that sometimes includes breakfast is very clearly told to you and I don't think you get charged for everything else including cleaners or throwing of the rubbish or whatever.* Ya. *Just thinking that the way the hospitals are unbundling all this to individual item is in one way maybe because of their own competition kind of comparison and therefore try to hide all the other things. Suggestion would be why — I mean if you are not able to approach the DRG, you know, so quickly, perhaps the room and board could be something that could be reformed, you know, where it would include all this thing. Because when they give the bill to the patient and they put down individually, you know, one tablet and cleaning of bed, changing a bedsheet and whatever else, there are so many items for them to check.*

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Not only creates pressure on the TPA and the insurance company to go through the list and to approve it so that the patient gets discharged as quickly as possible. Because I understand, sometimes the preparation for discharge starts right early in the morning. Sometimes 8 o'clock, 9 o'clock. But the time they get discharged is actually 2 to 3 p.m. Five to six hours because of waiting. Because the insurance company have to go through the list. You can shorten the list and room and board will cover all these things right including the oximeter, the temperature and all these. I thought that would be an easier way for us to look at how hospitals will operate efficiently. Because I think the way they are unbundling is the way to try to charge more. So, they'll make up for whatever else. Maybe a suggestion for the MOH side to look at that part as a reform first before the DRG comes up.

Tuan Wan Saifulrizal Wan Ismail [MTA]: *Maybe just to add, YB. I mean, of course, the question is why as an insurance of course, why we have the discretion of whether we want to pay for these things or not. But the issue is like what my colleague Zee Wang mentioned things have already been consumed. If we decide not to pay, the customer will have to pay. So, I don't think it's fair from the customer. That's why it links back to the discount question. Whenever we…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *I just want to respond quickly. This is not for that particular [Tidak jelas]. For the coming one, the future.*

Tuan Wan Saifulrizal Wan Ismail [MTA]: *Yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *To prevent from — this thing from happening again.*

Tuan Wan Saifulrizal Wan Ismail [MTA]: *Which links to — that's why when we go in and negotiate for a discount, we don't just go ask blanket for all hospitals give us whatever percentage discount. We actually benchmark this hospital versus hospitals in that location, all the common procedures. Actually this hospital your procedure this, your — this particular procedure is higher than this hospital we ask for discount specifically for that. Because we know that there are potential markups that have been happening right there. We tackle the future like what you mentioned.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya nak tanya kepada pihak Allianz. Tadi Allianz ada melaporkan dua peratus polisi luput akibat pelarasan premium. Saya nak tanya, bagaimana Allianz mengukur kesan yang terjadi terhadap pelanggan yang mungkin mereka tidak mampu tapi mereka terpaksa *maintain*, terpaksa kekal dengan bayaran yang lebih tinggi. Satu.

Yang kedua, apabila Allianz memperkenalkan produk baharu yang mana *co-payment* lima peratus dan juga *co-insurance* 15 peratus, bukankah ini nampak macam membebankan rakyat dan adakah pihak Allianz ada menjalankan kajian impak terhadap golongan *especially* pertengahan yang membelikan polisi ini?

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Baik, YB. Dua peratus itu makna dia kita dah cuba sedaya upaya. Kita bagi *alternative plan*. Kita bagi tahap macam 10 peratus sahaja tapi dia tak mahu. Dia kata, saya nekad saya nak berhenti. Kita tak boleh buat apa yang itu. Dia nak luputkan. Itu kita tak buat apa-apa. Tapi nasib baik peratusan dia taklah besar sangat kan. Mungkin dia ada sebab-sebab tertentu dia tak boleh *continue*. Oleh kerana itu dia diluputkan. Jumlah itu taklah besar tapi masih lagi ada.

Memang kita dari segi prosedur, kita akan buat sedaya upaya *we'll do our best*. Apa-apa tanya. Tak cukup duit, okey semua ini kita buat *co-insurance* ini. *Co-insurance* ini kita kena faham. Kita tanya. *How much money do you have? Do you want to — can you afford say RM1,000, RM2,000, RM3,000 on your own expenditure? You save on a premium. Because every year you pay a premium for a long term. But you don't go to hospital every time. If you save a little bit on your co-premium, you actually save money immediately because then your premium doesn't go up. Because nobody knows whether you're gonna go to hospital. Some people have never gone to hospital. They have the resources, say for example RM5,000. If I go in one time, I can afford myself one-time RM5,000. If I have a major sickness then I have to rely on insurance to pay for me. That is the kind of discussion and that we have with the customer.*

The reality is you cannot afford to pay all, we want you to pay a little bit just to be able to keep your premiums down to a level that is affordable to you. This discussion is happening all the time with the consumer. Alhamdulillah, it seems to be working. People accept. We are quite successful in actually moving on and maintaining over 90 percent of the book sales. So, which is in our opinion it's actually very good.

Tuan Wang Wee Keong [Ketua Pegawai Eksekutif, Allianz General Insurance Company (M) Berhad]: *Also, Pengerusi. Shawn Wang from Allianz. I'm representing CEO of Allianz Malaysia.* Pada soalan membebankan rakyat ini *or the policyholders there is a little bit — it depends on how much do we impose. So, it's not overbearing. This is a process* yang *I'm very proud that we have also trained our agents well. I think what is lacking is actually the way we explain ourselves and the proposition to the policyholders. Every policyholder is different anyway.* Yang itu nombor satu.

Yang keduanya, *which I feel that is more important this co-payment is actually giving the empowerment to the policyholder. Yesterday, Charles and myself we just came back from Singapore. I am very impressed with Singapore and what Singapore has done for AsiaPac. We had a health conference over there. They talked a lot about — they discussed DRG as well, capitation model, fee for service and stuffs like that.* Topik-topik ini dah — *it's not their most burning issue. The way they tackle it, if I may, it's actually to look at community dwelling. That means GP hospital, private hospital, community. Very refreshing actually when I look at that. Those are the right reform that I think we need to look at. Dr. Yap from MOH was also part of the team yesterday.*

Why I say the co-insurance is good? It's because when you empower the policyholder to ask questions, ask the right questions, because sekarang ini kalau kita *cover* daripada *zero dollar up* ini*, we are overrelying on this and we have forgone the right as the policyholder and as a patient.* Kalau kita masuk hospital ini kadang-kadang kita orang ini *either* kita tak kisah sebab *it's already being covered or* kita dengar sahajalah. Doktor ini cakap kalau buat MRI sekali lagi, kita buat sekali lagi. Kenapa nak buat MRI sekali lagi kalau dah pergi dekat Gleneagles ini? *In between* seminggu itu, dia kena buat sekali lagi. *Do we ask those questions? Obviously, no.* Sebab apa? Sebab produk itu dah *cover* sepenuhnya. Itulah yang kedua, *I think it's very,very important that it's not just a notion of insurance company is trying to save that RM3,000* ataupun RM5,000.

Insurance is supposed to take care of you when you get terminal illness. We want to take care of you for the next 15 to 20 years if you have cancer. Right? It's not

— let us say the overtreatment by way of buat sekali lagi, MRI. MRI kalau tak puas hati, buat *CT scan* lagi.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Macam mana *you educate — I mean your agent to educate the policyholder?*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: Itulah. *It's a very comprehensive — it took us a while. As a matter of fact, I want to be entirely honest.* Bila kita mempertengahkan kita punya produk ini, ejen pun tak suka. Sebab susah nak *— to engage the policyholder to have the conversation.* Ejen pun akan tanya kita orang kenapa *you* nak suruh *patient* itu bayar RM5,000? Itulah. *It's a process and I am proud to say* dekat *Allianz* ini *it took us a while* tapi sekarang *I am quite positive, optimistic that we are doing the right thing. We are looking at — the policyholder* pun dah faham.

Pada yang dapat luput ini, *we are not giving up.* Yang dah luput pun *we are asking our agent to go back and offer again, by explaining again.* Kalau boleh itu *we don't want to see people drop out from this whole cohort. Insya-Allah. That's our...*

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Tuan Wan Saifulrizal Wan Ismail [MTA]: *Maybe I just add on too…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Maybe* Datuk Wira *Chairman*, boleh saya *— the latest subject…*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya bagi Kubang Pasu lepas itu saya bagi Shah Alam.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *...the latest subject,* tak? Pengerusi, *I'm trying to make a comparison between health insurance and automotive insurance. Automotive insurance* ini*, I pick up you all* punya *no-claim bonus (NCB).* Kalau dia *small accident, RM500.* Dia tak mahu *sacrifice* dia punya *no-claim bonus.* Betul tak? Dia nak rugi, lepas ini banyak lagi daripada itu. Jadinya, *no-claim bonus* ini, *I think you should expand. It can help because you can tell them, if you claim, then your no-claim bonus will be affected. So, let's say* dia kena hanya RM1,000, *just one night,* tak payahlah *claim insurance,* dia bayar *and then* dia *still continue with no-claim bonus.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Betul.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *That will encourage as a big incentive for the patient, for your customer.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Absolutely, absolutely*.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Betul, YB. Betul, Yang Berhormat.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *This is something that you should add to…*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: Itulah hakikat dia sebenarnya. *So, the product* — memang betul YB.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *And people will think twice.* Eh, *I* nak rugi*? No-claim bonus* ini banyak kan? *Might as well I pay myself.* Sikit-sikit sahaja*, nak repair* sikit-sikit sahaja kereta. *That's what many people do. I'm sure we can do this even in the health insurance. Thank you, Chairman.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, Shah Alam.

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: Sekejap.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, you respond first, then after this* Shah Alam.

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: Okey. Tak ada, Pengerusi, *thank you very much once again. That's exactly YB, I would like to make a comment.* Memang itulah hakikat dia sebenarnya *and the reason why we need to rally these whole things about new product* punya *concept* dengan *deductible* ataupun akses. Dalam insurans kereta ini kita ada akses, *medical* ini mungkin kita pakai *deductible or whatever, it means the same thing. It's about empowerment. So, we have to take care of ourselves as well. So,* itulah dia punya hakikat di sebalik ini.

Pengerusi, *if you allow me, I just want to make one quick comment from some of the colleagues* yang dah *made a few points on medical bills and stuff like that* yang tadi itu. *I think let's circle back to* sidang yang pertama itu. *I think we also talked about regulations as well. So, I think we have spoken enough whether is risk-based capital is good or not good or whether Solvency II, those more advanced capital frameworks in Europe. You can also argue whether it is good or bad. But the end of the day, I guess insurance company is sufficiently regulated. Okay. So, there are not much room for us to manoeuvre cross-subsidisation, YB, as you have mentioned earlier on.*

Tapi *the biggest elephant in the room I guess you know, from the first* sidang yang kita orang ada ini*, I think a few months ago, we first had that was 90 percent of the bill doesn't sit with the doctors, 10 percent is heavily regulated where the doctor's fees is already has enough regulation and law to govern that.*

So, the 90 percent itu, *I hope the PAC will also look into this. We are not questioning whether the hospital should make money or how much they should make. Everybody should make money but the question here is, if you don't have a law to govern the 90 percent of the bill, we will not be able to. We will do our best, we will start questioning bedsheet, we will start questioning glove, even COVID-19 antigen has gone up, right. So, I mean, we all know that you know, during the pandemic that I don't know that it was very cheap and now we have seen that you know, 30 to 40 percent has gone up. So, things like that, I think we need a proper legislation to actually govern 90 percent of the bill. So, I'm just trying to circle back to the first session that we had the discussion. Thank you.*

Tuan Charles Ong [Ketua Pegawai Eksekutif, Allianz Life Insurance Malaysia]: Pengerusi, *this is Charles Ong from Allianz Life Malaysia. I just want to add on to what my colleagues said. I think we have started. All this proceeding has actually drive all the stakeholders in this healthcare industry into a health reform and I think it has started. Insurance company has fully committed and participated in this health reform but what we need is all the stakeholders. I think it's not — we do not want to intend the question who makes more money or this. Everyone wants to drive a sustainable business but be responsible to our consumers.*

We also want all the Malaysians that who can afford private insurance, of course, please. We want to protect. That is basically our job and we don't want to drive away people that to drop out from as you can see. We try to persuade people to go for affordable insurance and co-pay is actually one of the solutions because it addresses two things. Number one, of course, we want the fairer price and number two, wastage and abuse. I think everybody in this room knows that if you go to even a public hospital, get a big packet of drugs and a lot of time, 30 percent of those drugs are thrown away.

That kind of wastage abuse, I think our job is to really eliminate the wastage and the abuse. So, I think I just probably want to say, a lot of the time, I think when we see our customer drop out, we try to talk to them, you know. Do you really want to drop out? Can you afford a better plan? I think that is basically our job but if they decided, all together is about 10 percent. Additional two percent is from what we observe, that from a repricing sentiment. We think that is not so bad. Okay, I think we have tried our best. But this two percent that if they think that they feel that price increase and make them make the decision, sometimes we also try to share. A lot of people think that I was in the generation. I paid for my parents' private insurance and I'm sure that many of us in this room has paid for parents because we want to give

them. We loved them, we give them good healthcare. But it really creates — and it can dent the financial planning.

If these generations started to drop out, the next generations, meaning our children — because we have a decision. We think that we can get out, but our children will still send us, love us, send us to a private hospital and they are the ones will be bearing the burden because they love their parents, they want to give the best healthcare. Of course that, I'm not here to contend whether private or public is better but I think perception is that private hospital will give you more comprehensive, more better care. Okay? That is the public.

So, I think the health reform, what we want is hopefully all parties that really come in now, if you think have a better price transparency, work together to eliminate any wastage and abuse. I think everyone here should be able to agree on that part. Thank you, Chairman.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Thank you Chairman. I want to extend a little bit on Bayan Baru question just now because I fall in that category and in that cohort as well. I started paying insurance since I was late 20s when I joined workforce. Of course, the company paid but I take initiative to pay insurance for my own as well and thank God, until now I've never been hospitalised. All in good health and with extra initiative to get in better shape until now. But as I grow older, almost entering the senior citizen as well, those medical maintenance costs are getting higher and higher but that helps me from being trapped into or dragged into critical illness, right? And then that will also help me staying from — claiming from the insurance.*

Now — but that means I also have now to pay extra insurance premiums because of the cohort or the regime that the insurance premium structure is structured as such. My question is that would you consider a new computational model which will cater for the cohort that will be, you know, age at the later stage, right? Just like — it's like a saving. You know you pay the premium but at the same time, the portion of savings which will cater for your later age, where more policyholders will get sick and then also to cater for the increase in the medical cost, right?

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So, is not just for that particular cohort and to cater for the pool of money to pay for the cost. So, will that be considered in your — I mean maybe computational model that will help reduce the concern that we all now have with the excessive

increase in the insurance premium for the elderly people, which needed more of the medical service now, right? That's number one.

Just for my understanding or the rest of the members of the PAC is that this excessive increase in the premium cost now, is that due because more policyholders are getting sick or because mainly due to the increase in the medical cost? Which one contribute more? Because I believe when you prepare your model, you must have considered that more people would get sick as they age, right? But something that you would never be able to control is the increase in the medical cost. So, that — whether it's 50 percent increase in the premium or 100 percent increase or 150 percent increase, which one contributes more to that increase? I want to understand about that.

The last one is of course I think the computational model should include the NCB. I mean it's not just by encouraging people to go for preventive health but also because to reduce their burden in paying premium at the later stage. So, I believe that NCB should be included in your computational model in the future. Thank you.

Tuan Ng Kok Kheng [PIAM]: *Sorry YB, I just a minute. I am just to clarify on the NCD for the motors side. It is a regulated NCD. So, the Bank Negara will come in and make sure that everybody follows. So — and if you don't have that, I think the market competition might change a landscape a little bit. So, I am not sure how this would be done but at the moment I don't think there is regulated NCD for the health side. Yes, okey.*

Tuan Mark Steven O'dell [LIAM]: *Okay, thank you YB. Your first question was about savings I think, right? You talked about — I think it's been discussed actually and it will be something that may be considered when we're designing the basic plan. But what a lot company is trying to do today and it's not perfect by any means is, they add investment-linked into the equation and supposedly, theoretically the additional money that is going into the investment are supposed to help offset your future premium increases.*

But then, you're at a mercy of the returns first from that investment and the actual increase in a cost of the insurance. Now, as of I think it was five years ago, every company has to send their sustainability statement with their policy to tell them at the current premium level, how many years your policy will be sustained and the customers can decide whether they want to increase their premium or not increase their premium. But there could also be different types of savings as well. It doesn't have to be investment-linked. It could be general account where you can earn a certain amount of interest on your savings. So, I think that's an idea that has been floating around.

Your question about which has been more important? Frequency of claims or the medical claims cost, right? This has been quite volatile, actually. I have numbers in front of me from 2018.

We did the study in 2013 to 2018 and definitely the bigger factor was the cost of medical care. It was about eight percent a year from 2013 to 2018 and the frequency was quite consistent. But COVID-19 threw all that out of whack, right? So during the COVID-19 years, frequency went down but the severity went up. So, the ones who are in the hospital are the ones who had the most severe conditions, right? Because they had no choice. They had to go into to hospital.

Post-COVID-19, the frequency played a bigger role. So, from 2022, 2023 and 2024 the frequency went up 38 percent, 12.3 percent and now down to eight percent. So, it is tapering off. So, the medical cost — the cost of the medical care or what we sort of defined it as 'claims severity' meaning the average cost of hospital stay has gone up. I'll quote you the same years. It went down in 2022 by three percent then up four percent and then up two percent. So, the frequency has been the bigger driver in recent years.

Tuan Haji Azli bin Yusof [Ahli PAC]: *So, am I right to say that, I mean the sudden increase, I mean in recent insurance premium is due to response or to react to that increase in the frequency? So…*

Tuan Mark Steven O'dell [LIAM]: *Generally speaking, yes.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Generally speaking. So, would that mean that — would that mean as the frequency gets lower, lower, lower…*

Tuan Mark Steven O'dell [LIAM]: *Lower, yes.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *…more stabilised, will the — will we get lesser insurance premium later on or what?*

Tuan Mark Steven O'dell [LIAM]: *Well, I think what we'll see manifest in longer period of time in between companies adjusting rates because the claims inflation is still going be there but hopefully to a lesser degree and smaller increases. I think that's what we'll see.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Okay, Bayan Baru.*

Tuan Sim Tze Tzin [Ahli PAC]: *Thank you, Chairman for the second round.*

Tuan Mark Steven O'dell [LIAM]: *[Ketawa] Many rounds we have.*

Tuan Sim Tze Tzin [Ahli PAC]: *All right. First, I want to respond on this colleague from — I mean representative from Allianz. You're talking about the hospitals must — okay*-lah *I mean basically hospitals must reform themselves, which I think I agree. Generally, everyone wants fair billing, you know. I mean if they can*

squeeze off 25 percent, 20 percent discount meaning they should be able to cut their cost or be a bit fair pricing. But I think is a chicken-and-egg as well. Because they expect the insurance company will ask for 20 to 25 percent discount, so they mark up-lah *just to protect their margin.*

So, actually this is very unfair to fee-paying patients because they're still charged the same. Okay, the same line of let's say gloves is RM20 to everyone. Let's say just now whatever machine is the same. So, for fee-paying is unintended inflation to them, okay?

So, I think the industry must work together under the RESET committee, chaired by both ministers to work out a framework to reduce-lah. *There's no, absolutely need for discount. It should be a fair pricing for everyone and reduce it. So, it doesn't look so bad for everyone. Okay, that's my first comment.*

But second thing is also I feel that the issue is the recorded inflation is actually six percent and even TPA say it's less than two percent, it's 1.7 percent. So, the crux of the problem is actually a delay — pent-up demand. Delayed treatment and pent-up demand after COVID-19. And it goes back down that the problem of unsustainable pool or closed pool is your problem. It's the insurance companies' problem, okay?

So, I want to say is that the real inflation is not that much, it's about maximum six percent. Okay? And then you also said that it's about eight percent generally, so it's not far off. So, I think from all these proceedings, I think I come to an observation. It's not a conclusion but observation that something has to be done at the insurance level, the companies level. All right.

So, now I want to go to just now the billing structures of HSS because you guys demand for a reform or regulation on hospital supplies and services. How do you do it? That one I want to ask first question, how do you recommend government to do it because it has 5,000 lines, there are 5,000 items.

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It's very complex and we don't want to have liability issues.

Government will not want to — first of all, I also feel that the less regulations is better because the industry must grow with the framework of — let's say regulation. Overregulation you squeeze the goose that lays golden eggs. But now, since insurance sector want to regulate, so can you propose how to regulate it? Because what I find that the room and board is unsustainable because you are giving RM300. Even budget hotel now some are charging RM250. But if a hospital that with all kinds of complicated air-con system, life-saving machines and you only allow them to

charge RM300, I think it's not justifiable. So, how are you going to have this kind of a fair billing and how do you regulate from the — that's my first question.

Tuan Mark Steven O'dell [LIAM]: *YB, maybe I can take it as a crack at it first and my colleagues can jump in. I think it's really through the DRG pricing mechanism through Diagnosis-Related Group pricing because that is — as you know, it takes into account the bottom-up inputs that go into the bill and taking into account even the difference in complexity, in terms of comorbidities or complications on even maybe even the value of the land that the hospital sits on. And those all cost roll up into what ends up a packaged price that has agreed between the hospital and the payor. Through that, then we don't have to get bogged down into trying to regulate like you said you know, 5,000 items. This is just not possible. It's just not possible. So, I think it's really true the Diagnosis-Related Group pricing, which is one of our big initiatives that we hope to get over the line.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, so I think…*

Tuan Heng Zee Wang [AIA Berhad]: *Maybe I can supplement on a few points. So YB, I mean the biggest challenge that we have as mentioned is appropriate measure of cost inflation. As I showed today in three different types of insurance or inflation that can add to medical cost. First, it is the most simple one. The same item, how much it costed three months ago and how much it costs today. So, those items as we see, look some can go up to like two and half times and some can go up to three percent. So, maybe average six, eight percent.*

The other inflations that we are also seeing is items that was not there. Like pillowcase maybe were not there. Throwing garbage maybe was not there. But now, it's added to the bill. So, there is no base to measure the inflation. It's a 100 percent additional cost you know, to the bill. Then third, when we talk about utilisation. So, utilisation is there are two types. If you price the product wrongly, for example and then there is more utilisation or it's like death. If you have seen, one in 100 will die and two in 100 die, then we've got to [Tidak jelas] the 100.

In this case of utilisation from medical, it's very, very different. As I illustrated in the case of the scopes, if everyone goes in — the past used one scope, now everyone go in do two scopes. That scope cost itself — individual upper-lower scope itself may not have increased. But the whole additional of an upper and lower scope will add 30 percent or 40 percent to the bill in itself, right. So, some of this practice if it's not regulated, then perhaps transparency is very, very important. Like what good should be, what is reasonable and say look like, other places, other country publish maybe, the statistics of using combined scope is 10 percent. But in Malaysia, from what we are seeing in insured patients is 60 percent or 65 percent. Maybe the private

hospitals should publish what is a fee-paying patient rate or if government can publish in government hospital maybe is 10 percent. Then we can tell whether the 65 percent is reasonable or unreasonable. Because that is — it adds a lot to inflation. But the big question whether that is necessary or not. So, that's you know, the crux of it.

How we want to make this sustainable for example, we said look room and board. Actually, today we have plans. We have different — most company actually offer plans of RM200, RM300, RM500 for example. Those plans were designed to cater for the different types of care. For example, in the past, you buy maybe a RM100, RM150 plan, it meant for a quad share for example. Four people share the room, right. Then, the single room maybe cost RM500. So, that's the plan. Of course, the popular plan could be RM200 or RM250 for example. So, what effectively the hospitals or the provider has done is to circumvent insurances by saying that look, we artificially keep down the room. But we did not mandate the — we didn't say that look, you can only charge — you can charge whatever it is. It's just insurance cover RM300 for this customer plan. But for another customer, his plan could be RM500 and all this are available. But, if hospital choose to suppress the room at RM300 and put the rest into seemingly medical fees, we deem that as inappropriate.

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *YB, if I can add one small point here? I think also during the first round we have mentioned, the current legislation — I would said guideline*-lah, garis panduan, bukan *legislative.* Kita ada *clinical practice guideline,* CPG itu ada, memang ada. Kebanyakan fasiliti kerajaan, *public hospitals I think they are following it. It is just that is has not been adopted by the private hospitals. So, I also agree with you YB, that should we come out with something to regulate 5,000 lines, impossible. But the current framework — there is a starting point. I think we should make that step, engage them. If they think that they should hold higher standard, if they feel that the current* CPG itu tak cukup untuk menampung *the way they do business or the way they want run the business, I think it's a good starting point. That is number one.*

The other one is obviously all the DRG is also good, outcome-based. That doesn't mean that you cannot charge appendix or appendectomy more than RM12,000 for instance. Because there will be situations where appendix can get complicated. So, all those is allowable actually.

The other one, the third one, I — obviously in Singapore, they do a very hard capitation. So, everything has been capped. So, that is the third model. Capitation DRG, outcome-based, plus fees for service if you like what I saw. CPG will be a good starter, that will be my recommendation YB. Thank you.

Tuan Charles Ong [Allianz Life Insurance Malaysia]: *YB, if I may add-on. You know, the industry — I think everyone, we all want transparency. I think we are responsible for that, for our consumers. One way is that we have seen the billing of the hospitals. I think there are pages, pages and pages. It is like a small book for one treatment. Because when they unbundle, the layer, all this. If there is any stronger so-called driving towards a standardised, having a real good quotes. So, consumer can really understand. I think all of us in this room will really be able to look into each of these treatments what are the components. So, if the hospitals can come together driving — let's say have a roadmap, driving towards a standardised billing and to achieve a transparency, that will be great.*

Tuan Sim Tze Tzin [Ahli PAC]: *I think the hospital — APHM actually during their proceeding, they actually suggested, they call it Healthcare Cost and Reimbursement Committee. I think you guys have to look into this and maybe the arbitrator can be the RESET committee to trash out. Because ultimately is industry with industry. It's not the government to come in and regulate everything. I think it's not fair to your industry as well.*

Alright, next I want to ask about that actually insurance company also come out with a lot of innovations. Innovation is not entirely bad. But some of the products are actually encouraging wastages. So for example, some of your products are million dollar payout. Actually we all know by now, most 80 percent of the hospitalisation bills is on average is about RM12,000 or below, alright.

■1250

You really don't need million dollars. Now is unlimited million. You know recently my agent asked me to upgrade my plan to RM2 million. Of course, I was not. I don't know. I just bought it-lah. *Upgrade*-lah ya. *Now, I said "Hey, why should I need RM2 million?"*

People said that if you need RM2 million, I think you better go to heaven-lah *because you body is already overhauled. Everything cannot be fixed, okay. Only you need RM2 million to fix it. So, the issue now is you have product which is encouraging wastages. How do you respond to this?*

Tuan Mark Steven O'dell [LIAM]: *I think YB this is exactly the issues that is the proactively basic plan that we are trying to design where coverages would be more reasonable. I do agree with you. I think that you know in the back in our mind if I have RM 2 million of coverage then I am entitled to consume up to that RM2 million amount, right? I think you are right.*

I think the high limit do encourage the attitude right that I can consume more or so. But what we will find in the outcome, I believe the design of the basic plan would be more reasonable but still adequate coverage amount.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *YB, we are taking a very I mean stream end of the spectrum in respect to this. I mean RM1 million, RM2 million. There are cases. I am not saying that it is correct but there are cases where I can say I can come out to about RM1 million and if you want to buy because this is driven also by demand.*

There are customers who actually request for it. But these are basically not the norm. The people who actually participate in this is much smaller than ones in the normal [Tidak jelas]. So, discussing our wastage of premium is we react to the current issues. So, if we have a problem in our main book, we will try to continue the book by also generating profits which then turn into capital.

So, you must understand the concept of risk-based framework. You know it is not cross-subsidy, you cannot, but you have to make money from somewhere else to generate so that you can sustain. There is enough capital to pay for a particular book. So, this is all part of it. It's not so when you say we should sell something that is I would say wasted premium. There is a reason. Good or bad. There is a reason as to why insurance company do this. So, it's basically the way the system works. Changing system, yes, but changing system requires a lot of other changes as well okay.

Now, I want take the point of the hospital charges. This is insurance. We have a very difficult industry called motor insurance. Why? Because almost every other workshop will be there to try to make a quick buck. But the insurance industry is able to deal with it because we know exactly how much is the cost to repair a fender. How much it is cost to this kind of repair, time and stuff like that. So, we are able to do that.

The other one of the spectrum is health insurance. That we don't know. We actually don't know because there is no guidance, there is no DRG, there is no CPG in respect to this. So actually, there is an example [Tidak jelas] industry where a guided process of claim actually helps to keep the premium at the very reasonable level.

So, this is another thing. I am not saying that a car and a human being is the same, YB. But I am saying that the process in which how we approach the claims can be very similar. If we have information on the procedure, we would charge accordingly.

The problem here more often than not we are very surprised with the bill that comes, correct? This is where we get caught unaware. So, whilst inflation as you said is not but added over treatment, utilization, all this add to the course.

So, the overall course of health claims has increased. It may not be the inflation itself is increased but overall cost of health insurance claims has increased. I am not throwing the hospitals under the bus. We are also at fault here. Everybody is at fault YB, but everybody has got to calm down and sit down on a landing page and discuss this openly. More transparency, more data and then that would be a lot better.

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, next issue is about age rating alright. I have a little bit problem with the age rating-*lah *because when people are young okay, we are being offered very cheap product so everyone signs on it. As we age 30 years later, we are loyal to the insurance company. When we retire, that is the problem that starts. Of course, you get older and every five years you have this age bracket.*

Recently I have one case. There are being repriced as well as age and they got 262 percent increase. 262 percent. Biologically, he's only older by one day. Biologically alright. He's coming from 59 to become 60 years old. When they celebrate his birthday one day later, he kena 262 percent. How do you explain this?

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: YB.

Tuan Sim Tze Tzin [Ahli PAC]: Ya.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *I agree and that is very unfortunate but first of all I don't know which company does this but it sounds very extreme. But again, that is the extreme. The norm is not the case, you see.*

So, level premium — I mean I have a very good qualified, actual research so I will be very careful of what I say. The point here is if you were to charge a life policy, this is very rudimentary and you charge on the basis of the total life.

Actually, it becomes really unaffordable because you will charge at the lowest point where the person is at. You create all the profits early just to pay for your ultimate aim at the end. So, if you have a proper level premium, because mortality is like when you are young, you are young. So, there is an element in which you are actually overcharging now to pay for the possibility of a particular claims in the future.

So, it makes a particular product quite unaffordable. So hence the age rating comes and also based on economic rating, we charge you to attract you to come in first and then gradually increases over the years. I am not saying it's bad, I am just saying that is the reality of how we charge.

To go through a process where we charge a similar premium for the duration of the life would require fundamental change in actually how we rate our policies. It's a good idea, I don't know whether it cannot be done because of the economics of it because it will make the initial product very, very expensive. So, the question of economic affordability.

Tuan Wan Saifulrizal Wan Ismail [MTA]: *Maybe I just add in also, YB. So typically for those what we call — I think what the example you quoted. I am guessing likely is a standalone medical plan, they break the premium every five years, each band. Typically, the disclosure has also being made upfront as well. Year on year in terms of the increase of one band to another.*

So, I think there is transparency element at the front but of course as medical inflations creeps out, definitely there will be add on to it. I mean similar — it's just more — I mean we need to break down in terms of what is cost by the age and what is cost by the cost the medical inflation.

Tuan Sim Tze Tzin [Ahli PAC]: *That's why I have this big, huge problem with you guys because of this excessive. I don't think if you put yourself into that guy shoes. He's just a little guy. Work throughout the years, okay, working class, and then when he retired — just retired one day later then he's [Tidak jelas] with 262 percent. Loyal to you, you know. He's your customer.*

I think there is something wrong with your calculations. I think you should look into this because the mangsa ya *actually the retirees. I think by now we all know*-lah *who — majority of the problem when they stop working and you punish them. Sorry to use the strong word 'punish' but that is the reality. They feel being* dimangsakan, *okay. I think I don't know how — I mean you run the business. You should think how to revamp this, okay. Just — yes?*

■1300

Tuan Charles Ong [Allianz Life Insurance Malaysia]: *Maybe I just thought YB Sim you have mentioned the insurance industry we also need to reform. That's correct, okay. You know, there has been a lot of talk, just now we mentioned cohorting. Okay, the cohorting of business is supposed to be fairness, to create fairness, okay. Why I say that? People like us buy insurance, maybe my age, now my children come in, let's say we join my cohort, you know they will have to pay, subsidise me*-lah. *I think that has been already explained. But, we also look into some of the areas. For example, we may have a smaller cohort. Remember some products we may not sell well, people has already died off or they get out, okay. They have lapsed away already. I think we also want to work in the industries. How to make it*

joint together, small cohort or come in to make it more sustainable and that is the — you know the increase.

Second point that I think there has been a lot of questions about life insurance industry. Yes, average inflationary cost. Okay, drugs go up, treatment, so-called new treatments, the price goes up. Okay, I think that — I call that the inflationary part is the utilisation in our books. And again you have pointed correctly; some cohorts they are ageing. We all know ageing is not just insurance, I think it's a country's, that we have to tackle that as a major issue. So, I think it's the how the utilisation rates. Okay, what we want to see utilisation is not we don't want. Okay, I think you are right. Our insurance industry has created products with million, million dollars. In fact, we also have been encouraging but we have to come down to really start thinking about that as well in part of this whole reform, okay.

The utilisation, of course, what we want to drive away is the wastage. We all know that. I think a lot of statistics show in our books. People has a gastro problem, if it is a CPG, take antibiotics. Okay, are you alright? If not alright, further test to be done. But, for private hospital, they may also just jump in. We have almost 90 percent of gastro will end up in a scope but probably five percent to 10 percent actually is actually didn't require because antibiotics could have cured them. Thank you, YB.

Tuan Sim Tze Tzin [Ahli PAC]: *That's why this is my last question. Okay, I give you discount also. I don't want to ask the 11 questions. You asked for 25 percent, I give you discount. Alright, I think the — another thing is that insurances are not paying for primary care. Most of your products and this is where you — there's a buffet syndrome here. Everyone with an insurance, they go to hospital. So, I think the — your policy has to be revamped as well ya. Start with GP first. Okay, GP, screening, if not go to the hospital. I think that is a very basic thing that you should start first for all your policies. You can revise your policies.*

Then, second thing is reinstatement. This is a problem that this interim measure, some people they don't know about reinstatement, they give up already and then your reinstatement ends 30th of June, a lot of companies. So, can you extend? Okay, because a lot of people are not aware, insurance agents also don't know what is the cut-off date, what should be done, it's not properly communicated. So, I would want to ask for extension of this cohort of people. Thank you.

Tuan Mark Steven O'dell [LIAM]: Ya, YB. *We anticipated your questions. So, we've had some discussions the last couple of days and unanimously the industry is prepared to extend reinstatement without waiting period for another 60 days and then from there, from say tomorrow onwards, we can see issue a press release and*

we can issue communication to our members that we will say the same thing and encourage them to make sure that their sales force is well aware.

Tuan Sim Tze Tzin [Ahli PAC]: *How about the GP thing? GP?*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Ya, *GP is something that we will look at and you are very right. I say — say let's go back to the scope, colonoscopy. The CPG — sorry, the CPG is you have stomach problem, you are supposed to do stool sample first. Take the sample to the lab, see got blood or got this whatever bacteria and stuff like that. Then, that's a telltale sign, if you don't have, you don't have to do the scope, okay. But, if you have something else, then only you do the scope. That is missing. Very hardly now any doctor will ask you to do stool sample. That one major step which can save so much money is not done. So, for what you said, yes this is something what the GP can do. So, if you introduce the CGP in the process and they say actually you have to do scope, do your stool sample first. Because the GP cannot do a scope. It's I can send it to the lab to do a stool sample.*

So, that's a very simple example of how it really can help.

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *YB, if I may add one more point on GP. The primary care I think is definitely the first line of defense, if you like. As a matter of fact, it's no longer a defensive move if you're like in mature market. For lack of example, I quote Singapore again. GP is not being used to treatment. GP in Singapore are being used to do preventive care. As a community-based, they are being incentivised financially, not based on the fees that they charge or no longer those fees based. Coming back to my original point,* kita punya *fees* bagi dekat GP ini — *I could be wrong, I stand to be corrected* — dah 35, kalau tak silap saya 40 tahun kita tak pernah. *So, as a GP* dekat Malaysia ini YB, *to ask me to step up and do more, I think that is a big question mark* dekat sanalah. *If I think I have glanced, I could be wrong as well, so our fees are being based on the measurement of square feet* dengan *some very rudimentary [Tidak jelas]. I think this is also something that probably we can probably propose to MOH as well to have a look.*

Yes, we are ready. We want to work with a GP and you are absolutely right. The GP should be our first line of defense and we should look at macam mana Singapura — tak payahlah nak *adopt the whole thing* yang macam *Singapore but the starting point should be that*-lah. Terima kasih, YB.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, ini.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih, YB *Chairman.* Ini soalan terakhir saya. Saya nak tujukan kepada Allianz. Tadi, Encik

Zakri buat *presentation.* Saya amat tertarik dengan ini muka surat dua Encik Zakri ya. Pilihan produk mampu milik bagi pelanggan yang terkesan. Pelan *deductible,* produk baru yang mampan, pelan perubatan bercirikan *co-payment* dan *non-claim.* Boleh terang sikit tak?

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Boleh, boleh.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Pencerahan. Terima kasih.

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *So,* masa ini kita ada produk yang mana kita *introduce co-payment. Co-payment* ini you bayar sikitlah bila ada *claim* itu. Macam kita terang tadi, katakan *let's say what? RM5,000? [Merujuk pegawai]*

Seorang Ahli: Ya, *RM5,000. [Bercakap tanpa menggunakan pembesar suara]*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Ya, *RM5,000.*

Tuan Charles Ong [Allianz Life Insurance Malaysia]: *If I...?*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Ya, *sorry.*

Tuan Charles Ong [Allianz Life Insurance Malaysia]: YB, *I just want to add on. Plan deductible basically means that we have various levels of deductibles. The higher the deductible, the plan is actually cheaper. And deductible for example it starts from RM5,000. So, it can be RM10,000. It basically means that per annum, the first RM5,000, per annum, not per treatment, it's not — customer has to bear it. So, people buy deductible, number one for affordability, for a bigger treatment.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Memang *now* sedang dilaksanakanlah?

Tuan Charles Ong [Allianz Life Insurance Malaysia]: Sudah dilaksanakan. *It's available. So, it's actually one of the plans that we tell the customers, "Please don't drop out. Please really consider the deductible plan or the co-pay plan". So, the co-pay plan is actually 15 percent co-pay subject to a limit. Okay, the limit could be about RM2,500 or RM3,000. So, there are two types, whatever that suits because some customers say RM5,000 is actually quite a burden. So, they can actually choose to go for deductible which is if a treatment is RM30,000, the 15 percent which is not — say RM3,000, RM4,000 over is borned by them. But subject to a limit of RM2,500. So, that means the RM2,500 is actually borned by the customers.*

■1310

So, but this actually the intention of this deductible and sustainability — sorry and this co-pay, is to really drive a sustainable medical insurance. Still enjoy, still can

able — enjoy the comprehensive care. But it helps to drive the customer's behaviour. That means that people are not abusing it to go to sick. Want to get like a scope, then they use insurance to go in.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey. Adakah *only Allianz* yang laksanakan ataupun syarikat insurans lain juga laksanakan?

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Saya rasa semua. Saya rasa semua, semua, semuanya.

Tuan Charles Ong [Allianz Life Insurance Malaysia]: *Most of my colleagues have the plan. Yes.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *[Bercakap tanpa menggunakan pembesar suara]* Yang lain-lain pun ada juga.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. *Last question* saya bagi kepada YB Kuala Pilah.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Terima kasih, Yang Berhormat *Chairman*.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey dan YB Betong *last question* sebab *we need to finish it before 1.30. Thank you.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: Soalan pendek sahaja. Saya lihat, saya rangkumkan daripada cerita tentang *billing*, pembayaran. Saya lihat *90 percent* daripada *billing* yang terpaksa dibayar oleh *insured patient it goes to the medical supplies instead of the doctor itself. You just mentioned just now doctor, 10 percent* sahaja*. So, do you agree with me that a revise should be made to the — you're are talking about GP, you just mentioned just now GP. They are subject to* Akta Fi, akta yuran. Dia tak boleh *increase simply their consultation fee and all this. As APHM mentioned a day before yesterday, the fee has not been revised since 1994.*

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara] Yes.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Am I correct?*

Beberapa Ahli: Betul. Betul.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *So, do you agree* — adakah anda bersetuju dengan saya bahawa mungkin *probably* kita boleh buat usul serba sedikit daripada PAC supaya ini *revision* dibuat terhadap Akta Fi ini. *But* seperti yang saya nyatakan tadi, *90 percent* daripada *billing* ini datang daripada *medical supplies. So*, itulah mungkin saya minta pandangan daripada...

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: YB, dia macam ini. Sekarang ini fasal fi dia *limited*. Dia nak buat duit, doktor. Doktor pun manusia juga. *So*, dia jual ubat.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *I think it would be fair. We are talking about fairness.* Dia orang doktor*, they should get the chunk of the — rather than paying the medical supplies.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *Yes.* Memang*. So,* sekarang ini kita terpaksa *incentivise skills* dia *as a doctor.* Maknanya *you* jumpa dia, dia beritahu sekian, sekian, mungkin tak payah bagi ubat fasal dia dah beritahu *you* jangan makan ini, *so we should pay for the doctor's skill. Not the fact the doctor is going to dispense medicine.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Yes.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *The fee cap is actually wrong. We should allow the fee to increase. That is definitely — we are promoting that. Then only we can introduce the primary care. Because then they will upgrade themselves. They are willing to because in primary care, if we're going to cover, they have to upgrade themselves because they have to do a lot more things.*

In their current income structure, tak boleh. Tak cukup kan*. So, all these things come into place. Yes. I support that.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Absolutely YB. I* rasa senario sekarang ini memang macam YB *you mentioned earlier*. 30, 40 tahun. *Nobody can run a clinic by giving advisory, consultation* sampai 20 minit. Kalau dah mencecah 20 minit satu *patient*...

Dato' Adnan bin Abu Hassan [Ahli PAC]: *I am referring to the young GPs.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *The GP ya?*

Dato' Adnan bin Abu Hassan [Ahli PAC]: *The GP. Young GPs. Those who start up soon.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Exactly.* Kalau GP ini, *you look at it* dia macam *factory. They need volume to sustain. Of course, we want to pay GP to give the quality care. Again, for lack of example, also* macam dekat Singapore ini dia orang tak…

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Probably from the negative side of it. Probably you can — probably foresee that there will be an increase of medical inflation, you know. But you know, not to the extent of — to the expense of the GPs…*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Absolutely, absolutely.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: *I think it has to be increased but I think you'll see efficiency increase. Better care, less wastage in prescribing medicine, there is no need to prescribe and things like that.*

Dato' Adnan bin Abu Hassan [Ahli PAC]: Okey, terima kasih.

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Because now the GP — our GP is capable YB. So, I think we should change the fee structure, number one.*

Number two is also to work with the insurance company, let them be the first line of defence and give a proper consultation. Sekarang ini, *dispense drugs 10 minutes, another patient comes in. So,* RM30 sahaja satu *patient*.

Dato' Adnan bin Abu Hassan [Ahli PAC]: Soalan saya yang terakhir, doktor. Ramai orang bercakap tentang DRG. *The implementation of DRG. We just came back from Singapore. Singapore* telah *implement DRG because there are certain countries* yang saya baca. DRG tidak berfungsi. *We've just been informed by APHM that our neighbouring countries, Thailand, for instance, have been implementing DRG for more than 20 years.*

So, pada pandangan tuan, *is it workable,* akan memberi impak yang positif DRG ini kepada *somehow or rather,* secara langsung, tidak langsung kepada *the reduction of medical inflation? Your anticipation.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Maybe I'll go first and maybe Mark and the representative from the association can chip in as well. I think Singapore* punya DRG ataupun dekat Thailand, *I don't think it's the only system.* Kebanyakan negara yang ada DRG ini sebenarnya bukan dalam *private sector.* Kebanyakan dia orang ini yang dah *implemented in the public sector first.* Okey, yang itu nombor satu.

Yang keduanya, DRG ini *to what extent? Is it all in?* Semua, *all kinds of diseases, or is it partial, how do they segmentise it?* Negara-negara ini semua ada itu ada, YB. Tapi bukannya semua dah buat *comprehensive DRG only, for instance.* Singapore bukan DRG sahaja. Dia pun ada *capitation, for instance. It's a very, very straightforward model.* Kalau *appendix* ini itu sahaja jumlah dia, tak boleh kurang, tak boleh lebih, itu sahaja.

So, there are multiple different fee structures that have been adopted by Singapore, for instance. I think we can negotiate and also have this meaningful conversation with MOH…

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Probably we can have a modified DRG suitable for our country.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Correct.* Pun boleh juga.

Dato' Adnan bin Abu Hassan [Ahli PAC]: *Thank you.*

Tuan Wang Wee Keong [Allianz General Insurance Company (M) Berhad]: *Absolutely.*

Tuan Zakri Mohd Khir [Allianz Malaysia Berhad]: Dia tak boleh pakai alasan, *"Oh,* kita tak boleh buat DRG fasal dia kata DRG semua". Tak ada. Kita *start*. Kita *start* antara *certain diseases, small steps. We should do that. With all due respect to hospitals, they are giving very blanket statements that DRG is difficult to — yes, but you start small.*

Tuan Mark Steven O'dell [LIAM]: *I think your earlier comment, almost every country has some variation and how they have actually designed their DRG. The chief benefit is that it puts both the provider and the payer in a more equal risk-sharing position because the provider now has to become more efficient. They have incentives to become more efficient, whereas the fee for service, they have no incentive. They have — it is just the opposite. They have incentive to actually prescribe more treatment, right. So, those are the two major things.*

Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *Thank you.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, YB Betong.

Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: Terima kasih YB *Chair*. *A short one from me. I just would like to seek your clarification or response with regards to the MHIT reform initiative that you laid out. This is on the proposed implementation of your basic MHIT plan that you would like to roll out in 2026. My question is, how would you address certain issues that I might foresee*-lah?

Firstly, on the sustainability of this kind of plan. What kind of mechanism that I — should be put in place to ensure that this would be sustainable?

Secondly, of course, we have various groups of communities. I am talking about the lower income groups. So, how would this medical health insurance and takaful plan to cater for the B40 groups?

Thirdly, of course, there are regional differences in the access to healthcare. How would you address the regional inequalities in access to healthcare in Malaysia, it varies from region to region.

■1320

And of course, finally and lastly, every plan, there would be challenges. So, how or what are the possible challenges that you would foresee when you are going to implement this plan coming 2026? Thank you.

Tuan Mark Steven O'Dell [LIAM]: *Okay, maybe I can give my best because with the joint task force if you want to call that, is made out of MOF, MOH, EPF, MTA, LIAM and Bank Negara and the first step that we've done is run a tender for a consultant to actually develop the plan together with the oversight from the bodies I just mentioned.*

But some of the things that are being talked about certainly is lower but still adequate coverage levels, you know? So, we talked about YB's two million that leads to the attitude that I can spend as much as I want because my policy is quite more than adequate.

So, there will be lower limits, there'll be reasonable co-shares, there will be likely a way to utilise GPs as a gatekeeper, you know? So, you ask to go to GP and before you can go to a specialist, you need a referral. Those are just some of the mechanisms that we hope would make the plan more sustainable and also you know, choosing the panel of hospitals that are on the approved panel for this plan is also important. It may not include the most expensive hospitals in the country.

So, that's our challenge actually; it is to come out with the plan that is both affordable and adequate. We think we can do it. So, we have as I mentioned before, the consultant will be on board in the next couple weeks and we have three months in terms of the design phase and there will be focus groups, there will be — all the stakeholders will be consulted including the consumer groups, the public, et cetera, before it's finalised. I think when you ask about the biggest challenge, I think the biggest challenge is again making it attractive yet also scalable. So, if you have the basic plan then maybe any number of customers or policyholders that want more than the basic plan.

So, our ideal is that every plan has an element of the basic plan. So, it becomes the sort of the coverage of last resort that you might want to step down to maybe for affordability reasons or maybe now I'm retired and you know, have to balance the premium together with the coverage so I can revert to the basic plan. And so we see that playing a big part in every, we see the basic plan playing integral role in every medical plan sold going forward.

Tuan Sim Tze Tzin [Ahli PAC]: *How about the current plan? Can they be revamped? So that everything starts with basic plan and everyone who wants say example, my RM2 million one, I buy a rider on it.*

Tuan Mark Steven O'Dell [LIAM]: *Right.*

Tuan Sim Tze Tzin [Ahli PAC]: *Yes. Can everyone been revamped, come back to? Because we need to start with a big pool.*

Tuan Mark Steven O'Dell [LIAM]: *Yes, yes. No, I mean ideally yes but I think there will be a lot of challenges in terms of let's say a massive convergence but I think that will be up for discussion in every one of the things that we're looking at. Yes.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *All right.* Terima kasih saya ucapkan kepada semua yang terlibat di dalam memberikan penjelasan dan juga huraian berkenaan dengan perkara-perkara yang dibangkitkan. Saya ucapkan terima kasih kepada wakil daripada LIAM, PIAM, AIA Malaysia, saya tak perlu nak sebutkan nama ya? Sebab ramai sangat. Great Eastern Life, Allianz Malaysia, Prudential Assurance, MTA dan semualah yang terlibat secara langsung ataupun tidak langsung dalam prosiding tengah hari ini dan ada permintaan daripada sahabat PAC sekalian untuk wakil semua yang terlibat di dalam prosiding pada hari ini untuk bergambar di ruang legar.

Saya minta untuk sekretariat uruskan kerusi dan juga jurufoto untuk ambil gambar. Terima kasih. Kita tangguhkan kita punya prosiding pada jam 1.25 tengah hari dan kita akan kembali semula pada jam 2 petang nanti bersama dengan Bank Negara. Terima kasih.

[Mesyuarat ditangguhkan pada pukul 1.25 tengah hari]

MALAYSIA

LAPORAN PROSIDING (HANSARD)

Khamis, 19 Jun 2025

Bil. 5(q) / 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan dan Caj Hospital Swasta serta Impak kepada Kesihatan Awam di bawah MOF, MOH dan BNM

(i) Bank Negara Malaysia
YBhg. Dato' Seri Abdul Rasheed Ghaffour
Gabenor

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 19 JUN 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Tuan Haji Azli bin Yusof [Shah Alam]

Tidak Hadir *[Dengan Maaf]*
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Datuk Ali anak Biju [Saratok]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]

URUS SETIA

Encik Mohd Sukri bin Busro [Ketua Sekretariat (Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]
Cik Farah binti Mohamed Rafiee [Penolong Setiausaha (Seksyen Jawatankuasa Kira-kira Wang Negara), Parlimen Malaysia]

HADIR BERSAMA

Jabatan Perkhidmatan Awam (JPA)
Encik Aznirul Fariz bin Alwi [Ketua Penolong Pengarah (Bahagian Perkhidmatan)]

Kementerian Kewangan Malaysia (MoF)
Encik Nurul Allbiir bin Nordin [Penolong Setiausaha Kanan (Kawalan Kewangan Strategik dan Korporat)]
Encik Abdillah bin Azizudin [Ketua Penolong Setiausaha (KSID(P)1) (Bahagian Pelaburan Strategik)]

Suruhanjaya Pencegahan Rasuah Malaysia
PKPj. Zulhairy bin Zaidel [Ketua Cawangan (Bahagian Siasatan)]
PKPj. Premraj a/l Isaac Dawson Martin Victor [Pegawai Penyiasat]

Kementerian Ekonomi (KE)
Encik Imran bin Abdullah [Pengarah (Bahagian Industri Perkhidmatan)]
YBrs. Dr. Nik Rozelin Nik Ramzi Shah [Timbalan Pengarah 1 (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah Bahagian Perkhidmatan Sosial (Bahagian Perkhidmatan Sosial)]

Jabatan Akauntan Negara
Encik Mohd Taufik bin Haji Ahmad [Akauntan (BPOPA)]

SAKSI

Bank Negara Malaysia (BNM)
YBhg. Dato' Seri Abdul Rasheed Ghaffour [Gabenor]
Encik Aznan Abdul Aziz [Timbalan Gabenor]
Encik Suhaimi Ali [Penolong Gabenor]
YBhg. Datuk Jesicca Chew Cheng Lian [Penasihat Teknikal]
Tuan Hoo Hon Shiong [Pengarah]
Tuan Harizal bin Alias [Pengarah]
Tuan Surannit Sureen Chit [Timbalan Pengarah]
Tuan Ang Jian Wei [Timbalan Pengarah]
Puan Yom Nurul Akma [Pengurus]
Puan Khairunnisa Azhar [Pegawai]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

KHAMIS, 19 JUN 2025

BILIK JAWATANKUASA 1, BLOK UTAMA,
BANGUNA PARLIMEN, PARLIMEN MALAYSIA

Mesyuarat dimulakan pada pukul 2.05 petang

*[Yang Berhormat Puan Teresa Kok Suh Sim **mempengerusikan Mesyuarat**]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Selamat petang, salam sejahtera. *Public Accounts Committee* (PAC) Parlimen akan menyambung semula prosiding berhubung isu Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam di bawah Kementerian Kewangan, Kementerian Kesihatan dan Bank Negara Malaysia. Seperti mana kita sedia maklum, isu ini tidak dilaporkan dalam Laporan Ketua Audit Negara. Sehubungan itu, PAC menggunakan punca kuasa seperti berikut iaitu:

(i) Peraturan Mesyuarat 77(1)(d) Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat;
(ii) Peraturan Mesyuarat 83(2) PPMMDR; dan
(ii) Arahan Perbendaharaan 301 (Pindaan) 2023 dan seksyen 5(3)(d) Pekeliling Am 1 Tahun 2024, Organisasi Kementerian-kementerian Jabatan Perdana Menteri.

Yang Berhormat, Ahli-ahli Mesyuarat sekalian, hadir bagi memberi penjelasan di hadapan PAC dalam prosiding pada petang ini ialah Yang Berhormat Datuk Seri Dr. Haji Zulkif— *no. Eh, you give the wrong one. [Ketawa] Sorry, sorry. Okay.*

Yang Berbahagia Dato' Seri Abdul Rasheed Ghaffour, Gabenor Bank Negara Malaysia; Datuk Jessica Chew Cheng Lian, Penasihat Teknikal; dan Encik Aznan Abdul Aziz, Timbalan Gabenor Bank Negara Malaysia. *I think* tiga sahajalah. Ada lagi? Juga, Tuan Ang Jian Wei, Timbalan Pengarah Bank Negara Malaysia; Tuan Hoo Hon Shiong, Pengarah Bank Negara Malaysia; Encik Harizal bin Alias, Pengarah Bank Negara Malaysia; Encik Suhaimi Ali, Penolong Gabenor Bank Negara Malaysia; dan juga Puan Yom Nurul Akma, Pengurus Bank Negara Malaysia; Tuan Surannit Sureen Chit, Timbalan Pengarah Bank Negara Malaysia.

Jadi, tanpa membuang masa, saya menjemput Yang Berbahagia Dato' Seri Abdul Rasheed Ghaffour, Gabenor Bank Negara Malaysia untuk memberi pembentangan. Dipersilakan. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [Bank Negara Malaysia (BNM)]: Terima kasih Yang Berhormat. *Bismillahi Rahmani Rahim*. Yang Berhormat Puan Teresa Kok, Timbalan Pengerusi PAC Parlimen dan juga pengerusi mesyuarat pada hari ini, Yang Berhormat-Yang Berhormat Ahli PAC Parlimen sekalian, pegawai-pegawai kementerian dan jabatan serta Sekretariat PAC Parlimen. *Assalamualaikum* dan salam sejahtera. Terima kasih Yang Berhormat Pengerusi dan juga Ahli-ahli Jawatankuasa Kira-kira Wang Negara atas peluang untuk hadir dan membuat pembentangan pada hari ini.

Susulan pembentangan kepada PAC pada bulan Februari yang lalu berkaitan isu ini, pembentangan saya pada hari ini akan tertumpu pada memberi perkembangan terkini berhubung dengan usaha untuk menangani punca utama kenaikan bayaran premium MHIT serta pembaharuan sektor kesihatan swasta seperti yang telah dibentangkan pada mesyuarat yang lalu. Oleh itu, saya memohon untuk diberi izin untuk membuat pembentangan terlebih dahulu bagi memberi gambaran dan konteks yang jelas kepada semua Ahli Yang Berhormat sebelum membuka ruang untuk sebarang pertanyaan dan juga maklum balas daripada Yang Berhormat sekalian. Saya dan rakan-rakan saya bersedia untuk mendengar pandangan, cadangan serta sebarang persoalan daripada Yang Berhormat selepas pembentangan ini.

Seperti mana yang Ahli-ahli Yang Berhormat sedia maklum, Bank Negara Malaysia, Kementerian Kesihatan, Kementerian Kewangan dan juga pihak berkepentingan lain telah pun bersetuju untuk melaksanakan inisiatif pembaharuan sektor kesihatan swasta berdasarkan lima teras utama. Lima teras utama ini atau singkatannya dalam bahasa Inggeris, RESET adalah penting untuk meletakan negara pada landasan yang lebih mampan dalam memenuhi keperluan penjagaan kesihatan masyarakat di Malaysia.

■1410

Inisiatif RESET ini akan menangani beberapa cabaran utama dari segi pembiayaan kesihatan, penyedia perkhidmatan kesihatan serta struktur pasaran yang telah menyumbang kepada peningkatan kos perubatan. Saya akan mengulas lebih lanjut mengenai perkara ini di slaid seterusnya.

Untuk makluman Ahli Yang Berhormat, inisiatif RESET ini telah pun dibentang dan dipersetujui di Majlis Tindakan Sara Hidup Negara (NACCOL). Selain itu, seperti yang telah diumumkan oleh Yang Amat Berhormat Perdana Menteri pada hari Selasa yang lalu ketika perasmian Sasana Symposium 2025, sebuah jawatankuasa bersama peringkat Menteri mengenai kos penjagaan kesihatan swasta yang diterajui oleh Yang Berhormat Menteri Kesihatan dan juga Yang Berhormat Menteri Kewangan II telah ditubuhkan bagi menggerak dan memantau pelaksanaan inisiatif RESET ini.

Oleh itu, sukacita ingin saya maklumkan bahawa pelaksanaan inisiatif RESET telah pun bermula dan kemajuan pelaksanaan inisiatif-inisiatif ini akan dilaporkan kepada jawatankuasa bersama peringkat Menteri tersebut dari masa ke semasa. Pelaksanaan inisiatif RESET ini juga turut melibatkan sesi libat urus dengan pihak-pihak berkepentingan.

Susulan daripada perbincangan yang diadakan, dua inisiatif telah ditambah kepada sembilan inisiatif asal. Dua yang baru itu adalah pertamanya, untuk membantu pengguna menentukan keperluan dan pilihan MHIT, inisiatif *number* dua dan juga, pengumpulan data mengenai kos penjagaan kesihatan swasta, inisiatif *number* tujuh.

Sebelum ini pada bulan Februari, bila kami bentangkan, ada sembilan sahaja inisiatif. Pada masa ini, ada 11 semuanya setelah kita ambil maklum pandangan dan juga cadangan daripada pihak berkepentingan *[Tidak jelas]*.

Inisiatif RESET juga bertujuan untuk menangani beberapa cabaran utama dalam sistem penjagaan kesihatan di Malaysia. Antaranya termasuk inflasi perubatan yang tinggi yang didorong oleh reka bentuk produk MHIT telah menggalakkan penggunaan perkhidmatan kesihatan secara berlebihan. Sebagai contoh, had manfaat yang tinggi di bawah pelan MHIT memberi kesan dari segi tingkah laku yang mendorong penggunaan dan pengenaan caj yang tinggi bagi perkhidmatan kesihatan. Maklumat harga perubatan dan juga caj kesihatan yang kurang telus juga telah menyebabkan kesulitan bagi pelbagai pihak untuk membuat perbandingan harga serta jangkaan kos dalam penggunaan perkhidmatan kesihatan.

Tahap perlindungan dan simpanan yang rendah di kalangan rakyat untuk tujuan kesihatan juga telah menyumbang kepada kesesakan dan juga tekanan kapasiti dalam sektor kesihatan awam. Peranan penjagaan primer (*primary care*) dan pesakit luar yang terhad dalam pelbagai peringkat penjagaan kesihatan juga telah menyumbang kepada perkara ini serta model pembayaran *fee for service* di sektor swasta yang tidak mampan. Melalui inisiatif RESET ini, cabaran-cabaran ini akan diberi perhatian untuk memastikan ekosistem penjagaan kesihatan di Malaysia kekal mampan. Oleh itu, keutamaan kami pada masa ini di bawah inisiatif RESET ini adalah untuk membangunkan produk asas MHIT yang seragam, yang akan menjadi asas kepada penawaran produk MHIT pada masa hadapan oleh ITO.

Pembangunan produk asas MHIT ini adalah penting untuk pertamanya, membantu lebih ramai rakyat Malaysia untuk mendapatkan perlindungan kewangan untuk menghadapi kos rawatan perubatan yang lebih tinggi. Kedua, memastikan perbelanjaan penjagaan kesihatan swasta digunakan dengan lebih cekap dan juga berkesan serta ketiga, mendorong penambahbaikan penjagaan kesihatan yang memberi tumpuan kepada nilai keseluruhan kepada pesakit. Kami menyasarkan reka bentuk produk asas ini akan dimuktamadkan menjelang akhir tahun 2025.

Seterusnya, produk ini akan melalui fasa rintis pada separuh pertama tahun 2026 dan akan dilancarkan dengan lebih meluas pada separuh kedua tahun 2026. Produk asas MHIT

ini bertujuan untuk menyusun semula pasaran insurans kesihatan swasta. Ia juga akan membuka jalan kepada sistem penjagaan kesihatan yang lebih bersepadu dan mampan demi kesejahteraan rakyat Malaysia.

Produk asas MHIT juga akan berfungsi sebagai lapisan teras yang seragam yang ditawarkan oleh semua ITO yang menjalankan perniagaan MHIT. Melalui produk ini, pengguna yang berkemampuan termasuklah golongan M40 boleh mendapatkan perlindungan bagi menampung perbelanjaan perkhidmatan kesihatan yang asas (*essential services*). Pada masa yang sama, golongan yang memerlukan perlindungan tambahan boleh mendapatkan produk MHIT tambah ataupun *base plus.* Produk ini boleh ditawarkan secara kompetitif oleh ITO di pasaran untuk memenuhi keperluan pemegang polisi yang berbeza.

Perlindungan asas yang seragam ini juga akan membolehkan pengumpulan risiko yang lebih luas. Ini seterusnya akan mendorong beberapa perubahan penting kepada ekosistem kesihatan seperti pertamanya, premium produk asas yang lebih mampan serta mekanisme pengumpulan risiko yang lebih saksama.

Kedua, peralihan kepada modal pembayaran berasaskan nilai seperti *diagnosis-related group* bagi kesihatan swasta melalui produk asas sebagai pembayar utama.

Ketiga, peningkatan peranan penjagaan *primary care* sebagai tempat rujukan pertama dan kesinambungan rawatan yang tidak memerlukan penjagaan di hospital.

Keempat, menggalakkan simpanan kesihatan individu dengan jangkaan yang lebih baik untuk menampung bayaran *out of pocket* serta premium pada masa hadapan.

Dengan pengambilan produk asas MHIT secara lebih meluas yang memberi akses kepada hospital swasta, perkhidmatan kesihatan awam akan kekal sebagai jaringan keselamatan sosial (*social safety net*) untuk orang ramai khususnya bagi mereka yang tidak mampu untuk membeli insurans.

Yang Berhormat sekalian, untuk slaid yang ini, kami menunjukkan ciri-ciri reka bentuk produk asas yang sedang dibangunkan pada masa ini. Memandangkan reka bentuk produk asas ini sedang dibangunkan pada masa ini, saya memohon supaya slaid ini serta penerangan saya berkaitan faktor-faktor pertimbangan berkaitan produk asas MHIT ini adalah *off-record.* Ini kerana ciri-ciri ini masih belum dimuktamadkan dan memerlukan kajian lanjut serta perundingan bersama pihak berkepentingan yang lain untuk memastikan ia dapat dilaksanakan secara berkesan.

[Off record]

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ok, terima kasih. Ok, mungkin saya mula tanya terima kasih YBhg. Dato' Seri, pagi tadi kami ada prosiding dengan semua CEO *insurance companies*. *So*, salah satu cadangan yang mereka rasa dia akan lakukan

ialah kerana kita tahu yang *private hospital* dengan pihak insurans, *actually they have been blaming each other*. *Last*, *you know* sudah setengah—lebih setengah tahun kita ada prosiding berkenaan dengan isu ini, semua salahkan orang lain selain daripada mereka.

But this time, they also come out with this recommendation, dia kata sini saya baca *"appoint an independent consultant paid by insurance and hospitals to analyze and recommend sick holder actions to reduce claims inflation". So, update* ialah *"work in progress to appoint a consultant to develop basic MHIT product secondary outcome from this initiative will be to understand what other jurisdiction have done in this area of reducing claim inflation". Okay, I mean the impression is that,* selepas isu ini sebenarnya telah menjadi satu *hot topic* sejak Disember pada tahun lepas sampai sekarang. Sekarang mereka baru mahu lantik *independent consultant* untuk melihat macam mana syarikat insurans dan juga hospital swasta mereka boleh kerjasama untuk kurangkan aduan *inflation*.

So, it's good that Bank Negara *also coming out with the, all the* langkah-langkah untuk mengatasi masalah ini. *But I think your role will be more on insurance companies, right? So,* sekarang kita baca yang *Cabinet said they want to set up a special committee to handle private healthcare inflation. So, just now I heard from you that you know your* Bank Negara dan KKM *will come together to monitor this*. *Do you all set a timeline or not? I mean it's good that we see you know, what you have presented to us compare to last time, right? A lot of thinking had been putting into efforts to see how to reduce this issue insurance premium thing, but so far, your Bank Negara and Health Ministry, any further cooperation because if I look at the industry— because we have been questioning the insurance company and the private hospitals, these two industries they should work together rather than blaming each other. The answer is now only in progress appointing a consultant to do that. I don't know whether you want to comment on this.*

■1430

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Thank you* Yang Berhormat *for the question. In fact, if I can,* saya boleh jelaskan. Pertamanya, *all the* inisiatif, yang 11 ini *with the* lima teras yang kita terangkan tadi itu, *it is* inisiatif yang telah dipersetujui oleh Bank Negara Malaysia, industri insurans, Kementerian Kesihatan, Kementerian Kewangan dan semua pihak-pihak berkepentingan termasuklah APHM, hospital swasta. Kita telah bermesyuarat berkali-kali dan kita semua telah bersetuju. *So, this is the five* teras *that we want to do and this are 11 the initiatives.*

Initially, pada *[Tidak jelas]* Februari, bila kita bentangkan kepada PAC, kita ada sembilan inisiatif sahaja. Setelah kita berbincang dengan pihak hospital dan sebagainya, mereka mencadangkan dua lagi. Jadi sekarang kita ada 11 inisiatif. *So, all initiatives* ini *is part and parcel of one initiative actually,* pertama.

Kedua, memang terdapat koordinasi yang menyeluruh di antara Bank Negara, Kementerian Kesihatan, industri insurans dan juga pihak hospital. *So, that is where we have come out with all these recommendations.*

Ketiga, dari segi konsultan, kita telah pun melantik konsultan baru-baru ini, ia telah pun dilantik dan mereka akan bermula dari segi kerja-kerja mereka untuk mengeluarkan rangka kerja dari segi perlaksanaan inisiatif-inisiatif yang telah kita *identify*-kan ini.

Dari segi 11 inisiatif ini pun, contohnya, salah satu daripada inisiatif itu, nombor sembilan, Rakan KKM telah pun diluluskan oleh Kabinet pada hari Rabu, semalam. Jadi untuk makluman Yang Berhormat, perkara ini sebenarnya adalah satu koordinasi yang kukuh di antara pihak-pihak terbabit, Bank Negara, KKM, syarikat insurans dan juga syarikat hospital. Kita juga telah menubuhkan jawatankuasa peringkat Menteri itu, termasuklah yang akan dipengerusikan oleh Menteri Kewangan dan Menteri Kesihatan dan kita akan ada *steering committee* yang dipengerusikan oleh penasihat teknikal kami Datuk Jessica dan juga dengan wakil daripada Kementerian Kesihatan Dr. Yap. *Steering committee* ini akan merangkumi pihak-pihak yang terlibat, yang tertentu termasuklah industri insurans, Kementerian Kesihatan, Bank Negara dan sebagainya.

Selain daripada itu, kita juga akan menubuhkan *consultative committee (council)* yang akan melibatkan pihak-pihak terbabit yang lain. Contohnya macam NGO, *consumer association,* persatuan hospital dan sebagainya untuk memberi pandangan dan juga komen ke atas perlaksanaan 11 inisiatif ini. *So,* perkara ini telah pun sedang dilaksanakan, Yang Berhormat.

Datuk Jesicca Chew Cheng Lian [BNM]: Kalau saya boleh tambah sikit *on the based product. Can we go to the slide on the ecosystem? [Merujuk pada slaid pembentangan]* Jadi, dalam memikir *the structure for the based product* ini, kami pun telah memberi banyak pertimbangan kepada ekosistem yang kita nak capai ini, dengan *reform* ini. Jadi, *this is the depiction,* apa peranan *primary care.* Contohnya, apa peranan kita nak masukkan *coverage for preventive care, how we want to deal with pre-existing condition. So,* dengan – bagaimana perkhidmatan kesihatan swasta ini boleh disepadukan dengan lebih baik dengan perkhidmatan awam. *So, this is the big picture.*

Jadi, yang *appointment of consultant* ini Yang Berhormat Pengerusi, *is really to* memperincikan *benefit package* dengan *pricing, the premium rate.* Jadi bila kita buat itu, kita akan mengambil kira juga *affordability. So, we will look at the demographic of society* yang sekarang ini tidak dapat, *cannot afford insurance* dan kita akan menentukan apa tahap premium yang boleh, yang sesuai. Jadi, kita boleh meliputi lebih ramai orang dalam pakej ini. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Terima kasih. Saya nak tanya satu lagi soalan. Bila kami berjumpa dengan APHM pada hari Selasa, *so,* mereka yang juga

menuduh syarikat insurans, mereka mengehendaki pihak hospital swasta bagi mereka diskaun sampai 25 peratus. Jadi, mereka kata ini juga menyumbang kepada peningkatan bayaran pada pesakit. *So, just now we asked insurances companies. "Can you waive the 25 percent discount that you imposed on private hospital?" You know, the answer was "We want to make sure yang hospital swasta itu tidak mengaut keuntungan yang berlebihan". So, I mean since this 25 percent discount is actually quite a big amount, I wonder whether Bank Negara can step in and put in the regulation to stop any form of discount for insurances.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *[Bercakap tanpa menggunakan pembesar suara] ...Start to answer this question, I will invite my colleagues to also come in. First is that,* langkah-langkah ini adalah di antara langkah-langkah untuk mengawal kenaikan kos inflasi perubatan sebab kita dapat lihat dari segi penggunaan berlebihan dan juga kos-kos yang tinggi terutamanya dari segi *surplus* dan sebagainya. Jadi, untuk mengekang atau menahan kenaikan inflasi ini, salah satu langkah yang kita ambil adalah untuk memastikan pihak insurans menetapkan beberapa langkah ataupun inisiatif bagi mengurangkan kos dari segi perubatan ini supaya ini dapat mengurangkan kenaikan dari segi premium mereka.

One of the measures that taken by the industry is to actually ask the hospital to reduce the cost, to provide discount. Walau bagaimanapun, memang kita tahu terdapat sedikit perundingan di antara pihak insurans dan juga pihak hospital di mana kami pihak Bank Negara telah pun memberi pandangan kami dan juga cuba membantu untuk mereka memastikan sebarang diskaun yang dikenakan atau diperuntukkan adalah *fair* kepada kedua-dua pihak, kepada pihak insurans dan juga kepada pihak hospital. Kami juga telah beberapa kali berjumpa dengan kedua-dua pihak untuk menangani isu ini. *If you want to add on this,* Datuk Jesicca?

Datuk Jesicca Chew Cheng Lian [BNM]: Ya, kami memang memantau *cost containment measures* yang diambil oleh pihak ITO sebab dengan— sebelum, *even before* kita *implement interim measures* ini, memang dah wujud *the pressure on the performance* macam kita tunjuk tadi pun dah— portfolio itu memang *loss-making* sekarang. Jadi, dengan *implementation of the interim measures,* tekanan ke atas syarikat ITO memang akan berterusan sampai 2027. Jadi, salah satu daripada respons syarikat insurans adalah untuk berunding dengan pihak hospital swasta. Jadi, sama-sama kita kena *control cost* sikit sepanjang tempoh ini sehingga produk asas ini boleh dikeluarkan.

Jadi, itu rundingan dan kami pun sudah pun dah memantau langkah-langkah yang diambil oleh syarikat insurans. Yang paling *removal,* macam diskaun ini memang *will continue* YB Pengerusi *because it is important to contain cost. Everybody needs to play a part, right? If not, the pressure on the insurance companies, the premium, you know? Although it will be interim for three years, it will be limited to 10 percent. After that, you will see this big jump. So, all need to cooperate, to try and bring the cost down.*

We understand sometimes this discount terlalu tinggi. Jadi *in those cases, we will ask the insurances companies to explain the basis and they will show us the data that they used to negotiate with the hospital and we invite the hospitals to do the same, to present their data, then they can come to agreement on this.*

We also Yang Berhormat Pengerusi, *we also have something called a grievances mechanism actually, that was setup* dua, tiga tahun yang lalu *to allow private hospitals, doctors* ke *who have complaint about such action by ITO, to bring to this body. This body has medical professionals. It will have independent people who will look at cases and then will recommend what would be appropriate course of action but that has been suspended temporarily.* Sambil kita menjelaskan dengan *Competition Commission because there could be some concern over collusion and all that. So, we wanted to make sure that it is not an issue* tapi *we intend to reactivate this mechanism to allow them to resolve such disputes between private hospital* dengan insurans.

Lagipun kita dah— *also we offered,* yang mana hospital yang ada masalah macam ini boleh, *can approach* Bank negara *and we have opened a channel for them to do so. We said* yang kita boleh *address* ini, *we need specific cases.* Susah kata, yang kita *speak generally,* kan? *So, if you give us specific cases, our team will look into it, will get the insurances companies to explain their action and we have done so in the number of cases.* Cuma *you know, the— we have not seen many its specific cases brought forward to us but we have opened the avenue for the hospitals to come forward.*

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Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Bayan Baru.

Encik Aznan Abdul Aziz [Bank Negara Malaysia (BNM)]: Yang Berhormat*, maybe if I want to add to that.* Kami juga ada melakukan perbincangan dengan beberapa syarikat insurans dan diskaun ini adalah berdasarkan satu rundingan dan lagi satu, statistik. *So*, maknanya dia bukan *across the board, let's say 20, 25, 30 percent. It depends on the hospital. So*, dia buat perbandingan kos hospital A, hospital B, hospital C. *So*, hospital mana yang kosnya tinggi, yang itu akan diminta diskaun untuk menyelaraskan kos supaya tidak berlebihanlah.

So, mungkin yang kompelin itu adalah hospital yang kos dia agak tinggi berbanding dengan hospital-hospital lain. *So*, syarikat insurans akan memberi justifikasi kenapa diskaun tersebut diminta. *Like Datuk Jessica said*, kalau ada yang bukan seperti itu, *then* bolehlah laporkan kepada kami. *Then, we can take a look into it.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Pengerusi. *On this point*, sebenarnya apa yang hospital *complaint to us* adalah sebenarnya ada hospital-hospital kecil yang kena

buli sebab mereka tidak ada *negotiating power*. Jadi, mereka dikenakan diskaun yang berlebihan untuk— kerana mereka senang dibulilah.

So, issue of this discount, it actually creates another problem kerana dengan diskaun, dia— hospital *expect* diskaun. Jadi, mereka akan *mark up*. *It's a chicken and egg.* Apabila dia *mark up*, dia akan *affect the fee pay for service client* sebab *line* sama. *Glove RM20*, dia *mark up, expecting a discount. So, the fee paying* punya— *this out-of-pocket* punya *customer*, *client* kena juga.

Jadi, saya rasa ini bukan sesuatu yang sangat sihat untuk industri di mana *expecting a discount of 25 percent. So,* lebih baik diturunkan semua. *Everyone comes out if a— they suggested, the APHM suggested a Healthcare Cost and Reimbursement Committee where they can go come down and really discuss and come out everyone together.* Jadi, itu adalah satu cadangan. Okey, itu— tetapi, saya nak masuk ke isu yang utama di sini adalah *medical inflation.* Sebenarnya, kenapa kita semua *discuss* ini adalah isunya *inflation*. Tetapi, kita tidak tahu sebenarnya *inflation* berapa peratus. *According to APHM— sorry*. Syarikat-syarikat seperti insurans, mereka kata *15 percent. But that is based on one survey company*. *The 15 percent is coined from there. It's plucked, is quoted from there.* Tetapi, apabila kita tanya APHM, mereka kata *real inflation is about six to seven percent.*

Hari Selasa, kami pun panggil *third party administrator.* Itu mereka mempunyai data yang sangat konkrit. Mereka memberitahu kepada PAC bahawa sebenarnya *based on their record, per case basis, per case* ya, sebenarnya *inflation* hanya *less than two percent. It's about 1.7 percent. So, I'm*— kami ini rasa bahawa disebabkan— sebenarnya setiap kes itu, *inflation* tidak begitu tinggi. *Maybe 1.7 percent.* APHM kata *six to seven percent.*

Tetapi, yang betul-betul *problem* sebenarnya adalah *the pent-up demand* sebab masa COVID, tak ada orang *claim.* Tetapi, lepas COVID, semua orang pergi jumpa hospital, *delayed treatment*. Maka, dia isunya adalah *volume* yang tiba-tiba naik. Dan akhirnya, itu dikira sebagai *inflation*. *But the fact of the matter is it doesn't make sense to have an inflation of 15 percent if our, what do we called— core inflation is about maybe less than two percent. You know, it doesn't make sense.*

So, that brings us to the next problem. The next problem is actually the product design by, what do we called, this insurance company which is not sustainable. The old pool, the closed pool, the dying pool. Apabila kita— *when we were young, we were offered this product. So, we all buy. But after 30 years of loyal to this product, to this company, when we retired, suddenly we are found in the situation where this is old pool. New product has already taken over and we are stuck with the old pool and dying pool. Eventually, we are being punish, so called punish by a steep inflation as repricing of as high as 183 percent.*

So, I think this is the clucks of the problem where pool or their design must be change, must be reform. Or else, we will continue to have this problem. Maybe I want to stop here for a while to get the comment from Gabenor. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Thank you Yang Berhormat on the two issues* itu. *First on inflation. In fact, we have agreed between* Bank Negara, KKM*,* APHM*. Basically, we know that the inflation data that we are using are all based on different sources.* Jadi, memang betullah, *it could be different* dari segi angkanya. *That is why one of the recommendations is to work* dengan *World Bank to come out with a method to really measure through inflation for medical services.*

At the moment, ada banyak cara untuk mengukur inflasi. Contohnya, pertama, dari segi *medical cost inflation* yang mengambil kira keseluruhan kos perubatan termasuklah *test* dan sebagainya.

Kedua, *medical claims insurance*. Data ini daripada *insurance company* sebab banyak *claim* meningkat dari tahun ke tahun. *That's how they measure the inflation.* Pada yang hospital tadi, dia kira dari segi berapa kos perubatan yang kita perlu bayar.

Ketiga, dari segi *medical services*. Dia ambil satu atau dua *services* sahaja, berapa banyak yang meningkat *medical services* tersebut. Jadi, kita bersetuju memang ada banyak indikator dan kita telah pun bersetuju untuk bersama-sama kongsi data. Daripada Bank Negara, KKM, insurans dan juga hospital. Kita *combine all the data* jadi satu pangkalan data yang komprehensif dan kita boleh dapatkan apakah angka sebenar inflasi. *That is one of the initiatives* di bawah RESET yang telah dipersetujui oleh kesemua pihak.

Kedua, dari segi secara mata kasar, *conclusion* yang kita boleh buat dari segi data-data yang kita lihat, Yang Berhormat, secara amnya, kadar inflasi perubatan di Malaysia adalah lebih tinggi daripada negara-negara lain. *That is a fact*. *So*, memang kita ada masalah di situ dari segi *medical inflation, but we are working on the data, on the numbers*.

Kedua, *in terms of product design— yes*, betul, *we agreed. So, that is why we are coming out with the base product. So, the base product will address this product design issue* di mana, *as what DG Jessica mentioned just now*, *this will be a standardized kind of coverage, standardized kind of benefits* di mana sekurang-kurangnya semua orang boleh mendapatkan *base product* ini pada harga yang berpatutan dan juga pada harga yang pada kos yang mereka mampu milik, contohnya. Kerana dua sebab. Pertama, kita dapat kawal dari segi apakah *benefit-benefit*-nya. Kedua, *pool* dia akan jadi besar sebab ramai akan dapat menggunakan produk ini. Jadi, akan berkongsi dengan lebih ramai lagi. Jadi, akan menurunkan harga.

Kedua, apabila kita masukkan *the add-ons*. *Add-ons* ini boleh jadi pilihan. Sesiapa yang nak lebih, tambah lagi, mereka boleh beli. Dan ini akan ditetapkan oleh harga

pasaranlah. Contohnya *demand and supply* dan juga dari segi kos sebenar perubatan. *So, that is something that will address the issue of the product design.*

Betul, Yang Berhormat, kita akui *product design was one of the* sumber atau faktor yang telah menyumbang kepada peningkatan kos MHIT dan juga premium MHIT ini. Jadi, dengan *base product* ini, harapan kita adalah kita dapat menangani kenaikan kos ini dan memberi satu produk di mana premium akan lebih mampan.

Go ahead, DG Jessica.

Datuk Jesicca Chew Cheng Lian [BNM]: Kalau saya boleh tambah, YB. Jadi, *the base product* juga akan membolehkan *risk pooling* itu merentas syarikat ITO. Itu yang penting sebab sekarang ini *all the risk pooling is within the ITO. So, it is a limited pool. So, with the standardized base product,* kita boleh *risk pool for the whole system and that will really bring down the premium pressure*.

Satu lagi. *I think* sementara itu— sebab *base product* belum keluar lagi. Sementara itu, kami juga telah melonggarkan kebolehan untuk syarikat ITO boleh *increase the flexibility for them to risk pool* sebab kita ada peraturan *risk pooling* ini sebab *also for fairness.* Kalau *risk pool* itu kita campurkan produk-produk yang memang berbeza dari segi *design* itu, memang *it won't be fair for some of those who bought different product.* Contohnya, *with higher deductibles,* sebab mereka akan dikenakan premium yang jauh lebih tinggi.

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So, kita ada beberapa peraturan yang cuba *ensure fairness across the policy holders*. Tapi sekarang kami juga telah melonggarkan itu bagi membolehkan syarikat- ITO boleh *pool across-* gabungkan lebih banyak daripada *risk pool* ini. Terima kasih.

Tuan Sim Tze Tzin [Ahli PAC]: Terima kasih Pengerusi. *I think*, kita ada perbincangan yang sangat lama tadi- pagi tadi tentang isu inilah. Sebenarnya, mereka mengakui bahawa *product design* memang sudah lapuk dan memang perlu ada *reform*. Tetapi antara alasan yang mereka kata, bahawa mereka tidak dapat *reform* adalah *because regulator* iaitu Bank Negara ada satu *policy,* di mana *risk-based capital framework*. Jadi, mereka kata *of course,* ada kebaikannya dengan RBC ini tetapi itu antara mereka ini tidak dapat— mereka *design based on this framework*. Jadi, saya rasa perlu ada— *look into it. Because, we are not experts, you guys are the experts*. *But at the same time, we also feel that, I mean, we are fighting for the* rakyat. *The* rakyat *is very simple, they pay for 30 years, loyal to this company, when they retire, suddenly they are slapped with 183 percent repricing*.

Then, the worst part is, age bracket itu, satu lagi isu yang besar, di mana apabila just setakat dia satu hari *older, they celebrate 60 years old birthday and then, they are retire. Suddenly, the insurance- bill comes, 263 percent. Age bracket and repricing, all together, come together. So, I think,* ini adalah isu yang rakyat sangat marah. Kerana walaupun kita boleh kata polisi ini bagus, ini *system framework* dan sebagainya tapi rakyat ini, *they look at dollar*

and cents. 263 percent, if you put yourself into the shoes Datuk- Dato Seri, *you also cannot accept it. And for me personally, I was given a 50 percent repricing. I am healthy, never claim, I do my exercise, okay. But, at the age not even 50* tetapi kena *50 percent. To me, I also feel aggrieve. So, I think the issue*-nya adalah— adakah *insurance company* boleh *reform? As a regulator, can you have a look into this kind of framework and whatever framework that you talk about. To the people, they cannot accept it.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat, dari segi *RBC Capital Framework, in terms of constraint* untuk mereka mengeluarkan *product design* yang sesuai, kita akan lihat dari segi aspek itu. *We need to get in terms of,* apakah masalah-masalah yang mereka hadapi? Sepatutnya, tidak ada masalah.

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *I think maybe we can show this slide* yang tambahan ini. Okey. *So*, kita rasa contohnya dari segi isu kedua yang dibangkitkan oleh Yang Berhormat tadi, dari segi peningkatan premium apabila umur telah meningkat. Dengan adanya produk– *based product* ini, ia akan dapat mengurangkan peningkatan tersebut. Contohnya pada masa ini, kita nampak apabila meningkat tahun 50 tahun dan ke atas, peningkatan premium itu memang lebih tinggi. Dia agak menegak peningkatan premium tersebut. Apabila kita ada produk *based* ini, di mana ia lebih meluas dari segi *coverage*-nya dan juga dari segi *benefit*-nya dia lebih terkawal. Ia akan menurunkan dari segi peningkatan premium apabila walaupun telah sampai ke tahap umur lebih kepada 50 tahun ataupun 60 tahun. *So*, ini satu perkara yang kita boleh capai dari segi *age bracket* ini.

Kenapa ini berlaku pada masa ini adalah kerana semuanya diambil dari segi *risk-pooling*-lah. Mengikut *experience* tertentu dari segi kadar umur dan sebagainya. Memang agak— *I would say in terms of- it is normal for people who are above 60 to use medical services*. *The probability is higher for those above 60 to* dapat penyakit dan juga mengguna kemudahan hospital dan juga mendapat *claim* yang lebih tinggilah daripada syarikat insurans. *That is why the pool is higher*. Sekiranya kita gabungkan *pool* ini dengan yang lebih muda, jadi mungkin kita tak *fair* kepada yang muda itu. Dia kena bayar, dia kena macam *subsidise— cross subsidise those* yang lebih berumur, contohnya. *That is why we cannot do that.* Walau bagaimanapun, kami *are open to see whether we can try to combine certain groups. That is where we have to discuss with the insurance companies, we are open to do that. But, we need to look into those cases.*

Tapi secara amnya, apabila kita ada produk asas ini, ia akan meng-*adjust automatically* dari segi trend kenaikan premium ini. Ia akan lebih *flat* berbanding dengan kadar sekarang ini. *So, that is* dari segi *age bracket*. *But,* dari segi RBC, *I think we look into that*-lah.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Kubang Pasu.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih YB Pengerusi. Yang Berbahagia Dato Seri Gabenor, saya nak merujuk kepada muka surat enam, Dato Seri. Penyelarasan dengan penjagaan kesihatan berasaskan nilai untuk mengawal kos. Banyak disebut di situ, termasuk pembayaran DRG. DRG ini Dato Seri, dalam beberapa prosiding yang kita laksanakan, dia sebenarnya ada yang masih peringkat awal dan masih tersekat di peringkat percubaan. Soalannya ialah apakah ini sudah mendapat persetujuan daripada mereka-mereka yang terlibat dalam *medical* swasta ini? Keduanya, keutamaan penggunaan untuk ubat generik. *Fine*, kita setuju. Tadi pun syarikat insurans bersetuju. Mekanisme perkongsian *cost-sharing* ini, ertinya antara insurans dengan pesakit, mungkin Dato Seri boleh beri pencerahan dan yang seterusnya ialah tentang pembelian strategik.

Seterusnya, muka surat tujuh. Yang ini sebenarnya ia menunjukkan *details* pembayaran DRG lah. Kalau boleh Dato Seri terangkan dengan lebih jelas mengenai DRG ini dan juga mengenai pembelian strategik dan juga mekanisme perkongsian *cost-sharing*. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat, inisiatif-inisiatif yang telah kita nyatakan di sini ini, termasuklah DRG, telah pun dibincangkan dengan pelbagai pihak. Contohnya, dengan KKM dan juga dengan pihak-pihak lain. Kami juga telah mendapat maklum balas daripada pihak hospital swasta. Memang betul, pada peringkat awal terdapat beberapa isu berkenaan dengan pelaksanaan DRG ini. Walau bagaimanapun, dengan adanya produk asas ini, adalah lebih mudah untuk DRG dimasukkan melalui asas ini. *So, this is where* kita akan perlu *discuss* lagi dengan hospital, contohnya untuk memastikan kita dapat melaksanakan DRG ini. Tetapi salah satu perkara utama yang penting untuk DRG ini dilaksanakan adalah data.

So, that is where I think, kita perlu sokongan daripada kerajaan dan juga pihak PAC, untuk menggalakkan dan membolehkan perkongsian data. Di mana kita dapat menggunakan data-data tersebut untuk mengeluarkan kadar ataupun tahap DRG yang sesuai, yang boleh dipersetujui oleh pihak KKM dan juga pihak hospital swasta *itself. So, that is how* kita akan cuba bekerja bersama dengan pihak APHM. Di mana kita akan mengambil pandangan dan pendapat mereka juga dan juga dari segi cara-cara bagaimana untuk kita melaksanakan DRG ini. *So, that is number one*. Kedua, dari segi *cost-sharing* itu. Kita telah laksanakan *cost-sharing* daripada lama dah pun sebab di mana apabila ada *cost-sharing* ini, ia akan lebih meningkatkan tanggungjawab dari segi pemegang polisi tersebut untuk mengurangkan sebaik mungkin kos perubatan mereka dengan cara memilih untuk pergi ke hospital yang lebih-mungkin caj dia lebih munasabah ataupun lebih baik.

Dan juga dari segi menggunakan perubatan ubat-ubatan yang lebih murah daripada ubat-ubatan yang *branded* dan sebagainya. Ini telah mendorong dari segi perubahan tingkah laku pengguna. Ini secara langsung akan dapat mengurangkan peningkatan *cost medical*

inflation-lah. Dari segi pembelian strategik, *so this is where* perkongsian di mananya, apabila *government* ataupun swasta untuk membeli alat-alat tertentu, *instead of them going alone on their own, so they come together and they purchase together. So, that is where I think we can get a better deal with the* syarikat yang menjualkan alat-alat tersebut dan juga dari segi *pharmaceutical* juga.

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Datuk Jessica Chew Cheng Lian [BNM]: *On the* DRG. Sebenarnya dalam perbincangan kami dengan syarikat-syarikat hospital swasta, keraguannya itu berpunca daripada cara kita *design* DRG terutamanya *the cost, the price you know, how we set the prices. So*, kami pun peka fasal perkara ini. Jadi, data itu yang penting. Kalau kita boleh kumpulkan data *that will inform* bagaimana kita tentukan harga DRG untuk prosedur-prosedur yang berbeza-beza.

Dalam hal ini juga, kami pun telah memaklumkan pihak hospital swasta bahawa pelaksanaan DRG ini boleh dilakukan secara berfasa. Jadi, dalam fasa awalnya kita mungkin *get* data dahulu dan kita boleh monitor dia punya *performance and then*, baru kita tetapkan harga bagi pelaksanaan pembayaran. *So*, ini telah— *they are more receptive* sebab yang *assurance* yang dia nak ini yang kita tak meragu-ragu melaksanakan DRG tetapi kita buat dengan cara teliti dan dengan makluman yang sesuailah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dato' Seri, nak balik pada DRG. Sikit lagi. Sebenarnya, tak banyak negara yang melaksanakan DRG ini. Kalau kita tengok daripada pembentangan Dato' Seri sendiri, penerimaan DRG secara wajib oleh semua hospital swasta ialah Jerman dan Taiwan. Kemudiannya, ada secara hibrid dengan *[Tidak jelas]*, Estonia dengan Australia dan dua lagi DRG berdasarkan perjanjian kontrak macam Dato' Seri sebut tadi ITO dan hospital. Hanya enam. Mesti ada sebabnya kenapa negara-negara lain tidak mengguna DRG dan kita mahu *going into this direction*. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Ya, mungkin disebabkan oleh struktur ekosistem perubatan di negara-negara tersebut. Contohnya di Amerika, contohnya. Dia lebih kompleks. Jadi, mungkin sukar untuk mereka melaksanakan DRG secara keseluruhan. Di Malaysia, walaupun kita ada banyak *players* tetapi *it's something that* kita rasa kita boleh buat. Walau bagaimanapun, kita rasa kita akan buat secara berperingkat. Kita *test* dahulu. Dapat *the data* dahulu, sama-sama kita lihat data tersebut dan keluarkan angka sama ada angka ini sesuai dan munasabah tak bagi pihak Kementerian Kesihatan, pihak insurans dan dari segi pihak hospital juga.

Apabila kita dah dapat persetujuan dari segi cara untuk mengira kadar tertentu tersebut, *that's where* kita boleh dan *apply* sama ada secara hibrid ataupun secara kontrak ataupun secara mandatori. Itu terpulang kepada pilihan kita, apabila kita dah dapat data-data tertentu dan dah dapat dari segi fasa pertama pelaksanaan DRG tersebut. *We are quite open*

to the idea of how we implement it but I think we want to work together and get an agreement first before we move to the next phase.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Secara peringkatnya Dato' Seri *that means it's better to go through the hybrid type? Just like* kita nak pergi *electric from petrol into electric. We go hybrid first.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Possible, possible. Yes, possible.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *And then, we go in full electric*. Kalau tidak, orang terkejut.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Betul.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Terima kasih Dato'.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Dato' Seri, saya nak tanya satu soalan. *Last year* November, *I* lihat yang bila Dr. Zaleha dia memegang jawatan Menteri Kesihatan kan. *Wait. I think it's 2023, sorry.* November 2023. Dia pernah mengumumkan kerajaan mungkin akan memperkenalkan *National Health Insurance with employee, employer and government contributions.*

So, kalau kita— saya rasa kalau kita sebut insurans *it must be under* Bank Negara lah. *I don't know whether in your process of discussion with the various sectors whether you all had brought up these issues. Is it in the pipeline of government?*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat, *so far not in the pipeline because we heard the announcement but there's no follow through to that. But even that is not really under Bank Negara because it's really in terms of part of the social protection of the government* dari segi memastikan sosial insurans *this* perubatan ini kan. *National Health Insurance* ini. *That's more from the government's perspective.*

So, perhaps I think MOH maybe in a better position to provide some clarification on this.

Tuan Aznan Abdul Aziz [BNM]: *National Health Insurance is normally because you need to big— have a big pool*, ia nya secara mandatori *and the only people I suppose that can impose mandatory contribution is the government. So, it's like pension and all that. It has to be a government initiative.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Macam PERKESO lah.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Maybe I can just add. Jessica just reminded me that our base product* ini contohnya *this can be a pathway towards that.* Bila ada *base product* ini lebih ramai masyarakat rakyat Malaysia akan ada insurans polisi dan contohnya, katalah kalau kita dapat menggunakan caruman KWSP dan sebagainya untuk membayar sebahagian daripada kos insurans ini, ia juga akan mendorong ke arah tersebut. Ke arah *this National Health Insurance*.

So, this could be also a test case for us. To start with this base product and then we have some kind of support from the government to help people to buy the insurance coverage sama ada *through* EPF ataupun dari segi bantuan MySalam*, tax incentive* dan sebagainya. Ia akan perlahan-perlahan akan mendorong kepada ke arah *National Health Insurance*.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, Yang Berhormat Bayan Baru.

Tuan Sim Tze Tzin [Ahli PAC]: Okey, terima kasih Yang Berhormat Pengerusi. *Actually, I want to congratulate BNM for actually working very hard to come out with these five* teras *and nine, now eleven initiative. I think I want to congratulate and put on record here because without your leadership as well as dedication, this will not happen so fast. So, this is what I feel and very proud that Bank Negara has and also MOH has keep spearhead this kind of reform.*

Okey, *on this just now when we met with insurance companies. They also* minta supaya produk ini *has to be market-driven.* Mereka nak jual. Sebab mereka takut bahawa sesuatu produk *we have to learn from the past mistake* macam i-Lindung *or something* Sihat Malaysia *that eventually failed. When I heard there's a National Health Insurance kind of thing I get scared because a lot of government initiatives it turns out to be* rugi dan kerajaan kena *bailed out. A lot of so-called scandal per se.*

So, I hope that when you design this product, it has to be market-driven. I'm not a communist. So, I want— is a market driven, market accepted and sustainable and when we have successful roll out of this base product, very popular, sustainable then only we talk about National Health Insurance. That's my personal opinion.

Okey, satu lagi adalah *feedback* daripada rakyat adalah selalunya mereka datang cari YB, maksudnya mereka sudah marah. Mereka tak ada *no other avenue then they come to see us. So, one of the issues that the rakyat have with Bank Negara— I'm sorry, for right reason or wrong reason, I don't know— is that Bank Negara is seen as protecting the industry rather than protecting the consumer. So,* apabila mereka ada rasa ketidakadilan, *aggrieve they have a problem* dengan insurans. *First thing*, Bank Negara boleh kata you kena bincang dengan *insurance company, fine. No problem. They go there, of course.* Mereka akan dikenakan. Sebab mereka ini *fight against a small person, David versus a Goliath which is huge international insurance company with billion dollars with lawyers and fine prints and the terms and conditions that nobody understand.*

So, of course there will be tidak dapat, apa yang mereka *complaint* tidak dapat. *Of course, they'll come back to* Bank Negara dan selalunya mereka dapat e-mel bahawa *this is a commercial decision by insurance. Then* habis itu. Lepas itu habis. *So, then they will come to* YB lah *and of course, we all are not be able to because we don't have that kind of corporate lawyer that we can help so ultimately they are very angry with government, with YB or everyone. I think this is not healthy.*

So, saya nak minta supaya ada satu *[Tidak jelas] more consumer protection. I mean change the government* punya— Bank Negara punya *regulator* punya *mindset* kepada *we have to stand out for all this small, small people. Ya, maybe get some comment.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih Yang Berhormat. *First of all, thank you for your words of encouragement. I think we will definitely continue to medicate our resources and also our commitment in terms of* nak menyelesaikan masalah ini dan untuk memastikan rakyat ada penerimaan insurans untuk kesihatan dengan yang mampu, *affordable* dan juga *in terms of sustainable* sebagaimana Yang Berhormat sebutkan tadi.

On the issue of market-based driven. Memang *that is one of the principles that we want to come out with. In terms of coming out with a base product so that is one of the principles that we want. Why? Because we want to ensure that this product can be sustainable. No point having for one, two or three years then it goes— I think it cannot be continued.*

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So because of that, that is where we get input from the industry. We don't come out alone. We come out this product together with the industry. So, they can understand in terms of what can work, what cannot work. So, that is number two.

Number three is that— so that's why kita buat *based product* dan ada juga *based plus. So, that's where* di mana ada unsur-unsur pasaran dan *competition* di situ juga. *Based product is something that is* terhad, *everybody should be able to get a coverage,* sekurang-kurangnya. *But if they want more, they go on the based plus. So, this way they can compete in terms of product* dan sebagainya.

So, that's where memang unsur *market driven* ini memang salah satu *principle* utama yang kita akan gunakan untuk mengeluarkan dasar-dasar ini *especially on the based product* tersebut.

Ketiga, dari segi *perception* yang Bank Negara selalunya lebih memberi penekanan kepada syarikat insurans, industri dan juga bank pun sama juga. *To me, that is a perception,* Yang Berhormat. *Again, I think something that we need to also address.* Pertama, kenapa kita memberi penekanan terhadap isu industri insurans dan juga bank, sebab *we are coming from stability angle.*

We need to ensure that these banks, insurance companies continue to be sustainable and they can provide services to the rakyat. Sekiranya kita tidak menjaga ataupun betul-betul kawal *in terms of* kestabilan syarikat insurans ini, memastikan mereka dapat terus beroperasi, ini akan mengakibatkan ketidakstabilan sektor kewangan di mana mereka tidak akan dapat langsung mengeluarkan produk untuk penggunaan rakyat.

So, that's why we are also protective about these industry. Not protective but more of making sure they can continue to be sustainable, both insurance and banks. That's where I

think if people see— perceive us to be so protective on the insurance industry and the banks is for that reason, not because something we want to make a profit.

Kedua, mungkin Bank Negara pun kita kurang menguar-uarkan apa yang kita buat dengan bank dan *insurance company. If* YB tengok dari segi *action that we have taken on the banks and insurance companies, then you will see how strict we are with them. We are very strict with the industry. In fact, we really imposed penalty on them.*

In fact, now kita *even published the penalty that we imposed on these banks and insurance company and we even put it in annual report. So that*, rakyat akan tahu *that we are serious about the industry and if they do wrong and if they don't protect consumer, we'll go after them as well.*

Ketiga, dari segi *how we* tangani aduan dan sebagainya, memang kita akan sokong pengguna *because* salah satu daripada objektif kita adalah memastikan *fairness to the consumer. So, that is one of the important principle that we* pegang. *So,* apa kita lakukan contohnya?

If kita tengok bila ada sebarang aduan dan sebagainya, kita akan berhubung dengan syarikat insurans tersebut. *First part of call, we have to be with the insurance company. They have to go to the ITO's and see whether they can solve the problem. If they can't solve the problem, they can come to us. So, that's where we will look into the case.*

Sometimes, although we say commercial decisions, the fact that there is a letter that comes from Bank Negara to the insurance company, they will react already without us having to tell them to do anything. From what we have seen, from the data that we have Yang Berhormat, about 80 plus percent of the cases that comes to us has been resolved.

Resolved meaning it's now fair to both, the insurance dan juga kepada pelanggan. Ada beberapa kes yang mungkin tak dapat di- *resolved* atau sebab-sebab tertentu. Kadang-kadang, mungkin ada sebarang— contoh-contoh penipuan dan sebagainya, mungkin tak dapat di-*resolved*-lah.

Sekiranya mereka tak *happy* dengan apa yang dilakukan oleh Bank Negara dan juga syarikat insurans, *they also have AKPK* dan juga *the Ombudsman for them to approach as well. So,* ada beberapa peringkat dari segi aduan dan sebagainya. *But,* dari segi Bank Negara, memang kita akan selalu menekankan kepada insurans dan juga bank *that they need to ensure they are fair to the consumer especially* kalau *consumer* yang macam individu, di mana mereka tidak *savvy* sangat untuk mempertahankan diri mereka berbanding dengan syarikat-syarikat besarlah. *So, that is our principle,* Yang Berhormat.

If kalau ada kes-kes spesifik yang memang ketara, ada sebarang— *kind of* [*Tidak jelas*] ada pula kata *this is not being fair, please come to us. We will definitely go after the insurance company or the banks.*

Tuan Haji Azli bin Yusof [Ahli PAC]: Tuan Pengerusi.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Shah Alam.

Tuan Haji Azli bin Yusof [Ahli PAC]: Terima kasih Yang Berhormat Timbalan Pengerusi. Saya nak bertanya sikit tentang pembangunan produk asas ini. Tadi, masa perjumpaan dengan pengamal insurans sebentar tadi, saya ada bertanya tentang premium insurans dalam— yang mengambil kira bentuk *saving*-lah untuk pengiraan dan juga sebagai pendanaan pada masa usia tua, senior ya.

Tetapi, *alhamdulillah*. Saya lihat ini sudah diambil kira oleh pihak Bank Negara dalam bahagian kadar premium jangka panjang ataupun yang disebut sebagai pendanaan awal.

Saya berpandangan, ini antara faktor yang mungkin kebimbangan yang sebelum ini yang dipanggil sebagai *cross subsidy,* tak *fair* kepada generasi ataupun mereka yang mencarum di peringkat awal kan, yang muda ya. Tetapi, sebenarnya pada saya inilah solusinyalah dan dia harus mengambil kira *incremental increase for the premium* kan? Sesuai dengan peningkatan gajilah.

Maksudnya, mereka yang di peringkat awal, gajinya agak rendah. Bila gaji meningkat, dia sudah ada *affordability* untuk dinaikkan kadar itu. Maksudnya, mungkin *I don't know, not sure* lah dia punya *term* ataupun *calculation method* dia tetapi mungkin— *maybe five years* ke *or seven* lah kan, *seven.*

Tetapi, tidaklah macam sekarang ini, tiba-tiba bila kita ada krisis *and sudden increase crisis, COVID-19,* kemudian *sudden increase in the frequency of claim* dan juga *increase in the medical cost, suddenly* yang muda pun terkesan juga.

Anak saya empat orang, anak yang ada premium. *Then, suddenly* dalam masa yang pendek, tiba-tiba mereka pun terkesan juga surat kenaikan itu. Itu pada saya tidak adil pada mereka, kan? Yang tadi, kita bicara banyak tidak adil kepada yang macam saya sebab contohnya, saya dah mencarum selama hampir 30 tahun, tak pernah *claim. Alhamdulillah* lah kan, sihat tetapi *to maintain that healthy condition* tak pernah *claim* ini, kita pun terpaksa banyak juga *spend* untuk *maintain the healthy lifestyle* kan?

Maksudnya, awal-awal dulu, mungkin kita *spend on sport* dan sebagainya tetapi bila dah meningkat usia macam ini, *for aging*— disebabkan *aging* ini, kita kata *you maintain* macam mana *healthy lifestyle* pun, faktor *aging* itu tetap akan menjejaskan kesihatan juga. *So, you have to maybe buy supplement, you buy medication* untuk *reduce the BP, sugar whatever* kan? *But, that help you not to go for hospitalization* lah, okey.

So, I think this one is good, definitely very good and I congratulate for Bank Negara for having this, the plan lah. Cuma, satu lagi yang saya ingin bertanya ialah berkenaan dengan *non-claim discount (NCD) for automotive. But, do you have any sort of similar plan for medical insurance* kan?

Tadi, bila kita tanya tentang dengan pengamal industri, dia kata NCD itu di-*regulate* oleh Bank Negara. *So, we can't do anything, so, that's what they say,* kan? *[Ketawa]* Tetapi,

ini ramai di kalangan senior ataupun mereka yang mencarum lama tidak *claim,* mereka juga tertanya-tanya kenapa tidak ada *sort of scheme* yang boleh mengurangkan premium pada masa jangka yang akan datang.

Last one, saya nak tahu sikitlah, mungkin ini terlalu awal untuk saya bertanya tetapi ada tak bayangan apakah bentuk-bentuk produk asas yang sudah dalam pertimbangan ataupun perbincangan dengan pihak insurans dan apakah bentuk-bentuk produk tambahan, *just* sebagai *maybe pre-empt* apa yang kita boleh jangkakan akan berlaku? Terima kasih.

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Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat*, on the two question* itu Yang Berhormat, pertama dari segi NCD itu, sebenarnya *there is no regulation from* Bank Negara yang tidak membenarkan mereka memberi NCD sebenarnya dan terdapat juga beberapa syarikat insurans telah pun memberi NCD. Cuma satu, kita tidak menggalakkan sangatlah kerana sebab bila ada NCD ini, kadang-kadang ada *cases where* orang itu sakit tetapi dia tidak pergi ke hospital sebab hendak jaga NCD dia. Jadi, bila sudah teruk baru dia pergi ke hospital. Jadi*, that is where I think the cost will be even higher. So, that is why I think we try to* tidak menggalakkan tetapi memang ada hospital yang telah pun memberi NCD.

Kedua, dari segi *preventive care*. Memang syarikat insurans menggalakkan *preventive care* oleh pemegang-pemegang polisi mereka. Mereka juga memberikan beberapa ganjaran kepada polisi *holder* yang mengambil langkah ataupun inisiatif sendiri untuk mengamal *healthy living*.

Ketiga, dari segi produk *design* itu, memang kita masih di peringkat awal untuk membuat *base product* ini, kita masih lagi dalam perbincangan, sebagaimana yang kita telah tunjukkan dalam *slide* ini, apa yang hendak kita capaikan, pertamanya adalah memastikan *product design* ini akan memberi satu *product insurance coverage* yang sekurang-kurangnya munasabah untuk rakyat Malaysia, yang *affordable*. Inilah prinsip-prinsip dia, yang *affordable* dan juga yang ketiga, yang mampan yang boleh bertahan untuk tempoh jangka masa yang panjang dan di mana peningkatan premium untuk *base product* ini adalah terlaraslah. Ia tidaklah tinggi sebagaimana yang kita lihat pada masa ini.

Ini akan dapat dicapai pertama sebab *the base pool* itu akan jadi besar sebab ramai akan lebih dapat, *can afford to have this product. So, once the base is bigger, the sharing is bigger then the pressure on the pool* itu akan kurang. Jadi, peningkatan premium akan lebih mendatarlah. *So,* itu dari segi prinsip-prinsip ataupun *outcome* yang kita mahu capaikan.

Ketiga, dari segi kita akan menekankan lebih kepada *primary care* dan *preventive care. Primary care meaning* sekarang ini kadang-kadang orang pergi hospital, yang mana ada *insurance policy* dia terus pergi hospital walaupun demam biasa sahaja dan selesema biasa sahaja dan kos adalah tinggi. Dengan ada peranan *primary care* ini mereka mungkin perlu

pergi kepada *primary care* dahulu untuk mendapat *referral letter*. Jadi akan ada *some* saringan di situ dahulu sebelum mereka ke hospital. *That can also contain cost.*

Ketiga, kita akan menggalakkan *preventive care* di mana *this primary care can pick that role as well. Primary care, normally* dia di kawasan perumahan tertentu, dia akan merupakan doktor keluarga contohnya. Dia tahu, *this is the life style*. Dia akan cuba ajar, *educate* dan rakyat, bagaimana hendak membuat kehidupan secara lebih *healthy* dan juga kalau dia tahu keluarga ini ada risiko sakit jantung contohnya. Dia akan beri nasihat tertentu, buat *test* ini awal-awal dan kalau ada *some indication of* sakit jantung, apa langkah-langlah awal dia kena lakukan. *So, this will also will help. So, that is the part of the base product that we are thinking off. Maybe the element will be in there*.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, okey. Bayan Baru mahu tanya? *Okay, let me ask the last question. I remember last month, there was one panelist,* dia buat satu cadangan, dia kata dia pernah buat cadangan kepada Bank Negara juga tentang macam mana kerajaan sokong *the healthcare insurance or whatever*. Dia kata *we can maybe impose 0.01 or 0.1 percent of the market, Bursa, the market transaction. From there we are going to get many millions to come and support this health insurance. I mean am not sure about this kind of regulation. Is that workable, is that possible?*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *I don't think I am at right position to comment on this. Maybe* Kementerian Kewangan dan sebagainya, mungkin lebih ada *authority* untuk *comment on this issue* tetapi *this is something that if the corporate want to do it, we welcome. Definitely* kita akan galakkan sekiranya mereka bersetuju dan hendak menyumbang kepada kerajaan untuk membantu menangani kos perubatan, *it is something that we welcome.*

Datuk Jesicca Chew Cheng Lian [BNM]: *If I can. Maybe not so much the percentage of market Bursa transaction but because when we think about the base product, because it is a risk pool, a universal risk pool, so, it is possible – we mention risk equalization,* kan? *So that we can spread the risk across different ITOs to manage the premium. It is theoretically possible that within that risk pool say a portion of the total premium collector right, can be deployed to provide certain to smoothen out cost for certain groups for example.*

I mean that's one possibility, we have to think through whether it is doable but the point is with the pooling under the base product and the mechanism that we are thinking through, it is— that the options are much broader for us to consider this kind of solution.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Bayan Baru, *last* ya.

Tuan Sim Tze Tzin [Ahli PAC]: *Ya, last*. Terima kasih. Pengerusi, apabila kita *go through all kind of a proceedings some of them they have some problem that they need attention from government.* Contohnya adalah TPA. TPA, *they are not regulated, so call regulated by MOH but is very loose and then industry actually asked us to bring it up to you,*

whether they can regulated because its neither there or not. And then there are some industry player that actually cause problem to GP. GPs are being ditekan *oleh some TPA which is not a very good practice so they hope that the regulator can look at it. Either MOH or Bank Negara can regulate TPA. Also, it shows that such as— I think over many years, the ITOs has developed a lot of creative products which may have a problem to us, will cause problem to us.*

Satu, contohnya adalah *the million dollar payout. Okay, like for example few years ago, I was offered two million and then I was like "Oh, two million, okay. Baguslah, okay". I pay-*lah. *I upgrade my plan to two million but you know now, after this proceeding I know that actually I shouldn't be claiming two million, you know? If I have to claim two million, meaning my body is like useless ready, everything has to patch, everything has to change. The average payout is about RM12,000. Maximum 80 percent of the medical cost is about RM20,000, max. So, I think Bank Negara has not been— I mean you leave it to market forces but that two million insurance* itu*, actually it encourage buffet syndrome and it's a wastage. Okay, if you want to look at this we have to regulate properly.*

Last point is that this investment link product, a lot of investment link product is— medical insurance is an opening. They actually, they open up, they offer us than they introduce this, this, this and you buy investment link, you buy life insurance, macam-macam lah*. So, as a consumer, we are not so well verse and we* layan *our friend who as an agent and one after next, we are paying like hundreds and hundreds every month just for insurance.*

I just got the SMS, RM500 gone, okay. Next day pay few for my mom and dad, pay for my daughter, then habislah*. So, I think this is the problem that I think Bank Negara has to help us to regulate properly especially the medical. I think we need to really reign in the industry and let them— not to let them have all these so call market forces in creative product that actually ultimately consumer suffer*. Terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Yang Berhormat, *I think very good insight you provided here because the thing is that, I think first on the TPA. I think of course it's good if there some kind regulation* ataupun *overside on the TPA. I think the right body would be the Ministry of Health on the TPAs* ini*. For us, if at all it will be via the insurance company because we only regulate the insurances companies.*

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But there's so much that I think we can do through the insurance company to kind of, I think, impose certain recommendation on the TPAs. But the best would be the Ministry of Health, some kind of an oversight under TPAs and garis panduan dan sebagainya.

Kedua, dari segi *creative product. So, that's where striking the balance*-lah *because sometimes I think there is demand for some products by some segment of the population. So that's where we also want to allow the industry to be innovative and creative in terms of coming*

of its products. But having said that— you are right, your observation is correct— it has evolved to become unsustainable and unreasonable as well. Contohnya, *RM2 million coverage*; dan kedua, *100 years or more than 100 years coverage. It's not— unnecessity. So that's where we want to bring everybody back to basic, what is the basic need that we need. That's where with the base product would cover. If beyond that, it's up to individual. You want to top up the add on, how much you want to top up. So that is where we try to* pecahkan *this product* ini *to make sure I think is basic* dulu *and everybody has to offer this basic, the base product, the add on you can coming and be creative and innovative about it.*

But again, I think we believe when product is being implemented, if there is no demand, product will not be there. So, that's why we are also does not want to be in terms of inhibit the creativity and also the innovativeness of the industry. Kita *try to strike a right balance*-lah *on this,* Yang Berhormat.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Betong masih mahu? *Short one* ya.

Dr. Richard Rapu @ Aman anak Begri [Ahli PAC]: *I think time is a little bit* cemburu. *Thank you, YB Chair. Short one. Talking about the development of this* produk asas MHIT ini dengan mengubah suai beberapa ciri-ciri produklah. *So, I'm just asking out of the box.* Adakah ada kemungkinan bahawa dengan ubah suai ciri-ciri produk ini dia memberi kesan kepada penurunan kualiti penjagaan kesihatan? *I mean the healthcare— by our healthcare provider that the quality of the healthcare might go down. If that the case, what kind mechanism that Bank Negara can provide to ensure that our healthcare will not be affected by this? Thank you.*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Terima kasih, Yang Berhormat. *I think two points.* Pertama, dari segi— *one of the* prinsip *that we also apply here is that we want to make sure that it is a value-based healthcare. So, meaning, it has provide value. Whatever amount that they pay in the base product or even add on,* dia kena *provide the respected value and the quality must be there.* Itu pertama.

Kedua, *besides Bank Negara and the ITOs, Ministry of Health* juga akan bersama-sama kami dalam *product design* tersebut. Jadi, mereka akan juga lihat dari segi memastikan kualiti perkhidmatan perubatan yang diberi adalah baik dan sesuai dan memenuhi keperluan minimum dari segi standard dan sebagainya.

Datuk Jesicca Chew Cheng Lian [BNM]: *Sorry,* Gabenor. Memang tekanan kepada *quality of care* itu memang tinggi *in our thinking for the base product. And one of the things that we're working on—* selain daripada *inflation* sahaja, *just measures of* inflasi, *we are also looking to work with,* macam *the World Bank and all that, to develop indicators on quality. So, for example, readmission rate— you know,* benda-benda macam itu *that we can also track for the base product. Thanks.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, kita sampai *3.34 pm now.* Bagi pihak PAC, kami nak terima kasih kepada Yang Berbahagia Dato Seri Abdul Rasheed Ghaffour, Gabenor Bank Negara Malaysia; Tuan Aznan Abdul Aziz, Timbalan Gabenor Bank Negara; dan Datuk Jesicca Chew Cheng Lian, Penasihat Teknikal; dan kesemua pengurus BNM dan timbalan-timbalan Pengarah BNM. Terima kasih kerana sudi meluangkan masa untuk mengkongsikan pembentangan tadi.

So, mesyuarat kita akan berakhir pada pukul 3.34. Sekian, terima kasih, dan kita akan ada satu *group photo* di luar. Okey, terima kasih.

Dato' Seri Abdul Rasheed Ghaffour [BNM]: Sebelum itu, Yang Berhormat. Kalau boleh *just some concluding remarks from our side.*

Pertama, kita nak mengucapkan terima kasih kepada pihak PAC di atas peluang untuk kami memberi pembentangan ini. Kami dapati setelah beberapa kali datang membentang kepada PAC, kita dapat banyak cadangan-cadangan dan juga idea-idea yang baik daripada Yang Berhormat sekalian untuk kami menggunakan dan keluarkan. Contohnya, RESET ini pun sebenarnya *some of the suggestion came from the PAC. So, we taken on board, we put on to the RESET as one of the initiative taken.*

But maybe kalau saya boleh? Ada tiga perkara yang kita nak menekankan di mana memang perlu sokongan daripada PAC. Pertama, untuk menyokong pelaksanaan RESET ini tersebut yang kita telah *identified 11 initiatives* ini terutamanya dari segi pembangunan produk asas MHIT. Ini termasuklah memperkenalkan inisiatif, insentif yang sewajarnya untuk menggalakkan pemegang polisi beralih kepada produk *base* ini. Sebab, kita tahu apabila kita ada produk *base* ini, mungkin *the transition from the current product to the base product may have some issues. So,* kita memerlukan sokongan daripada pihak PAC dan pihak kerajaan untuk menggalakkan rakyat supaya *transition towards this base product.* Pertama.

Kedua, untuk memperjelaskan pelaksanaan DRG, sebab ada banyak isu-isu terutamanya yang dibangkitkan oleh pihak hospital. Tetapi, dari segi perundingan kami dengan mereka, mereka telah bersetuju dan kita pun bersetuju kita akan memastikan kita buat secara berperingkat dan mengambil input dan juga pandangan mereka. Jadi, kita memohon jasa baik pihak PAC untuk menyokong pergerakan ke arah DRG ini.

Dan ketiga, yang penting adalah dari segi *database. In terms of* meningkatkan pelaburan kerajaan dalam sektor kesihatan awam termasuk dalam ekosistem kesihatan digital seperti, terutamanya, rekod kesihatan elektronik *or the EMR* lah— *electronic medical record. This is very important.* Sebab, bila ada *this electronic medical record,* kita dapat kurangkan kos perubatan kerana— contohnya, katalah kita pergi kepada *primary care, the clinic, we did our x-ray and a few tests there. So, this record* ini *would be incorporated in our EMR. So* bila kita pergi ke hospital, kita tak perlu ulang lagi x-ray tersebut, tak perlu ulang lagi *test-test* yang

telah dilakukan sebelum ini. Jadi, ini akan dapat mengurangkan kos perubatan dan juga mengurangkan kos premium kepada rakyat pada masa hadapan.

So, these are the three areas that kita juga ingin memohon sokongan daripada pihak PAC dan pihak kerajaan. Terima kasih, Yang Berhormat.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi, *is it possible that— I think these are the things that is sometimes government has to come out with legislation. I think sometimes you have to follow.* Kalau kita minta *private sector* bantu, bantu, *but they 'taichi'—* sebab ini dia punya *interest. But ultimately, the government must be firm. You want to do something, we legislate it. And I think PAC has no problem to support that legislation. Hopefully within one or two years*-lah *before the 2027. Thank you*

Dato' Seri Abdul Rasheed Ghaffour [BNM]: *Thank you.* Terima kasih, YB semua. Terima kasih.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Jemput semua anggota Bank Negara, kita ambil satu *group photo* dengan kami.

[Mesyuarat ditangguhkan pada pukul 3.38 petang]



MALAYSIA

LAPORAN PROSIDING (HANSARD)

Rabu, 13 Ogos 2025

Bil 5(r) / 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insurans Kesihatan dan Caj Hospital Swasta serta Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

Malaysian Reinsurance Berhad [Malaysian Re]

(i) Encik Ahmad Noor Azhari bin Abdul Manaf,
Presiden & Ketua Pegawai Eksekutif

(ii) Encik Mohammad Nizam bin Yahya,
Naib Presiden Kanan

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

RABU, 13 OGOS 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Datuk Wira Mas Ermieyati binti Samsudin [Masjid Tanah] - *Pengerusi*
YB. Puan Teresa Kok Suh Sim [Seputeh] - *Naib Pengerusi*
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dr. Hajah Halimah Ali [Kapar]
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Datuk Ali anak Biju [Saratok]

Tidak Hadir *(Dengan Maaf)*
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Puan Vivian Wong Shir Yee [Sandakan]

URUS SETIA

Mohd Sukri Bin Busro [Ketua Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara)]
Puan Farah Binti Mohamed Rafiee [Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Encik Anzirul Fariz bin Alwi [Ketua Penolong Pengarah (Perkhidmatan)]
Encik Johan Ariff bin Salim Khan [Penolong Pengarah (Perkhidmatan)]

Kementerian Kewangan Malaysia (MOF)
Encik Abdillah bin Azizudin [Ketua Penolong Pengarah (Bahagian Pelaburan Strategik)]
Encik Nik Azan Shah Reza bin Nik Abdul Rashid [Sekretariat GEAR-uP]

Kementerian Ekonomi (KE)

Puan Noor Diana binti Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]
Puan Genevieve Clarinda Joanis [Timbalan Pengarah (K) [Bahagian Perkhidmatan Sosial)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Encik Chang Ching [Ketua Sektor Intra Agensi (Bahagian Siasatan)]
Encik Ahmad Kamal bin Abdul Rahman [Pegawai Siasatan (Penyiasatan Tata kelola)]
Encik Arman bin Alies [Ketua Penolong Kanan Penguasa (Bahagian Siasatan)]

Jabatan Akauntan Negara (JAN)
Encik Mohd Nizurlizham bin Jamaludin Akauntan [(Bahagian Perkhidmatan Operasi Pusat dan Agensi)]

HADIR BERSAMA

Malaysian Reinsurance Berhad [Malaysian Re]
Encik Ahmad Noor Azhari bin Abdul Manaf [Presiden & Ketua Pegawai Eksekutif (Pejabat Presiden @ Ketua Pegawai Eksekutif)]
Encik Mohammad Nizam bin Yahya [Naib Presiden Kanan (Takaful Semula)]
Puan Farha binti Abd Rahim [Naib Presiden Kanan (Takaful Semula)]
Encik Fidrus bin Sukor [Naib Presiden (Pejabat Presiden & Ketua Pegawai Eksekutif)]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1,
PARLIMEN MALAYSIA, KUALA LUMPUR

RABU, 13 OGOS 2025

Mesyuarat dimulakan pada pukul 3.00 petang

[Datuk Wira Mas Ermieyati binti Samsudin ***mempengerusikan Mesyuarat****]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, kita mula ya. *Assalamualaikum warahmatullahi wabarakatuh*. Salam sejahtera, selamat tengah hari Yang Berhormat ahli-ahli PAC Parlimen Kelima Belas, ahli-ahli ex officio daripada JPA, Kementerian Kewangan, Jabatan Audit Negara, SPRM, Kementerian Ekonomi, Jabatan Akauntan Negara dan juga Penasihat Undang-undang Parlimen Malaysia.

Yang Berhormat ahli mesyuarat sekalian, hari ini kita akan sambung semula prosiding berhubung dengan isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan juga impak kepada kesihatan awam di bawah Kementerian Kewangan, bawah KKM dan juga bawah Bank Negara Malaysia. Dan semua sedia maklum, ini tidak dilaporkan dalam Laporan Ketua Audit Negara. Sebab itu kita menggunakan punca kuasa di bawah peraturan mesyuarat.

Yang Berhormat ahli mesyuarat sekalian, hari ini hadir di hadapan PAC adalah Yang Berusaha Tuan Ahmad Noor Azhari bin Abdul Manaf, Presiden dan juga Ketua Pegawai Eksekutif Malaysian Reinsurance Berhad. Yang seterusnya Yang Berusaha Tuan Mohammad Nizam bin Yahya, Naib Presiden Kanan Malaysian Reinsurance Berhad. Yang ketiga, Yang Berusaha Puan Farha binti Abd Rahim, Naib Presiden Kanan Malaysian Reinsurance Berhad dan Yang Berusaha Tuan Fidrus bin Sukor, Naib Presiden Malaysian Reinsurance Berhad. Terima kasih, saya dan juga PAC ucapkan kepada semua kerana sudi hadir di hadapan PAC pada petang ini untuk memberikan penjelasan.

Dan sebelum saya menjemput saksi untuk mulakan pembentangan, saya nak maklumkan bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 [*Akta 88*] dan juga Peraturan Mesyuarat 85 sehinggalah prosiding ini selesai dan juga laporan dibentangkan di dalam Dewan Rakyat. Jadi tanpa membuang masa, saya

dengan ini menjemput Tuan Ahmad Noor Azhari untuk memulakan pembentangan. Dipersilakan Tuan.

Encik Ahmad Noor Azhari bin Abdul Manaf [Presiden & Ketua Pegawai Eksekutif (Pejabat Presiden @ Ketua Pegawai Eksekutif)]: Okey. *Bismillahirrahmanirrahim*. Yang Berhormat Pengerusi, Ahli-ahli PAC, tuan-tuan, puan-puan yang saya hormati. *Assalamualaikum warahmatullahi taala wabarakatuh* dan salam sejahtera.

Saya rasa tak perlulah saya nak men-*introduce*-kan balik *team* saya di sini ya. Saya terus sajalah. Untuk permulaannya, saya ingin minta kebenaran daripada Pengerusi PAC lah ya kami akan bertutur dalam dwibahasa, bahasa Malaysia dengan bahasa Inggeris kerana *sometimes a bit more technical*-lah nak kena *explain* dalam bahasa Malaysia.

Okey. Terima kasih saya ingin mengucapkan ke atas peluang yang diberi pada hari ini untuk saya dan rakan-rakan saya berkongsi sedikit mengenai profil *company* kami, Malaysian Re. Malaysian Re adalah sebuah syarikat *reinsurance national* Malaysia dan peranan penting kami dalam menyokong kestabilan pasaran insurans serta ketahanan ekonomi negara. Di samping itu, pihak kami akan memperkenalkan satu solusi baharu bagi menyemarakkan pembangunan sektor insurans kesihatan di negara ini melalui pelaksanaan perlindungan perubatan tepat khusus untuk penyakit kanser. Langkah ini dijangka dapat meningkatkan akses kepada rawatan berkualiti sekali gus memperkukuhkan kesejahteraan rakyat.

Bagi sesi ini, saya akan membawa Yang Berhormat semua melalui susunan slaid yang telah disediakan bermula dengan sejarah dan profil syarikat kami, diikuti perkembangan pasaran dan seterusnya kepentingan *reinsurance* kepada negara. Rakan saya Encik Nizam akan meneruskan pembentangan seterusnya menerusi cadangan daripada pihak kami mengenai perubatan tepat penyakit kanser. *[Merujuk pada slaid pembentangan]*

Slaid *number* – profil ya? Okey. Okey. Mula-mula sekali, saya ingin memperkenalkan struktur korporat kumpulan MNRB yang merupakan syarikat induk kepada Malaysian Re. Malaysian Re adalah anak syarikat milik penuh ya kumpulan MNRB Holdings ataupun MNRB yang merupakan salah satu syarikat strategik Permodalan Nasional Berhad atau PNB. Selain Malaysian Re, anak syarikat milik MNRB adalah seperti Takaful Ikhlas Family, Takaful Ikhlas General, Motordata Research, MMIP Services, Sinar Seroja.

Bagi Malaysian Re, selain perniagaan utama kami, kami juga memiliki 20 peratus pegangan saham di dalam syarikat Labuan Reinsurance (L) Limited yang

beroperasi di bawah pentadbiran *Labuan Financial Services Authority* (LFSA). Setakat 30 Jun 2025, pegangan saham MNRB adalah sebanyak 53.91 peratus di dalam pegangan PNB dan *fleet group which is* Amanah Saham Bumiputera dan selainnya *public float,* 46.09 persen.

Sikit berkenaan sejarah Malaysia Re. Bermula pada Ogos 73, kami telah ditubuhkan sebagai Malaysian National Reinsurance Berhad oleh Kerajaan Malaysia. Tujuan adalah untuk mengurangkan kebergantungan Malaysia kepada syarikat insurans asing. Di samping itu, tujuan yang lain adalah untuk meningkatkan tenaga profesional di dalam bidang insurans dan reinsurans, membendung aliran keluar mata wang Malaysia dan juga mengukuh serta meningkatkan pengekalan retensi lokal untuk isu-isu yang ada di Malaysia ini.

Pada tahun 2005, daripada penstrukturan semula kumpulan, MNRB menjadi syarikat pegangan pelaburan, menjadi lesen dan aset reinsuransnya telah di-*transfer* kepada Malaysian Re *as you know, now.* Pada tahun 2015, kami telah mendapat kebenaran untuk kelulusan dari Bank Negara Malaysia di bawah seksyen 10, Akta Perkhidmatan Kewangan Islam 2013 untuk menjalankan perniagaan retakaful dan retakaful keluarga. *So, in essence* Malaysian Re *at this point of time,* kita boleh membuat *business* hampir kesemua kecuali *life insurance. Next slide.*

Tuan Haji Azli bin Yusof [Ahli PAC]: Tuan, boleh jelaskan sikit apa beza reinsurans dengan insurans?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Okey. Boleh saya pergi slaid nombor berapa ya? *[Bertanya kepada pegawai]* Ada, ada satu slaid saya buatkan. Slaid — okey, nombor 16. Slaid 16 ya.

Tuan Haji Azli bin Yusof [Ahli PAC]: Tidak *kang* kita dengar reinsurans tapi tak tahu...

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Tak apa, tak apa. Saya *explain*-kan. *In a simple… [Dicelah] [Ketawa] In simple terms,* reinsurans ni kita insuranskan *insurance company.* Jadi, YB-YB semua beli insurans *[Dicelah]*, ha YB semua beli insurans dengan *insurance company, insurance company* beli insurans dengan *reinsurance company.*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Kalau *gitu* ada tak re-reinsurans?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ya, *sorry?*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ada tak re-reinsurans?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ada.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Ketawa]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ada, ada. Di belakang kami kita panggil *retro*. Jadi, insurans – reinsurans – retro dan *until the risk* habislah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk Wira Pengerusi, jadi, kos lagi tinggilah banyak sangat *level* ni.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Tujuan reinsurans dan *retro is not about talking about cost rather* kita nak *stable*-kan *risk* yang diambil. Kalau kita lihat *insurance company* di Malaysia, kalau beroperasi di Malaysia kan, ia akan mengambil *risk* hanya di Malaysia dan *exposure*-nya tertakluk di Malaysia.

Contoh, pada 2021, *there was a big flood in Malaysia. Remember?* Teruk. Ada *loss* — ada lah dalam slaid tu. *The loss is about five to six billion and insurance loss is about close to two billion, if I remember correctly.* Jadi, *imagine* kalau *those kinds of losses* kena di tanah air kita ini dan kalau ada *loss* lagi besar, *meaning that the industry itself will not be able to sustain.* Kalau kita tengok apa jadi di Thailand masa dia orang ada *flood* besar 2011, *that is US12 billion loss.*

The industry currently kalau kita tengok di Malaysia, saiznya tak sebesar tu. Jadi, *just imagine.* Sebab itu adanya reinsurans dan *retro* di mana *risk* ini akan di-*transfer out. So*, kita untuk meningkatkan...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Dia tak ada kesan kepada individu pembeli insurans?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Tak. Kerananya apa yang dibuat untuk reinsurans, kita akan mengambil risiko yang *on the top, very highly volatile nature.* Kalau *individual* biasa, *let's say* motokar, PA semua tu, kebanyakannya hampir kesemuanya akan di-*retain* oleh *company* sini. Kalau macam — *let's say earthquake, flood* atau *mega risk* yang sampai bilion, bilion, bilion. *Let's say KLCC for example* kan, *I think it is about four billion in terms of sum insured.*

■1510

Those kind of risk ada sebahagiannya akan pergi ke luar. *So, it depends on the capacity* yang saya sebut tadi. Masa kita ditubuhkan, *how the capacity is being retain locally. That's what we want to do. Pricing* kita akan ikut *actually original pricing.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Kesan itu? *[Berucap tanpa menggunakan pembesar suara]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kesan itu kalau ada *losses* lah. Kalau ada *losses then of course it will goes according to…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ertinya ada kesan juga lah.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kesan ikut…

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ada *higher risk, high risk.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *On the lower end,* untuk masyarakat biasa ini, kesannya kurang. Kalau *in terms of volatility*. Yang akan kita ambil *is volatility of the risk* yang akan kita *carry.* Kita tak ambil *the normal simple risk* itu je. Okey, jauh dah jalan ini.

Okay history. Okey, *history* itu saya dah jelaskan sedikit. Okey ini mengenai profil Malaysian Re, *at this point of time. Malaysian Re as reinsurance company* ini, kita akan— kita *underwrite* lebih kurang *all line of business* lah daripada yang *small and then big ones, d*aripada yang *specialised lines including cyber* ataupun *aviation, mostly* kami akan melakukannya. Sebab itu di Malaysia ini, *insurance industry* ataupun *takaful operator* akan menggunakan *reinsurance in the way for them to write complicated risk. So that is where reinsurance is needed in a way.*

So, at this point of time, Malaysian Re adalah syarikat yang paling besar di— ataupun *national reinsurances* yang paling besar di Asia Tenggara. Lebih besar dari *the one in Indonesia* ataupun *Philippines. Based on* apa yang kita lihat, dari segi *premium income* dan juga dari segi aset, kami adalah yang terbesar.

In terms of kekuatan kami, boleh lihat antaranya *Fitch rating* dan juga *A.M. Best rating whereby we have given A* dan juga A- *by A.M. Best. On top of that*, *there is research done by NMG Consulting*. *That's show us MRB or Malaysian Re to be very good brand and we have been put as a number 43 worldwide as a good premium reinsurance company in the PNC or property and casualty business.*

Dr. Hajah Halimah Ali [Ahli PAC]: Datuk Wira nak tanya fasal *retakaful* itu. Malaysian Re itu satu hal. *Retakaful* itu. Apa bezanya dan— *because you* ini dengan Bank Islam kah apa.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: Okey.

Dr. Hajah Halimah Ali [Ahli PAC]: *How is— how takaful is it?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: *So* kita ada dua *licenses*. *One* untuk ber-*operate as conventional,* dan yang nombor dua untuk *Islamic takaful product. So, any takaful business that need to be protected* akan *goes under* kita punya *retakaful licence. So we separate the fund between* conventional dan *retakaful*. Bila kami *set up the Retakaful Division into 2015,* tujuannya untuk memperkasakan lagi kapasiti di Malaysia dan juga global lah. *So* apa yang kita lihat,

retakaful business kurang sikit *in terms of capability available* untuk *support* perkembangan *Islamic business, syariah business. So that's where takaful operator* akan pergi kepada *retakaful operator.*

So dalam Malaysian Re ataupun MRRD *or Malaysian Retakaful Reinsurance Division,* kita lebih bertumpu untuk meningkatkan kemampuan di dalam bahagian *family* dan juga *medical.*

Dr. Hajah Halimah Ali [Ahli PAC]: Yang penarafan ini, adakah mengikut—tak masuk *retakaful* lah, kan?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: Ini penarafan dan pengiktirafan ini untuk Malaysian Re. *Malaysian Retakaful* adalah *one of division inside Malaysian Re.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan, saya nak tanya. Okey lah dapat nombor 43 *global* itu satu kejayaan yang inilah. Boleh tak bagi tahu kan kepada PAC, siapakah antara *player* yang terbaik di *global, I mean* yang *top five* di dunia?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: *Okay. The top three* sekarang ini *is Munich Re, Swiss Re, Hannover Re.* Lepas itu kita ada *Berkshire Hathaway from US. The other one maybe the likes of SCOR Se* daripada *France. So* majoriti *top player* ini *coming from Europe or US and* kalau nak tengok saiz, *Swiss Re or Munich Re, their rating about EUR40 billion in terms of premium.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey tadi—*thank you to Shah Alam basic* tadi *resinsurance* sebab kita pun tak tahu. Mungkin Bayan Baru tahu lah tapi seumur hidup saya, 49 tahun ini saya tak tahu. *This is the first time* lah dan sejauh mana... *[Dicelah]*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: *[Berucap tanpa menggunakan pembesar suara]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saja je nak bagi tahu itu *[Ketawa]. So* saya nak tanya sejauh mana potensi yang *reinsurance* di Malaysia ini boleh pergi dan apa yang telah dilakukan untuk menyedari kewujudan *reinsurance* ini supaya rakyat umum tahu?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: Sebab yang paling utamanya, kita kena lihat ya, *reinsurance works on B2B – business to business. It's not business to consumer. So* masyarakat biasa tidak akan dapat melihat kewujudan *reinsurance.* Hanya *company-company* ataupun insurans ataupun takaful operator sahaja yang akan tahu *because the requirement that they need.*

In terms of potential, there is a big potential in terms of macam mana sebuah syarikat di Malaysia boleh dinaik taraf lagi di dalam dunia. *Of course as company,* kita *strive* lah *to be one of the best. At this point of time,* kita antara yang terbaik di ASEAN— *sorry* kita yang terbesar di ASEAN dan kita juga antara yang terbaik di Asia. *The* pengiktirafan yang dilakukan oleh *MNG Consultant* itu amat berguna untuk kami. *So, whenever we do our business, what they look at this actually in terms of our ability financially which is A.M. Best or Fitch or S&P, and then the ability for us to on the technical part of it. Meaning that* kalau kita buat produk baharu kah ataupun *give solutioning to our client. So, in that sense that is requirement needed for reinsurance company to excel in the field.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey teruskan. *[Berucap tanpa menggunakan pembesar suara]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: Okey saya terus kepada slaid nombor lapan lah. Slaid ini menunjukkan profil *company* kami dari segi premium, *the size of the company itself* lah. Berakhir 31 Mac 2025. Pencapaian pertubuhan premium kasar kami adalah sebanyak RM2.25 bilion. Ini adalah pencapaian yang kedua terbaik lah. Tahun lepas kami telah mencapai lebih kurang, *close to RM2.5 billion.* Yang *interesting*-nya kalau kita lihat *in terms of diversification geographically, we have* 48 persen di Malaysia *and the rest in Europe. 52 percent overseas, 48 percent locally. So, this is quite unique* ya. Tak banyak *reinsurance company* yang beroperasi yang ada operasi *international* lebih besar dari domestik kerana *normally, domestic is sizable. Whether or not, you can see from China, from India, from Indonesia, most of it* akan *cover* dia orang punya negara dahulu, domestik.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi nak tanya *exactly, what other countries Asia Pacific, 22 percent is— what are the countries in that category?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malasian Re]: *So Asia Pacific will include China, ASEAN region, Korea, Japan, Taiwan— that we are in, and then India subcontinent, Pakistan.*

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Dr. Hajah Halimah Ali [Ahli PAC]: *If I can understand*-lah sebab kami ini bukan orang insurans kan, baru nak dengar *re* ini pun... *[Dicelah]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *[Ketawa]* Tak apa, saya...

Dr. Hajah Halimah Ali [Ahli PAC]: ...*Reinsurance* pun baru nak dengar hari ini kan. *So*, bermakna *insurance companies in all this other countries,* Eropah ke

Timur Tengah, Asia Pasifik, *52 percent of the insurance companies they are using your Malaysian Re?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *I wouldn't put it that way. Business* yang kami dah *under right* komposisinya 48 persen *local business* dan selebihnya daripada *overseas. So, meaning that* kita berjaya *penetrate into overseas market. So, let say I take example* China ya. China *we are writing about close to RM100 million* lah tapi China *booked as a whole is sizeable that's the I think the third largest insurance market in the world.*

So, too sure that they are access capacity macam mana di Malaysia juga, *where foreign entity, foreign company will be able to write the business.*

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan, saya nak tanya apakah beza *reinsurance* ini dengan PIDM?

Beberapa Ahli: PIDM.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: PIDM. PIDM dia *cover* insurans untuk bank... *[Dicelah]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Bank ya.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: ...dan juga syarikat insurans jugakan?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Syarikat insurans *including* ke? PIDM, okey. Kita *as insurance or reinsurance company* kita *protect risk, PIDM protect saving* dalam bank kan? Dia punya akaun. Kalau kita ada akaun *let say* bank tu *collapse*, PIDM *guarantee* akan — kalau tak silap saya RM250,000 *kot* maksimum kan. Itu dia punya *guarantee just* lebih pada *guarantee of you losing your savings in the bank if a bank collapse.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk Wira Pengerusi, saya nak tanya sikit *if you don't mind,* saya nak tanya sikit.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Boleh.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Who is the owner of this company*?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ini?

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Siapa *owner* dia?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: PNB.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Shareholders*.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: PNB. Kita ini *consider as GLIC.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: CIMB.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Government Link Investment Company.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Oh, GLIC.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Lebih kurang *about*, tadi kata *about 50 percent, more than 50 percent owns by PNB Group plus* Amanah Saham Bumiputera.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Oh.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *The rest are floated* lah.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Oh, okey. *Is public listed* lah kan.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Public listed, yes.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Thank you.*

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Alright*, teruskan.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Okey. Kita pergi slaid nombor sembilan ya. *So*, selain daripada pengurusan insurans semula yang kami lakukan, kami juga melakukan sedikit projek khas untuk nasional lah. *Thats part of the function for Malaysian Re. The expectation is to assist any requirement in locally* lah. Seperti yang kita lihat di dalam slaid nombor sembilan ini, kita ada Perlindungan Tenang Voucher, *Flood Relief Fund* dan COVID *Test Fund* yang telah kami uruskan *on behalf of the country* bersama sama ada dengan PIAM, LIAM, MTA ataupun dengan MOF, Bank Negara. *So, this is part of things that we do* untuk negara. *Next slide.*

This slide is quite interesting because of this is the future looking that we are currently tengah buat lah sedikit sebanyak. *So*, ada sembilan topik di situ, *one of it is cyber.* Ini kami sudah *start* ya, kita melancarkan perlindungan khusus siber peribadi, *personal cyber.* Apa yang kami buat, kami *meng-offer product to the* takaful operator di Malaysia untuk mereka jualkan pada rakyat.

So, that's one of the functions macam *reinsurance company* ini *be able to provide to the market by having new products to be launch and in terms of pricing and all. So*, selain dari itu kita ada pertanian, aset negara, *EVs. Renewable energy something* yang kita tengah berjalan ya, kita *create a pool* untuk ASEAN *whereby* kita nak menaik lagi perkembangan tenaga hijau ya, *renewable energy* lah. *So*, di

ASEAN ini apa yang kami buat kapasiti akan dikongsi bersama *and then risk* akan dimasukkan *and then* kami akan mentadbirkan *pool* ini.

So, meaning that now there is new capacity available to Malaysian insured if they want to sit into the — untuk mencari kapasiti untuk *protection purpose. So, this is on an ASEAN level* punya *development that we have done. The other one that we are looking as currently* perlindungan dan pemodelan risiko banjir. Pada waktu ini, kami sedang ada kolaborasi dengan vendor model bencana banjir bertaraf global untuk menambah baik penilaian banjir tempatan.

I think this quite important because in terms of flood exposure, flood risk in Malaysia is the highest lah. Kita tak ada banyak *earthquake*, kita tak ada banyak *typhoon* itu semua tak tinggi tapi *flood* kita nampak. Kita nampak Pantai Timur, Kedah, dekat Johor kesemua *it's very important to have a model to look at* kita punya *exposure*.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan, ya lah Seputeh tanya saya, saya tak boleh jawab, saya kata tanya lah depan. *[Ketawa]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Silakan.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: *[Ketawa]* Apa nama ni, adakah wajib untuk syarikat insurans di-*reinsurance*-kan?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Tak wajib.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak wajib.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ha, tak wajib tapi *that's a function.* Kita kena tengok *universe* lah. *That is function why there is a reinsurance company involve because* macam — *page* berapa itu ya? Saya ada letak, kejap ya saya nak pergi kat *page* tu. Cerita fasal *reinsurance* semua inilah. Apa kita buat ya, kita menstabilkan kedudukan *capital* untuk syarikat. *By taking away the volatility from their business so* mereka akan senang sikit beroperasi. *Thats* satu.

Kedua, *by* adanya *reinsurance company* kita *provide capacity.* Kita *enlarge capacity* untuk syarikat-syarikat ini beroperasi atau menambah tenaga saing bila mereka membuat bisneslah. *For example*, saya tarik bab balik *example KLCC, RM4 billion worth,* satu *company* takkan boleh buat. Tapi dengan *reinsurance company, risk* ini boleh disimpan di Malaysia, *so support* itu ada.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Datuk Wira saya nak tanya, *who are your competitors in* Malaysia?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Oh, banyak itu. Banyak itu YB. Sekarang ini kalau di Malaysia ini *we are number one* dalam

reinsurance. Kita ada dalam *50-60 percent of market share. The next I would say* yang agresif sikit ini sekarang ini Hannover Re. Yang *license*– ha, okey kita cerita yang *license* di Malaysia ya. Kita ada Malaysian Re, Hannover Re, Swiss Re, Toa Re. Toa Re, Jepun. Swiss Re, Switzerland... *[Dicelah]*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Semua Re, Re belakang itu.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ha, ni semua Re, Re. Geng, geng Re. *[Ketawa] So, these are the four* yang *listed or license in* Malaysia dan kita ada yang *listed our license in* Labuan dan juga *the third-tier* yang beroperasi di luar Labuan dan juga domestik.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *So, you are the biggest* lah in Malaysia?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *At this point of time* kita masih kekal yang utamalah di Malaysia.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Macam mana *the identify* sebagai yang utama di Malaysia itu? Tadi ada sebut 51 peratus?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kita punya 51 peratus — tak kita punya *share* yang kami lihat untuk *treaty business* kita ada dalam *60 percent roughly.* Kami *lead there are about 20 companies in* Malaysia. Kami *lead* dia orang punya program dalam *about half of the company in Malaysia. Thats why we know we are stronger locally.* Benda ini kan *when comes to doing business with the insurance company, it's all about the understanding of the market* dan *the understanding of the people so its normally easier for us have the penetration into the local market.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Tuan.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ya.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *We are still confused* macam mana syarikat tuan ini boleh buat untunglah. Kerana kalau bencana pun *you* masuk, semua pergi tolong dan — Okey, bagi mungkin boleh bagi satu contoh. *Let say,* dulu kita pernah ada dua kapal terbang terhempas kan, satu yang hilang, okey.

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Jadi semua *insurance companies* yang terlibat itu mereka terpaksa bayar kepada mangsa dan macam mana yang — ia kaitkan dengan syarikat ini?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Okay, like I said just now is all about how the things flow. Insurance company will provide*

insurance coverage to the passenger. Okay, let's say kita ada 100 *passengers and everyone we'll pay RM100,000. That's about RM10 million that you need to pay.*

Where reinsurance comes in is that from RM10 million, we say that we're going to protect you RM9 million. So, your exposure is only RM1 million. Kalau kita buat kita punya programlah. *So, this is where reinsurance company worldwide will take it out from you the volatility part.*

As an insurance company, when you do your business, you know this is the limit that you are willing to accept in terms of loss and the rest are being transferred. For reinsurance company is similar, kita kata ada *retro* dekat belakangkan yang *support* kita. *So, similarly* kita ambil *RM9 million maybe* kita akan *transfer back half of it.*

The big difference between reinsurance and insurance company is that kita ada *spread. That's where reinsurance company placed. So,* margin tak besarlah tapi *we have spread.*

We are looking at severity and volatility but we are trying to reduce is the volatility. When you have bigger spread worldwide then you have less volatility to your numbers and if there's severity pun, *your spread will be able to cater for that.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Can I ask? What's the cost implication for the customer* hujung-hujung itulah, kan? Bila dia ini ada insurans *and reinsurance and retro. So, at the end of the day, what's the cost implication?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Cost implication to the customer?*

Dr. Hajah Halimah Ali [Ahli PAC]: *To the customer, yes.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Macam saya cerita tadi. *Actually,* bila kita…

Dr. Hajah Halimah Ali [Ahli PAC]: *How much more do they have to pay,* kalau dia syarikat insurans je, *instead of* dia ada *reinsurance and* ada *retro and all that.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kita ambil *simple* senang ya. *Let's say motor car* ataupun *property normal fire, property. Is a tariff business.* Kita ambil yang *tariff business* ini. *Motor car* kita kata kita *charge three percent* dekat Malaysia *roughly, about three percent of the sum insured. So, that is fixed for example, it's fixed. What being transferred to reinsurance company is based on that.*

So, price-wise tak berubah. *What we need to manage ourselves is actually the volatility,* yang macam saya sebut tadi *risk* yang kita ada *spread the whole world*

ini *and cost that associated to it. So, this is where we have to be more nimble in terms of doing business.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara] But..*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Bussiness, sorry.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara] Continue.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *The one that being transferred* kalau kita lihat, *the best example would be catastrophic event.* Kalau ada jadi *catastrophic event for example there is a huge* — kalau kita lihat di Jepun *in 2018, 2017, you have two major typhoon events. That can go into back to the [Tidak jelas] people. Whereby, your policy — if the market, let's say* teruk kenalah, kan? *Billions and billions, you need to get the recovery.*

So, the concept of insurance takaful ini semua *is all about pooling of funds and we share. If the experience is bad then you have to adjust in terms of the rate.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Timbalan Pengerusi, *that means* macam Jepun, *your premium is very high*-lah? *Because* selalu *earthquake.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Tak. Okey, kalau nak cerita pasal Jepun ini *different* sikit. Dia orang punya sistem itu kalau ada *earthquake* ia akan naik *price automatically.* Naik *20 percent. The last one,* kalau lihat ia punya *pricing quite fast in terms of readjusting to the loss. Certain market may not be the same.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *To make good profit over the years?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Recently, over the years not really.* Kita margin *actually quite small. There will be times when you have that margin available* lebihlah, *then there will be time you* kena *whack* jugalah *in terms of…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Jadi orang akan takut beli *you* punya insuranslah, nak *invest in your company* sebab…

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kalau lihat...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: ...nak *listed in your shares.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Not necessary because of when investor will look at from the potential,* kan? *Potential of you growing…*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Long term*-lah.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Long-term.* Sebab *reinsurance company the margin quite small,* saya kata *but then if you look at how the company has been growing,* potensi memang ada.

You have to remember kita punya *penetration rate in Malaysia is quite low. It's not comparable to US and Europe. If you understand this and then of course the industry has been pushed to accept more and* kita nak tarik orang lagi membeli insurans.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *How do you managed to compete with in Europe and all that. How do managed to compete with them?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kita *complement rather compete in a way because of I cannot say that we would be able to compete* dengan *let's say Munich Re 40 billion euro company* dengan RM2 bilion, macam mana nak *compete?* Tapi, *there would be pockets that we can play.*

For example, company besar *sometime will take a look at bigger risk. They do not,* eh, tak naklah ambil 10 ribu euro punya premium, kan? *So small, not effective. So, that's where we can come in. It's complementing.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *Okay, thank you.*

Dr. Hajah Halimah Ali [Ahli PAC]: Tak, tadi kata tadi *globally your* penarafan *and all that you gain including Asia* itu. *So, if you are saying you're not make it much money, one of the thing,* yang *Fitch Ratings is* kekuatan kewangan, kan?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ya.

Dr. Hajah Halimah Ali [Ahli PAC]: *Is that profit or what?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *So,* kekuatan kewangan itu *is a capital that you have to put up because regulatory-wise in Malaysia regulatory* untuk *car* kita ini *quite tough,* Bank Negara kasi. *You need to show to the rating agency that you have capital to do the business.*

Profit, there are two ways in terms of doing profit. One is the underwriting profit. Second, the investment profit. As any insurance companies, how it works that premium datang dulu *you invest. You have to manage to fund*-lah *in a way. So, sometimes your underwriting will not be profitable but your investment will be able to support.* Oh, terima kasih. Air ke apa itu?

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, kita teruskan pembentangan sebab ini ada muka surat banyak lagi ini.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Kita pergi — okeylah.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Mungkin boleh cepatkan mana yang perlu dan kita boleh terus kepada sesi soal jawab. Sebab kita ada banyak soalan ini terutama sekali Bayan Baru.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Saya cepat sikit ya. Okey, saya *do a quick one*-lah ya. *Page 12,* ini untuk menunjukkan premium insurans dunia sejagat. *Whereby we can see that US is the biggest market* yang adalah.

Nombor 13, *slide 13 is actually* nak tunjukkan pasaran insurans dan takaful am di Malaysia. *The size that we are looking at. Although,* kita nampak *growth* sudah ada *about seven percent on annual basis but then penetration rate* di Malaysia *is still quite low about one percent also.*

And then, if you look at kita punya *composition,* motor *sizeable 40 percent and then* kita tengok *fire dan miscellaneous, that's the class of business that we are having. But,* kalau kita lihat untuk takaful *business,* takaful am ini motor sahaja besar. *Why? Because of takaful normally looks into personal lines rather than bigger risk.*

Okay, next slide. Untuk insurans hayat dan takaful keluarga, *composition*-nya sebegini. *[Merujuk kepada slaid pembentangan]. Whole life is the biggest portion* dan *followed by medical and health.* Kenapa *medical and heatlh* itu *reduced negative?* Itu nampak. *[Merujuk kepada pegawai]*

Dr. Hajah Halimah Ali [Ahli PAC]: Kenapa *less than 25.9 percent on that takaful MHI* itu? *Growth?*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *25.9.*

Dr. Hajah Halimah Ali [Ahli PAC]: Ya, *the growth. Why?*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *That was a* — ada peningkatan cuma peningkatannya menurun berbanding dengan semasa COVID-19. Jadi semasa COVID-19 ini ramai orang beli. Jadi peningkatannya *double digit.*

Jadi selepas COVID-19 jadi peningkatannya ada tapi tidak setinggi semasa COVID-19 hari itu. Semua orang ada kesedaran untuk mendapatkan perlindungan kesihatan semasa COVID-19.

Seorang Ahli: *[Berucap tanpa menggunakan pembesar suara] So* dia relatif...

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya, betul.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *So, this is a problem when we look at insurance, when people buy insurance is when they think they need it. It's not long-term* punya *view because insurance has to be a long term view where actually in one particular point of time you are going to have — we have seen the problem and this is where insurance or takaful* polisi akan *cover you.*

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Page 16, tadi saya dah bercerita sikit fasal apa itu...

Tuan Haji Azli bin Yusof [Ahli PAC]: Boleh saya tanya sikit tuan?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Boleh.

Tuan Haji Azli bin Yusof [Ahli PAC]: Kenapa dia ya takaful itu dia negatif tapi *conventional is still good, figures?* Ada boleh komen?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Konvensional ni industri yang lama lagi daripada takaful. Jadi, *percentage growth* untuk takaful ni jadi dengan peningkatan semasa COVID tu dia punya *number of percentage* tu *is very, very big because the base number* tu kecil. Jadi berlaku juga di konvensional tapi sebab *base* dia tu dah memang besar. Jadi tu dia punya *percentage* tu tak — masih kekal positif tapi di takaful, akibat daripada tu, dia dah sebenarnya *stabilise*-lah.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *Page — slide number* 17 ya. Ini sedikit *information* untuk melihat *the difference between insurance* dan *reinsurance* lah ya. Yang paling pentingnya kita tengok di bawah tu lah, *is between B2C and B2B. And then of course, insurance normally operates in a single market, whereas reinsurance operates in a bigger market worldwide.*

Next slide. Ini pun saya ada *mentioned just now with regards to* kenapa adanya *reinsurance requirement*. *And* di sebelah kanan tu contoh kerugian bencana yang *I* — yang saya juga *mentioned in 2021, whereby Malaysian Re, as a company, we have to pay close to 500 million as a loss.* Tu kita punya *takaful operators* dan juga *insurance company.*

Saya rasa dah untuk pengenalan syarikat dan apa itu reinsurans, slaid dah habis kan? *[Bertanya kepada pegawai].* Itu sahaja slaidnya. Saya — *I'm more than happy to take up question if there is any which is...*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Saya bukakan kepada semua Ahli Parlimen untuk bertanyakan soalan.

Beberapa Ahli: *[Bercakap tanpa menggunakan pembesar suara]*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Ha, ada. Saya nak *stop* dekat pengenalan apa itu reinsurans tu dulu.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Ada?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Sebab saya takut kalau ada soalan-soalan lain fasal insurans...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Saya rasa yang bab ini okey *kut.*

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Okey?

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Kalau buka *kang,* nanti dia akan pergi lebih jauh. *So,* saya rasa baik *settle*-kan...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Di dalam.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Perubatan ya? Okey.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: *Settle*-kan semua *then* baru kita tanya soalan.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *All right.* Yang mana Yang Berhormat mana yang nampak itu...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya nak tanya fasal perubatan.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Okey. Jadi saya akan *pass* pada...

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Belum masuk. Yang tu belum masuk lagi?

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Belum, belum.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Nak masuk? Kan saya dah cakap.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Encik Nizam akan buat pembentangan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya dah cakap. Baru sekejap saya cakap.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: *[Ketawa]* Banyak soalan. Saya boleh keluar.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. *So* kita *settle* dulu ini, *then* baru kita buka untuk soalan ya. *All right.* Terima kasih.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Okey, Nizam. *The floor is yours.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Sebab kita cadang untuk habis ni *by 5, insya-Allah. [Dicelah]* Kalau *before, then* okeylah.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. *Bismillahirrahmanirrahim.* Yang Berhormat Pengerusi, ahli-ahli jawatankuasa dan para hadirin sekalian. Jadi, terima kasih kerana memberi peluang untuk kami mencadangkan langkah-langkah yang berkaitan dengan pengurangan kos perubatan dan seterusnya secara langsung mengawal dan menurunkan caj hospital dan juga premium perlindungan insurans kesihatan di Malaysia. Ini adalah cadangan dan pandangan daripada kami di Malaysian Reinsurance Berhad sebagai sebuah syarikat reinsurans di Malaysia.

Jadi, saya nak tambah sedikit mengenai apa yang telah dibentangkan oleh sahabat saya, Tuan Ahmad Noor Azhari iaitu peranan *reinsurance company* yang sebenarnya kita ini pusat pengumpulan data. Apa yang berlaku di syarikat insurans, mungkin antara mereka sendiri mereka tak berkongsi maklumat, tetapi melalui kita punya perhubungan dan juga *partnership,* kita mempunyai data yang terkumpul daripada syarikat-syarikat insurans dan juga takaful.

Jadi, *the strength* untuk *reinsurance company* ialah pengumpulan data dan juga kita mempunyai kepakaran untuk *data analytics* untuk mencadangkan langkah-langkah penyelesaian yang dapat disesuaikan untuk disampaikan kepada rakyat melalui syarikat-syarikat insurans dan juga *takaful operator*.

Okey. Jadi seterusnya saya teruskan dengan slaid 20 di mana izinkan saya memulakan dengan memetik rumusan kajian firma perunding aktuari, *Actuarial Partners* mengenai tujuh faktor utama yang dikenal pasti penyumbang kepada peningkatan kos perubatan dan juga tuntutan insurans. Jadi secara asasnya, kalau kos yang terlibat dengan faktor-faktor tersebut dapat dikawal dengan pengurusan salah satu atau keseluruhan faktor yang dikenal pasti ini, kos keseluruhan dapat dikawal dan dibendung.

Namun, usaha ini memerlukan kawal selia, libat urus dan kerjasama pihak kerajaan khususnya Kementerian Kesihatan serta Kementerian Kewangan dan juga pihak swasta meliputi syarikat-syarikat insurans, hospital swasta dan pemegang taruh-pemegang taruh yang berkaitan.

Sebagai langkah permulaan, saya ingin mengesyorkan kita meneliti salah satu faktor penyumbang kenaikan kos berkaitan peningkatan jumlah pesakit menghidap penyakit tidak berjangkit ataupun *non-communicable diseases* (NCD) seperti sakit jantung, kencing manis, kanser dan sebagainya.

Mengikut laporan yang diterbitkan oleh Kementerian Kesihatan dan Pertubuhan Kesihatan Sedunia (WHO) bertajuk, *"Direct Healthcare Cost of Non-Communicable Diseases in Malaysia"* yang diterbitkan pada tahun 2022. Pada tahun

2017, negara kita telah membelanjakan sejumlah hampir 10 bilion atau 16.8 peratus daripada jumlah perbelanjaan kesihatan untuk mengubati tiga kategori utama NCD tersebut.

Sehubungan dengan itu juga, dianggarkan impak kepada ekonomi akibat penurunan produktiviti berkaitan NCD berjumlah sekitar 13 bilion. Jumlah ini dijangkakan akan terus meningkat sejajar pertambahan jumlah populasi rakyat Malaysia yang makin menua. Beberapa langkah tindakan telah dicadangkan dalam laporan tersebut dan kami di pihak Malaysian Reinsurance Berhad sebagai syarikat reinsurans dari Takaful Nasional terpanggil untuk mengambil bahagian dalam membantu menyelesaikan situasi ini.

Kami memilih untuk memulakan usaha dengan memperkenalkan solusi reinsurans atau retakaful dengan matlamat mengawal kos salah satu daripada tiga NCD utama iaitu penyakit kanser sebagai langkah yang pertama.

Pada tahun 2017, kos ubat kanser dianggarkan berjumlah sekitar 23.67 peratus daripada kos ubat tiga NCD utama. Rawatan kanser bukan sahaja melibatkan perbelanjaan yang besar, malahan juga memerlukan rawatan susulan yang lebih lama dan membebankan berbanding dengan penyakit NCD yang lain. Punca utama kos rawatan kanser di Malaysia datang daripada radioterapi, kemoterapi, ubat terapi bersasar dan juga hospitalisasi berkaitan dengan rawatan kanser.

Seterusnya saya ingin menerangkan bagaimana solusi reinsurans ataupun retakaful dan perlindungan insurans dan takaful bagi perubatan tepat untuk penyakit kanser atau *cancer precision medicine* dapat membantu membendung kenaikan kos ubat kanser dan seterusnya mengurangkan beban rawatan kanser.

Dalam usaha penyelesaian ini, kami berpandukan kepada hasrat rakyat Malaysia yang mengidamkan sesuatu langkah penyelesaian yang mampu milik, berterusan dan dapat dinikmati oleh setiap keluarga Malaysia. Kita semua impikan premium insurans ataupun caruman takaful yang mampu dibayar terutamanya di usia yang semakin meningkat.

■1550

Kita sebagai rakyat Malaysia juga mengharapkan masa menunggu yang singkat di fasiliti kesihatan terutamanya di klinik dan juga hospital kerajaan. Untuk pesakit kanser, kemajuan teknologi perubatan telah menemukan ubat-ubatan tepat bagi jenis-jenis kanser tertentu yang mampu menyelamatkan nyawa. Namun pada harga yang sangat mahal, tidak semua pesakit mendapat akses kepada ubat-ubatan

di saat mereka memerlukannya. Jadi mungkinkah solusi insurans ataupun takaful dapat membantu memberi akses kepada ubat tepat kanser dengan kos mampu milik.

Mengikut kajian, rawatan konvensional kadangkala kurang berkesan kerana ia tidak disasarkan ke profil genetik tumor pesakit. Ini menyebabkan keberkesanan rawatan rendah, kesan sampingan tinggi dan kekerapan kemasukan semula ke hospital. Kekerapan kemasukan semula ke hospital ini juga mengakibatkan kos tuntutan insurans meningkat lalu mendorong premium insurans kesihatan naik saban tahun.

Di sebaliknya, perubatan tempat kanser menggunakan ujian genetik dan *biomarker* untuk mengenal pasti rawatan yang paling berkesan untuk pesakit secara individu. Apabila rawatan disasarkan dengan tepat, kadar keberkesanan meningkat. Tempoh rawatan lebih singkat dan komplikasi berkurangan. Negara-negara seperti China, Singapura, Jepun dan United Kingdom telah membuktikan bahawa penggunaan perubatan tepat kanser boleh menjimatkan kos rawatan kanser jangka panjang sebanyak 20 hingga 30 peratus berbanding rawatan konvensional.

Jadi bagaimanakah pengurangan kos perubatan ini boleh berlaku? Pertamanya, ujian genetik dan *biomarker* membolehkan kita mengurangkan rawatan sia-sia dan mengelakkan penggunaan ubat yang mahal yang tidak berkesan kepada profil genetik pesakit.

Keduanya, sesetengah rawatan tidak memerlukan rawatan yang berpanjangan di hospital. Tambahan pula rawatan tepat mengurangkan risiko kanser berulang dalam tempoh rawatan awal.

Ketiga, rawatan tepat dan tersasar mengurangkan komplikasi sekali gus mengurangkan kos rawatan sokongan.

Keempat sekiranya solusi insurans dan takaful ini dilaksanakan di peringkat nasional, pembelian secara pukal dapat menurunkan harga ubat. Mandat pembelian ubat secara pukal *(pool procurement)* ataupun perjanjian harga *(volume based)* dengan pembekal membolehkan harga ubat *targeted therapy* turun secara signifikan seperti yang terbukti dalam program rawatan HIV dan juga Hepatitis C yang telah dilaksanakan oleh kerajaan sebelum ini. Penjimatan daripada *strategic purchasing* ini boleh dialihkan untuk meluaskan lagi liputan perlindungan insurans dan takaful.

Akhir sekali, kesan secara langsung dan tidak secara langsung kepada premium insurans kesihatan, premium insurans ataupun caruman takaful juga terkawal kerana kos tuntutan berkurang ekoran rawatan kanser menurun melalui rawatan ubat kanser tepat dan harga ubat yang lebih rendah menjadikan perlindungan insurans dan takaful kesihatan lebih mampu milik.

Seterusnya kami ingin berkongsi pemerhatian kepada contoh perlaksanaan di negara China di mana solusi insurans kesihatan negara China (NHIS) sejak tahun 2017 dapat mengurangkan harga ubat tepat kanser sehingga sebanyak 65 peratus dalam tempoh lima tahun. Kelebihan kuasa perundingan negara China adalah rakyatnya yang begitu ramai dengan dana yang lebih besar. Namun perlaksanaan di Malaysia mungkin payah untuk mencapai pengurangan sebegitu banyak. Namun, sebarang pengurangan akan dapat membantu mengawal kos rawatan kanser di negara ini.

Seterusnya mengambil pelajaran daripada kejayaan negara China, kerajaan wajar mempertimbangkan penubuhan sebuah dana khusus iaitu dana perubatan kanser rakyat bersumberkan perbelanjaan rawatan kanser semasa. Dana khusus ini bertujuan menyediakan pembiayaan bagi rawatan tepat kanser yang dapat mengurangkan beban kos rawatan dan meningkatkan akses kepada kemajuan teknologi rawatan kanser. Model kerjasama awam dan swasta dalam usaha ini perlu dirangka dengan pengurusan yang profesional untuk menjamin ketelusan dan keberlanjutan. Usaha memastikan rawatan kanser yang berkualiti dan dapat diakses tanpa halangan kewangan.

Seterusnya sebagai langkah permulaan, kami mengemukakan contoh projek perintis ataupun *pilot project* ke arah mencapai penubuhan dana perubatan kanser rakyat yang lebih menyeluruh dan mengambil jangka masa perlaksanaan yang lebih rumit. Di tahap satu, di bawah projek perintis ini, dengan sasaran manfaat kepada kumpulan sasaran 200,000 penjawat awam contohnya. Dana pembiayaan yang diperlukan dijangkakan berjumlah RM60 juta iaitu dengan kos RM25 sebulan setiap peserta atau RM300 setahun yang ditanggung sepenuhnya oleh kerajaan. Harga kos ini adalah ilustrasi projek perintis ini dan hanya akan dapat disahkan bergantung pada jumlah perlindungan ubat yang akan ditawarkan, jumlah peserta kumpulan sasaran serta reka bentuk produk ataupun program di bawah projek perintis ini. Bergantung kepada jumlah dana permulaan ini, kelayakan peserta boleh juga ditawarkan kepada warga B40 di peringkat negeri, wilayah dan sebagainya.

Kerjasama swasta bersama syarikat insurans dan takaful melalui perlindungan yang lebih meluas dan baik yang dibayar sendiri atau melalui subsidi digambarkan pada tahap dua dan tahap tiga pada harga kos yang lebih tinggi.

Ilustrasi projek perintis tahap satu dalam pakej slaid yang saya sertakan di dalam slaid yang dibiayai sepenuhnya oleh kerajaan dan pakej *enhanced* dan *comprehensive* ditawarkan di tahap dua dan tahap tiga melalui syarikat insurans dan takaful. Kos ujian genetik juga dimasukkan di dalam pakej kerana kos yang

diperlukan untuk kos ujian genetik masih tinggi jika dibayarkan sendiri. Kesemua pakej disalurkan melalui solusi *reinsurance* dan juga *retakaful* oleh Malaysian Reinsurance Berhad. Dengan perlindungan insurans takaful dalam program perintis ini, kita dapat pertamanya mengumpul data klinikal dan mengenal pasti kos sebenar di peringkat nasional. Seterusnya kita dapat berunding harga ubatan dan juga rawatan secara pukal. Kita juga dapat menilai pulangan pelaburan kepada sistem kesihatan, dan seterusnya kita boleh membina model aktuari untuk mengira penjimatan premium secara jangka panjang.

Tuan Haji Azli bin Yusof [Ahli PAC]: Saya nak tanya sedikit, yang *page* 28 itu, yang contoh projek perintis ini. Ini merujuk kepada rawatan tepat kanser kah ataupun *general medical health?*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ini rawatan untuk tepat kanser.

Tuan Haji Azli bin Yusof [Ahli PAC]: Sahaja, kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Kanser sahaja.

Tuan Sim Tze Tzin [Ahli PAC]: Ini adalah cadangan syarikat Malaysian Re?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: *You want to roll out this plan?*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Dengan *support* daripada kerajaan yang kita bukakan kepada syarikat insurans dan takaful untuk tahap dua dan tahap tiga.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Sejauh mana cadangan ini dah dipersembahkan kepada mana-mana pihak, *I mean* di pihak kerajaan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ini yang baru dibentangkan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: PAC baru pihak pertama mendengar cadangan ini?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya betul.

Tuan Sim Tze Tzin [Ahli PAC]: *So* daripada *you become reinsurance company, you want to go direct becomes an insurance company?*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Tak. Kita selama ini pun memang bekerjasama dengan syarikat insurans dan juga syarikat takaful untuk memperkenalkan produk-produk di pasaran. Jadi ini cadangan kita untuk mulakan di peringkat tahap satu dengan pembiayaan kerajaan dan tahap kedua dan ketiga, kita

organise syarikat insurans dan juga syarikat takaful untuk menambah baik pakej yang dibayar sendiri oleh rakyat yang lebih mampu.

■1600

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey. Kenapa pilih kanser? Tahulah kanser tu sekarang ini adalah penyakit senyap dan sebagainya dan ada juga sakit lain. *What makes* syarikat *reinsurance* ini memilih kanser sebagai satu *I mean* produk ataupun untuk diperkenalkan kepada umum.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. Pertamanya *treatment* kanser yang biasa yang akan dicadangkan oleh *oncologist* di hospital biasanya meliputi kemoterapi ataupun radioterapi kerana ia lebih murah. Akses kepada ubat tepat kanser ini amat terhad kerana kosnya lebih tinggi. Jadi, *immediately* semasa seorang pesakit kanser hadir kepada hospital dia tidak akan di-*recommend*-kan untuk ubat tepat kanser sedangkan kalau dia dapat akses *immediately* sebenarnya mungkin penyakitnya dapat diubati dengan lebih awal. Itu yang pertama sekali.

Jadi, kita nak sediakan satu tabung ataupun dana di peringkat kerajaan dan juga swasta untuk memberi akses yang secara *immediate* kepada pesakit kanser, itu yang pertama sekali.

Yang keduanya *treatment*-nya biasanya mengambil masa yang lama berbanding dengan NCD yang lain. Contohnya kalau yang pesakit jantung hari ini kita di *detect* oleh satu *blockage* besok dah boleh *book* untuk *treatment for stent,* lusa dah boleh keluar berjalan, *right*. Sedangkan kalau kanser *the* persediaan untuk kemoterapi, radioterapi itu mengambil masa berbulan-bulan, jadi menambahkan kepada bil, rawatan dan sebagainya.

Jadi, itu yang kita nampak mungkin salah satu sebab kita memilih kanser sesuatu yang kita boleh buat kerjasama antara kerajaan dan swasta dan memberi impak yang *immediate* kepada rakyat.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Saya nampak ini satu cadangan yang baik dan juga dapat membantu rakyat. Sebab kalau kita tengok, walaupun contoh ya, pelan asas itu RM300 setahun, RM25 sebulan ia adalah praktikallah untuk *especially* untuk golongan B40. Itulah, satu cadangan yang baik.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tapi nak tengok sejauh mana boleh pihak kerajaan mengambil perkara ini sebagai satu

pendekatan terutama sekali untuk golongan yang memerlukan dan juga membantu mereka.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi sikit *je* nak apa itu tak boleh apakan. Sebab kita daripada *medical, so* tadi cakap melibatkan radioterapi, *about chemotherapy this is immunotherapy*? *Is that what you are talking about*?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Dia termasuk di bawah *immunotherapy*, ubat tepat...

Dr. Hajah Halimah Ali [Ahli PAC]: Dan segala pelan-pelan asas, semua-semua ini.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Haah.

Dr. Hajah Halimah Ali [Ahli PAC]: Ini melibatkan diagnosis? Sebab dia bukannya macam yang lain dia kena tepat dan... *[Dicelah]*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Betul.

Dr. Hajah Halimah Ali [Ahli PAC]: *So*, dia inklusif lah, pakej itu dah inklusif itu dan ini akan dijaga oleh syarikat insurans biasa *not Malaysian Re,* betul atau macam mana?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Yang akan mengedarkan untuk rakyat Malaysia adalah daripada syarikat insurans dan juga syarikat takaful dan mereka akan mengumpulkan polisi-polisi ataupun *certificate* di takaful dan di-*reinsurance*-kan kepada *Malaysian Re.* Jadi, data yang terkumpul itu di *Malaysian Re.* Jadi, kami akan dapat mengkaji dan juga menilaikan data klinikal dan mengenal pasti kos sebenarnya yang menyebabkan tuntutan insurans itu ubat apa dan kita akan menggunakan data itu untuk kita *negotiate* dengan syarikat-syarikat farmaseutikal dan kita boleh *preorder based on our statistic and also data.*

Dr. Hajah Halimah Ali [Ahli PAC]: *So, basically* tahap satu ini *its pilot project*, betul?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *Pilot project... [Dicelah]*

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tahukan berapa harga dan sebagai-sebagainya kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya, betul.

Dr. Hajah Halimah Ali [Ahli PAC]: Sebab dia *involve* penjawat awam.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Dr. Hajah Halimah Ali [Ahli PAC]: *And then.* baru *you go to the* tahap kedua itu kan.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Kita... *[Dicelah]*

Dr. Hajah Halimah Ali [Ahli PAC]: *Because they are not paying*?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *Yes*, ya betul. Cuma jangka masanya itu kita sebenarnya tak perlu lama. Kita sebelum ini pun kalau di pihak swasta *Malaysian Re* telah memperkenalkan produk *cancer precision medicine* kepada pihak swasta. Jadi, kita — kalau tahap satu dapat dimulakan kita juga itulah boleh membangunkan produk-produk yang sesuai untuk tahap dua dan tahap tiga.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Pengerusi, sikit ya. Okey, dalam cadangan projek perintis ini, okey *Malaysian Re* punya maknanya dapatan kalau contohnya dalam pelan asas itu melibatkan kakitangan kerajaan 250,000 ya dianggar tadi?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: 200,000.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Eh, 200,000 ya, anggota ya.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Jadi, maksudnya kita akan dapat *collection RM60 million.* Okey, daripada 200,000 itu mungkin — okey maknanya ini anggaran ya. Maksudnya berapa *percent* daripada situ yang maknanya akan terima rawatan ya? Adakah dana itu dia akan mencukupi? Dilihat trend peningkatan kos rawatan kanser itu pun juga dia semakin meningkat ya.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya, betul.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Dalam sekarang ini kalau Malaysian Cancer apa ini, disebut apa itu? Malaysian National Cancer Registry ya disebut RM50 hingga RM200, beratus ribu RM untuk satu kes kanser.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Betul.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Jadi, di situ maknanya mungkin perlu secara lebih dalam berapa anggaran perawatan itu, dari segi jumlah pesakit itu sendiri termasuklah tahap dua dan tiga itu dan di situ saya nampak mungkin kerajaan akan melihat perintis ini, projek sangat baik ya untuk kita *implement*.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Juga yang kedua, dari segi mungkin pembayaran itu kita akan lihat sama ada dia dalam bentuk subsidi penuh ataupun *coinsurance*, maksudnya skim insurans bersama. Maknanya pesakit bayar *half*, kerajaan bayar *half*.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Ataupun pembayaran ataupun dipanggil *copayment* ya, di luar sama ada *coinsurance* atau *copayment*. Jadi, di situ mungkin boleh diperdetilkan perintis ini. Mungkin maknanya kita boleh aju kepada pihak kerajaan supaya maknanya dibuat dengan lebih serius supaya di laksana dalam negara kita inilah. Terima kasih. Tadi soalan — okey yang jumlah tadi ini, kalau tahap satu itu berapa anggaran kita kata pesakit yang kita boleh rawat daripada jumlah dana yang kita ada itu.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. Data yang dimiliki oleh Malaysian Re Insurance, kita ada akses kepada kos ubat dan juga *efficacy*, maknanya kemujaraban ubat. Maknanya, kalau contohnya profil genetik sekian, sekian berapa botol ubat yang diperlukan untuk contohnya, *breast cancer.* Jadi kita boleh *estimate the cost,* okey.

Kos keseluruhan mungkin yang lebih baiknya kita berbincang dengan Kementerian Kesihatan untuk *target* sasaran. Jadi, kerjasama antara kerajaan dan juga pihak kami kita boleh susun untuk kita kenal pasti untuk kumpulan sasaran tertentu berapa kos yang diperlukan untuk *treatment* dan juga untuk kita *initiate* projek perintis.

Tuan Haji Azli bin Yusof [Ahli PAC]: Saya nak tanya soalan lanjutan. Dia tadi tuan sebut tentang volum kan untuk nak dapatkan *the most economical of scale* bagi rawatan perubatan tepat kanser ini. Maksudnya *the more* lagi banyak... *[Dicelah]*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Penggunaan.

Tuan Haji Azli bin Yusof [Ahli PAC]: ...rakyat yang dilindungi, maknanya lebih baik lagilah untuk contohlah kata lah ya macam perintis ni 200,000 pegawai kerajaan. Tapi kalau katakan yang dilindungi ini termasuk juga keseluruhan 800,000 penjawat awam, contohlah ya. Maknanya itu lagi banyak *pool* dia.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Betul.

Tuan Haji Azli bin Yusof [Ahli PAC]: Maknanya kalau *you* dah ada *base* yang dilindungi ni, maksudnya dia boleh akan membantu mengurangkan kos bagi yang awam yang bukan penjawat.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya, betul.

Tuan Haji Azli bin Yusof [Ahli PAC]: Betul?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Betul.

Tuan Haji Azli bin Yusof [Ahli PAC]: Maknanya penting ada... *[Dicelah]*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *Yes*.

Tuan Haji Azli bin Yusof [Ahli PAC]: ...penglibatan daripada pihak kerajaan jugalah untuk memastikan bahawa... *[Dicelah]*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya. Jadi tanpa penglibatan daripada tahap satu ini, apa yang berlaku sebenarnya dipihak swasta ini kita cuma menetapkan harga mengikut harga semasa.

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Kita tak ada *negotiation* dengan syarikat farmasi untuk menurunkan dan kita tak boleh mempengaruhi mesin-mesin di hospital untuk *genetic profiling* dengan sebagainya.

Tuan Haji Azli bin Yusof [Ahli PAC]: Cuma saya ada kawan saya yang mengadu, dia kata macam dia dah habis duitlah *because* dia dah *spend* untuk anak dia *RM150,000* untuk *treat the cancer* punya *treatment.*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Rasanya kita semua ada pengalaman sendiri saudara-saudara yang menghadapi kes macam ini sehingga ada yang sanggup jual rumah untuk mendapatkan *treatment* untuk orang tua dan sebagainya.

Tuan Haji Azli bin Yusof [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Tapi *in general,* kalau katakan macam rakyat yang sudah ada, ramai yang sudah ada insurans adakah yang anggaran ini, takaful hayat ini adalah *on top of what they already have* ataupun kalau dah memang ada, bukan tidak sebanyak itu.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Jadi peluang untuk syarikat swasta insurans dan juga takaful ialah mereka boleh *approach* kita untuk dia *carve out cancer risk.* Jadi dalam insurans *medical* ini ia akan bayar semua. *Heart attack, diabetic* dan semuanya. Jadi salah satu peluang daripada syarikat insurans ialah jika kita dapat menetapkan harga yang rendah ia boleh menyerahkan risiko kanser di bawah program ini.

Jadi kita letakkan *price* mungkin asal daripada usaha kita di tahap satu tadi kita dapat *negotiate price for medication, cost of that cancer treatment* itu dia boleh masuk dalam produk-produk *medical and health* di syarikat insurans dan juga takaful.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Tuan Pengerusi sikit lagi. Soalan berkaitan. Di pihak Malaysia hari ini sebagai langkah kawalan kuat *cost containment,* adakah pihak tuan juga melihat model-model yang dilakukan oleh beberapa negara? Mungkin ada perundingan dengan pihak hospital swasta sebelum ini di pihak tuan?

Kalau di *Singapore* ia mempunyai dipanggil *Fee Benchmarks Advisory Committee* iaitu ia nak menetapkan julat harga munasabah dalam rawatan itu ya. Termasuklah juga di UK sendiri ada NIHR *Health Technology Assessment.* Mana itu

satu badan ia nak *control* kenaikan kos yang mendadak yang kadang-kadang itu tanpa kawalan oleh pihak-pihak ini maksudnya kementerian sendiri.

Jadi mungkin juga Malaysian Re tengok dari segi kaedah kita di Malaysia ini maksudnya seperti ataupun pra kebenaran atau *pre-authorisation* penilaian kos itu sebelum di caj oleh pihak swasta. Jadi itu mungkin juga langkah-langkah awal sebagai kawalan kos itu supaya maknanya daripada peringkat asas itu kita dah ada *control* sebelum ia terus melonjak akhirnya kita tak boleh nak berpatah balik. Terima kasih.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Jadi langkah itu sebenarnya satu proses yang tengah berlaku di Malaysia juga. Sebenarnya *negotiation on hospital cost and also admission* yang kita pun tak tahu sekarang ini macam mana impak dalam masa yang terdekat.

Jadi yang kita cadangkan dalam projek perintis ini hanyalah untuk khusus kepada ubat. Jadi kita tidak memasukkan kos *hospitalisation* dan sebagainya di dalam projek perintis ini. Jadi fokusnya lebih kepada perubatan dan pembelian ubat untuk kanser dan memberi akses bila pesakit itu sudah berada di hospital di jabatan onkologi.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey teruskan.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Minta maaf Pengerusi sikit, yang tadi maknanya kita nak *control* untuk perintis ini adalah soal harga ubat itu. Maknanya secara kelaziman yang dipraktis di hospital sekarang ini, maknanya ia guna kaedah macam mana? Maksudnya sama ada ubat rawatan mengikut profil genetik pesakit itu atau ia terus guna ubat yang sedia ada, ubat yang mahal itu dan tidak ada *control* di situ. Jadi apa yang sedang yang berlaku sekarang ini?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey, pada masa sekarang ini, *the clinical pathway* kita panggil, maknanya bila seseorang pesakit datang ke hospital dan di-*diagnosed* di jabatan onkologi sebagai penghidap kanser, rawatannya yang ditawarkan biasanya dimulakan dengan radioterapi dan juga kemoterapi. Melainkan pesakit itu sendiri ada *awareness* mengenai ubat-ubat tepat kanser.

Jadi dia mungkin akan bertanya dan menawarkan untuk bertanyakan kos sebab kos untuk ubat tepat kanser ini amat mahal macam tadi yang YB cakap RM150,000 untuk *full complete treatment.*

Jadi biasanya saya pernah berbual dengan *oncologist.* Dia akan buat *financial assessment* untuk pesakit itu. Adakah sesuai untuk dimulakan ubat tepat kanser sebelum dia nak cadangkan ubat tepat kanser.

Jadi kalau kita sediakan satu pelan perlindungan khusus yang mana kalau pesakit itu dia tahu dia mendapat perlindungan ubat tepat kanser, dia boleh terus cakap kepada *oncologist* saya ada *coverage* dan *oncologist* boleh terus mulakan dengan ubat tepat kanser.

Sekarang ini sebenarnya pun sudah ada tapi ia punya *supply is very, very limited and then globally only* yang *elite*-lah boleh dapat akses kepada ubat inilah, tak kepada semua rakyat Malaysia, okey.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, teruskan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ada soalan. Datuk Wira Pengerusi saya nak tanya lebih terperinci lagi. Model yang kita ambil adalah model daripada negara China, betul tak?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ini bukan keseluruhannya model negara China kerananya pelaksanaan di negara China itu ia bermula pada tahun 2017, Kerajaan Negara China yang memulakan satu program *National Medical Health Scheme (NHIS)* meliputi keseluruhan perkhidmatan kesihatan termasuk kanser.

Jadi di bawah *National Health Insurance Scheme* itu ada program *cancer precision* juga, ubat tepat...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: *One of them.*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *Yes, one of them.*

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Oh, okey. *Not specific cancer* sahaja.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Bukan spesifik kanser. Ia begitu menyeluruh dan di negara China juga, syarikat *reinsurance* negara China juga terlibat langsung dalam menguruskan data dan juga program-program antara kerajaan dan juga swasta.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey, kita — cadangan syarikat tuan ini adalah untuk penyakit kanser, kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak termasuk pesakit-pesakit lain?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Tak ada sebab ada perintis.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Okey, kanser ini ada pelbagai jenis, kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ia ada kanser paru-paru, ada kanser — macam-macamlah, perut dan sebagainya. Adakah ia akan *cover* semua *type of cancer or the certain cancer* sahaja?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey, yang kita nyatakan dalam contoh itu 10 ubat-ubatan, 10 *drugs* dalam *package lite, package enhanced,* tambah lagi lima *drugs* dan seterusnya *comprehensive* 20 ataupun lebih.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Apa sakit kanser yang tak termasuk dalam ubat-ubat ini.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Itu bergantung kepada *design, product design.* Jadi adakah kita nak tumpukan kepada 10 jenis kanser yang tertinggi...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ataupun *all type?*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ataupun *all type.* Jadi mungkin kita boleh kenal pasti 30 ubat-ubat. Sebab sekarang ada kalanya satu ubat itu dia dapat mengubati beberapa jenis kanser.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tapi memang ada kemungkinanlah boleh *cover* semua kanserlah?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Setakat ini di Malaysia ada dalam setahu saya dalam 40 jenis ubat yang telah diluluskan oleh Kementerian Kesihatan.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: 40 ya?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya, lebih kurang.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Adakah itu akan *cover* keseluruhan penyakit kanser?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ini — *it would be depending* kepada hargalah. Jadi kalau kerajaan...

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tapi kalau orang itu mampu ia boleh *cover*-lah semua.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya, betul *under comprehensive* itu apa yang kita telah perkenalkan dekat swasta ini ada sehingga 30 jenis ubat yang dapat *Insya-Allah*-lah mengubati keseluruhanlah.

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Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Saya tanya ni sebab saya kenal ramai yang dapat macam-macam jenis penyakit kanserlah. *Kut-kut* mereka *you know,* berminat dalam benda-benda yang macam ni lah. Kalau kata keseluruhan tu maknanya sudah ada ubatlah untuk semua *type of cancer*...

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Tak ada.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: ...Yang *exist* ni?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Tak ada. Bukan semua — bukan semua jenis kanser ada ubat setakat ni.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Apa jenis kanser yang tak ada ubat? Tanya macam doktor pula. *[Ketawa]*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Yang ini di luar skop Yang Berhormat.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak luar skop. Dia ada kaitan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Tak boleh jawab tak apalah.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Tuan boleh jawab?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Saya tak boleh jawab.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Aa, tak boleh jawab, okey. Tak boleh jawab. Jadi saya ni.

Tuan Sim Tze Tzin [Ahli PAC]: Saya nak tanya sikit. Selain daripada *this precision medicine,* ada juga *heavy iron therapy, right?* Adakah itu juga terlibat dalam ni *heavy iron therapy*?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Dia yang kita nak fokuskan ialah kepada ubat-ubatan yang telah diluluskan oleh Kementerian Kesihatan dan kita nak memberi akses kepada rakyat. Jadi, untuk kita *develop the product design,* mungkin kita — *the best* ialah kita berbincang dengan Kementerian Kesihatan dan kita dengan data dan *experience* kita, kita boleh *determine the price to incur* dan kita *design* program untuk di peringkat tahap satu dan bawa kepada tahap dua dan tahap tiga.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, teruskan.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *All right.* Seterusnya, slaid — *yup. So,* diharapkan melalui projek perintis yang kita bentangkan tadi, Malaysian Reinsurance Berhad dapat menawarkan akses kepada aplikasi telefon yang kita nak tawarkan kepada ahli-ahli kepada projek perintis ini di mana aplikasi telefon ini dapat memudahkan rakyat Malaysia yang terlibat mendapatkan maklumat secara mudah bagi nasihat dan pengurusan rawatan kanser.

Dengan pengenalan aplikasi ini di bawah projek perintis, pelbagai pembangunan produk berkaitan kanser dapat ditawarkan oleh syarikat insurans dan takaful. Contohnya, pelan perlindungan bayaran terhad seumur hidup dan sebagainya. usaha ini seterusnya membantu menambahkan dana perubatan kanser rakyat secara berperingkat dan mengalih sebahagian beban di antara kerajaan dan pihak swasta.

Penambahbaikan akses kepada ubat tepat kanser mengurangkan kesesakan hospitalisasi kerana sebahagian rawatan dapat dibuat tanpa memerlukan kemasukan hospital. Tambahan pula, dengan aplikasi mudah alih di *handphone,* pesakit akan dapat menikmati perkhidmatan tuntutan yang *seamless* serta juga dapat mendapat khidmat nasihat *online* atas kesan-kesan sampingan rawatan kanser tanpa perlu beratur di hospital.

Jadi, hasil daripada projek perintis ini, manfaat langsung kepada rakyat Malaysia meliputi akses kepada rawatan kanser berteknologi tinggi melalui pembiayaan kerajaan dan juga produk-produk kanser mampu milik yang bakal ditawarkan oleh syarikat insurans dan takaful. Projek perintis ini juga membantu mengurangkan beban kewangan kepada keluarga pesakit.

Jadi kesimpulan Puan Pengerusi dan ahli-ahli yang dihormati, kami di Malaysian Re percaya bahawa insurans dan reinsurans adalah sebahagian daripada penyelesaian yang holistik dan berdaya tahan. Jadi, langkah pertama yang kita cadangkan adalah melaksanakan program ataupun projek perintis perubatan tepat kanser yang dapat menangani salah satu cabaran kesihatan yang paling kritikal di negara kita.

Jadi kami mencadangkan penubuhan dana perubatan kanser sebagai instrumen pembiayaan khusus untuk memastikan rawatan inovatif ini dapat diakses oleh kumpulan sasaran. Seterusnya pada masa yang akan datang, berhasil daripada projek perintis ini, kita boleh memperluaskan perlindungan kepada penyakit-penyakit lain melalui produk insurans inovatif yang direka khusus mengikut keperluan rakyat

Malaysia. Jadi, dengan pelaksanaan yang lebih besar di peringkat nasional, kita dapat merunding harga ubat kanser yang lebih rendah dan seterusnya mengawal bayaran insurans dan juga caj hospital.

Tuan Haji Azli bin Yusof [Ahli PAC]: Nak tanya tuan.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, Shah Alam.

Tuan Haji Azli bin Yusof [Ahli PAC]: Saya nak kembali ke *page* 21. Kalau kita lihat yang menyumbang besar kepada kos ubat-ubatan tu ialah penyakit jantunglah kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Penyakit jantung.

Tuan Haji Azli bin Yusof [Ahli PAC]: Tapi kenapa kanser yang dipilih sebagai perintis? Adakah kerana tadi yang — kerana sudah ada solusi yang boleh mengurangkan kos perubatan itu daripada yang berbanding dengan yang tradisionallah kan, berbanding dengan perubatan tepat kanser itu ataupun ada sebab lain? Terima kasih.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ada beberapa sebab kepada cadangan kita untuk memulakan dengan kanser. Yang pertamanya, memang sebenarnya kos ubat sakit jantung tu yang paling tinggi. Namun, kepada kos tersebut, sebahagian besarnya ditanggung oleh pihak swasta. Jadi, *public sector* menanggung dalam 29 sahaja daripada peratus daripada keseluruhan. Sedangkan kalau di kanser itu hampir separuh-separuhlah. Itu yang pertamanya.

Dan yang keduanya, dari segi tahap kebimbangan rakyat atas rawatan kanser. Jadi kalau contohnya, sakit jantung bukan sahaja nak kata tak sakit cuma rawatannya *on the spot* tu macam masuk *workshop* keluar *workshop,* boleh sembuh. Sedangkan kanser ini peratus pemulihannya kalau kemoterapi dan juga radioterapi itu amat-amat rendah sehingga *digit percentage recovery rate,* sedangkan pada masa yang sama sudah ada ubat-ubat. Ini kemajuan teknologi.

Sebab itu tadi ada soalan YB, adakah semua? Masih belum kerana *laboratory, laboratory*, *research companies* di seluruh dunia membuat *research* untuk menghasilkan ubat-ubat kepada semua jenis kanserlah. Jadi masih dalam *work in progress.* Namun, sudah ada ubat-ubat yang sudah berada di Malaysia, yang diluluskan oleh KKM yang pada masa ini masih belum dapat diakses secara sepenuhnya oleh rakyat Malaysia. Okey.

Dr. Hajah Halimah Ali [Ahli PAC]: Nak tanyakan. *This is percentage, percentage, cost, percentage* kan, tapi *the volume* kes *cardiovascular disease* tu, mungkin tidaklah sebanyak *per patient* dengan kanser. *So,* daripada segi kesnya,

berapa orang yang dikatakan kanser ni? *Contributing 23.67 percent* tu maknanya berapa orang yang dimaksudkan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Oh, saya *takde* info pada masa sekarang YB. Namun, kalau *treatment — the treatment* untuk ubat jantung, biasanya lebih pendek tempoh dia. Jadi tempoh dia berada di hospital, *cost of medical pricing* sebenarnya sebahagian besarnya di atas kos berada di hospital. *Per day* RM300, RM400.

Jadi kalau jantung, mungkin seminggu, dua minggu. Tapi kalau kanser, boleh jadi berbulan untuk mendapatkan rawatan kanser. Jadi, kalau kita fokuskan kepada kanser, kita dapat memperbaiki ataupun menurunkan tu, saya percaya dengan lebih efektif.

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Datuk Wira Pengerusi, kalau boleh saya tanya, okey, tujuan kita adakan prosiding adalah untuk — adalah disebabkan oleh kenaikan insurans yang mendadak tahun lepas. *Some goes up to 70 percent and repricing* dan sebagainya.

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Malaysian Re *works together very closely* dengan *insurance company.* Itu sebab kami ingin menjemput Malaysian Re untuk memberi sedikit pencerahan tentang *the working of the insurance company.* Sebab apabila kita panggil *insurance company,* mereka akan memberi macam-macam alasan lah. Kata, *"oh kerana NCD naik." Then* dia punya *pool fund* tak cukup dan sebagainya dan mereka terpaksa naik insurans.

Tetapi apabila kita tengok dia punya keuntungan, masih berbilion-bilion Ringgit lagi. *Then when we get to know, that actually they passed on their risk* kepada Malaysian Re. Maksudnya *they are also buying insurance.* Jadi saya nampak bahawa apabila konsumer dia beli insurans, dia *surrender their money to the company. The company also, they take the money, and then they also buy insurances to reduce the risk.*

So maksudnya duit itu banyak yang dia simpan. Dia dapat banyak duit tetapi dia sudah *pay some of the risk to you, transfer the risk to you. So* ke mana duit-duit itu pergi? *Then* dia *complain* kata dia punya *pool* terlalu kecil dan dia terpaksa naikkan insurans. *So, I don't get it. Can you explain to us?* Terima kasih.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Pertama sekali penglibatan Malaysian Re di dalam *medical insurance* ini amat-amat baru lah. Kita terpanggil untuk terlibat bersama dengan industri insurans dan juga takaful sejak tahun 2022, setelah kita terlibat di dalam *association*— LIAM, PIAM dan juga MTA

untuk sama-sama menangani isu kenaikan premium. Jadi untuk mengulas dengan lebih detil mengenai status di syarikat insurans dan juga takaful, kami tidak ada akses kepada data yang mereka ada untuk setakat ini. Jadi dalam projek perintis, ini adalah merupakan cadangan daripada Malaysian Reinsurance untuk terlibat langsung dalam mengurus kenaikan kos perubatan dan juga premium insurans dengan cadangan kami seperti yang telah dibentangkan.

Saya rasa mungkin sebelum ini telah dibentangkan dalam perbincangan bersama *association* dan juga Bank Negara tentang penubuhan *central data.* Jadi tidak ada satu *central data* pada masa ini yang dapat mengumpulkan data-data daripada semua syarikat insurans dan juga takaful operator. Jadi termasuk juga dalam cadangan projek perintis ini ialah kami yang memulakan pengumpulan data dan pada masa satu hari nanti, mungkin saya boleh dapat menjawab soalan YB tadi apa, ke mana perginya kos-kos yang kita belanjakan untuk rawatan di hospital.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Tuan Pengerusi, berbalik juga soalan berkaitan. Dalam tempoh operasi Malaysian Re ini, mungkin kalau ada datanya, berapa jumlah tuntutan pihak insurans kepada Malaysian Re sendiri dan bagaimana proses itu berlaku, dalam situasi bagaimana ya? Dan dari segi maksudnya adakah juga kes kalau di pihak hospital, kita akan bertemu juga lah maknanya dipanggil *fraud,* tuntutan yang tak munasabah ini, kan? Jadi di pihak Malaysian Re juga sendiri, adakah berlaku ketika mana berurusan dengan syarikat-syarikat insurans ini?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Sejak kita terlibat daripada 2022 itu, kita masih belum ada data yang menyeluruh untuk menganalisa *fraud* dan juga *abuse cases.* Namun, saya sendiri pun menerima laporan-laporan daripada media dan sebagainya antara perbincangan pihak insurans dan *association of private hospitals.*

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Jadi soalan saya awal tadi, adakah ada kes maknanya syarikat insurans sudah membuat *claim* kepada Malaysian Re ini ketika ada situasi tertentu yang mungkin maknanya mereka membuat tuntutan? Adakah ada sudah berlaku ataupun belum, atau bagaimana?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Untuk kes-kes yang saya pernah dengar itu, sudah ada lah.

Tuan Ahmad Tarmizi bin Sulaiman [Ahli PAC]: Maksud saya, yang tadi diceritakan fungsi Malaysian Re ini, kan? Maknanya dia orang— syarikat insurans dia *cover* insurans dengan Malaysian Re. Jadi adakah ada kes yang syarikat insurans ini telah membuat *claim* insurans itu kepada Malaysian Re sendiri.

Bagaimana situasi itu? Untuk kes yang dia ada sebut tadi ini, yang sebut caj dia meningkat, dana dia pun dia sudah berkurangan dan sebagainya kerana tuntutan-tuntutan daripada hospital ini. Jadi itu maknanya galur proses itu, adakah sudah berlaku di pihak Malaysian Re sendiri?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Setakat ini kita tak ada terlibat dengan produk insurans *individual medical* daripada syarikat insurans ataupun syarikat takaful. Jadi tak ada data untuk kes-kes tersebut lah.

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey Tuan berkenaan dengan isu kenaikan premium ini. Apakah pandangan Malaysian Re terhadap persepsi rakyat apabila kenaikan isu premium insurans ini telah pun mengakibatkan kesan dari segi penarikan balik, terhentinya polisi dan bagaimana ia nya memberi kesan kepada syarikat insurans dalam pemerhatian Malaysian Re ini, satu.

Kedua, bagaimanakah Malaysian Re melihat ataupun peranan yang dimainkan oleh Malaysian Re dalam membetulkan persepsi rakyat terhadap isu kenaikan premium ini yang mana rakyat menyalahkan syarikat insurans— macam apa yang Bayan Baru sebut tadi lah, mendapat keuntungan berlipat kali ganda, kenaikan yang tidak wajar, menekan pemegang polisi dan sebagainya. *How* yang dimainkan peranan oleh Malaysian Re?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. Pertama sekali peranan *reinsurance* ini kita lebih kepada menstabilkan *volatility* ataupun apabila jumlah tuntutan yang tinggi. Jadi kebanyakan tuntutan untuk *medical* ini adalah kebanyakannya lah mengikut yang sebenar tengok data, *60 to 80 percent* sebenarnya adalah *the normal cough and cold admission to the hospital. So* ini biasanya boleh disimpan oleh syarikat takaful dan juga syarikat insurans tanpa di-*reinsured*. Jadi mereka cuma akan *reinsure the higher amount. So, the data* untuk *the normal cost of claim,* kita tak dapat analisa melainkan ada *centralise data* dan yang kita akan cuba stabilkan ialah kos-kos yang tinggi. Kita punya contoh untuk kanser ini ialah kos yang RM100,000, RM150,000 untuk *treatment.* Okey, itu yang pertama sekali lah. Jadi untuk *image* dan persepsi rakyat Malaysia atas kenaikan harga ini memang saya sendiri pun sebenarnya terkesan juga sehingga saya pun terpaksa *terminate* saya punya *medical cover for some plan.*

Datuk Wira Mas Ermieyati binti Samsudin [Pengerusi PAC]: Kejap. Ini menarik ini. Boleh jelaskan sikit.

■1640

Mungkin boleh kongsi sedikit kenapa *terminate* ini?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya. Samalah dia punya, saya tak pernah *claim*, saya tak pernah masuk hospital, sekali dapat premium notis kena *increase 200 percent. So,* itu daripada sentimen sebagai pengguna, pengguna, *alright*. Secara industri, mungkin datanya sebegitu kan, sebab melihat kepada seluruh tabungan dana risiko mungkin memerlukan kenaikan harga. *Alright*.

So, itu *to justify* mungkin daripada pihak insurans dan takaful operator. Namun yang saya nyatakan tadilah yang paling pentingnya ialah ada akses kepada data untuk dianalisakan, okey. *So*, apa yang kita menumpukan fokus kepada kanser ini kerana kita ada akses kepada pengalaman daripada luar negara untuk *treatment of cancer* yang dapat menurunkan harga.

Jadi, itu yang kita untuk langkah yang dalam bidang kuasa kita untuk dapat kita laksanakan, itu yang kita nak cadangkan kita mulakan dengan kos rawatan kanser dan mungkin daripada disiplin dan juga *capability* untuk kita analisa rawatan kanser kita akan dapat kembangkan lagi daripada projek perintis ini kepada *treatment-treatment* yang lain.

Kita akan ada data *hospitalization*, kita akan data kos dan juga *negotiation* untuk ubat-ubat yang lain dengan syarikat-syarikat farmaseutikal.

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi. Okey, antara alasan syarikat-syarikat insurans untuk menaikkan premium, tuan pun menjadi mangsa juga kepada itu dan kita semua pun jadi mangsa. Saya pun sendiri jadi mangsa adalah antara alasannya dia kata kerana *pool*-nya, *aging pool.* Sebab dia tak ada — produk itu dah lama dan produk itu tak ada orang baru masuk maka orang muda semua masuk pool yang lain dan pool lama itu sudah semakin kurang. Jadi terpaksa mereka naikkan harga, okey.

Jadi, boleh secara pendapat *Malaysian Re* ini yang *work closely with insurance company, is this are normal practice or how do you reform this*? Sebab, saya nampak bahawa ini adalah sesuatu yang tidak sihat, okey kerana dia macam orang lama yang setia, bayar tak pernah masuk hospital menjadi mangsa tetapi syarikat itu masih mendapat keuntungan di pool yang lain. Okey.

Saya nak tanya adakah *insurance company* dia naikkan kerana mereka mahu keuntungan atau benda-benda, betul-betul mereka mengalami kerugian dari segi *medical insurance* ini.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Maaf YB, saya tak ada data dan juga akses kepada data untuk memberikan apa itu jawapan secara *factual*. Saya percaya *association* dan juga Bank Negara sedang menjalankan satu usaha untuk mengumpulkan data *claims* untuk seluruh syarikat insurans dan juga

takaful dan dengan harapan dapat menganalisa punca-punca dan juga kadar kenaikan kos-kos *hospitalization.*

Mungkin daripada usaha itu nanti akan dapat memberikan jawapan apa yang disoalkan oleh YB tadi. Ya.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Teruskan.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. So... *[Dicelah]*

Tuan Sim Tze Tzin [Ahli PAC]: Okey. Itu saya nak tanya soalan sebab saya nampak baru hari ini *you* membawa satu produk yang baru ya, satu perintis lah ya.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: Sebenarnya saya nampak bahawa ini adalah produk yang baik dan walau bagaimanapun kerajaan tengah berusaha untuk mengadakan *based* MHIT. *I am sure Malaysia Re knows about it.*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Tuan Sim Tze Tzin [Ahli PAC]: Adakah *Malaysian Re* ya, produk yang dicadangkan itu boleh ada kolaborasi-kah dengan *based* MHIT. Sebab *based* MHIT saya tak pasti dia ada — dia akan adakan *like a mess based pool* dan *maybe they cover a little bit of cancer,* mungkin tak semua. Tapi dengan *you* punya *is some kind like a rider, a product* tambahan kepada itu. Adakah telah berhubung dengan kerajaan dari segi itu?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Kita ada berbincang dengan syarikat insurans juga, takaful operator mengenai cadangan untuk *National MHIT programme* tapi tidak ada perkembangan yang setakat ini dapat dikongsikan dengan YB. Namun seperti yang YB *mention* tadi, kita juga telah mengunjurkan cadangan untuk produk kanser ini kepada syarikat-syarikat yang berminat untuk membendung kos akibat rawatan kanser.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, teruskan.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. *That was my last slide just now, slide 30... [Dicelah]*

Tuan Sim Tze Tzin [Ahli PAC]: Okey soalan tambahan. Syarikat apa yang terlibat dengan MHIT? Syarikat — selain tadi *Malaysian Re* baru masuk kepada *health insurance* kan. Tapi syarikat yang mana yang di pasaran yang terlibat dengan MHIT yang *reinsurance company.*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Okey. Dari segi — pertama sekali izinkan saya dari segi definisilah. Membezakan antara *medical*

product dan juga *health product.* Jadi, secara definisinya sebarang produk yang berkaitan dengan kesihatan yang membayar secara *lump sum* tanpa *actual cost* daripada hospital, itu kita panggil *health product* dan *medical product* ini adalah *product insurance* yang berkaitan dengan caj di hospital. Contohnya ialah kalau *critical illness* yang membayar *sum insured RM100,000*, maknanya *regardless* kos di hospital dia berapa, syarikat insurans akan membayarkan RM100,000 lah. Jadi, itu kita rujuk sebagai produk *health* dan untuk yang *medical* ini dia bergantung kepada bil di hospital.

Jadi, seterusnya untuk *medical and health product* ini sebenarnya semua syarikat insurans am dan juga syarikat insurans nyawa dapat mengedar, mempunyai *license* untuk *distribute* produk-produk *medical and health.* Jadi, secara keseluruhannya mereka terlibat dalam apa benda bentuk *even* sehingga ada produk-produk PA yang juga *cover hospitalization due to accident* yang disediakan oleh syarikat-syarikat insurans am.

Jadi, semuanya terlibat. Namun, ada beberapa syarikat gergasi yang memonopoli produk-produk MHIT ini.

Tuan Sim Tze Tzin [Ahli PAC]: Dari segi syarikat *reinsurance* siapa yang memberi *reinsurance* kepada syarikat-syarikat seperti Great Eastern, Prudential dan sebagainya, di Malaysia.

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Saya tak tahu untuk maklumat terkini YB. Kita tahu *historical* tapi maklumat terkini itu kalau kita tak terlibat, kita tak diberikan maklumat. Itu maklumat sulit syarikat masing-masinglah.

Tuan Sim Tze Tzin [Ahli PAC]: *Historically*?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: *Historically* berbeza-beza. Ada satu masa Swiss Re, ada satu masa Munich Re, ada juga Gen Re, SCOR Re, syarikat-syarikat yang tadi sahabat saya *mention* ya, *the giants* itu ada pernah terlibat di Malaysia dalam *portfolio medical.* Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Boleh tanya sikit Datuk Wira. Ini yang dibentangkan tadi ialah merupakan cadangan lah kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Bila agaknya nak buat macam *pilot project to find out what's the real cost* dan benda-benda yang lainlah. Bila dan adakah syarikat *Malaysian Re* ini berkeyakinan berdasarkan kepada matlamat kita, kita nak mengurangkan insurans perubatan. Cadangan ini boleh menurunkan insurans perubatan yang menjadi isu utama kitalah. Terima kasih.

■1650

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Jadi pelaksanaan projek perintis ini memerlukan kerjasama kesemua pihak termasuk juga Kementerian Kesihatan dan juga Kementerian Kewangan di pihak kerajaan dan juga di pihak swasta juga memerlukan penglibatan secara langsung oleh syarikat-syarikat insurans dan takaful dan juga *reinsurance.* Kita juga perlu bekerjasama dengan hospital-hospital swasta untuk melaksanakan projek perintis ini secara menyeluruh.

Jadi, *to move forward* sebenarnya memerlukan satu projek *theme* untuk dilaksanakan sebelum dilancarkan kepada rakyat Malaysia.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Ia juga akan melibatkan syarikat insurans yang lain juga, kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Yang nak terlibat untuk tahap dua dan tahap tiga. Itu *optional* kepada syarikat insurans dan takaful *operator.* Namun jika mereka dapat melihat manfaat kepada penurunan kos rawatan kanser untuk tahap satu mereka juga saya rasa akan berminat untuk menawarkan produk-produk di tahap dua dan tahap tiga berdasarkan kepada harga-harga yang ditetapkan oleh Malaysia Reinsurance Berhad.

Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Ahli PAC]: Agak-agaknya berapa lama projek perintis ini dilaksanakan supaya akhirnya kita tahu *the full implementation* itu bila akan berlaku?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Hasil daripada pelaksanaan ini biasanya untuk produk *medical* ini kita memerlukan data sekurang-kurangnya untuk satu tahun.

Dr. Hajah Halimah Ali [Ahli PAC]: *The thing is that you all* tak jumpa lagi dengan Kementerian Kesihatan, kan? Dia orang tak pernah dengar lagi yang ini, kan?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Ya.

Dr. Hajah Halimah Ali [Ahli PAC]: *We are the first ones* mendengar itu. Pernah tak ada apa-apa jaringan dengan Kementerian Kesihatan sebelum ini, *whatever*-lah, *on whatever issues beside this?*

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Untuk projek perintis ini tak ada.

Dr. Hajah Halimah Ali [Ahli PAC]: Sebelum ini ada jaringan untuk apa-apa lainlah?

Encik Mohammad Nizam bin Yahya [Malaysian Re]: Di peringkat industri, *association* LIAM, MTA dan juga PIAM bekerjasama dengan MOH dan juga Bank Negara untuk membincangkan topik kenaikan harga premium.

Datuk Wira Hajah Mas Ermieyati binti Samsudin [Pengerusi PAC]: Okey, ada apa-apa lagi soalan Yang Berhormat? Tak ada? Puas hati? Jadi saya ucapkan ribuan terima kasih sekali lagi kepada pihak Malaysia Reinsurance Berhad di atas kerjasama dan juga penjelasan yang telah pun diberikan kepada PAC pada petang ini. Dan semoga apa juga cadangan yang telah pun dibentangkan tadi dapat direalisasikan demi untuk masa depan negara kita yang mana semua rakyat Malaysia boleh menikmati perlindungan kesihatan yang terbaik untuk diri dan juga keluarga mereka.

Dengan itu, saya tangguhkan prosiding kita pada jam 4.54 minit petang dan saya ucapkan selamat maju jaya kepada Malaysia Reinsurance Berhad. Terima kasih.

Encik Ahmad Noor Azhari bin Abdul Manaf [Malaysian Re]: Terima kasih, YB.

[Mesyuarat ditangguhkan pada pukul 4.54 petang]



MALAYSIA

LAPORAN PROSIDING (HANSARD)

Khamis, 14 Ogos 2025

Bil. 5(s) 2025

MESYUARAT
JAWATANKUASA
KIRA-KIRA WANG NEGARA

Prosiding:
Peningkatan Bayaran Premium Insuran Kesihatan dan Caj Hospital Swasta serta Impak kepada Kesihatan Awam di bawah MOF, MOH & BNM

Munich Reinsurance Company

(i) Puan Thio Hui Ming Serena,
Ketua Pegawai Eksekutif

(ii) Puan Catherine Love Soper,
Ketua Serantau Kesihatan Asia Tenggara

PENGGAL KEEMPAT
PARLIMEN KELIMA BELAS

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 14 OGOS 2025

AHLI-AHLI JAWATANKUASA

Hadir
YB. Puan Teresa Kok Suh Sim [Seputeh] – *Naib Pengerusi*
YB. Tuan Sim Tze Tzin [Bayan Baru]
YB. Tuan Ahmad Tarmizi bin Sulaiman [Sik]
YB. Tuan Haji Azli bin Yusof [Shah Alam]
YB. Tuan Syahredzan bin Johan [Bangi]
YB. Dr. Hajah Halimah Ali [Kapar]

Tidak Hadir [*Dengan maaf*]
YB. Datuk Wira Hajah Mas Ermieyati binti Samsudin [Masjid Tanah] – *Pengerusi*
YB. Tuan Ir. Ts. Zahir bin Hasan [Wangsa Maju]
YB. Dato' Adnan bin Abu Hassan [Kuala Pilah]
YB. Dato' Wira Dr. Ku Abd Rahman bin Ku Ismail [Kubang Pasu]
YB. Datuk Ali anak Biju [Saratok]
YB. Puan Vivian Wong Shir Yee [Sandakan]
YB. Dato' Mohd Isam bin Mohd Isa [Tampin]
YB. Dato Dr. Richard Rapu @ Aman anak Begri [Betong]

URUS SETIA

Encik Mohd Sukri bin Busro [Ketua Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Aidahanie binti Baharuddin [Penolong Setiausaha Kanan (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Puan Siti Noor Akmar binti Zulkafli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]
Encik Muhammad Zydil Iman bin Zulkefli [Juruaudit (Pejabat Jawatankuasa Kira-kira Wang Negara)]
Puan Farah binti Mohamed Rafiee [Penolong Setiausaha (Pejabat Jawatankuasa Kira-kira Wang Negara) Parlimen Malaysia]

HADIR BERSAMA

EX OFFICIO

Jabatan Perkhidmatan Awam (JPA)
Puan Ilyani binti Md Razak [Ketua Penolong Pengarah]

Kementerian Kewangan Malaysia (MOF)
Puan Noni Salmina binti Abu [Ketua Seksyen]

Kementerian Ekonomi (KE)

Puan Noor Diana binti Mohamad Jusoh [Ketua Penolong Pengarah (Bahagian Industri Perkhidmatan)]

Suruhanjaya Pencegahan Rasuah Malaysia (SPRM)
Encik Chang Ching [Ketua Sektor Intra Agensi (Bahagian Siasatan)]
Puan Sharimah binti Mat Zin [Penguasa Kanan]
Encik Rosli bin Abdul Ghani [Penguasa]

Jabatan Akauntan Negara (JAN)
Encik Mohd Taufik Bin Hj Ahmad [Akauntan]

SAKSI

Munich Reinsurance Company
Puan Thio Hui Ming Serena [Ketua Pegawai Eksekutif]
Puan Catherine Love Soper [Ketua Serantau Kesihatan Asia Tenggara
Puan Cynthia Goh Sin Pei [Ketua Pegawai Risiko dan Pematuhan]]

LAPORAN PROSIDING

MESYUARAT JAWATANKUASA KIRA-KIRA WANG NEGARA
PARLIMEN KELIMA BELAS, PENGGAL KEEMPAT

BILIK JAWATANKUASA 1, BLOK UTAMA
BANGUNAN PARLIMEN, PARLIMEN MALAYSIA

KHAMIS, 14 OGOS 2025

Mesyuarat dimulakan pada pukul 3.05 petang

*[Yang Berhormat Puan Teresa Kok Suh Sim **mempengerusikan Mesyuarat**]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey, selamat petang, salam sejahtera dan selamat datang saya ucapkan kepada Yang Berhormat Ahli-ahli PAC Parlimen Kelima Belas, ahli-ahli ex officio PAC terdiri daripada Jabatan Perkhidmatan Awam, Kementerian Kewangan, Jabatan Audit Negara, Suruhanjaya Pencegahan Rasuah Malaysia, Kementerian Ekonomi, Jabatan Akauntan Negara dan Penasihat Undang-undang Parlimen.

Yang Berhormat, ahli-ahli mesyuarat sekalian, petang ini PAC Parlimen akan menyambung semula prosiding berhubung isu peningkatan bayaran premium insurans kesihatan, caj hospital swasta dan impak kepada kesihatan awam di bawah Kementerian Kewangan (MOF), Kementerian Kesihatan (KKM) dan Bank Negara Malaysia (BNM). Seperti mana semua sedia maklum, isu ini tidak dilaporkan dalam Laporan Ketua Audit Negara. Sehubungan itu, PAC menggunakan punca kuasa seperti berikut:-

(i) Peraturan Mesyuarat 77(1)(d) Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat;
(ii) P.M. 83(2) PPMMDR;
(iii) Arahan Perbendaharaan 301 (Pindaan 2023); dan
(iv) seksyen 5(3)(d) Pekeliling Am No.1 Tahun 2024 Organisasi Kementerian-kementerian Jabatan Perdana Menteri.

Yang Berhormat, ahli-ahli mesyuarat sekalian, hadir bagi memberi penjelasan di hadapan PAC dalam prosiding pada petang ini ialah Yang Berusaha Puan Serena Thio Hui Ming, Ketua Pegawai Eksekutif Munich Reinsurance Company, Malaysia *branch*. Yang kedua, Yang Berusaha Puan Catherine Love Soper, Ketua Serantau Kesihatan Asia Tenggara Munich Reinsurance Company, Malaysia *branch*. Dan yang ketiga, Yang Berusaha Cik Cynthia Goh Sin Pei, Ketua Pegawai Risiko dan Pematuhan Munich Reinsurance Company, Malaysia *branch*.

Terima kasih saya dan PAC ucapkan kepada semua kerana sudi hadir di hadapan PAC bagi memberikan penjelasan pada hari ini. Sebelum saya menjemput saksi untuk memulakan pembentangan dan memberikan penjelasan, ingin saya maklumkan kepada semua ahli-ahli mesyuarat sekalian bahawa prosiding PAC adalah tertakluk kepada Akta Rahsia Rasmi 1972 [*Akta 88*] dan Peraturan Mesyuarat 85, Peraturan-peraturan Majlis Mesyuarat Dewan Rakyat (PPMMDR) sehingga prosiding selesai dan laporan dibentangkan di Dewan Rakyat.

Jadi, tanpa membuang masa, saya menjemput Puan Serena Thio Hui Ming untuk memulakan pembentangan. Dipersilakan.

Puan Thio Hui Ming Serena [Ketua Pegawai Eksekutif, Munich Reinsurance Company]: Selamat petang dan salam sejahtera. Di kesempatan ini, izinkan saya Serena Thio Ketua Pengerusi Eksekutif Munich Reinsurance, Malaysia *branch* merakamkan ucapan terima kasih kepada Yang Berhormat Puan Teresa Kok Suh Sim, Timbalan Pengerusi Jawatankuasa Kira-kira Wang Negara Parlimen Kelima Belas, Yang Berusaha Dr. Nizam Mydin bin Bacha Mydin, Setiausaha Jawatankuasa Kira-kira Wang Negara Parlimen Kelima Belas, yang dihormati Ahli-ahli Jawatankuasa Kira-kira Wang Negara Parlimen Kelima Belas.

Di atas jemputan untuk hadir ke mesyuarat Jawatankuasa Kira-kira Wang Negara serta membentangkan topik berhubung peningkatan bayaran premium insurans kesihatan dan caj hospital swasta serta impak kepada kesihatan awam di bawah MOF, MOH dan Bank Negara Malaysia pada hari ini.

Yang Berhormat Timbalan Pengerusi PAC, Yang Berusaha Setiausaha PAC, yang dihormati Ahli-ahli PAC dan wakil daripada jabatan kerajaan, saya mohon izin keizinan untuk memulakan pembentangan ini dalam bahasa Inggeris memandangkan terdapat kehadiran dari luar negara. Okey. *Okay, thank you very much. If I could just start my presentation now?*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Yes please.*

Puan Thio Hui Ming Serena [Munich Re]: *Okay, so next slide please, Cynthia.*

■1510

So, these are the agendas that we plan to cover and showcase the PAC, what we want to present today. So, you will see that will be seven key topics that we will actually be covering. I will cover the first, two topics. Firstly, a brief introduction of who we are. And then secondly, what is our role in the insurance ecosystem.

And then, following from that my colleague from Singapore, Cathy will actually then present the few following sections which is firstly, what our cedant or basically our clients experience is with regards to medical insurance. And then, we will also showcase what we observe are the drivers of increasing medical insurance claims.

Following from that, we will also share the practices that we have observed elsewhere that has helped to manage medical insurance claims cost. And on the sixth agenda, we will also show some case studies of well-intended interventions.

Lastly, but not least, Cathy will then hand that back to me on concluding remarks and we will be happy to take any questions at that point in time.

So, firstly, who are we? So, Munich Reinsurance Group — we are a top provider of reinsurance, direct insurance and insurance related risk solution in the world. Munich Re Group is one of the world's leading risk managers. Founded in 1880. So we are over, nearly 150 years old, in Germany, headquartered in Munich.

The company is now active on a global scale. If I could just point you to the map in the left side of slide. You will see that we do indeed have a very wide, Munich Re has very a wide global presence. We are active in the Americas, also in Europe, South Africa and also, you'll see a good part of Asia Pacific.

Munich Re has held the number one spot in the top 50 of global reinsurance groups since 2010 with the exception of 2017. The portfolios of Munich Re and its business units, comprise reinsurance, direct insurance, related services and capital market solutions.

If I could bring the attention of your esteemed audience to the bar chart at the bottom, that says business segments. So, you will see that Munich Re we do have a direct insurer, we do write direct business Munich Re Group but with under the company's name of ERGO. But this — we don't have this company in Malaysia, they're predominantly in Europe and 35 percent of our business is actually coming in from this direct insurer.

The remaining 65 percent is actually where the reinsurance business comes in. And from this 65 percent of the business that's written in the reinsurance space, 46 percent of it is actually in the what we call it property and casualty which is the same as general insurance. And the remaining 19 percent is life and health.

As you can see, backed by offices across 50 plus countries, we have actually take a holistic view, while offering specialised expertise to the markets, companies and customers they we serve, both locally and globally.

You will also notice that Munich Re has got extremely strong credit ratings. We are double A rated both Fitch and also Standard & Poor's and A+ rated by A.M. Best. Munich Re shares are also traded in leading stock exchange indices including the Frankfurt Stock Exchange (DAX 40) and the Dow Jones Euro (STOXX 50).

So, let's just come slightly closer to home. So, who are we here Munich Re in Malaysia. Munich Re Malaysia is actually a licensed Retakaful Operator by Bank Negara Malaysia and we've opened our branch in Kuala Lumpur, wrote our very first Malaysian contract in 2008. That is devoted to just retakaful business.

Retakaful is reinsurance that's actually based on principles that comply with Shariah principles or we call it Islamic law. And the Munich Re Retakaful branch currently offers family which is the equivalent life and health. Retakaful support to Southeast Asian countries and also GCC countries in the Middle East.

Since Munich Re Retakaful inception, we have provided reinsurance support to all takaful operators in Malaysia, across various lines of business in the family takaful space. Under the takaful system, the takaful premiums we call them Tabbaru' are deemed as contribution into a risk pool to help policyholders who sustain losses.

These takaful premiums are invested according to strict Islamic principles. Most of the profits are also returned to the policyholder risk pool. The Retakaful company in turn receives a fee to cover the expenses in providing their reinsurance services.

As a branch of a foreign reinsurer, Munich Re Retakaful has helped bring technical expertise and foreign capital into Malaysia. We also build local talent. I'm actually very proud to say that out branch who has about 30 personnels, we are all Malaysians. And today, over the last five years, Munich Re Retakaful has actually paid out nearly RM1 billion in claims to the insurance industry in Malaysia.

So, to now put into perspective what is our role exactly in the insurance ecosystem. So, firstly, if I were to just out it very simply, a reinsurer provides insurance for direct insurance companies. So, you will see in this diagram on this slide, that there are three key stakeholders here.

Firstly, we have to the policyholder, that's people like yourselves and myself, we are the public. The man on the street. We are effectively the individual holders of insurance policies. Then we have the direct insurance company, who provides insurance products and services to public. So, in the context of Malaysia, you would think of companies like AIA, Prudential, Great Eastern, Etiqa. And lastly but not least, we have the reinsurer, company like ourselves who are basically insurer of direct insurance companies, covering a portion of the risk that the direct insurance company has assumed.

So, if you could help make that a little bit clearer, firstly, you will have a case where the policyholder pays premiums to the direct insurance company for the insurance coverage that they have to purchased.

And then following from that, the direct insurance company would pay a portion of that premium, we call it the reinsurance premium for the portion of the risk that has been transferred from the direct insurance company to the reinsurer.

In the event of the claim, what would then happen is that a direct insurance company would pay the policyholder the insurance claim. And following from that, the

reinsurer will then pay the direct insurance company, the portion of claims that has actually been reinsured to us.

So, in the nutshell, we insure direct insurance companies. So, we do have reinsurance agreement that's in place. So, just like how a policyholder has a formal insurance contract with a direct insurance company, the same holds for reinsurance.

A reinsurance or retakaful transaction is an agreement between the reinsurer and the direct insurance company — here in this case, we refer them as ceding company or the cedant. And the reinsurer basically agrees to accept a certain portion of the reinsured risk on terms and conditions that's clearly set up in the reinsurance agreement.

So, MRR or Malaysian Re Retakaful, sorry, Munich Re Retakaful primary roles as a reinsurer is as follows. We limit our cedants financial exposure to large or unusual risk by transferring a portion of their risk to us. By transferring part of their risk to us, our cedants can actually stabilise their loss experience. We also help maintain the financial stability of the insurance industry by ensuring that our cedants have sufficient capital to pay out claims when the claims are actually due.

We enable our cedants to write larger risk or offer higher coverage limits than they would otherwise be unable to do on their own. Therefore, expanding our ceding companies' capacity and business opportunities. We obviously provide specialised knowledge and expertise in specific risks which we would have being a global company versus maybe a ceding company that's probably does not that kind of exposure.

And as I have mentioned earlier, our parent company Munich Re Group is a publicly listed company on various stock indexes, we do have a responsibility for our shareholders or to our shareholders to ensure that we do not knowingly enter into loss-making business as we are responsible for our shareholders investment.

So, now, if we were think about what I had shared was a general concept about how reinsurance work. Let's see how would that now apply to medical reinsurance.

■1520

As you can see, we do have the same three parties involved here policyholders, the direct insurance company and the insurer. However, you will see in this chart now or in this diagram on this slide, there are lot of many other parties now involved as well.

So similarly, firstly, you will have a case where the policyholder pays premium for his medical insurance coverage to the direct insurance company. And likewise, the direct insurance company pays the reinsurance premium for the portion of the medical risk that has been transferred. A few years or subsequently down the road,

unfortunately, the policyholder has had to get himself admitted or goes to the clinic to actually seek some medical treatment.

So, what happen obviously when he goes to the clinic and hospital, there were be medical cost incurred. And when the medical cost that incurred, the third-party claim administrators were actually pays the clinic and hospital. So, the clinic and the hospital will claim — firstly claim the medical cost from the direct insurance company via the third-party claim administrator and the third-party claim administrator who are usually the party involved in processing claims on behalf of direct insurance company would then pay their eligible medical claims to the clinic and hospital.

In turn, the direct insurance company will then pay the third-party administrator for the eligible medical claims cost that they have pay out on behalf of the company. Following from this, the reinsurance company will then pay the direct insurance company for the reinsured portion of the medical claims to direct insurance company.

Just to clarify a little bit, third-party claims administrator may is we have shown here as a party that could potentially be involved in the whole ecosystem but not all company used third-party claims administrator. The mid to smaller size insurance company would usually use them but the larger insurance companies would usually maintain that process fully in house.

Next, please. So, if I were to then explain what our specific roles are in the space of medical reinsurance. We are actually have two keys focus areas. Our reinsurance arrangement involves a payment of reinsurance premiums from our cedents to Munich Re Retakaful to take on a portion of their medical insurance risk. This risk transfer is assessed on an annual basis.

Such an arrangement helps our cedents better manage their claims experience and relieves some of the requirements on how much capital they must hold.

On top of that, we also provide value-added consultancy services. The fees for which are costed within these reinsurance premiums. These services are as follows. We provide pricing and product design advice. We support medical underwriting when policies are actually onboarded. We also help our cedents with claims management reviews to assist during the claims assessment process if required. We also provide data analytics and experience analysis of the risks that actually transferred to us. And we assist in identifying fraud, waste and abuse of claims.

Most of our reinsurance premium pays for the claims in exchange for the risk that actually transferred. These are calculated simply to reflect the emerging claim experience. Therefore, we are one of the payers of claims. The cost of these claims

on the other hands, come from hospital chargers and policyholder usage which are not in our direct influence or control as the reinsurer.

Next. I would like to kindly request that I will hand this over now to Cathy and we would like to kindly request for the next section of the slides that would be presented to be made off record as were actually be presenting some confidential information that is not publicly made available.

Puan Teresa Kok Suh Sim [Naib Pengerusi]: Ya, *no problem. Shah Alam, you want to ask something?*

Tuan Haji Azli bin Yusof [Ahli PAC]: Ya, *just want to ask, we can understand simply how the payment is made to — from the insurance company to the policyholder but how do you normally pay out to the insurance company*? *Is it by bulk or by group*? *So just want to understand.*

Puan Thio Hui Ming Serena [Munich Re]: *No problem. It is very good question. So, we actually do have there is a reporting process that we also agreed. As part of the agreement, the reinsurance agreement that we have actually had with the direct company. There is usually a process where were actually required the direct company to submit quarterly bordereau — we called them bordereau which are basically would contain information like premiums, how much premium they are supposed to pay us and also in that same set of bordereau, they were also tell us the certain number of claims that we actually owe them.*

So that there is the formal process in place which actually enable this and it is actually part and parcel and outline in the reinsurance arrangement and agreement that we have with each of our clients.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Is a quarterly arrangement.*

Puan Thio Hui Ming Serena [Munich Re]: *Correct.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *Is it normal or is it similar across the board of reinsurance industry*?

Puan Thio Hui Ming Serena [Munich Re]: *Yes. This is very, very common practice for reinsurance. Thank you.*

Puan Teresa Kok Suh Sim [Naib Pengerusi]: Ya, okey.

Puan Catherine Love Soper [Ketua Serantau Kesihatan Asia Tenggara, Munich Reinsurance Company]: *Okay. Thank you very much for inviting me here today. So here marks the start of the off the record section.*

[Off record]

Tuan Sim Tze Tzin [Ahli PAC]: *Can you tell us how much is margin so that we can understand, put it in context*?

Puan Catherine Love Soper [Munich Re]: *I'm unable to give the actual quantum unfortunately. I can just state that it was negative for 2022, 2023 and 2024 and negative for the whole four-year periods.*

Tuan Sim Tze Tzin [Ahli PAC]: *Negative five percent, negative 10 percent or? Because we need to understand how much losses insurance company suffers. I mean, due to this inflation of medical inflation.*

Puan Thio Hui Ming Serena [Munich Re]: *So, I understand Cathy's apprehension because this margins so it is taken off record.*

■1530

So, what we could probably do is give you an indication of potential range but we are not able to give you the exact number, if I trust that is okay with the members?

So, we're looking at easily loses in the range of minus 20 to 30 percent easily. So, just think of it in that sense of this scale because the next few slides that we will show you is on the same scale, just that we couldn't show you the numbers but we would also show you the experience of a neighbouring country and you will see that the situation there is actually was, okay.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *pertaining to this. Okay, 2021 you said you made positive margin there because people were not interested go to hospital. But can — is there any indication that after the COVID-19, some relate it to maybe post COVID-19 problems, issues, some maybe say it's post-vaccination and all that. Is there any relation it all? Do you have any kind of evidence that that's happening because this includes hospitalisation isn't it? Maybe prolonged with lots of procedures?*

Puan Catherine Love Soper [Munich RE]: *Correct. It's an excellent question and I actually I discuss it later on the deck. You're right, that this experience is solely about in-patient admission. Actually I will talk about more in detail later but actually our experience has shown that it was the heavy loses that we continue to incur were not solely in respect of short-term post-COVID-19 problem. It does seem to be more a longer term as you — if it's okay, I will talk about more in later slide.*

[Off record]

Okay, so this marks the end of the more sensitive section and the slide after the section can be continued to be recorded.

Tuan Haji Azli bin Yusof [Ahli PAC]: *Question.*

Puan Catherine Love Soper [Munich Re]: *Oh, sure, okay.*

Tuan Haji Azli bin Yusof [Ahli PAC]: *You show the graph…*

Puan Thio Hui Ming Serena [Munich Re]: *Sorry, could I request any questions relating to the sensitive slides to also be taken off record, please? That's fine, we can ask the question. Thank you.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Yes, no problem.*

[off record]

Tuan Haji Azli bin Yusof [Ahli PAC]: *All right.*

Tuan Syahredzan bin Johan [Ahli PAC]: Naib Pengerusi,

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Ya, sila-sila Bangi.

Tuan Syahredzan bin Johan [Ahli PAC]: *Just for the record,* nanti bila *Hansard* ini telah disempurnakan, satu salinan akan diberikan kepada pihak puan-puan. Dan masa itu, puan pun ada peluang untuk tengok yang mana satu sepatutnya tak keluar untuk jadi *off record.*

So, jangan risau sangat tak perlu ulang-ulang semula *because we get your point that it's off record. So, you would have the opportunity to actually go through and say this is supposed to be off record, shouldn't go into the Hansard. Okay? So, don't worry about that.*

Puan Thio Hui Ming Serena [Munich Re]: *Thank you very much for that clarification.*

Tuan Syahredzan bin Johan [Ahli PAC]: *It appears to me that you don't trust us.*

Puan Thio Hui Ming Serena [Munich Re]: *Sorry, this is our first experience I hope you can also excuse us.*

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *about this slide, about Munich Re. You have got clients in other countries, right? Yes. So, you are just mentioning about Malaysia and Indonesia…*

Puan Catherine Love Soper [Munich Re]: *Yes.*

Dr. Hajah Halimah Ali [Ahli PAC]: *What about your clients elsewhere. You said Indonesia is way even worse than Malaysia. So, what about the other countries? What countries spesifically were doing well, better than Malaysia.*

Puan Catherine Love Soper [Munich Re]: *Sure. So, a biggest two blocks are probably in Malaysia and Indonesia but also have a big block in Thailand. I would say Thailand was on a very similar path but seemed to be to just a year or so behind Malaysia and Thailand in terms of the impact of COVID. So, we quoted slightly earlier but they still experience loses over 2021 and 2022.*

Dr. Hajah Halimah Ali [Ahli PAC]: *What about Europe — do you have any experience in Europe?*

Puan Catherine Love Soper [Munich Re]: *Unfortunately, I only cover South East Asia. I believe they had a similar experience in Europe but I am not well qualified to talk about it unfortunately.*

Tuan Sim Tze Tzin [Ahli PAC]: Pengerusi. *Okay, from your slides you are talking about — okay just now you gave us an indication of 20 or 30 percent loss ratio. I mean loss ratio.*

■1540

Puan Catherine Love Soper [Munich Re]: *Negative net margins....*

Tuan Sim Tze Tzin [Ahli PAC]: *Negative* ya. *So — but however, in Malaysia, the repricing is about 75 to 210 percent, 216 percent the highest that I have seen.*

Puan Catherine Love Soper [Munich Re]: *Ya.*

Tuan Sim Tze Tzin [Ahli PAC]: *So, does it mean that it is fair for us 75 percent because of 2023 percent. So, my question is insurance company taking advantage of this repricing to make their profit?*

Puan Catherine Love Soper [Munich Re]: *It's a very good question. The answer is not, hopefully this table will address your question which is that in year one, the net negative margin was small and a small rate rise would have done the job. However, during COVID-19, people tend not to reprice, very understandable reason. And if you can see from the table, if you miss one or two years of rate rises, there's 75 or 78 in year three.*

So, that magnitude of rate rise is in line with my calculation here and is in line with a kind of experience we're seeing. So again, going back to path the graph on slide 15, if that so, okay. This again hopefully demonstrates that we won't be taking advantage, we, ourselves experience negative, pretty large negative net margins in those — in fact all three years 22, 23 and 24.

Tuan Sim Tze Tzin [Ahli PAC]: *Subsequent question is that, so this is on a macro level but actually a lot of pool that the insurance companies created was old pool or dying pool because they keep on creating new products. The young people are no longer buying into the old products. The old products like us, that we bought 20 years ago, are already dying. So that compounds the issues.*

So, it's actually the fall is not at the consumer side but is the business practice or the insurance companies' fault for not maintaining a pool but they created too many pools. What do you think about this?

Puan Catherine Love Soper [Munich Re]: *So, in terms of reporting our clients' experience, I have grouped all the plans together for each client. Again, going back to graph on page 13, you can see that the very high and your increases of*

inflation aren't respective all the plans which include plans returned many years ago and also very recently and this is the way to the average experience. I would say that we are actually as we takaful, we don't have many plans that are results as your — you're talking about, how plans and products tend to be much younger. Okay.

So, if we head back to slide 19. Sorry. Next slide. Okay, thank you. So, this section has talking about the drivers of increasing medical insurance claims. So, what is driving these higher medical insurance claims? This is a summary about observations. Immediately post-COVID, it was assumed that the causes of the high medical claims incurred by the insurance sector was due to delayed elective procedures and perhaps worsened immunity as well, especially with the young children and the elderly.

This is getting back to your point earlier. These high medical claims were there for presumed to be temporary. However, the high medical claims that are being faced by the insurance sector have continued to persist for years post-COVID-19, I mean write up to today. Which has now invalidated this earlier presumption and indicates that other causes are driving this trend real long-term causes. So, the drivers can be taught of as being bucketed into two main areas.

Number one, increased usage of medical insurance. So, this is policyholders' increased usage of their insurance benefits, coupled with health facilities practices that encourage policyholders to utilise their medical insurance coverage. And the other bucket is increased medical inflation cost. So, increase in the costs themselves. This is where healthcare costs are going up due to more advanced treatments, rising prices from retail price inflation, currency movement, so will see affect imported medicines and medical equipment.

Next slide, please. So, I'm going to deep dive into both two areas and a bit more detail. So, what is driving these higher medical insurance claims in respect of the policyholder's increased usage of their insurance benefit. Firstly, growing awareness and concern about health issues following COVID-19, especially nowadays, there's more ease of information access online with social media. There are also potential long-term adverse health effects for individuals who have had COVID-19, again a point that you mentioned earlier. It is a real phenomenon that we have observed.

This always see a lifestyle and environmental factors, for example, a more inactive lifestyle and an unhealthy diet, potentially contributing to more non-communicable diseases and the development over them into longer-term chronic conditions. And worsening levels of pollution, for example, causing more respiratory conditions. Respiratory issues have been a key area of causes of claims that we observed.

There is also what is commonly known as buffet syndrome mindset where policyholders tend to claim in order to receive back with perceived value of what they have paid for with their insurance premiums. This is also made easier with cashless cards, where policyholders are less incentivised to understand or question what charges are actually being billed.

And then there is of course, fraud, waste and abuse incidents where unnecessary medical tests may be carried out and unnecessary medication prescribed, unfortunately.

And next slide. And if we deep dive into what is actually increasing the medical cost themselves, again, advancements in medical treatment which incur higher costs. Underlying retail price inflation that affects the costs of the medical equipment, transportation and the drugs and currency movements, as I mentioned before, where imported medication or imported medical equipment is affected and recently trade tariffs will play the part as well. Okay, next slide please.

So, the next section talks about managing medical insurance claim cost and particular the practices that we have observed elsewhere. Next slide. So, the observed practices — the practices we have observed that may mitigate unsustainable increases in medical claims cost can be thought of us again bucket in three different areas.

The first one would be around building sustainable product design. The second one would be around managing the health provider practices and the third one would be government-driven initiatives. And I will talk three several points under each of those topics. So next slide.

This talk about the observed practices with regard to sustainable product design. The three key areas are this set up in the slide. Firstly, co-pay. So, co-pay design where policyholders share a portion of the medical claims can be very effective. This policy provides an incentive for the policyholder to scrutinise what is being charged. This is a pretty common product design that we see practised across the Southeast Asia region these days.

The second point is a no-claim discount and it encourages policyholders to only claim when truly required. And again, it's a common product design in Southeast Asia this time at these days and also for the other lines of insurance, as well as, for example, mutual insurance is very common.

And thirdly, annual repricing for medical products. So regular incremental rate rises or rate increases will help to mitigate against sudden large rate rises being needed.

So, now discusses the key practices observed with regard to managing health provider practices. So, number one, price transparency is key and for standard

medical procedures and fees charged by the providers. This allows consumers to compare prices and reduces incidences of complicated pricing structures and hidden costs.

■1550

Number two, pre-authorisation which refers to authorisation prior to hospital admission. These allows the insurers to evaluate and approve coverage for medical expenses strictly based on the policy benefits and the medical information provided. This can really help to curb over consumption, overtreatment and fraud. And this is quite common in Europe and across the US.

And lastly, a move away from a purely fixed fee-based remuneration structure for Third Party Claim Administrators to one perhaps that is performance based and linked, for example to claim experience or loss ratio.

And the next slide.

Tuan Sim Tze Tzin [Ahli PAC]: *Can you explain more about this move away from a purely fixed fee-based on TPA?*

Puan Catherine Love Soper [Munich Re]: *Yes, sure. There are lots of pricing structures that can be implemented with your TPAs. The worst kind I've seen is where they are financially incentivised per claim that they approve. [Ketawa] That's at the worst but that is actually quite common because obviously then they are incentivised to approve claims without question.*

So, what we've suggested here is sort of the opposite where it is a performance-based. I do want to emphasis we are here to pay medically necessary claims — that's very important to us and that serves the greater public good.

But, where there is wasteful abuse of fraudulent claims, it is important that someone is keeping a check on them in order to keep the prices as reasonable as possible, again for the wider good. And certainly, for medium to smaller sized insurance companies, really is the TPA that has most ability to control the claims because they're the ones that approve the claims. So, yeah. So, the financial remuneration incentivises them in the right way is something we encourage.

Lastly, this is about the practices that we have observed relating to government-driven initiatives. Firstly, we do recommend establishing a national digital platform that requires health providers to produce structured digital medical records that can be transferred to insurers and TPAs in real time. That really does help with detecting fraud, waste and abuse. We recommended it particularly because we've seen it operated in the UAE, where Munich Re also has a big branch there.

Number two, the development of a long term sustainable base no-frills medical product by all insurers, again it supported by the government. This product

would be focused on medical necessity and affordability. So, needs to have rather than nice to have.

Lastly, promoting preventative care, so free vaccines to greater proportion of society, free regular medical checkups through public heath campaign to raise public awareness that prevention is really better than cure.

Lastly, I'm going to present two case studies, both of which involved well intended interventions.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *before you are going into the next slide. Can I ask you about that digital medical records, is that ethical? And what happened if the information is leaked?*

Puan Catherine Love Soper [Munich Re]: *It would certainly have to be kept completely confidential and extremely tight security. It's operated in the UAE. So, in the UAE they consider ethical under those conditions of high security and confidentiality.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *I think now the Health Ministry already start this digital app right for the public to register their health condition. Because in my constituency there have been a few health checks that involved the Health Ministry, the local what do you call that, the clinics. So, they come — it takes a long queue for people to wait for, then to check — have their sugar checked and all that because they have to key in all the data into the KKM system.*

But actually, our — the COVID time, the MySejahtera is also one of those that collect our health information, right. Which we already giving our data. Okay.

Puan Thio Hui Ming Serena [Munich RE]: *Sorry, If I could add, I think what the point here we're trying to say is that we are aware of you know maybe different parts of the organisation or the government agency collecting the data but I think the key here is there is one centralised platform where that information is kept. That's what I think Cathy trying to say for the UAE. It's one centralised platform where all the data is. So, everything consolidated in one place and there's consistency in the information and the structure is actually organised basically.*

Puan Catherine Love Soper [Munich Re]: *Yeah, for all your record and then transferred to the TPAs in real time.*

Okay, so this is the first case study. So, this case study is an example of the successfully executed intervention. So, it's an example of the case study that worked well.

This is about the California Proposition 103 to do with auto insurance reform. It's actually happened in 1988, a while ago. So, what actually happened, well insurers faced with skyrocketing auto insurance premiums and customer complaints. The California voters passed this Proposition 103 which gave the state's department of

insurance authority to approve rate changes and required insurers to justify their pricing with actuarial data.

And why it worked? The measure introduced transparent data-driven rate oversight, not arbitrary price controls. It helped reduce excessive pricing, promote competition and limit discriminatory practices without driving insurers out of the market.

So, the overall outcome was that over time California's auto insurance rates grew more slowly than the national average and insurer participation remained healthy. So, intervention can work when it supports the market function rather than overrides it. Hence it is risk based, temporary or transparent and it balances policyholder protection with insurer solvency.

So, this is another case study, again of well-intended interventions but this case study inadvertently undermined policyholder protection. So, we are citing this example as a case study that did not work well. So, this is about as closer to home, it's about Thailand COVID insurance mandate, it's recent 2021 to 2022.

Okay, what happened? Thai insurers sold low cost COVID insurance policies often lumpsum payout types during the pandemic to meet consumer demand. The regulator later mandated that insurers must honor all their claims under these policies despite a surge in infections and payouts far exceeding their actuarial forecasts.

So, potentially sounds reasonable, but why did it not work? Firstly, inability to reprice risk. The regulatory price control blocked insurers from raising premiums, even as the claim volume soared locking insurers into unprofitable products.

And secondly, they also implemented restrictions on policy cancellations. So, when the losses mounted, insurers tried to cancel high risk policies, which is something under normal circumstances they are allowed to do but were prohibited from doing so, eliminating a key risk management tool.

So, the overall outcome was insurer failures, at least four insurance companies become insolvent in 2022 due to unsustainable claims obligations and arguably reduced consumer protection. The market disruption led to fewer active insurers, undermining competition and long-term policyholder protection.

So, some final concluding remarks on these two case studies. As the case study in Thailand shows where intervention involves price suppression or forced liabilities, it can cause a destabilisation of the insurance sector.

However, when grounded in sound economic and actuarial principles, interventions can strengthen trust and strengthen stability in insurance sector as illustrated in California auto reform case.

■1600

And I also want to note that in Thailand, we are also observed an increased pressure on public hospitals for certain segments of people in particular the juvenile medical insurance segment has become so expensive that many insurance companies have opted to cease writing this segment of medical business. And with reduced insurance offerings being made available for juvenile, an increasing number of hospital admissions will fall back to the public hospitals, increasing the strain on public hospitals.

Okay, next slide please.

Puan Thio Hui Ming Serena [Munich Re]: *So, I will just wrap up a quick conclusion of what we presented today. Next slide, please.*

As we have shown and shared the medical insurance and reinsurance line of business has historically been challenging to manage. Usually demonstrates volatile experience and thin margins to both the insurers and reinsurers.

We have also noted that medical claims costs have been escalating at a worrying trend in recent years. The key drivers of this trend is due to increase usage of medical insurance and increasing medical costs.

While we are observing positive developments on product design and claims management from the insurance industry, premium rises are still required by design of the product itself.

We have also demonstrated that the compounding impact of delaying rate increase can be substantial.

Medical insurers are only one of the many stakeholders in the health ecosystem. As such, a whole of nation approach is required to manage the very worrying trend on increasing medical claim costs.

Collective efforts on product design, health provider practices and government initiatives will help to mitigate unsustainable increase in medical claim costs.

We have also shared some cases of government and or regulatory intervention which have been conducted always with the best of intentions. Some have succeeded in achieving the desired outcome while some have had unintended and long-term adverse implications to the insurance and to the community.

I think this wraps up our session and our presentation happy to take any further questions. Thank you.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya. *Thank you for the presentation. I myself would like to ask the slides that you ask us not to show. I think I looked at the chart, there are four years, right. The first year we have to increase 44 percent of the medical insurance then come down to I think the fourth year is 200 percent. That is your calculation. So that is your suggestion that all medical insurance*

come to the fourth year we should increase at least 200 percent in order to cover the cost. Am I right? *Is that what you mean*? Ya, *this one. Sorry, it's 112 percent.*

Puan Catherine Love Soper [Munich Re]: *Correct. If you when without doing any right rises in years one, two or three, the modest 11 percent which will be needed at the start would have grown to 112 percent rate rise. I'm more doubling the rates. That would have been if there has been no other action during that time period.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *But I think Malaysia — Sim maybe you can correct me. And we are ready increase to 11 percent, right*? *Malaysia.*

Tuan Sim Tze Tzin [Ahli PAC]: *Okay, before that. It is a based on 15 percent annual medical increases. Is it*?

Puan Catherine Love Soper [Munich Re]: *Correct,* ya.

Tuan Sim Tze Tzin [Ahli PAC]: *So, this is very relevant to Malaysia situation. Am I right*?

Puan Catherine Love Soper [Munich Re]: *Correct. We have pick number here for illustrator purposes but we did try to pick broadly reasonable figures, yes*.

Tuan Sim Tze Tzin [Ahli PAC]: *So the government intervention is giving them 10 percent increase, so what is your based on your 10 percent increase for next three years*? *So where are we now*? *Is it like we are in year two or year three when we announced the 10 percent*?

Puan Catherine Love Soper [Munich Re]: *[Ketawa] For detail calculation I think we would have to provide them later with email. However, I can't say that if the starting position had been around the 100 percent, then the 10 percent rate rise would been broadly appropriate. However unfortunately with my clients, I can really provide my clients but my clients in 2024, the loss ratio were much, much higher than 100 percent which linked back to the graph on slide 15 and 16. Unfortunately, the repricing start when loss ratio were well, well, well above the 100 percent.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: *Okay, my another question is in we have been having proceedings on this topic and the insurance companies have complaints that the private hospitals press, you know the what you called that, the fees that they have to pay what lower fee. Not complaining. It is hospitals that complaint that…*

Tuan Sim Tze Tzin [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] Asking them for discount.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ya, *for discount up to 25 percent. So, I didn't see this you know appear in your presentation. So, do you think that this should be you know I just said whether you are insured or not insured,*

you should just pay the what flat rate — the rates that, you know given by the hospitals.

Puan Catherine Love Soper [Munich Re]: *In our experience, the chargers from hospitals very significantly by client. It tends to relate to then negotiating power with the hospitals which tend to relate to the size and how many policyholders they send that way to the hospitals. So, it is quite hard to compare they'll have different prices often or get different levels of discount. But it would be in built into these numbers. This reflects actual cost truly experience by our clients. So, if they have been a discounting hospital prices that would be reflect within these figures. That's answer your question*?

Tuan Sim Tze Tzin [Ahli PAC]: *Okay. Based on your presentation, you are coming from a perspective of insurance company, okay. But however, we also want to know what are the insurance company do to actually help to reduce the cost because there is also responsibility of the insurance company to play their part.*

Puan Catherine Love Soper [Munich Re]: *Fully, fully agree with that. Absolutely, if we can go back to slide 10. So, a significant portion of our reinsurance premium — sorry, slide 10.*

Is significant portion of variant reinsurance premium, is in respect of what we called value-add consulting services — here we go, for our insurance partners, for our cedents and this in turn do help to keep prices to a minimum. So, for example, we would support them to have the most efficient claims management processes as possible to minimize the waste in their cost there and we also do lots of work to support our clients in identifying fraudulent or abusive claims. Again, that is for a wider policyholder good because we are only here to payout medical necessity claims. And in identifying the fraudulent claims that will help keep premiums to a minimum.

And we do all these services that was listed here as well. Data analytics, experienced analysis and they indirectly help to keep premium low because they allowed insurer to better understand their experience identify trends, identify which product design are more popular et cetera.

Tuan Sim Tze Tzin [Ahli PAC]: *Pengerusi, the recent announcement by the RESET by the government. I'm sure you guys' study about it. Perhaps heard about it. What do you guys think about that plan and what is your concern or do you have any comments about it*?

Puan Thio Hui Ming Serena [Munich Re]: *I think the main comment we have is I actually applauded it in a sense that it's finally recognising that to tackle this issue, it really takes a whole nation approach.*

And the RESET in that presentation of what I understand from it, is that it does make sure all the invested stakeholders in this ecosystem meaning the hospitals

which under the purview of medical — sorry, Ministry of Health basically the insurance companies coming out with product design and also basically all the areas I feel that is the right approach that everybody finally understand and acknowledges that it is a whole nation approach. All the invested stakeholders need to find a way to work together to come out with the solutions.

Because I think — again, this is just a view like if we don't solve this eventually, what is going to happen is what happen in Thailand as we can see is that, it would push people, it makes insurance policy slightly say unaffordable. There would be less people who buy it and when people don't have medical insurance coverage, they will be going to public hospitals. That would put a strain on the public hospital that is quite obvious.

■1610

At the same time, on their flip side, if companies are forced in a line of business that unfortunately we all have shareholders, that's the reality. A lot of our companies and our clients are also listed on the stock exchange in one form, shape or another. They have responsibilities to their shareholders. And if the shareholders are the view that they are writing business that's loss-making, they would probably like what has happened in Thailand, they were probably not be able to support those products moving forward and choose not to offer it.

So, like in Thailand, that one that Cathy mentioned about the juvenile segment. I mean I think we are all one way or another, we're all parents. When our child gets sick and the doctor says, "Oh you better bring you child in for observation. Just in case." As a parent, you would not take the risk of actually saying, "Oh it's fine, I'll take my kid home and everything would be fine."

So you would just listen to the doctor to do that and so because of that I think if that segment of the market or that product offering is no longer available, you can imagine parents will now start rushing to the public hospitals. It would put a strain on public hospitals and it does nobody any good that that offering is no longer made available or very restricted coverage that's actually provided to juveniles.

So, I think the reset approach is the right one. It feels — overall it feels right. We got all the right vested stakeholders, now having a role to play to trying and solve this issue that we are actually seeing.

Dr. Hajah Halimah Ali [Ahli PAC]: Pengerusi, *about the cost. Very drastic increase. Is there any relationship with increased cost of litigation or worry net, worry from the hospitals, just in case they miss something, they might be sued by this patient. So, they might as well get a proper thorough investigations and of course that will increase your price, increase your cost.*

Puan Catherine Love Soper [Munich Re]: *Yes, absolutely and it's a difficult balance to work because as a doctor you do want to ensure that you check for every potential realistic disease and problem. You don't want to miss something important and be sued. But equally if you're pushing test that are clearly not needed with by any sensible medical opinion then that would counter wasteful or potentially even abusive. And it is a difficult balance to work. I am not a doctor myself, so I probably can't talk in details there.*

Dr. Hajah Halimah Ali [Ahli PAC]: *I am from medical profession, so I think that is the real worry among the medical circle. Before, nobody really wants to think about suing this — their doctors. But now everybody seems — I don't know the lawyer, sorry want to make money. [Ketawa]*

Okay, so maybe if you map the trend of medical litigation to the hospitals and the insurance and all that, maybe there might be some interesting relationship.

Puan Catherine Love Soper [Munich Re]: *I haven't done that analysis, but it's an interesting idea. Unfortunately, of course it is the policyholders who end up paying ultimately, for these extra tests and in cases where really, really unnecessary extra tests are still commissioned, that contributes to rising premium and that would be an unnecessary rise in premium arguably.*

Dr. Hajah Halimah Ali [Ahli PAC]: *Because I heard I am not sure hospital in Kajang or somewhere in Bangi or somewhere…*

Tuan Syahredzan bin Johan [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Bangi.

Dr. Hajah Halimah Ali [Ahli PAC]: *...Closed down because one made a litigation about that.*

Tuan Syahredzan bin Johan [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara] ...got slapped with a big [Tidak jelas]. Az-Zahrah.*

Tuan Sim Tze Tzin [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]*

Puan Catherine Love Soper [Munich Re]: *I mean as a reinsurer we don't get directly involved in the hospitals. We a bit far, further removed from that stakeholder.*

Dr. Hajah Halimah Ali [Ahli PAC]: *That's one things that you have to look it all angles, you know. What cause the escalation of this cost. It's not just one factor, it's multifactorial.*

Puan Catherine Love Soper [Munich Re]: *Absolutely correct.*

Dr. Hajah Halimah Ali [Ahli PAC]: *So, until and unless you get to the bottom of the problem, you know you might be getting to the wrong angle of the solutions especially by the government policies.*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Ada soalan lagi? Tak ada? Okey, kalau tak ada apa-apa. Tak ada, Bayan Baru?

Tuan Sim Tze Tzin [Ahli PAC]: *[Bercakap tanpa menggunakan pembesar suara]* Tak ada.

Seorang Ahli: *[Bercakap tanpa menggunakan pembesar suara]* Bayan Baru okey, kita pun okey. *[Ketawa]*

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Okey. Ya, *actually* Cik Cynthia Goh *is not here, right?*

Encik Mohd Sukri Bin Busro [Parlimen Malaysia]: Ada, ada.

Puan Teresa Kok Suh Sim [Naib Pengerusi PAC]: Oh ada, *sorry, sorry.* Bagi pihak PAC, kami ingin berterima kasih kepada Yang Berusaha Puan Serena Thio Hui Ming, Yang Berusaha Puan Catherine Love Soper dan Yang Berusaha Cik Cynthia Goh Sin Pei daripada Munich Reinsurance Company Malaysia *branch* kerana sudi hadir di hadapan PAC bagi memberi penjelasan tentang topik ini pada petang ini.

Jadi mesyuarat PAC hari ini bertangguh pada pukul 4.16 minit dan kita akan sambung mesyuarat pada minggu depan. *Okay, thank you very much for coming.*

Puan Thio Hui Ming Serena [Munich Re]: Terima kasih.

Puan Catherine Love Soper [Munich Re]: *Thank you.*

[Mesyuarat ditangguhkan pada pukul 4.16 petang]

GAMBAR PROSIDING



















APNM
APNM Proceeding with
Public Accounts Committee
(PAC)





































DOKUMEN PEMBENTANGAN

Pembentangan Mengenai Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan Impak kepada Kesihatan Awam

Mesyuarat Jawatankuasa Kira-Kira Wang Negara (PAC)

24 Februari 2025

- MHIT: Insurans dan takaful perubatan serta kesihatan
- ITO: Penanggung insurans dan pengendali takaful
- Sebarang rujukan kepada insurans/premium insurans juga termasuk takaful/sumbangan takaful

Inflasi perubatan merupakan isu kompleks dan memerlukan pendekatan '*whole-of-nation*'

Faktor sosial, persekitaran dan kemajuan teknologi



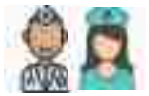
Peningkatan penyakit berjangkit dan tidak berjangkit *(non-communicable disease, NCDs)*



Masyarakat yang lebih berusia



Kemajuan teknologi kesihatan



Gaji tenaga kerja kesihatan



Perubahan iklim dan ekosistem

Kerjasama antara KKM, hospital swasta, ITO dan BNM penting untuk menangani kos inflasi perubatan



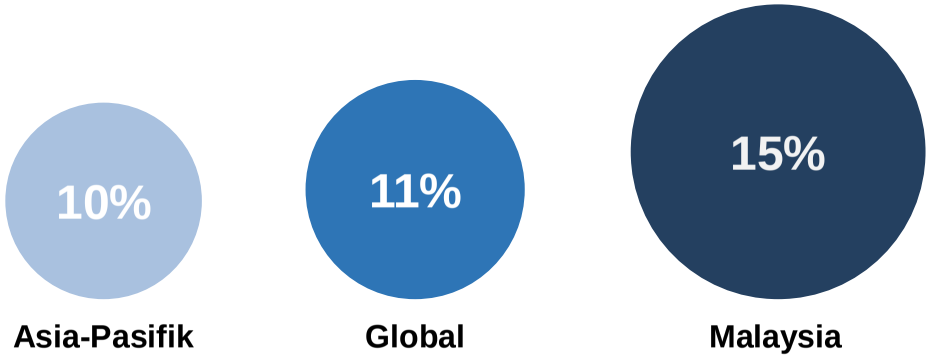
Sumber: Kertas Putih Kesihatan (KKM)

Inflasi kos perubatan telah menyebabkan tuntutan MHIT meningkat secara berterusan

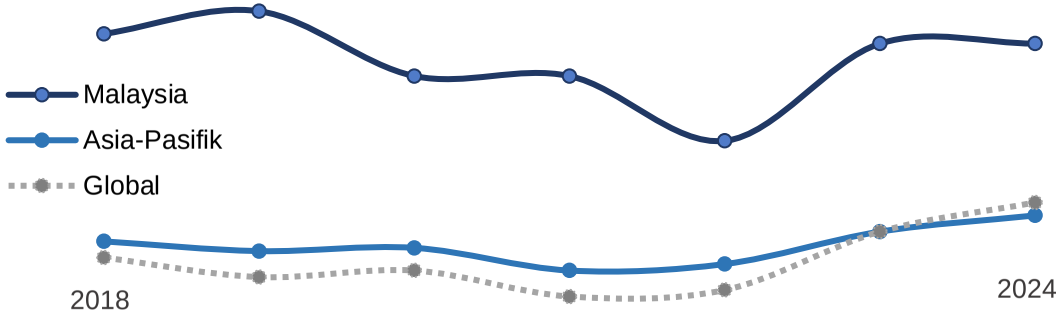
Peningkatan tuntutan MHIT didorong inflasi kos perubatan tinggi…

Kadar inflasi perubatan Malaysia adalah tinggi

Tahun 2025



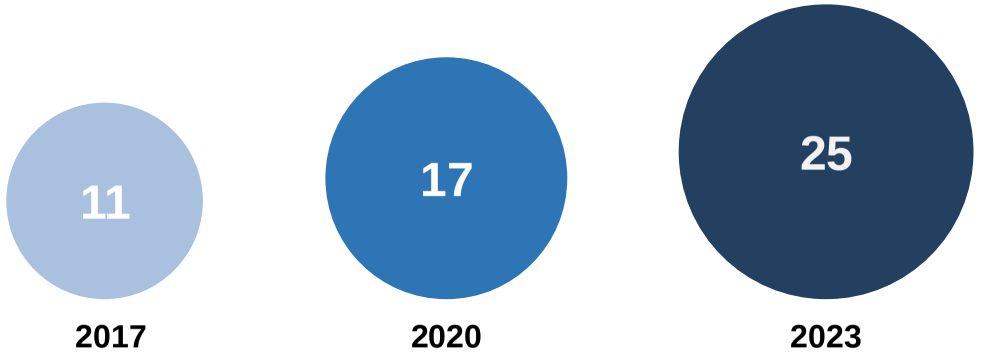
Trend yang sama sejak tahun 2018



…berserta peningkatan kekerapan tuntutan dan penggunaan perkhidmatan kesihatan hospital swasta

Peningkatan purata bilangan tuntutan

bagi setiap 100 pemegang polisi



1. **Caj bekalan dan perkhidmatan hospital yang tinggi dan tidak dikawal** (*hospital supplies and services, HSS**)

   59-70% *daripada komponen bil hospital swasta*

2. **Perbezaan jumlah kos rawatan** antara pesakit yang menggunakan surat jaminan *(guarantee letter)* dengan yang menggunakan *'pay-and-claim'***

* Barangan seperti makmal dan pengimejan, ubat-ubatan, kejururawatan dan peralatan perubatan (cth. ventilator perubatan dan mesin dialisis).

**Boleh dipengaruhi oleh kerumitan penyakit dan status kesihatan pesakit

Sumber: The Insurance and Takaful Industry Medical Cost Containment Task Force Study on the Drivers of Medical Costs and Medical Insurance Premium Inflation, 2020; Insurance Services Malaysia (ISM), Laporan AON Global Medical Trends.

BNM telah menyuarakan keperluan menangani inflasi kos perubatan sejak sedekad yang lalu

Inisiatif-inisiatif yang diketengahkan berdasarkan tiga keutamaan

1 Meningkatkan ketelusan harga perubatan

- **2016: Mesyuarat Penolong Gabenor dan KSU KKM:** menyuarakan kepentingan ketelusan harga oleh hospital swasta
- **2017:** Berkongsi dengan KKM format bil seragam untuk penerbitan oleh hospital swasta
- **2018: BNM-MyCC-KKM-APHM** bersetuju memperkenalkan bil terperinci, menerbitkan kos-kos prosedur lazim, dan mengkaji pendorong peningkatan kos perubatan

★ **2019:** ITO menerbitkan laporan tentang pendorong peningkatan kos tuntutan perubatan

★ **2025:** ITO menubuhkan **pangkalan data tuntutan MHIT**

2 Kawal selia caj, harga ubat-ubatan dan amalan hospital swasta

- **2017: Surat kepada KSU KKM:** menyeru agar peraturan ke atas hospital swasta dipertingkatkan
- **2018: Surat kepada Menteri Kesihatan**: bekerjasama untuk menambah baik pembiayaan kesihatan
- **2022: ITO-APHM-MMA-KKM-BNM: ‘**Grievance Mechanism Committee’ untuk menyelesaikan pertikaian dalam tuntutan perubatan
- **2025:** KKM **mewajibkan penerbitan** harga ubat oleh klinik dan hospital swasta

3 Pembaharuan pembiayaan kesihatan dan menangani kadar inflasi kos perubatan

- **2016: Laporan ‘Malaysia Health System Research’ oleh KKM-BNM** berkaitan reformasi sektor kesihatan
- **2019:** Rencana Laporan Tahunan BNM menekankan pembaharuan jangka panjang yang diperlukan
- **2021**
  - BNM menyokong **Health System Evaluation Study/Reform Plan** oleh KKM untuk pembaharuan sistem kesihatan
  - Penerbitan Tinjauan Kestabilan Kewangan oleh BNM menegaskan kepentingan mengawal inflasi kos perubatan
- **2022**
  - **Mesyuarat Gabenor-Menteri Kesihatan**: bersetuju dengan transformasi digital, ketelusan caj sektor swasta dan memperkukuh sistem pembiayaan kesihatan kebangsaan
  - Penerbitan Pelan Sektor Kewangan BNM 2022-2026 menekankan pembaharuan sektor kesihatan negara bagi kemampanan produk MHIT
- **2023:** BNM menyertai jawatankuasa pembaharuan pembiayaan kesihatan menerusi Kertas Putih Kesihatan

★ **2024**: BNM memperbaharui dokumen dasar MHIT.

Perubahan Menteri Kesihatan pada tahun 2018, 2020, 2021, 2022, 2023

Pandemik COVID-19 (2020-2021)

Pelarasan premium adalah simptom kepada peningkatan inflasi perubatan dan punca utama isu ini perlu ditangani



Objektif utama adalah memastikan ITO berupaya membayar tuntutan secara berterusan…

- Pelarasan premium dipertimbangkan apabila:
  a) pengalaman tuntutan merosot secara berterusan.
  b) premium MHIT dianggap tidak lagi mampan untuk menampung jumlah tuntutan dan perbelanjaan.
- Pelarasan premium tidak dibenarkan bagi tujuan peningkatan margin keuntungan.



…di samping memastikan amalan pasaran yang adil bagi semua pengguna…

- Dasar pengumpulan risiko bertujuan untuk memastikan subsidi silang *(cross-subsidisation)* dikendalikan dengan adil.

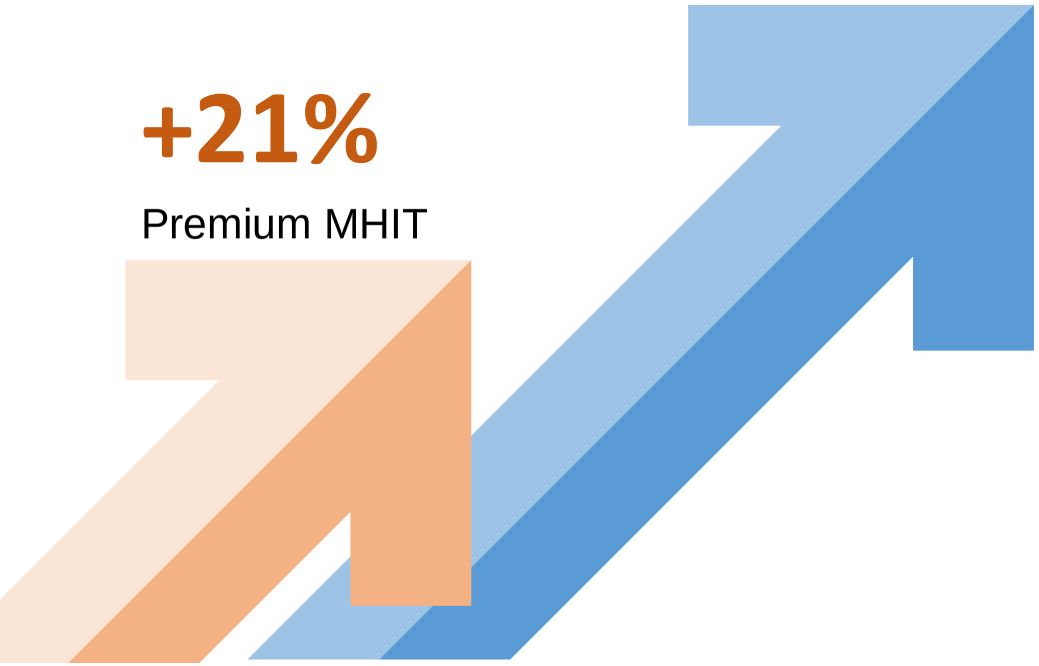


…serta mengambil kira daya kemampuan pengguna

- Pemegang polisi perlu diberi pilihan alternatif serta bantuan yang sesuai untuk mengurus premium.

Peningkatan kos tuntutan mengatasi peningkatan premium secara berterusan

Pertumbuhan antara tahun 2021-2023



Sumber: ISM, BNM

Taburan dan julat kenaikan premium pada 2024 sebelum pelaksanaan langkah-langkah interim[1]

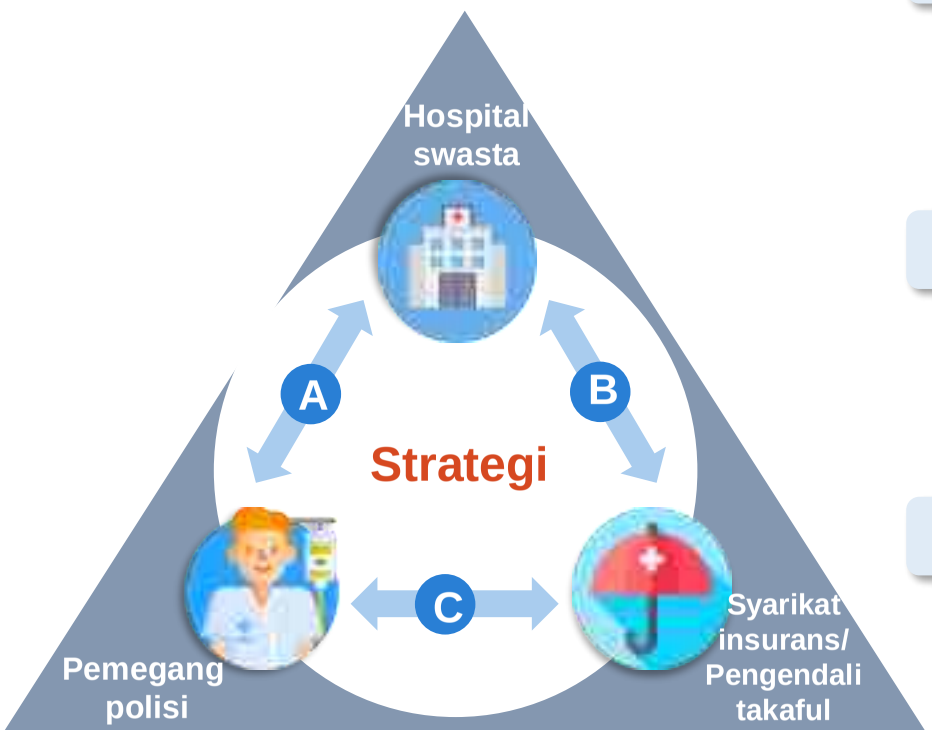
Julat kenaikan	<20%	21-40%	41-60%	>60%
% bilangan polisi yang dilaraskan	61%	30%	5%	4%

[1] Kenaikan premium disebabkan inflasi kos tuntutan perubatan serta peralihan kumpulan umur

Kadar pelarasan premium yang dialami oleh pemegang polisi individu bergantung kepada beberapa faktor:

1. Kitaran pelarasan premium yang berbeza (contoh 1 tahun, 3 tahun, dll.)
2. Saiz dan demografi kumpulan risiko
3. Kumpulan umur pemegang polisi

BNM telah menjalankan pelbagai usaha untuk memastikan perlindungan MHIT kekal mampan



Pautan: bnm.gov.my/documents/20124/938039/pd_mhit_feb2024.pdf

A. Perubahan tingkah laku yang positif

1. Pilihan ciri pembayaran bersama sebagai produk mampu milik alternatif
2. Program pendidikan pengguna mengenai MHIT

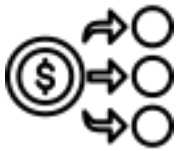
B. Pengurusan kos yang lebih baik dan telus

1. Pangkalan data tuntutan berpusat
2. Kos perubatan lazim akan diterbitkan sebagai penanda aras harga

C. Amalan perniagaan dan jualan produk MHIT

1. Lembaran penzahiran produk (*product disclosure sheet, PDS*) akan ditambah baik untuk menyertakan:
   - Maklumat produk MHIT mudah difahami
   - Perbandingan produk alternatif MHIT
   - Jangkaan premium masa depan
2. Amalan yang lebih adil dan mampan:
   - Meluaskan pengumpulan risiko merentasi produk yang serupa
   - Penambahbaikan penilaian kemampuan pemegang polisi oleh ITO

Langkah-langkah bagi mengekang impak kenaikan premium MHIT terhadap pemegang polisi yang terkesan hanya bersifat sementara (2024-2026)



1. Pengagihan kadar pelarasan premium* sekurang-kurangnya tiga tahun. 80% pemegang polisi mengalami pelarasan bawah 10% setahun.



2. Penangguhan pelarasan premium* selama setahun untuk pemegang polisi pelan minimum berumur 60 tahun ke atas.



3. Pengaktifan semula polisi yang terkesan dengan pelarasan premium tahun 2024 atas permintaan pemegang polisi.



4. Penyediaan produk alternatif yang lebih mampan pada premium yang sama atau lebih rendah.



Langkah-langkah ini bersifat sementara dan tidak mampan untuk jangka panjang jika inflasi kos tuntutan perubatan terus melebihi pelarasan premium yang dibenarkan.

**Pelarasan premium yang disebabkan oleh inflasi tuntutan perubatan.*

Inisiatif pembaharuan sektor kesihatan negara perlu disegerakan dalam tempoh tiga tahun ini (2024-2026)

Meningkatkan ketelusan kos

1 **Penerbitan harga ubat**
Diwajibkan untuk hospital dan klinik swasta

2 **Mekanisme kadar inflasi perubatan**
Pertubuhan mekanisme penganggaran yang tepat

3 **Mengkaji Akta 586***
Memperkukuh pengawasan hospital swasta. Memudahkan pelaksanaan pembayaran secara DRG

4 **Penerbitan harga perkhidmatan kesihatan**
Penerbitan julat harga perkhidmatan kesihatan lazim

Pelaksanaan DRG

5 **Model pembayaran Diagnosis-Related Group (DRG)**
Pembangunan sistem, perundangan dan pengenalan secara berfasa di hospital swasta

Transformasi MHIT

6 **Pembangunan produk asas MHIT**
Produk yang lebih mampan, mengutamakan penjagaan kesihatan berasaskan nilai *(strategic purchasing)*

Pembekalan pilihan mampu milik

7 **Rakan KKM**
Sebagai pilihan ekonomi premium dan penanda aras harga

8 **Hospital tidak berasaskan keuntungan**
Perkembangan hospital digalakkan

Pembangunan digital

9 **Rekod kesihatan elektronik (*Electronic Medical Records, EMR*)**
Untuk mengurangkan pertindanan ujian diagnostic dan meningkatkan kecekapan operasi

* *Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998*

Pelaksanaan inisiatif berdasarkan 5 teras untuk membendung kadar inflasi kos perubatan

Meningkatkan ketelusan kos

Pelaksanaan DRG

Transformasi MHIT

Pembekalan pilihan mampu milik

Pembangunan digital

Impak pembaharuan kesihatan

Membolehkan perbandingan kos dan menggalakkan penetapan harga yang lebih adil

Membendung penggunaan perkhidmatan kesihatan yang didorong oleh penawaran *(supply-induced demand)*

Memperluas pilihan perkhidmatan dan meningkatkan kecekapan operasi

Tiga penunjuk prestasi utama disasarkan *(Key performance indicator, KPI)*



Kadar inflasi kos perubatan yang lebih perlahan, sejajar dengan trend global



Pelarasan premium MHIT yang lebih perlahan



Penjimatan kos perubatan melalui pembelian secara strategik dan DRG

BNM juga akan terus meneliti dan menambah baik dasar pengumpulan risiko, reka bentuk produk dan amalan jualan produk MHIT

Penambahbaikan sektor MHIT

1. **Memastikan saiz kumpulan risiko yang lebih mampan untuk menambah baik pengumpulan risiko dan mengurangkan kadar pelarasan premium**
2. **Menangani inovasi produk yang tidak mampan**
   (contoh: manfaat tanpa had dan reka bentuk kompleks)
3. **Menambah baik struktur insentif jualan selaras dengan objektif untuk membendung inflasi kesihatan**
4. **Menambah baik lembaran penzahiran produk MHIT**
5. **Penerbitan panduan pembelian insurans yang mudah difahami**

KKM dan BNM sedang dalam proses membangunkan produk insurans/takaful kesihatan swasta asas yang diseragamkan

Prinsip Panduan

- Harga yang **lebih mampan dan mampu milik**
- Memperluaskan skala **perkongsian risiko**

Penjagaan Kesihatan Berasaskan Nilai

- Mekanisme pembayaran **Diagnosis-Related Group (DRG)** untuk perkhidmatan kesihatan lazim
- **Pembeli strategik** bersama *(shared strategic purchaser)*
- Kawalan lain termasuk **keperluan rujukan** dari doktor perubatan umum *(General practitioners gatekeeping)* sebelum kemasukan hospital

Parameter Produk

- **Kemasukan hospital[1] dan rawatan harian** bagi perkhidmatan kesihatan yang penting *(essential)*
- Tahap **had tahunan** yang bersesuaian dan mampan
- Ciri **pembayaran bersama** *(co-payment)*

[1] Termasuk ICU, prosedur pembedahan, yuran pakar bedah profesional dan pakar bius, caj hospital lain (e.g. ujian diagnostik, ubat-ubatan, bekalan perubatan)

Struktur tadbir urus untuk memastikan kelancaran dan keberkesanan inisiatif

Objektif utama:
Memperlahankan inflasi kos perubatan

Menteri Kesihatan dan Menteri Kewangan II

KKM dan BNM *sebagai penyelaras utama*

Pelbagai kumpulan kerja dianggotai oleh agensi dan pihak berkaitan

- KKM
- MOF
- BNM
- KE

- Persatuan insurans & takaful
- Persatuan Hospital Swasta Malaysia (APHM)
- Lain-lain

Slaid Tambahan

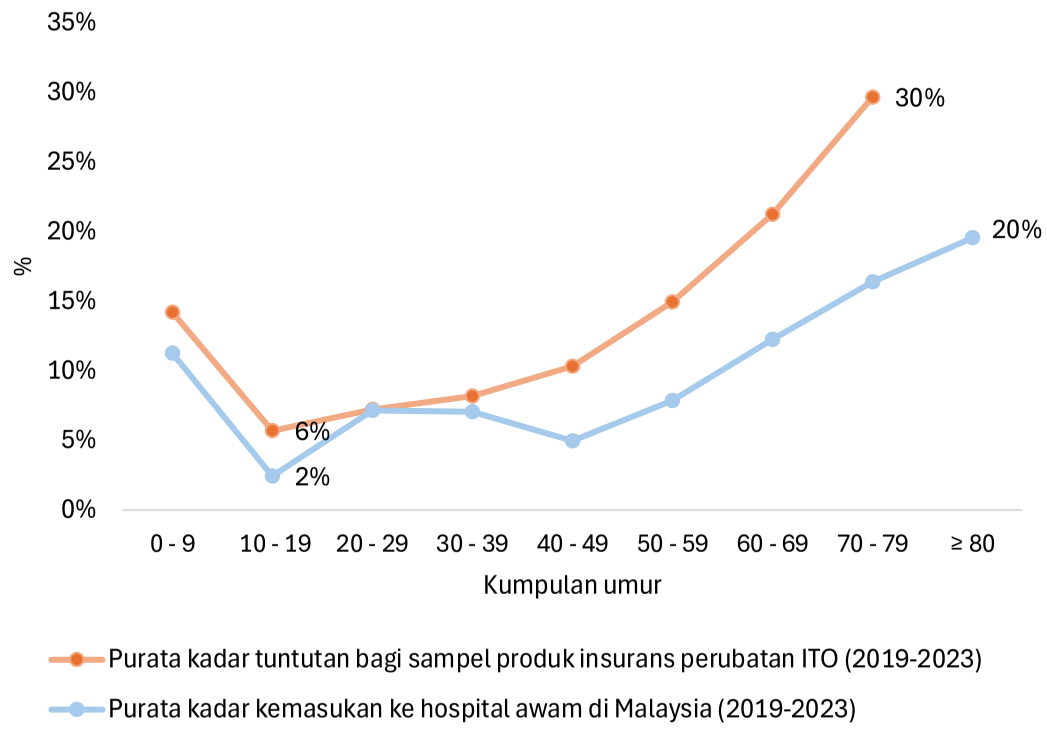
Penetapan premium berdasarkan kumpulan umur adalah selaras dengan risiko kadar dan kekerapan tuntutan kumpulan umur tersebut

1. Premium pemegang polisi yang memiliki profil risiko serupa (cth. *kumpulan umur, jenis pelan*) digabungkan untuk menampungkan kos tuntutan bagi pemegang polisi yang memerlukannya

2. Premium mencerminkan risiko kumpulan semasa berdasarkan data pengalaman tuntutan yang sahih *(credible)* dan digunakan untuk menampung tuntutan bagi setiap tahun polisi

3. Premium meningkat mengikut usia kerana risiko kesihatan dan kebarangkalian tuntutan meningkat dengan penambahan usia

Trend tuntutan berdasarkan kumpulan umur adalah lebih tinggi dari trend kemasukan ke hospital awam



Sumber: BNM, MOH

** Penarafan komuniti ('community rating') biasanya diperhatikan untuk program insurans kesihatan nasional yang mewajibkan/memberi insentif penyertaan*

CADANGAN UNTUK MENANGANI MASALAH PENINGKATAN BAYARAN PREMIUM INSURANS KESIHATAN, CAJ KESIHATAN & IMPAK KEPADA KESIHATAN AWAM

Association of Financial Advisers Malaysia (AFA)
Persatuan Penasihat Kewangan Malaysia

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Disclaimer :

The terminology and scenarios presented are for conceptual reference only. For precise definitions and official frameworks, please refer to the relevant authorities for clarification.

Policyholder (hereinafter 'PH') and Insurance and Takaful Operator (hereinafter 'ITO').

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Some additional scenario from public perspectives:

Risk Portfolio of Sick & Old PH insuring each other in a ‘left-over’ pool while healthy PH are invited to ‘upgrade’ to new medical plan/rider.

Currently, the risk portfolio of medical insurance is segregated by product. As a result, when healthy existing PHs migrate to new medical plans or riders, those who are elderly or have pre-existing conditions / with claim history remain in the older risk pool, effectively self-insuring one another which believe to be a key reason behind the drastic and frequent premium repricing. This leads to a sharp increase in insurance costs for the ‘old portfolio’ and undermines the fundamental principle of insurance and takaful, where risk is shared collectively between healthy and high-risk policyholders.

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The following group of Policyholders, who are significantly impacted by the existing challenges (hereinafter referred to as ‘Left-Out PH'), face the following issues:"

- Elderly Policyholders – Those who have exceeded the entry age limit for new medical plans
- Policyholders with Pre-Existing Conditions – Those who are ineligible to switch or upgrade to new medical plans due to their health status.
- Policyholders with Claim History – Those whose past claims may be excluded when transitioning to new plans.

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For benefit of doubt, new medical plan/rider may still be offered at affordable rate compared to the ‘old’ plan which are experiencing frequent repricing exercise.

If this condition left unattended, the public health care may collapse if the Left-Out PH have no choice to experience frequent drastic hike in medical insurance premium.

Thus, medical insurance pricing mechanism should be equally important for both new block of business and existing old block of business.

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Concern Parties & Possible Conflict of Interest:



A. Insurance Companies

- New business for launching new medical plan & riders
- KPI on New Business
- KPI on the profitability (Actuarial perspective - focusing on the pooled risk performance of life, critical illness, and medical plans, analyzed on a segregated product portfolio basis)



B. Insurance Intermediaries

- New business from launching of new medical plan & riders
- KPI on New Business

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Concern Parties & Possible Conflict of Interest:



C. Hospital

- Profitability



D. Policy Holders

- Some young and healthy PH who still do not yet to feel the pinch.

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4 ADDITIONAL PILLARS OF IMPROVEMENT

1.0 Aggregating Risk into a Single Risk Pool

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1.1 Aggregating all medical plans—both new and old—into a single risk pool

As mentioned earlier, Risk Portfolio of Sick & Old PH insuring each other in a ‘left-over’ pool in the old medical insurance risk pool while healthy PH are invited to ‘upgrade’ to new medical plan/rider. We believe that at this point of time where most of the healthy and young PH had been upgrading their medical plan away from the old pool to a new pool to make their premium more affordable with better bargain leaving the pity ‘left-over PH’ behind in the old pool whether medical re-pricing within the old pool due to self-insuring among the sick and old. These left-over old pool condition would probably goes out of control as of today and getting worst beyond. This undermines the fundamental principle of insurance and takaful, where risk is shared collectively between healthy and high-risk policyholders.

Thus, aggregating all medical plans both new and old pool into a single risk pool must be adopted immediately to rectify this problem to ensure sustainability and fairness. It will also facilitate a more balanced risk distribution, prevent adverse selection, and uphold the core principle of risk-sharing in insurance and takaful.

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1.2 Aggregating all medical plans, including those bundled with basic life and other riders (e.g., Critical Illness, Personal Accident, Waiver), into a single risk pool

- To leverage on claim ratio of bundled risk pool of other riders and insurance benefits to ensure a more balanced risk distribution.
- To promote sustainable profitability for insurance companies by balancing risk exposure across different business segments.
- To uphold the core principle of risk-sharing from a bundle perspective, fostering long-term stability in the insurance and takaful ecosystem.

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2.0 Implementation of a Mandatory Blanket Deductible for Old and New Medical Plans/Riders

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2.1 Ensuring Consistency and Reducing Confusion Among Stakeholders

A standardized mandatory deductible structure across all medical plans (both old and new) would create a uniform understanding among all stakeholders, including policyholders and hospitals. (though higher deductible rate would still be additional option)

Hospitals and policyholders may be unaware of whether a particular medical plan is subject to a deductible, leading to potential confusion and misuse. A blanket approach would mitigate these risks and enhance transparency.

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2.2 Managing Public Healthcare Risks and Ensuring Sustainability

Policyholders who pose a higher risk to the public healthcare system often belong to the "Left-Out PH" group. Therefore, implementing a mandatory deductible for the old block of business is crucial to ensure sustainability.

A blanket deductible for the old portfolio would:

A.

Improve claims ratio management by discouraging unnecessary medical utilization and mitigating potential misuse of medical insurance.

B.

Help stabilize or even reduce existing premiums, benefiting policyholders and insurers alike.

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2.3 Amendments to FSA 2013

Implementing a mandatory deductible for the old block of business would require amendments to the Financial Services Act (FSA) 2013, as ITOs are currently bound by existing policy contracts.

Amending the FSA 2013 to enforce a mandatory deductible across all medical insurance plans would provide a viable and legally sound solution, ensuring regulatory compliance while addressing sustainability concerns.

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3.0 Regulating the H&S Itemised Bill

Oversight Regulatory Bodies - MOH & Ministry of Domestic Trade & Costs of Living
Kementerian Perdagangan Dalam Negeri dan Kos Sara Hidup representing the rakyat interest

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4.0 Mandatory Option for Pay & Claim Medical Plans

To enhance cost control and sustainability, all medical insurance policies should include a mandatory option for policyholders to choose between a **Cashless Option** and a **Pay & Claim Option.**

This framework can be applied uniformly across both **existing (old block) and new medical plans**, ensuring consistency. However, implementing this for the old block of business would require an amendment to the **Financial Services Act (FSA) 2013** to facilitate regulatory compliance.

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Benefits of the Pay & Claim Option:

- Lower Claims Ratio – Encourages responsible medical spending, reducing unnecessary claims.
- Reduction in Overall Claim Amount – Policyholders become more price-conscious, leading to cost efficiency.
- Prevention of Misuse – Discourages unnecessary treatments and fraudulent claims.
- Mitigation of Overpriced Medical Bills – Policyholders who pay first are more likely to seek fair pricing, promoting cost transparency in healthcare services.
- More Affordable Premiums – Provides a cost-effective insurance option for policyholders who have the financial means to pay upfront and claim reimbursement later.

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Public Accounts Committee

Hearings on the Public Health Impact of Increases in Health Insurance Premiums

Witness testimony of:

Dr Chan Chee Khoon

Citizens' Health Initiative

February 25, 2025

Parliament of Malaysia

Contextualising insurance premium increases

- *healthcare ecosystem*: patients entangled in a tug-of-war between profit-driven health providers & profit-driven health insurers
- insofar as tendencies are not reined in for providers' unrestrained deployment of (prepaid) health interventions, the policy holders will eventually be burdened with high premiums
- over & above this (and *aging* and more costly *technology*), insurers' use of 2020-2021 as a baseline for demonstrating steep rises in 2022-2023 claims was misleading. 2020-2021 claims depressed due to Covid restrictions & risk avoidance (delay elective procedures). Rebound in 2022-2023 exaggerated the increase in claims, but provided an opportunity for insurers' hefty mark-up of premiums

THE Star
the people's paper

January 18, 2000

INSIDE

Boy, 13, held after school set on fire
Page 6

BUSINESS

Time for more money on Into highway

SECTION2



Shifting sands

Environment
On the trail of the whale



Mil
WI

Compute IT
The AOL-Time

The Star Online – http://thestar.com.my/

HEALTH OPTION

EPF members can use Account III for health insurance scheme from June

By K. PARKARAN

KUALA LUMPUR: The estimated five million active EPF members can use their savings to sign up for a health insurance scheme this June.

Under the scheme agreed upon by EPF and the Life Insurers Association of Malaysia (LIAM), contributors can authorise EPF to pay the premiums *from their Account III (health) annually.*

Members can opt for a low-premium scheme covering 13 critical illnesses or for one covering 36 major illnesses at a higher premium.

The 13 critical illnesses listed by the board are major organ transplants, coronary bypass surgery,

1st OPTION – ANNUAL PREMIUM BASED ON AGE FOR 13 CRITICAL ILLNESSES							
Sum Assured	Up to 35 years old	36-44	45-49	50-54	55-59	60-64	65-70
RM10,000	RM30	RM71	RM130	RM236	RM471	RM883	RM1,883
2nd OPTION – ANNUAL PREMIUM BASED ON AGE FOR 36 CRITICAL ILLNESSES							
RM25,000	RM95	RM205	RM361	RM642	RM1,267	RM2,361	RM5,017
RM50,000	RM182	RM401	RM713	RM1,276	RM2,529	RM4,713	RM10,026
RM100,000	RM347	RM784	RM1,409	RM2,534	RM5,034	RM9,409	RM20,034



risk-rated health insurance deprives high-risk individuals of access to healthcare because of unaffordably high premiums *(those people most at risk of falling ill and requiring treatment, will be those least likely to afford premiums, and therefore treatment)*

Risk Rating *vs.* Risk Pooling

- should BNM consider banning *risk-rated* health insurance premiums in favour of (uniform) *community-rated* premiums? (*e.g. Obamacare, Australia, among other implementors*)
- is non-profit health insurance (*e.g. SHI*) an option to consider?

SHI, an attempt to deal simultaneously with 2 distinct problems:

- how to raise more money for national health expenditures (through a proportional payroll tax), i.e. a *de facto* supplementary, regressive income tax, with matching employer contributions
- integrating an (over-burdened) public healthcare sector with an (under-utilized) private sector (through a unified provider payments system which can rationalize utilization of services across both sectors)
- DRG as a cost control mechanism for a unified provider payments system

Social Health Insurance *vs.* Tax-Financed Health Systems:

Evidence from the OECD

Adam Wagstaff (World Bank, 2009)

POLICY RESEARCH WORKING PAPER 4821

Abstract

This paper exploits the transitions between tax-financed health care and social health insurance in the OECD countries over the period 1960–2006 to assess the effects of adopting social health insurance over tax finance on per capita health spending, amenable mortality, and labor market outcomes. The paper uses regression-based generalizations of difference-in-differences and instrumental variables to address the possible endogeneity of a country's health system. It finds that adopting social health insurance in preference to tax financing increases per capita health spending by 3–4 percent, reduces the formal sector share of employment by 8–10 percent, and reduces total employment by as much as 6 percent. For the most part, social health insurance adoption has no significant impact on amenable mortality, but for one cause—breast cancer among women—social health insurance systems perform significantly worse, with 5-6 percent more potential years of life lost.

World Bank Study (2009)

Social Health Insurance

- per capita health spending increased by 3-4%, *without* corresponding improvement in health outcomes
- worse amenable mortality rates for diseases that require strong population-based public health programs, e.g. breast Ca
- formal sector employment ↓8-10% *(casualisation)* total employment as much as ↓6%

COMMENTARY | GLOBAL HEALTH POLICY
HEALTH AFFAIRS > VOL. 39, NO. 5: SUBSTANCE USE, SURPRISE BILLING & MORE
COMMENTARY

The Case Against Labor-Tax-Financed Social Health Insurance For Low- And Low-Middle-Income Countries

Abdo S. Yazbeck, William D. Savedoff, William C. Hsiao, Joe Kutzin, Agnès Soucat, Ajay Tandon, Adam Wagstaff, and Winnie Chi-Man Yip

AFFILIATIONS

PUBLISHED: MAY 2020 Free Access https://doi.org/10.1377/hlthaff.2019.00874

Abstract

An increasing interest in initiating and expanding social health insurance through labor taxes in low- and low-middle-income countries goes against available empirical evidence. This article builds on existing recommendations by leading health financing experts and summarizes recent research that makes the case against labor-tax financing of health care in low- and low-middle-income countries. We found very little evidence to justify the pursuit of labor-tax financing for health care in these countries and persistent evidence that such policies could lead to increased inequality and fragmentation of the health system. We recommend that countries considering such policies heed the evidence on labor-tax financing and seek alternative approaches to health financing: primarily using general taxes or, depending on the context, general taxes combined with adequately regulated insurance premiums.

What are better solutions we could consider for the 2 problems?

Dedicated ring-fenced ***Tabung Kesihatan Negara*** (funded by a supplementary progressive health tax, corporate taxes, property & capital gains taxes, Tobin-type taxes, 'sin' taxes, other public revenues, (zakat?) etc, subject to robust governance provisions (stakeholder representation, accountability, transparency)

This national health fund would be used to:

- re-invigorate public provision of healthcare: expanded delivery capacity – recruit and/or contract for more staff, strengthen comprehensive primary care with continuity-of-care and referral linkages to deal with increasing burden of NCDs, better mgt of staff (and facilities), terms of employment & benefits, transparent criteria & processes for upskilling, promotions, and career prospects (separate Health Services Commission? to attend to those grouses driving the perennial outmigration of senior experienced staff); rationalise & reorganise use of resources, build & equip more health facilities where needed, to ease congestion and bottlenecks, improve quality of care (in short, a reinforced public sector to provide timely, appropriate, no frills, quality care, on the basis of need, to all eligible care-seekers)
- where shortfalls in delivery capacity exist, spill-over patients from public hospitals can be channeled to 'panel' private hospitals in accordance with a (DRG-based?) fees schedule and (casemix-based?) institutional grants (KKM could be bulk purchaser of supplementary/top-up services from private sector, at negotiated, discounted prices required of licensed private providers) (much like housing developers being required to fulfill a certain quota of low-cost housing)

Tobin taxes to boost KKM's allocations?

- based on *Bursa Malaysia's* average daily trading value (ADTV) in 1H 2024, a 0.5% Tobin-type tax on share transactions could raise RM4.26 billion annually (Tobin subsequently increased his tax recommendation to 1%)
- a 1% tax on share transactions (administratively simple to implement) could increase KKM's budget by about 20% above its allocation for 2025 (RM45.3 billion)
- based on 1H 2024 daily average foreign exchange (FX) trading volumes, a 0.05% Tobin tax could raise USD4.69 billion (= 20.73 billion ringgit) in a year


Galen Centre
for Health and Social Policy
improving **health** and
social outcomes

Galen Centre for Health and Social Policy

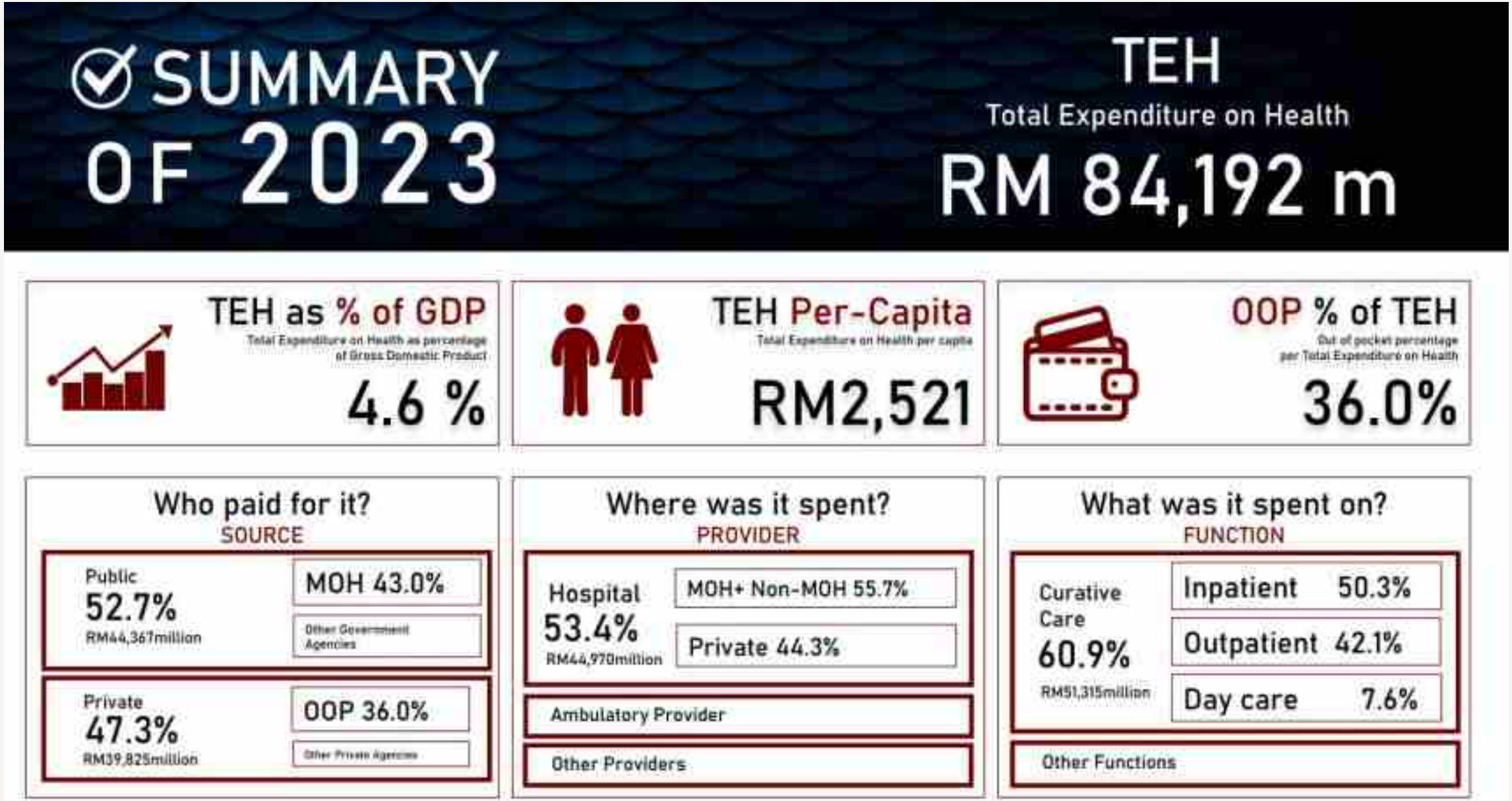
Mesyuarat Jawatankuasa Kira-kira Wang Negara (PAC), Parlimen Kelima Belas Bil. 5(D) Tahun 2025 Berhubung Peningkatan Bayaran Premium Insurans Kesihatan, Caj Hospital Swasta dan Impak Kepada Kesihatan Awam di Bawah Kementerian Kewangan, Kementerian Kesihatan dan Bank Negara

Bilik Jawatankuasa 1, Parlimen Malaysia | 25 February 2025

Azrul Mohd Khalib, Chief Executive Officer
Galen Centre for Health and Social Policy

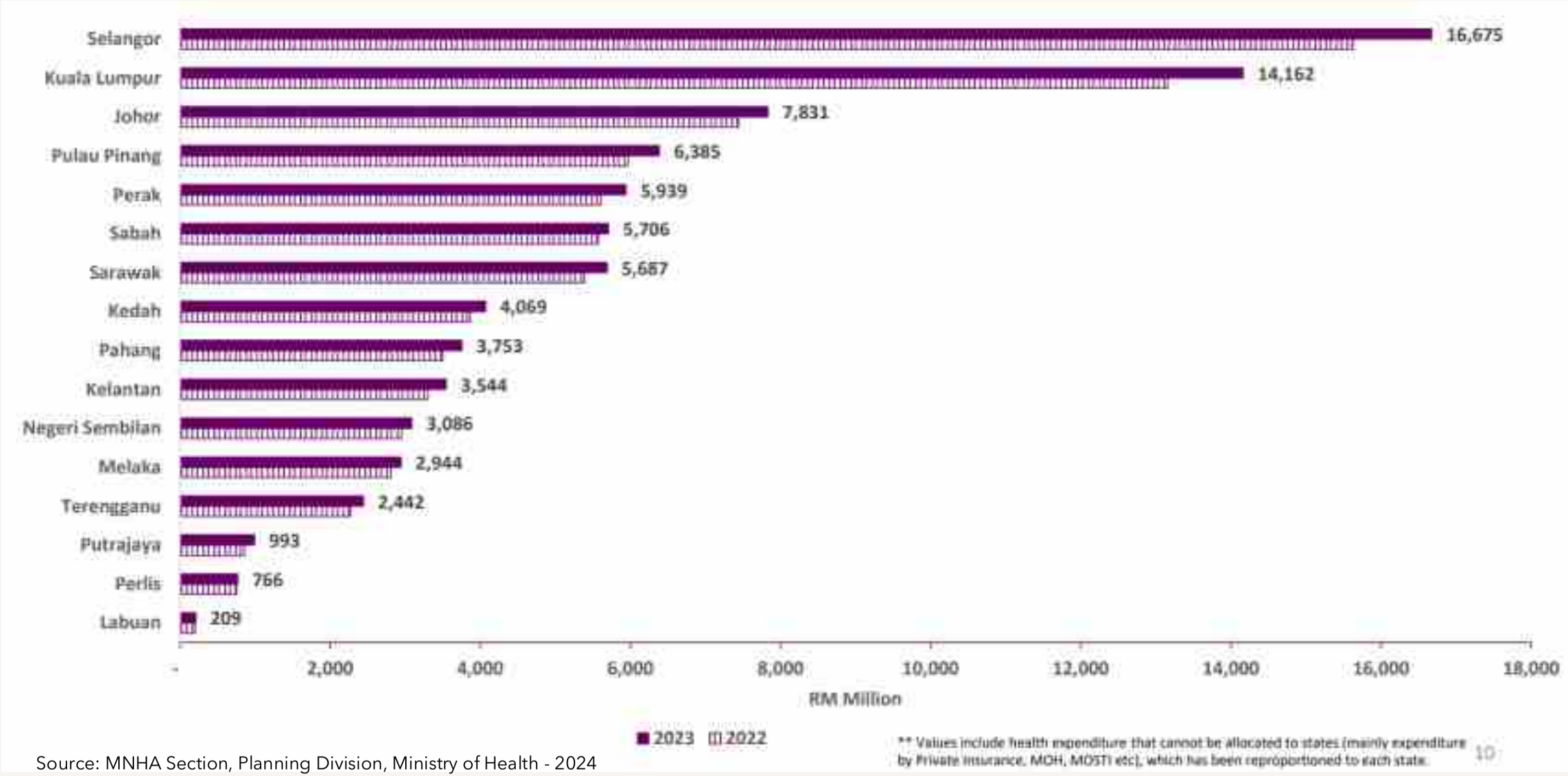
Outline of presentation

- Overview
- Medical and health insurance/takaful (MHIT)
- Private hospital charges
- Recommendation



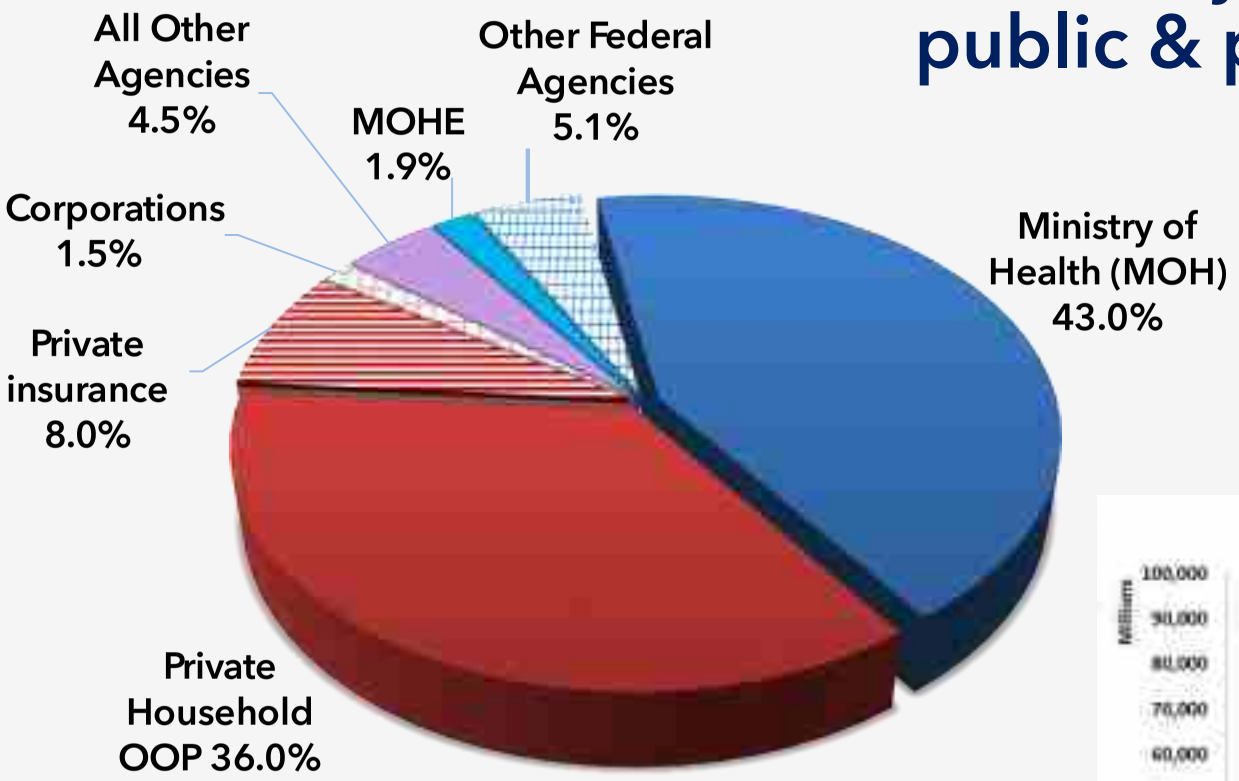
Source: MNHA Section, Planning Division, Ministry of Health - 2024

Expenditure on health by states, 2022-2023



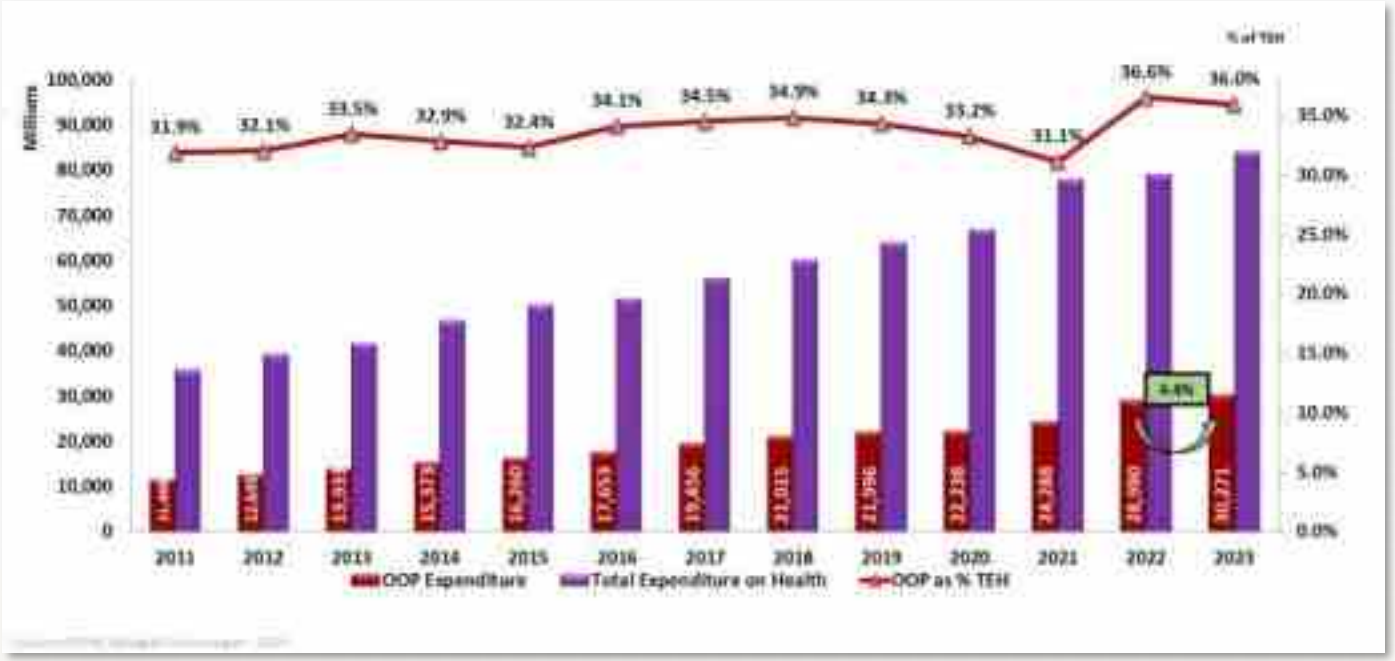
Source: MNHA Section, Planning Division, Ministry of Health - 2024

THE by sources of financing public & private sources, 2023



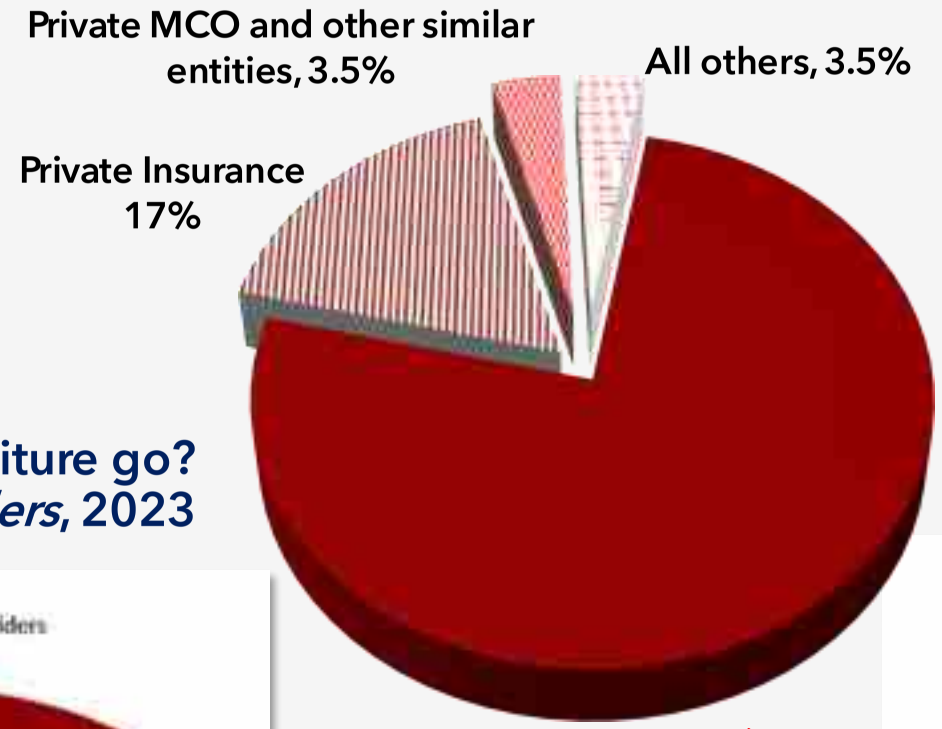
THE: Total health expenditure

Private: Out-of-pocket 2011 - 2023

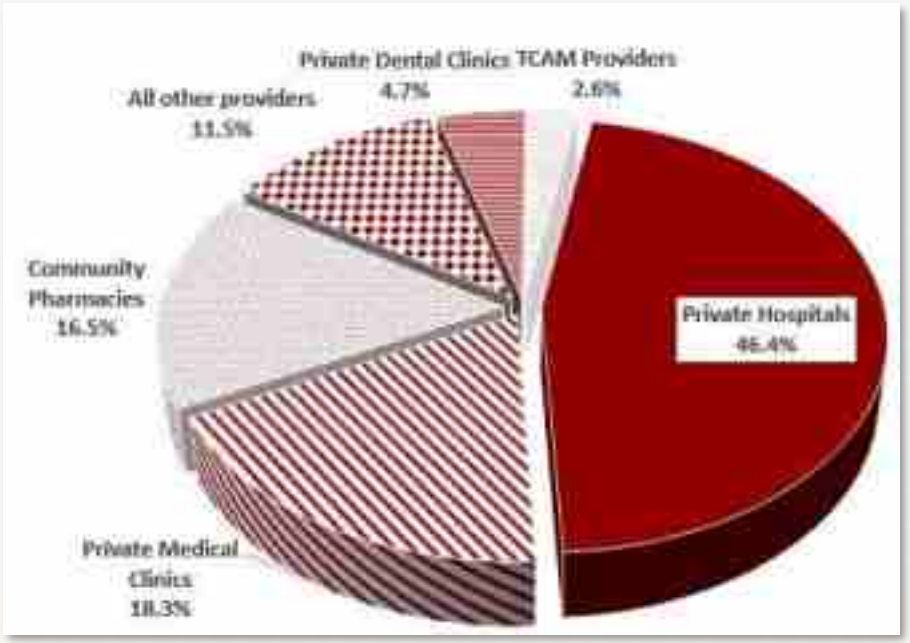


Source: MNHA Section, Planning Division, Ministry of Health - 2024

Sources of financing *private sources*, 2023

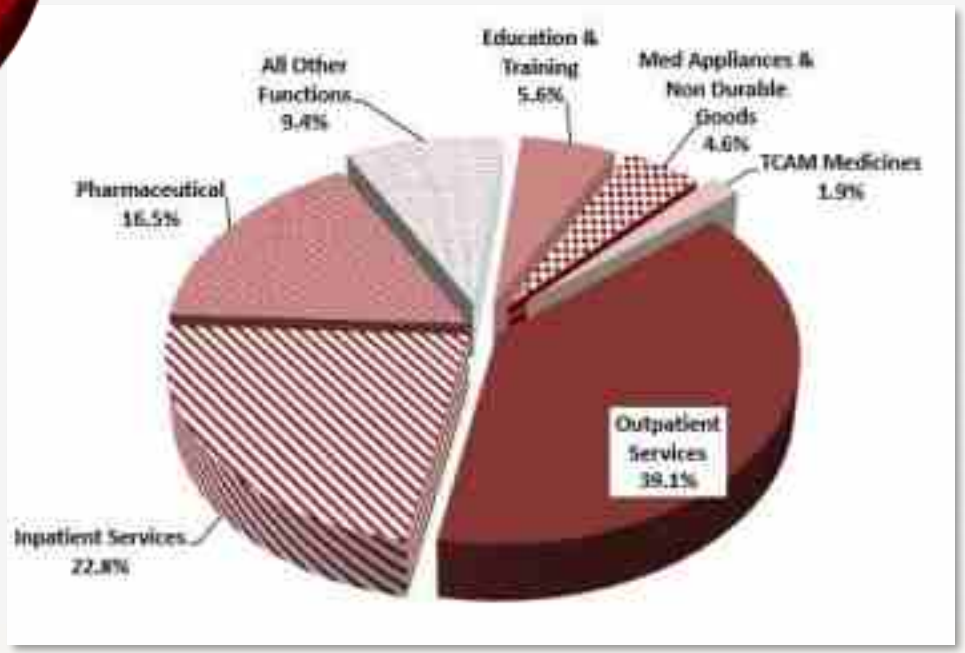


Where does this expenditure go? *healthcare providers*, 2023



Source: MNHA Section, Planning Division, Ministry of Health - 2024

What was it spent on? *healthcare functions/ services*, 2023



MCO: Managed care organisations
TCAM: Traditional, complementary and alternative medicine

Medical and health insurance/takaful (MHIT)



- **Increasing medical inflation:** 12.6% (2023) – 15% (2025)
- Among highest in Asia-Pacific (Indonesia & Philippines are higher)
- Region is experiencing double digit medical inflation
- Multiple causal factors
- **Private health insurance penetration in Malaysia is low** (NHMS: 22%; LIAM: 45%)

Source: *Pembentangan Mengenai Inflasi Kos Perubatan dan Penentuan Semula Harga Insurans dan Takaful Perubatan serta Kesihatan* Kelab Penyokong Kerajaan Malaysia (BBC), Jawatankuasa Pilihan Khas Kesihatan Parlimen, 10 Disember 2024



Source: *Pembentangan Mengenai Inflasi Kos Perubatan dan Penentuan Semula Harga Insurans dan Takaful Perubatan serta Kesihatan*
Kelab Penyokong Kerajaan Malaysia (BBC), Jawatankuasa Pilihan Khas Kesihatan Parlimen, 10 Disember 2024

February 2024

- BNM emphasises on **co-payment** and **deductibles** (BNM Policy Document – 29 February 2024)
- **Phasing out of cashless products** beginning 2025 (all new products are required to have co-payment – no predetermined caps - and/or deductible features)
- Galen Centre issues warning in July 2024



Source: *Pembentangan Mengenai Inflasi Kos Perubatan dan Penentuan Semula Harga Insurans dan Takaful Perubatan serta Kesihatan* Kelab Penyokong Kerajaan Malaysia (BBC), Jawatankuasa Pilihan Khas Kesihatan Parlimen, 10 Disember 2024

November - December 2024

- Utusan reported 40 – 70% increases (reality higher, >200% for many)
- People are **terminating** policies - notification of massive premium increases
- Change in how insurance is viewed (*no longer investment, now **liability***)
- Vulnerability, risk of **financial catastrophe** increases
- Cost containment measures **influencing treatment options**?

Interim measures - BNM: Are they working?

Measure 1: 10% cap on MHIT premium increases for 3 years (end of 2026)

At least 80% of policyholders were expected to experience yearly premium adjustments due to medical claims inflation of less than 10%.

- Few indications that this has been implemented from 15 January onwards.

Measure 2: Those > 60 yrs will not be affected by current repricing exercise

For those aged > 60 yrs covered under the minimum plan within the MHIT product that they purchased, ITOs will temporarily pause premium adjustments.

- Reportedly selective. Higher plans appear to be excluded.

Measure 3: Reinstatement of terminated/ lapsed policies

Policyholders who have surrendered or whose MHIT policies have lapsed in 2024 due to the repricing can request for a reinstatement.

- No report so far.

What happens after 3 years?

Private hospital charges

Life Insurance Association of Malaysia (LIAM) CEO Mark O'Dell's Hospital Bill For A Minor Hernia Surgery

The procedure in May 2024 involved an overnight stay at a major private hospital in Kuala Lumpur. Total hospital bill: RM19,837.55.

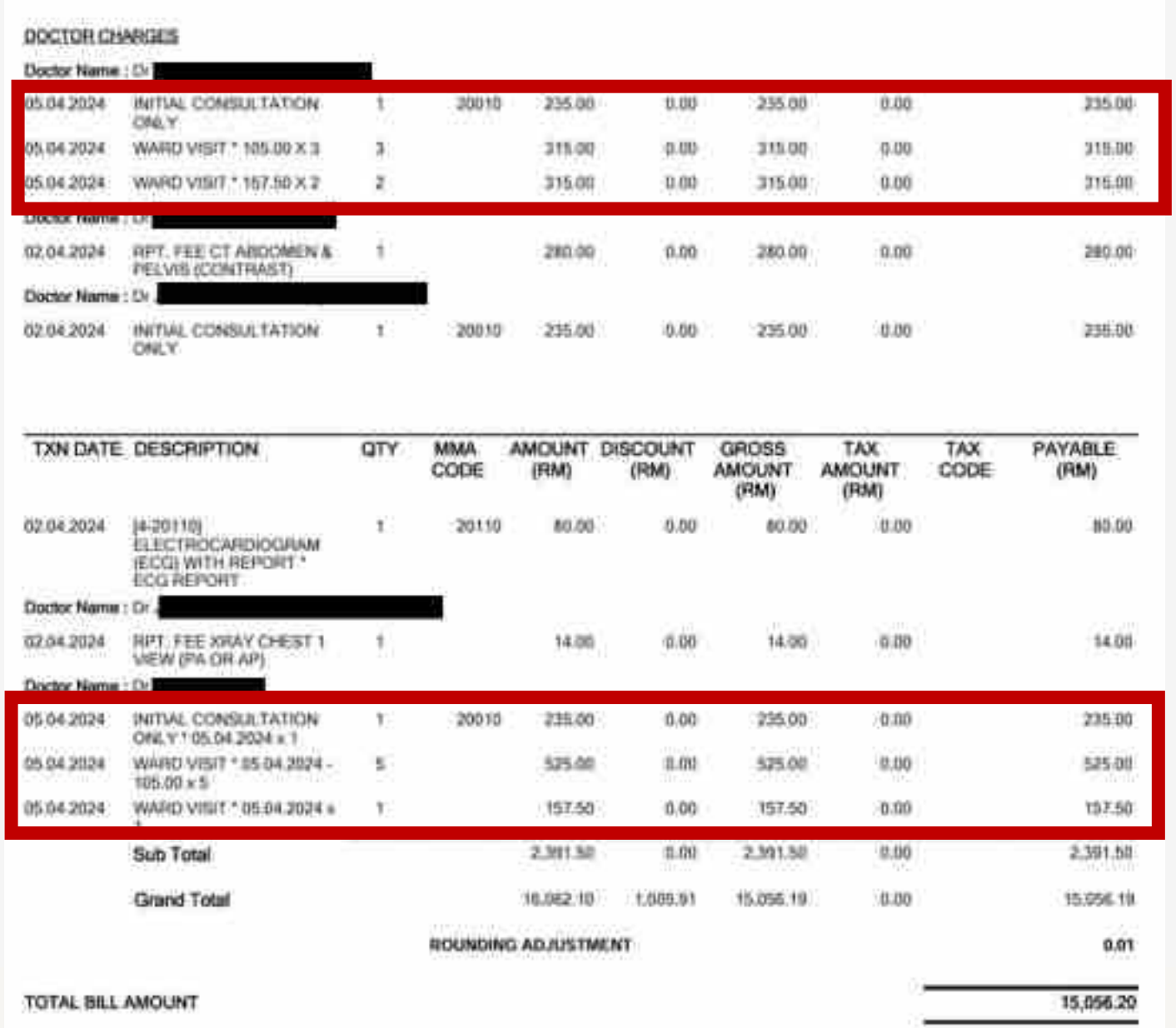


Description	Quantity	MMA Code	Amount (RM)	Discount (RM)	Gross Amount (RM)	Tax Amount (RM)	Payable (RM)
Gauze Swab X-Ray 10cm x	1		45.70		45.70		45.70
Glove Surgical Gammex Non Powder Latex 6.5 Ansell	1		20.90		20.90		20.90
Powder Latex 7.0 Ansell	1		20.90		20.90		20.90
Glove Surgical Gammex Non Powder Latex 8.0 Ansell	2		40.00		40.00		40.00
Gown Surgical Blue Line L1 Barrier	2		114.80		114.80		114.80
Gown Surgical Fully Reinforced XL with 2 Hand Towels Secure	1		50.10		50.10		50.10
IV Cannula G20x33mm Pur Vasofix Certo Safety	1		31.30		31.30		31.30
Needle Free Port BV10000NC Safelite Valve B Braun	1		24.10		24.10		24.10
Opsite Post Op 6.5cm x 5cm 100s S&N	1		52.20		52.20		52.20
Perioperative Package	1		97.40		97.40		97.40
Razor Double Edge with Cover Dahlhausen	1		8.00		8.00		8.00



Description	Quantity	MMA Code	Amount (RM)	Discount (RM)	Gross Amount (RM)	Tax Amount (RM)	Payable (RM)
Scrub Warmer	1		72.80		72.80		72.80
Sealy Disposable Applied Medical	1		92.50		92.50		92.50
Strong ECG Electrode T Blue Sensor Short Term Wet Gel Ambu	1		62.50		62.50		62.50
Suction Connecting Tubing Sterile 9' (Double Pouch) 3 Meter (Special Connector) Steril	1		77.60		77.60		77.60
Surgical Blade Carbon Steel	1		7.40		7.40		7.40
Syringe 10ml Luer Lock Terumo	1		23.40		23.40		23.40
Tube Tracheal Cuff (Soft Seal) 7.5mm Portex	1		61.60		61.60		61.60
Underpad Disposable 23" x 36"(60cm x 90cm) Derberg	1		32.70		32.70		32.70
Vacutainer Ultra Touch Push Button Blood Collection with Pre-Attached Holder 20g x 3/4 x 1" BD	1		26.70		26.70		26.70
Vicryl VCP317H Antibac 3/0, 45cm, 70cm Ethicon	1		74.60		74.60		74.60

- **Increases in insurance premiums do not occur in a vacuum.**
- "Do you have an insurance policy?"
- **Markups for health supplies and services** (e.g. consumables)



DOCTOR CHARGES

Doctor Name : Dr [redacted]

05.04.2024	INITIAL CONSULTATION ONLY	1	20010	235.00	0.00	235.00	0.00	235.00
05.04.2024	WARD VISIT * 105.00 X 3	3		315.00	0.00	315.00	0.00	315.00
05.04.2024	WARD VISIT * 157.50 X 2	2		315.00	0.00	315.00	0.00	315.00

Doctor Name : Dr [redacted]

02.04.2024	RPT. FEE CT ABDOMEN & PELVIS (CONTRAST)	1		280.00	0.00	280.00	0.00	280.00

Doctor Name : Dr [redacted]

02.04.2024	INITIAL CONSULTATION ONLY	1	20010	235.00	0.00	235.00	0.00	235.00

TXN DATE	DESCRIPTION	QTY	MMA CODE	AMOUNT (RM)	DISCOUNT (RM)	GROSS AMOUNT (RM)	TAX AMOUNT (RM)	TAX CODE	PAYABLE (RM)
02.04.2024	[4-20110] ELECTROCARDIOGRAM (ECG) WITH REPORT * ECG REPORT	1	20110	80.00	0.00	80.00	0.00		80.00

Doctor Name : Dr [redacted]

02.04.2024	RPT. FEE XRAY CHEST 1 VIEW (PA OR AP)	1		14.00	0.00	14.00	0.00		14.00

Doctor Name : Dr [redacted]

05.04.2024	INITIAL CONSULTATION ONLY * 05.04.2024 x 1	1	20010	235.00	0.00	235.00	0.00		235.00
05.04.2024	WARD VISIT * 05.04.2024 - 105.00 x 5	5		525.00	0.00	525.00	0.00		525.00
05.04.2024	WARD VISIT * 05.04.2024 x 1	1		157.50	0.00	157.50	0.00		157.50
	Sub Total			2,391.50	0.00	2,391.50	0.00		2,391.50
	Grand Total			16,062.10	1,005.91	15,056.19	0.00		15,056.19
			ROUNDING ADJUSTMENT						0.01
TOTAL BILL AMOUNT									15,056.20

- Under Schedule 7 of the **Private Healthcare Facilities and Services Act (PHFSA) 1998**, private clinic GPs and dentists' consultation fees are capped at **RM10 to RM35** (*unchanged for 30 years*), and **RM25 to RM250** respectively.
- Under Schedule 13, private hospital specialists' consultation fees are legislated at a rate of **RM80 to RM235**.
- **How are consultation fees charged** in private hospitals?



Breakdown of a private hospital bill

- **10%** - specialist consultation fees (regulated)
- **20%** - pharmaceutical (not regulated)
- **70 %** - hospital supplies and services (not regulated)

Up to 70% of a bill is currently unregulated

Source: *Pembentangan Mengenai Inflasi Kos Perubatan dan Penentuan Semula Harga Insurans dan Takaful Perubatan serta Kesihatan* Kelab Penyokong Kerajaan Malaysia (BBC), Jawatankuasa Pilihan Khas Kesihatan Parlimen, 10 Disember 2024

Recommendation



MP: Bank Negara, MOH Passing The Buck On Health Insurance, Private Hospital Charges

By CodeBlue | 25 November 2024

Kluang MP Wong Shu Qi says in MPs' meetings with Bank Negara and the Health Ministry on surging medical insurance premiums and private hospital charges, both regulators passed the buck to each other. "Can both parties sit together to resolve this issue?"

It is clearly apparent that in the case of private healthcare, health consumer protection is secondary.

MOH, BNM, KPDN?

There is no clear mandate, insufficient legislation and regulation, and <u>no one is in charge.</u>

Need consumer protection policy approach to healthcare

Recommendation

Setting up of an independent Private Healthcare Commission to regulate charges in the private healthcare sector

A regulator, similar in role and powers to the Malaysia Competition Commission (MyCC), is urgently needed and should be established. The Private Healthcare Facilities and Services Act (PHFSA) 1998 cannot provide adequate consumer protections. It should either be amended or new legislation introduced to provide necessary protections, enact and enforced by a Private Healthcare Commission.

The Commission could be mandated to independently review and regulate private healthcare charges and fees, including insurance premium increases.

Currently, caps and thresholds on insurance premiums and private hospital charges appear to be mainly determined by the industries/ free market rather than regulated. There appears to be minimal consumer protection mechanisms in place.

Thank you



The Galen Centre for Health and Social Policy is an independent public policy research and advocacy organisation based in Kuala Lumpur, Malaysia committed to the development of patient-centric and community focused health and social sectors.

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Galen Centre
for Health and Social Policy

The Need to Address Issues of Price Transparency and Market Competition in Healthcare & Medical Products

Lim Chee Han, PhD

Public Accounts Committee, Proceeding No. 5(C) Year 2025

The Parliament of Malaysia

25 FEB 2025

Introduce myself

- BSc. Biotechnology, MSc. Immunology (Imperial College London, United Kingdom) ; PhD in Infection Biology (Hannover Medical School, Germany)
- Senior Researcher at the Third World Network (2020 – present) : Health Cluster, working on the Access to Medicines Campaign; specialising in health financing, public health and health reform
- Co-convener of the People's Health Forum (PHF) coalition
- Assistant Secretary of Together Against Cancer (TAC)
- Policy Coordinator for the Health Chapter of Manifesto Rakyat (2022)
- Affiliate with Consumers' Association of Penang (CAP)
- Senior Analyst at Penang Institute (2014-2019): Economics Section

People pay MORE for Healthcare

(*Probably too much, feel unfair*)

Out of Pocket (OOP) Payment,
76% of Total Expenditure on Health (TEH) by Private Sources (2023)

Private Insurance,
17% of TEH by Private Sources (2023)

Premium Increases, Co-payments, Non-coverage

Number & Amount of Medical Claims

Private Healthcare Facilities (Hospitals and Clinics) charge patients TOO MUCH on **Medical Bills**

- Doctor's Fee/Service
- Tests & Investigations
- Ward, Food & Other Charges
- Drugs & Medication

Inflation in Malaysia, **1.8%** (2024)

Unregulated Market / Anti–Competitive Behaviour



- Non-transparent pricing; uncooperative in providing key information
- Abuse of dominant position / legal monopoly (patent)

Issue 1: Access to Affordable Medicines

(Generics & Regulated Mark-up)

- Expenditure on drugs and medication in a private hospital bill can vary: 10-20%;

Some patients pay disproportionately for medicines (e.g. cancer patients); financial catastrophe within 1 year (72% of those treated in private hospitals)

Source: Dr Nirmala Bhoo Pathy, 2015 ACTION study

- If originator medicines are used, costs are higher.

Median procurement price ratio for

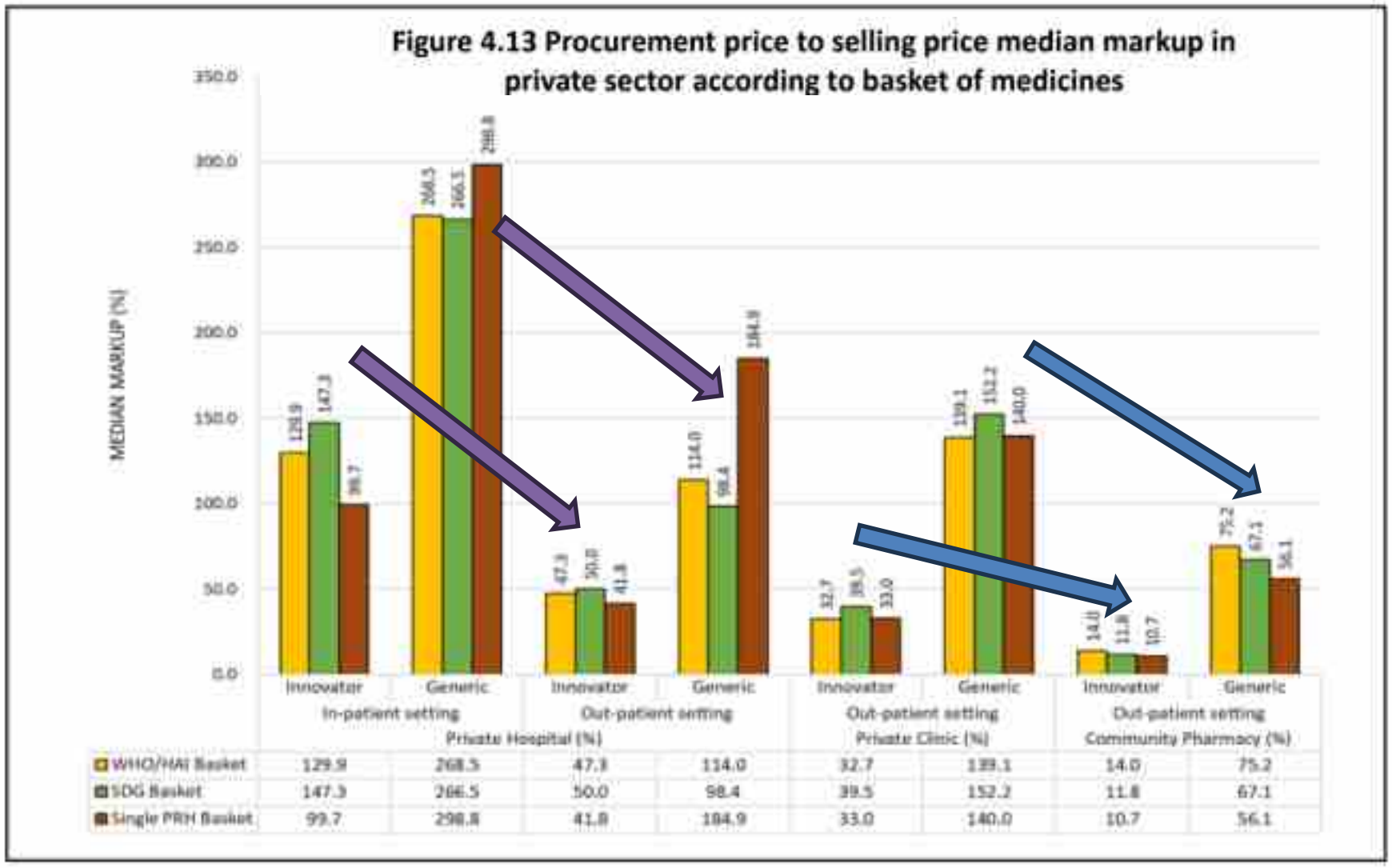
- ‘Originator:Generics’ in private sector = **3.91**, IQR= 1.77-6.26
- ‘Private:Public sector’ on originator products = **1.55**, IQR= 1.16-1.97

(*Medicine Prices Monitoring in Malaysia 2022, MOH)*



Issue 1: Access to Affordable Medicines

(Generics & Regulated Mark-up)



Why can private hospitals charge

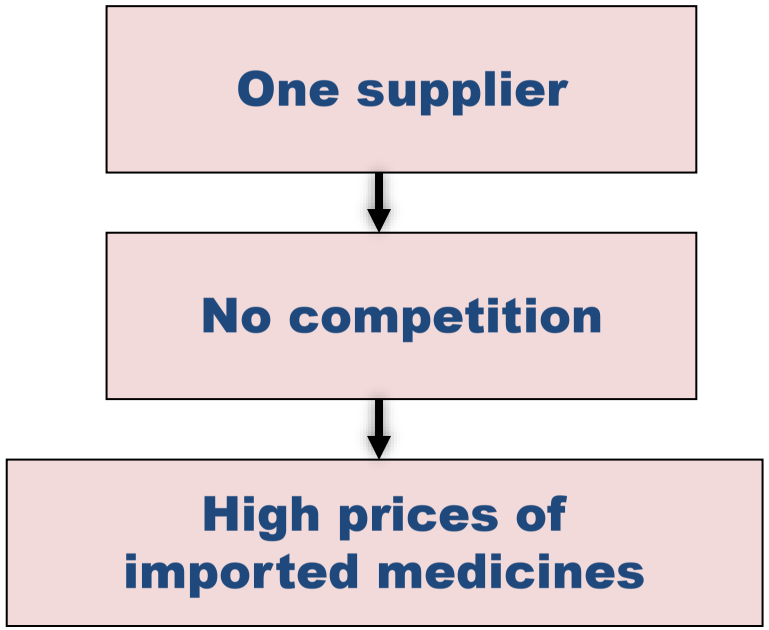
- 2.2x (innovator), 3.7x (generic) the purchase cost, also substantially more in the in-patient setting
- While halving the mark-up in the out-patient setting?

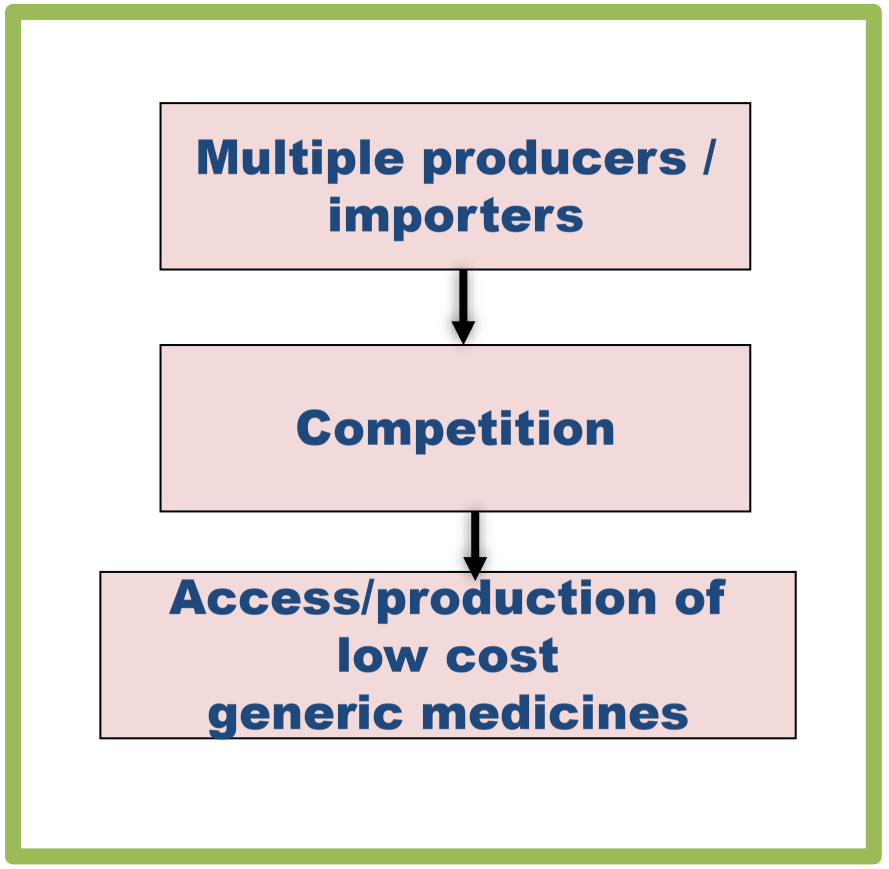
Mark up is also higher in private clinics and hospitals, compared to community pharmacies

(Medicine Prices Monitoring in Malaysia 2022, MOH)

Issue 2: Abuse of dominant position & anti-competitive behaviour to block/delay generic availability in Malaysia

Prices are linked to market monopoly,
Patent creates dominant position to set high price





Common Practices of the Pharmaceutical Industry (patent holders of originator drugs) to block / delay generic availability (also in Malaysia)

Patent Evergreening

A thicket of secondary patents that prolong the patent protection of the drug and thus the continuation of the market monopoly



Sponsor/incentivize doctors/specialists to prescribe originators over generics

Use threats to take legal action against local generic manufacturers or importers

Spreading misinformation, creating a narrative to cast doubt on generics

Delay or prevent registration of generic products

by refusing to sell the originator products to the other party for bioequivalence studies

Use media to influence public opinion, especially when it comes to opposing government regulation

Issue 2: Abuse of dominant position & anti-competitive behaviour to block/delay generic availability in Malaysia

CASE STUDY: Roche - Trastuzumab (Brand name Herceptin) https://canceralliance.org.za/global-day-of-action-against-roches-inhumanity/

In December 2018, a biosimilar version of trastuzumab which costs approximately 50% of the price of the originator trastuzumab was approved in Malaysia.

Following this, the Ministry of Health called for an open tender. The tender was awarded to the originator brand company, which **reduced the original price of trastuzumab by 52%**.



https://www.gabionline.net/biosimilars/general/dramatic-price-reduction-of-trastuzumab-in-malaysia

Issue 2: Abuse of dominant position & anti-competitive behaviour to block/delay generic availability in Malaysia

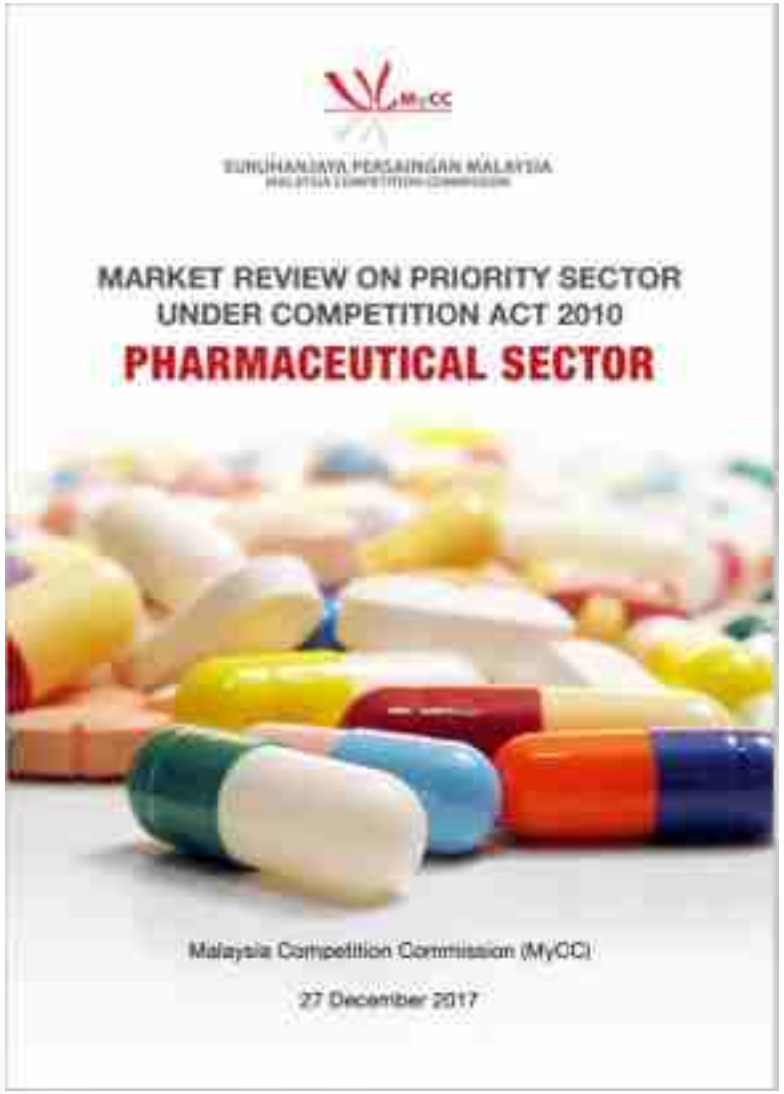
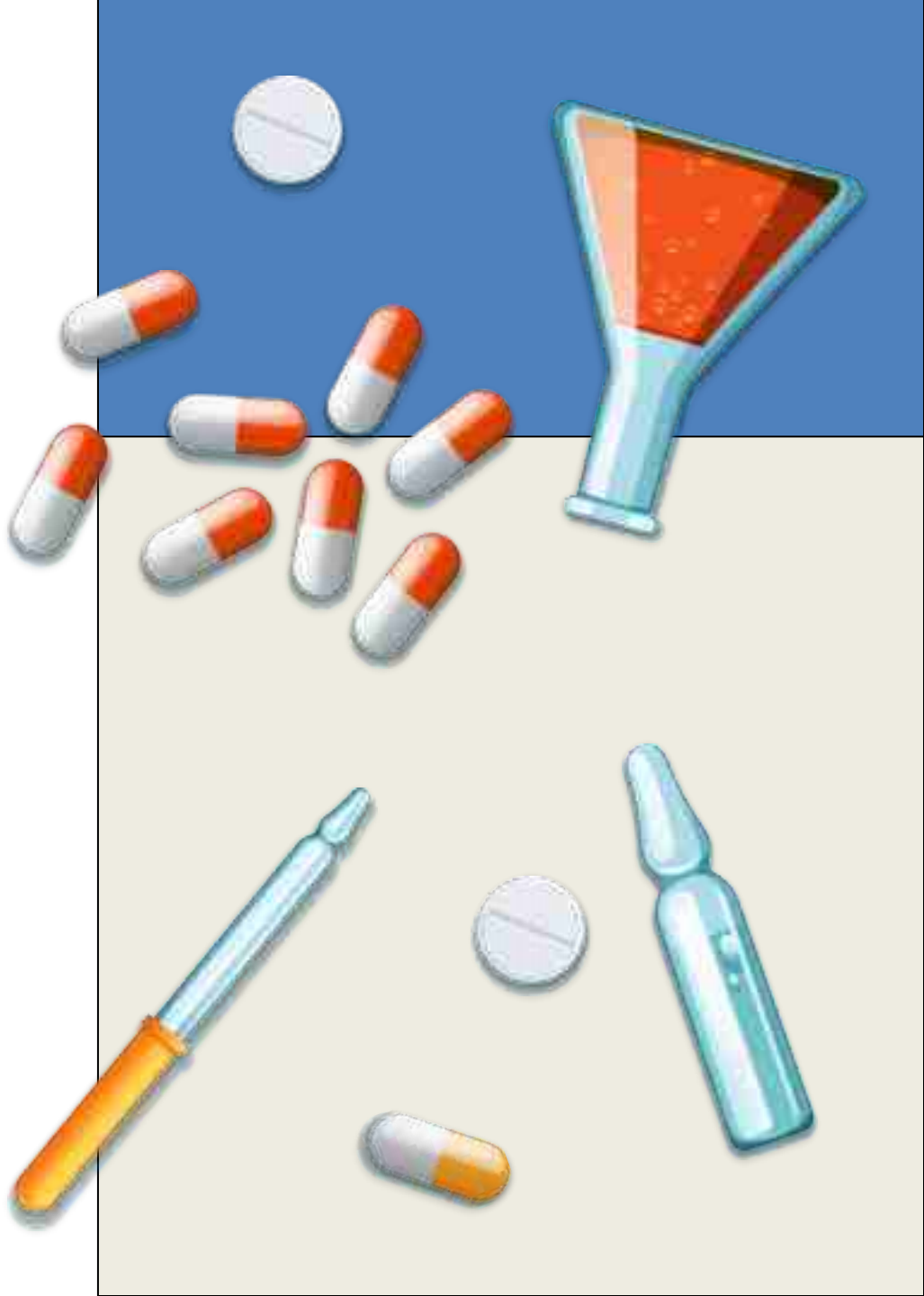


Table 3.4: Net Profit Margins of Parent versus Malaysian Subsidiaries, 2014		
Company	**Parent Company**	**Malaysian Subsidiary**
Pfizer	29.4%	2.4%
AbbVie	27.0%	1.9%
Roche	26.0%	3.4%
Novartis	24.6%	2.6%
Merck	24.2%	1.6%
Average	**26.2%**	**2.4%**

Table 3.5: Market Share and Market Concentration Ratios of 54 Pharmaceutical Importers					
No	**Company Name**	**Ownership**	**Revenue (RM '000)***	**Market Share**	**Concentration Ratios**
1	Pfizer (Malaysia) Sdn. Bhd.	Foreign	452,584	10.2%	CR3=29.0
2	Merck Sharp & Dohme (Malaysia) Sdn. Bhd.	Foreign	425,446	9.6%	CR5=46.5
3	Bayer Co. (Malaysia) Sdn. Bhd.	Foreign	408,665	9.2%	CR10=75.2
4	Sanofi-Aventis (Malaysia) Sdn. Bhd.	Foreign	404,825	9.1%	CR15=84.6
5	Novartis Corporation (Malaysia) Sdn. Bhd.	Foreign	370,162	8.4%	
6	GlaxoSmithKline Pharmaceutical Sdn. Bhd.	Foreign	349,387	7.9%	HHI= 842.9
7	Roche (Malaysia) Sdn. Bhd.	Foreign	299,327	6.8%	
8	AstraZeneca Sdn. Bhd.	Foreign	286,211	6.5%	
9	Merck Sdn. Bhd.	Foreign	185,462	4.2%	
10	CCM Pharmaceuticals Sdn. Bhd.	Local	146,541	3.3%	

Medicines Price Mechanism (MPM)

The Medicines Price Mechanism (MPM) is an initiative that was proposed to achieve the Malaysian National Medicines Policy (MNMP) objectives of promoting the availability of quality, safe and effective medicines at an affordable cost. The MPM also aims to increase the transparency of medicines price information and ensure affordable medicines prices for the people.



Cabinet approves drug price controls

Published 2 months ago on 02 May 2019
BY BOO SU-LYN



JUST IN POPULAR

1 hour ago
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out red carpet to 'w

1 hour ago
In rare honour, Dr
Asian leader award
Order of the Repub

2 hours ago
Najib's lawyer says
demand will bankr

Cadangan Proses Pelaksanaan: Mekanisme Harga Ubat



- Harga sama seluruh negara (Semenanjung, Sabah & Sarawak; bandar & luar bandar)
- Pewartaan dan paparan harga atas talian

Issue 3: Anti-competitive behaviour to block price regulation and transparency in Malaysia

- Despite numerous rounds of engagement with the pharmaceutical industry (especially PhAMA), private hospitals and private clinics, the private sector collectively said 'NO' and pushed back the policy since 2019, there is no regulation on medicine prices to date.

- The Pharmaceutical Services Programme under the Ministry of Health has diluted the proposed regulation, from setting wholesale drug prices and controlling mark-ups at both wholesale and retail levels, to postponing mark-up controls and only requiring pharmaceutical companies to declare wholesale prices, to only displaying retail drug prices - each step still met with strong objections from the private sector.

- To this day, some GPs still object to only displaying drug prices in their clinics, while APHM president Dr. Kuljit Singh denies overcharging in private hospitals and clearly does not want more regulation.



Issue 3: Anti-competitive behaviour to block price regulation and transparency in Malaysia

Free Malaysia Today

MMA pans plan to mandate medicine price display in private clinics, hospitals



The Malaysian Medical Association (MMA) has poured cold water on the government's plan to mandate the display of medication prices in private healthcare

4 weeks ago

MSN

Support Black Monday campaign, MMA tells private clinic doctors



In a statement, MMA said GPs in the country's 12,000 clinics face decades-long issues such as outdated fee schedules, the absence of regulation for...

4 days ago



'Regulating private hospital rates may hurt industry'

By CHARLES RAMENDRAN
charles.ramen@thestar.com.my

PETALING JAYA: Private hospital bills will come under greater scrutiny when the Public Accounts Committee holds its first public hearing on Friday to hear concerns about healthcare costs.

These charges have raised the ire of Malaysians who decried what they deem as overcharging by private hospitals.

Association Private Hospitals Malaysia president Datuk Dr Jaljit Singh said private hospitals are prepared to work with the government and insurers to make their rates more affordable.

However, he maintained that private hospitals do not overcharge "except for a few isolated cases".

"We can prove this if necessary. The government can carry out a scrutiny to ascertain if there are discrepancies in our charges," he said in an interview prior to PAC's announcement of the public hearing.

He said doctors' fees are fixed by the government but other charges for drugs and the use of facilities may vary at private hospitals, depending on its location or services.



"Patients who feel that they have been overcharged should raise it with officers at the hospital. If the dispute is unresolved, they can take it up with the Health Ministry," he said.

He emphasised that private hospitals in Malaysia are known for providing premium services but with the lowest rates in South-East Asia, making it the top choice in medical tourism.

A senior official of a private hospital, who did not want to be named, said critics of private healthcare are "missing the bigger picture".

Firstly, he said the cost of healthcare is high whether at public or private hospitals.

"But since public healthcare is provided almost free in Malaysia, many people are unaware of the true costs," he said.

So, he said only high-income patients (T20) will have the finances to seek treatment at a private hospital.

"Lower income groups or the B40 are unable to afford private healthcare, so they rely on government hospitals. It is the same with the majority of the middle-income group (M40)," he said.

However, the senior official pointed out that "a small fraction" of these from the higher range of M40, who have savings or purchase medical insurance, will go to private hospitals.

"These are the patients who are often stumped by the charges. The outcry on the supposed high charges often come from these patients.

"Hence, if the government decides to further regulate private hospital rates, it will only benefit this small group of people," he claimed, referring to those from the upper-middle class.

"This also means that the rich or top earners who can well afford the hospital charges will stand to gain off the government controls hospital charges."

Another private medical professional claimed that no other country regulates private hospital rates.

"Take our government schools as an example. They provide free education while private schools charge hefty fees. But do you cry to regulate charges at private schools to make it accessible to all?" he asked.

"If rates are regulated, private hospitals will go bust and investors will pull out. How much lower can we go when our rates are already rock bottom?"

He said the Malaysian situation calls for a dire need of reforms in public healthcare sector to address issues involving manpower, drug supplies and the maintenance of medical equipment.

Otherwise, he said the limitations at government hospitals are driving some "desperate patients especially from M40" to opt for treatment at private hospitals.

He estimated that with 75% of patients in the country being treated at public healthcare centres, the limitations in these government facilities are denying those who should be promptly given urgent treatment due to the severity of their ailments.

"Issues at public hospitals are mounting with major manpower problems. It takes hours to see a doctor," said the medical professional.

"The waiting list for surgeries or medical procedures can take months. More hospitals need to be built. Manpower must be increased and medical professionals must be remunerated fairly or they will jump to the private sector."

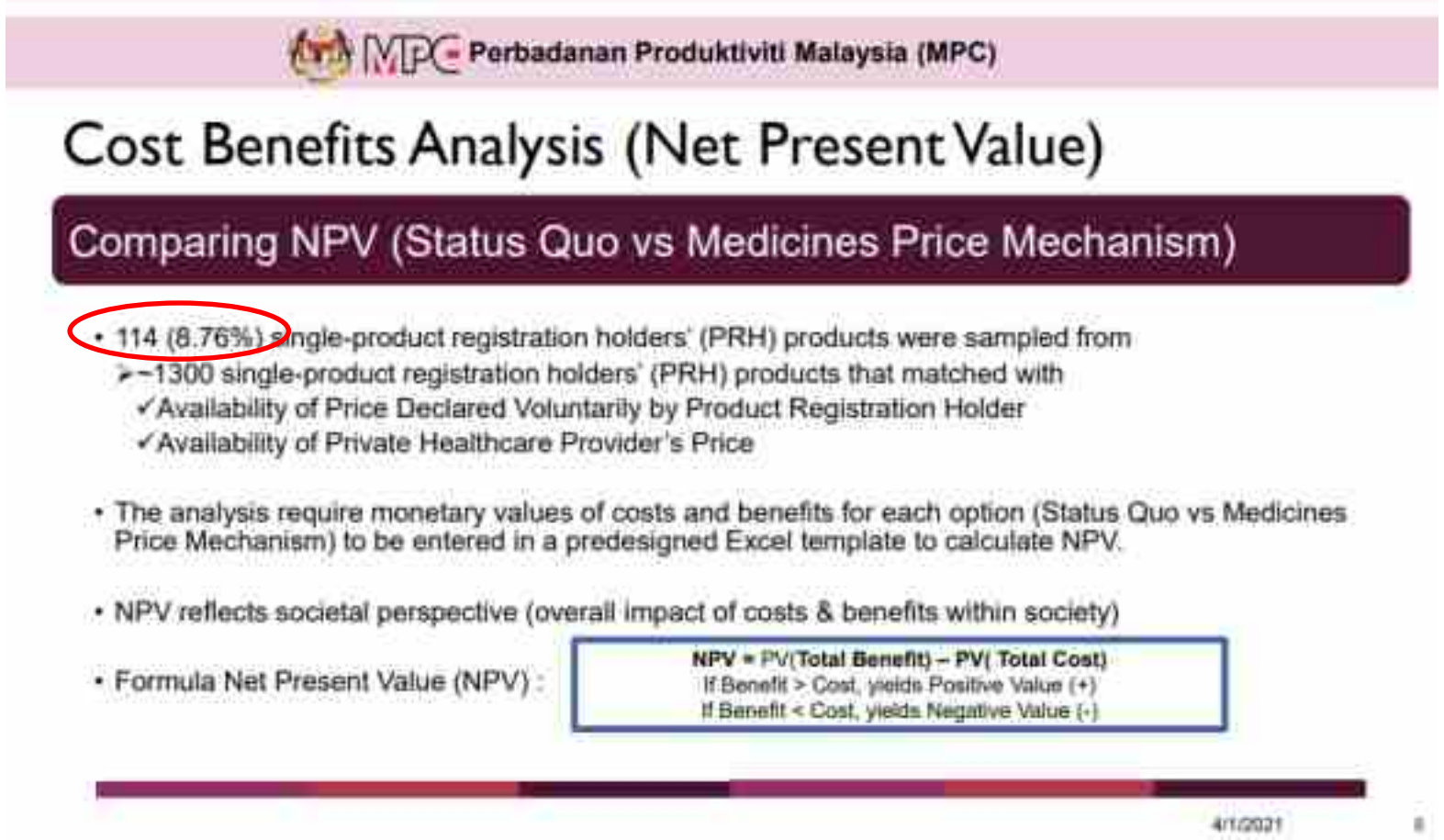
He said there should be a pay structure in tandem with the volume of work that government doctors have to carry out.

Under Budget 2023, the Health Ministry is allocated RM45.27bil, which is the second highest among all.

"But is the sum sufficient to sustain and fund its services? The government has a responsibility to beef up services at public healthcare facilities as it is essential for the majority of patients," he said.

Issue 3: Anti-competitive behaviour to block price regulation and transparency in Malaysia

Pharmaceutical companies have been uncooperative in providing **key price information**, leaving the government with only 9% of products to work with for the CBA study on Medicines Price Mechanism in 2021



Perbadanan Produktiviti Malaysia (MPC)

Cost Benefits Analysis (Net Present Value)

Comparing NPV (Status Quo vs Medicines Price Mechanism)

- 114 (8.76%) single-product registration holders' (PRH) products were sampled from
  - ~1300 single-product registration holders' (PRH) products that matched with
    - ✓Availability of Price Declared Voluntarily by Product Registration Holder
    - ✓Availability of Private Healthcare Provider's Price
- The analysis require monetary values of costs and benefits for each option (Status Quo vs Medicines Price Mechanism) to be entered in a predesigned Excel template to calculate NPV.
- NPV reflects societal perspective (overall impact of costs & benefits within society)
- Formula Net Present Value (NPV) :

NPV = PV(Total Benefit) – PV(Total Cost)
If Benefit > Cost, yields Positive Value (+)
If Benefit < Cost, yields Negative Value (-)

4/1/2021

Issue 3: Anti-competitive behaviour to block price regulation and transparency in Malaysia

Instead, the private sector sponsored another CBA study under MITI on the proposed Medicine Pricing Policy, claimed to have covered more products, and also disregarded the conflict of interest by co-chairing the Technical Committee

The **Comprehensive Cost-Benefit Assessment (CBA 2.0)** on the **Medicine Pricing Policy** is a collaboration project between public sector (MITI, MPC) and private sector (PhAMA, APHM, MOPI, MMA, PhRMA) and in engagement with a **third-party, independent consultant (TPC)**. The CBA 2.0 is augmented and build upon CBA 1.0 which will expand the product scope beyond CBA 1.0 and cover ~5,000 products. The main role of this CBA 2.0 working group is to assess the wider economic impact of medicine price control on the private healthcare ecosystem, the health of the Malaysian *rakyat* and the impact on overall economy and aspects of the Malaysian government.

The **two-tier governance structure** is as follows:

1. Steering Committee (SteerCo) made up of senior leadership from government and private industry groups that provides guidance and endorsement of the CBA 2.0 methodology, results and conclusion;
2. Technical Committee (TechCo) made up of the working group members from government and private industry groups and is responsible for information sharing and provide initial alignment

SteerCo: Chair – Deputy Secretary General, MITI

TechCo: Co-Chair – Deputy Director General Malaysia Productivity Corporation; Co-Chair – Senior Industry Representative PhAMA

Secretariat/Facilitator: Malaysia Productivity Corporation – Mr. Mohammed Alamin Rehan, Deputy Director, MPC

Members:

Government bodies:
Ministry of International Trade and Industry (MITI)
Ministry of Health (MOH)
Ministry of Finance (MOF)
Bank Negara Malaysia (BNM)
Economic Planning Unit (EPU)
Malaysia Health Tourism Council (MHTC)
Intellectual Property Corporation of Malaysia (MyIPO)
Department of Statistics Malaysia (DOSM)
Malaysia Productivity Corporation (MPC)

Private industry groups:
Pharmaceutical Association of Malaysia (PhAMA)
Malaysian Organisation of Pharmaceutical Industries (MOPI)
Malaysian Medical Association (MMA)
Association of Private Hospitals of Malaysia (APHM)
Pharmaceutical Research & Manufacturers of America (PhRMA)

Academicians:
Emeritus Professor Datuk Dr Zakariah bin Abdul Rashid
Professor Kenneth Kwing Chin Lee, Monash University Malaysia
Dr. Nur Ain Shahrier, Sunway University Malaysia

Issue 4: Private Insurance coverage is Insufficient for People with Certain Conditions



Crystal's Journey and Strategies

Mid 2013	➢ Mastectomy, chemotherapy, radiotherapy, Hormonal therapy for estrogen +ve and targeted therapy for HER2 +ve. Complete *Trastuzumab (Herceptin) within a year. Continued with Tamoxifen					
End 2017	➢ RECURRENCE TO BONE to neck bone spine Changed hormonal treatment to Aromasin month).Resume *Trastuzumab (Herceptin) 3 months later.					
	Her 2 TREATMENTS	**Cost per unit (every 3 weeks)**	**Patient assisted Program**	**Paid by**	**Hospital**	**Out of Pocket**
August 2013- July 2014 (Curative)	*17 Herceptin (ORIGINAL) RM 92,445.00	@RM 5,440/ treatment	Buy X Free Y package	Insurance Annual limit 100K Critical illness	Hospital A Private	Tamoxifen (Free in MOH, RM 80 - 400) Clinic Visits
Feb 2018- Jan 2019 (C1spine)	**17 Herceptin (ORIGINAL) RM 90,454	@ RM 5,328/ treatment	Buy X Free Y package	Insurance Critical Illness Savings	Hospital B Private	Aromasin (RM600-750) Denosumab (RM 1300-1800) Blood tests Clinic Visits
March 2019- Sept 2020	26 Zuhera (BIOSIMILAR) RM 86, 250	@RM 3,317/ treatment (reduced by 35%)	No Buy X Free Y package	Insurance	Hospital C Private	NO SURPRISES THIS YEAR
Oct 2020- (T12 spine)	19 TDM1 Kadcyla (ORIGINAL) RM 168, 503	@RM 8,870/ treatment	Buy X Free Y package	Insurance Savings	Hospital C Private	PROGRESSION (IM Faslodex- RM 1600)
TOTAL	RM 437, 652		-	-		2020-2021 (RM)

Issue 4: Private Insurance coverage is Insufficient for People with Certain Conditions

- Pre-existing conditions: Cancer survivors (>5 years and "clinically cleared") still discriminated and excluded from insurance coverage

"Patients with benign breast conditions, cannot get new insurance cover, whether past history with surgery or biopsy or even an ultrasound screening or mammogram detected."

- Some medicines or treatments are excluded, insurance company claims they are preventive but not treatment

"Insurance has recently stopped covering Hormone Therapy such as Tamoxifen, Letrozole as they are now considering these drugs preventive instead of treatment. 80% or more breast cancer patients are required to take these drugs daily for 5-10 years."

- Many outpatient treatments (and prophylactic procedures) are not covered





Recommendations

1) Implement the Medicine Price Display policy as soon as possible. Consider implementing the full Medicines Price Mechanism in the near future to control unreasonable mark-ups
2) Increase stringency of Patentability : stop Patent Evergreening, stop granting undeserving (secondary) patents for trivial changes to a drug (MyCC recommendation)
3) Private sector must be mandated to cooperate in providing key information for the purpose of market transparency and regulation, in particular pricing information
4) Insurance companies must justify their re-pricing to their policyholders by providing more information on the risk of their policies and their fund pool
5) Health insurance should move towards community rating rather than personal risk rating. More risk pooling needed
6) Develop DRG for hospital billing and introduce cost-containment measures in health insurance
7) Conduct a market review of private healthcare providers, as recommended in the MyCC Market Review on Pharmaceutical Sector (2017). MyCC must ensure healthy and fair market competition for healthcare sector



Contact email: cheehan@twnetwork.org

Thank you!







PEOPLE'S
HEALTH
FORUM

Health For People, Not For Profits

Allianz

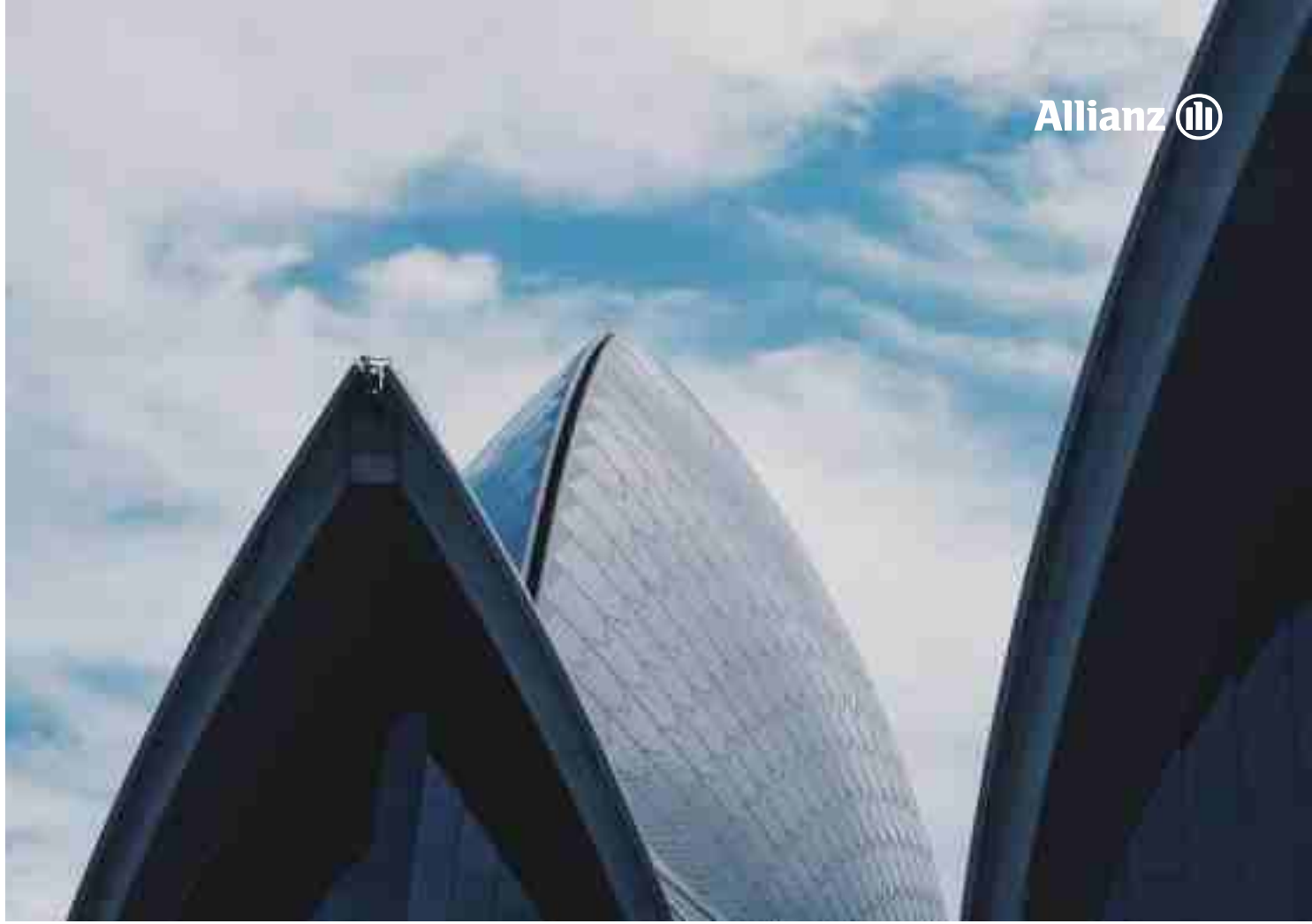
Pembentangan Kepada Jawatankuasa Kira-Kira Wang Negara

Inflasi Perubatan & Penentuan Semula Premium

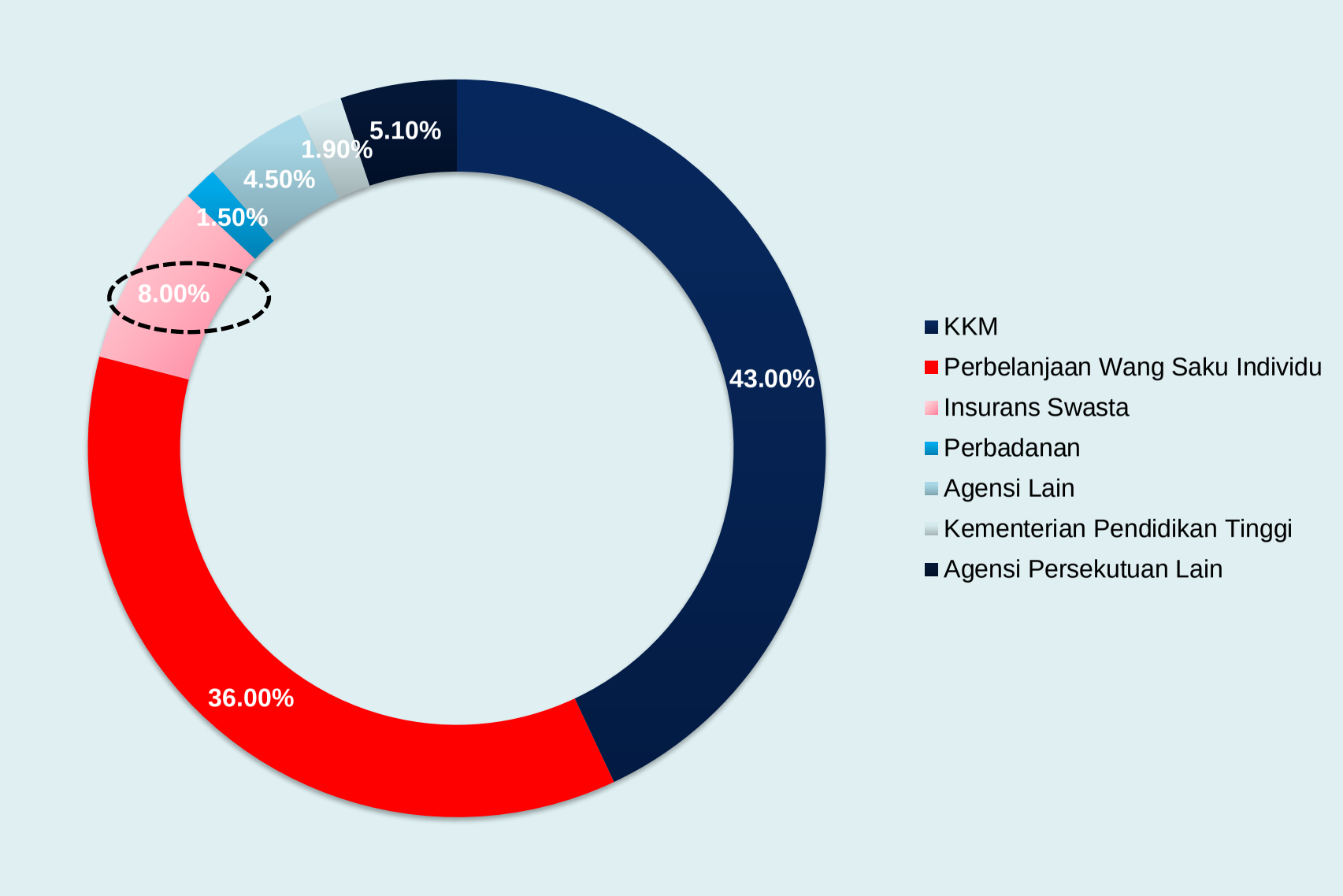
26 Feb 2025

© Allianz 2021

Inflasi Perubatan



Perbelanjaan Kesihatan- Sumber Pembiayaan



Sumber: Mesyuarat Pemandu MNHA Bil. 2/2024, Kementerian Kesihatan Malaysia

Allianz

Peningkatan Kos Perubatan

Kos perubatan meningkat sebanyak 19.6% setahun* (43.0% kumulatif)

Tahun	Bilangan polisi	Tuntutan Perubatan (RM juta)
2022	466k	394
2023	479k	492
2024	483k	584
Purata Kenaikan Setiap Tahun	+2%	+22%

Punca utama kenaikan kos perubatan adalah bilangan tuntutan yang semakin tinggi



Increase in number of claims



Increase in average claim amount

2022-2024

*Berdasarkan data tuntutan perubatan Allianz

Kekerapan Tuntutan Perubatan

Bilangan tuntutan pesakit dalam melonjak **23.8%** dari 2022 – 2024, jauh melangkaui paras pra-pandemik

Tahun	Bilangan Tuntutan
2022	45,696
2023	54,472
2024	56,472

Bilangan tuntutan bagi setiap 100 pemegang polisi **10.4 ➡ 13.2**



+73%
Gastrik , cirit-birit



+121%
Jangkitan saluran pernafasan



+38%
Demam denggi



+113%
Fibroid rahim



+138%
Kanser



+62%
Penyakit jantung koronari

*Berdasarkan data tuntutan perubatan Allianz

Inflasi Perubatan – Faktor Pemacu



Permintaan perkhidmatan kesihatan semakin meningkat

+41% kemasukan wad bagi pesakit bergejala ringan (demam, batuk, selsema)



Tokokan tinggi

IV Nexium: Tokokan +284%



Kemajuan teknologi perubatan: Peralatan & Ubat

Pembedahan Robotik



Pembaziran dan penyalahgunaan

Ujian diagnostik, pengimejan & rawatan tanpa keperluan klinikal (gastroskop, CT-scan)



Kenaikan tuntutan kanser

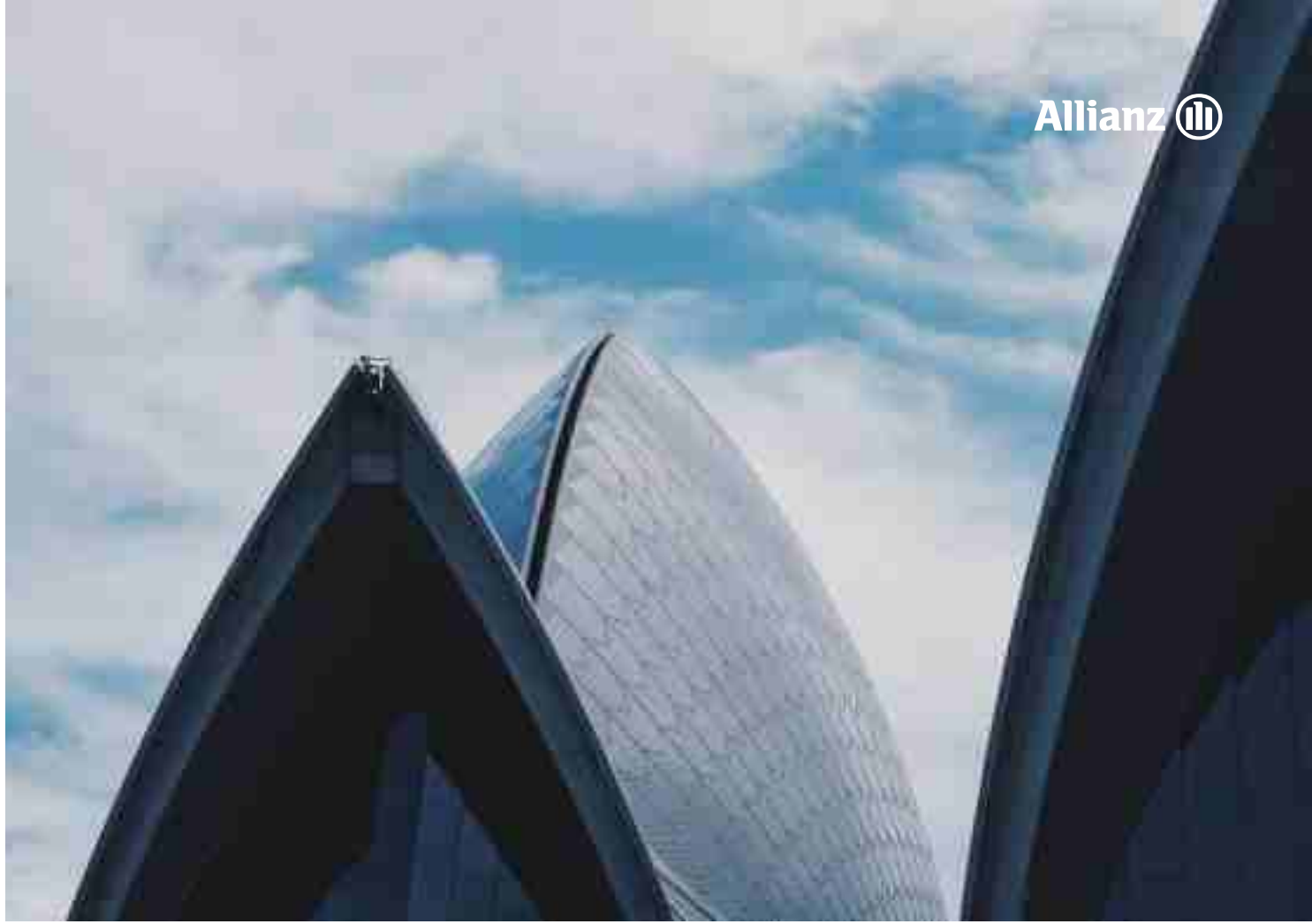
+84% bilangan kes kanser payu dara (2022-2024)



Kadar pertukaran matawang asing

1 USD : RM4.12 – RM4.78 (2022 – 2024)

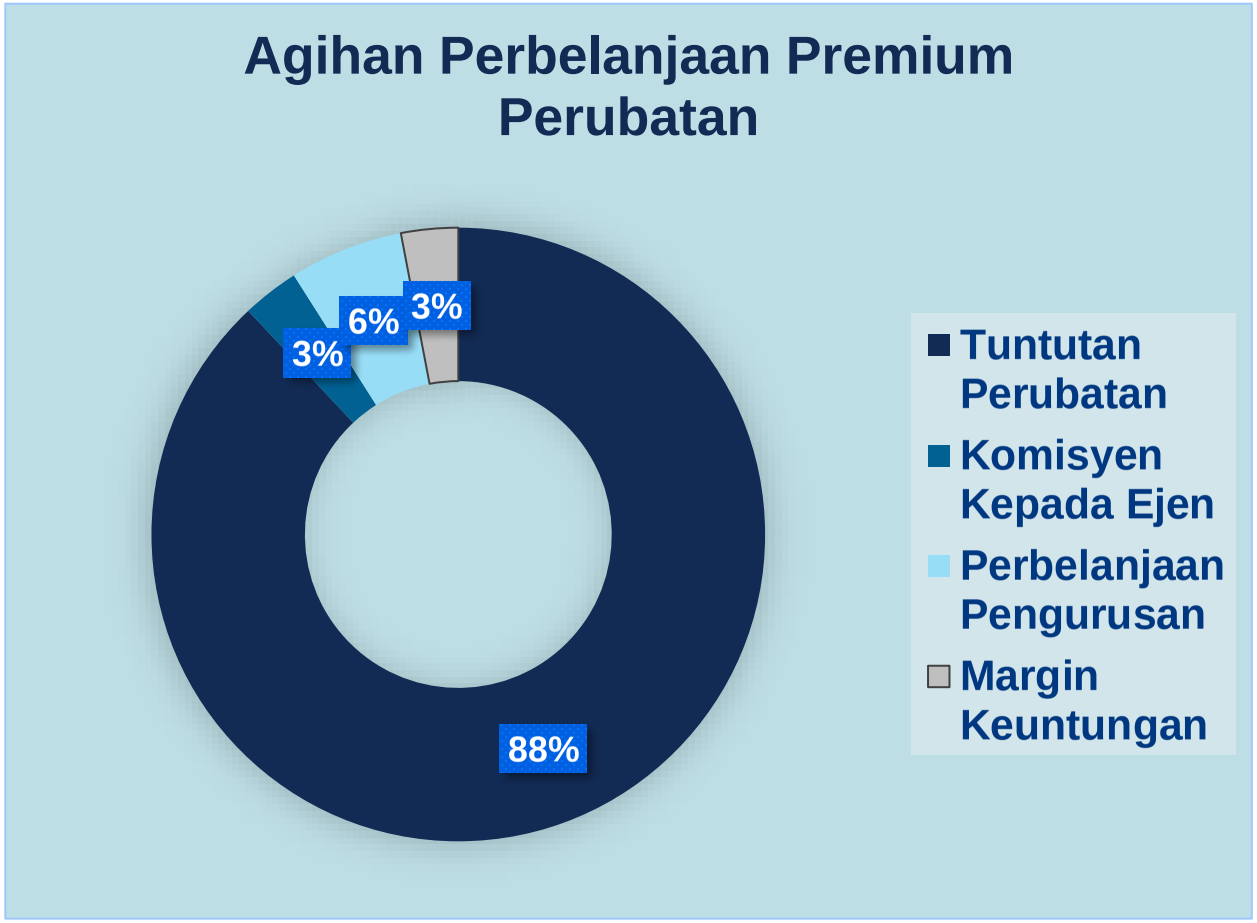
Portfolio Perubatan - Gambaran Keseluruhan



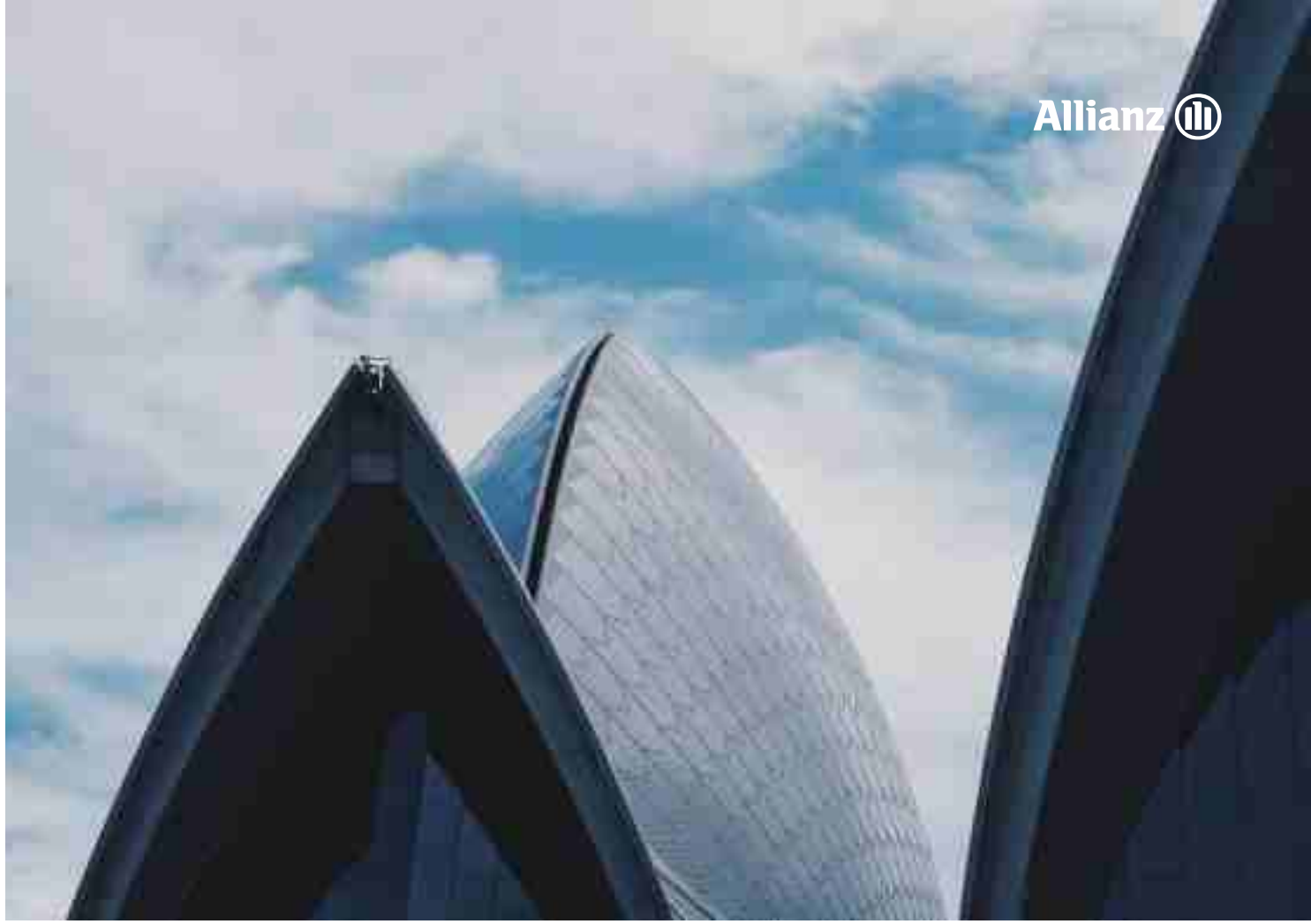
Premium Perubatan – Agihan Perbelanjaan

Kadar keuntungan insurans perubatan dalam lingkungan 0 – 6%

- Merangkumi hanya 6% daripada jumlah keuntungan Allianz Malaysia (RM1.0B) pada 2024
- Selain kadar keuntungan yang rendah, keperluan modal tinggi yang diperlukan untuk mengendalikan perkhidmatan insurans harus diambil kira



Halatuju



Mengurangkan Impak Kenaikan Premium

Langkah proaktif Allianz dalam menjaga kebajikan pemegang polisi

- ***Dedicated hotline***
- **Penambahbaikan komunikasi berkenaan kenaikan premium**– memberi pilihan bersesuaian
- **Mengalakkan pemilihan pelan alternatif**
- **Kelestarian polisi** –menawarkan pilihan kenaikan premium secara minima bagi mengurangkan beban kewangan
- **Tawaran produk mampu milik** – mengembangkan rangkaian produk insurans mampu milik dengan akses kepada subsidi yang berkenaan
- **Latihan dan penglibatan ejen** – Allianz memastikan ejen kami bersedia dengan kemahiran dan pengetahuan yang diperlukan untuk menyokong pemegang polisi
- **Kawalan Kos** – Rundingan bersama pihak hospital, membangunkan harga pakej

Mengawal Inflasi Perubatan – usaha bersama



Membangunkan produk insurans mampu milik, dengan ciri-ciri kawalan kos



Allianz menyokong inisiatif Rakan KKM dan pelaksanaan DRG



Ketelusan harga– Kerjasama dengan pihak hospital dalam mengawal kos



Perkongsian data – penerbitan harga prosedur tertentu



Mengukuhkan pelaksanaan dan penguatkuasaan Garis Panduan Klinikal (CPG)



Kawalselia Harga Ubat

-Syor Harga Borong/Runcit (Recommended retail / wholesale price)

Terima Kasih



Allianz

Harga Ubat

Tokokan harga tinggi, sehingga 8 kali ganda harga borong

Nama Ubat	Harga Borong (RM)	Harga Runcit Hospital (RM)	Tokokan
IV Meropenem	131.5	248.50 - 429.60	89% - 227%
IV Rocephine	50.0	108.00 - 476.00	116% - 852%
IV Tazocin	103.8	201.88 - 342.17	96% - 232%
IV Nexium	41.4	72.00 - 159.00	74% - 284%
IV Dynastat	52.8	85.00 - 176.00	61% - 233%

Harga Ubat

- Kenaikan harga yang kerap di peringkat hospital

IV Tazocin – Hospital X

Tarikh	Harga
31/12/2022	163.95
1/1/2023	253.05
1/4/2023	256.85
22/11/24	264.00
26/11/24	288.00

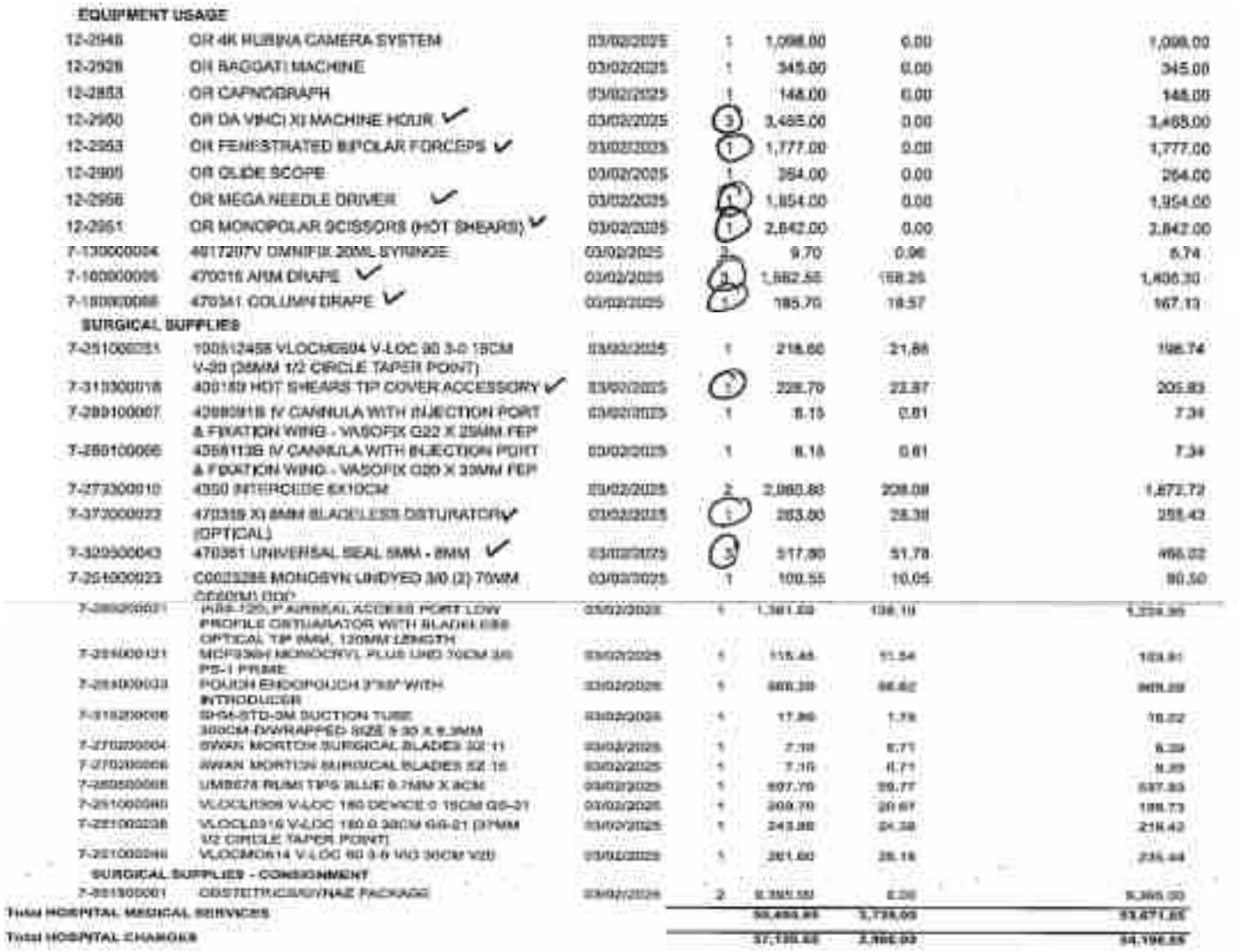


Allianz

Pembedahan Robotik

Bilangan hospital swasta yang menawarkan pembedahan robotik semakin meningkat

- Kos rawatan RM12-15k lebih tinggi berbanding pembedahan laparoskopik
- Bukti klinikal yang terhad bagi menyokong keberkesanan pembedahan robotik berbanding laparoskopik



EQUIPMENT USAGE						
12-2948	OR 4K HUBNA CAMERA SYSTEM	03/02/2025	1	1,098.00	0.00	1,098.00
12-2928	OR BAGGATI MACHINE	03/02/2025	1	345.00	0.00	345.00
12-2853	OR CAPNOGRAPH	03/02/2025	1	148.00	0.00	148.00
12-2950	OR DA VINCI XI MACHINE HOUR ✔	03/02/2025	3	3,465.00	0.00	3,465.00
12-2953	OR FENESTRATED BIPOLAR FORCEPS ✔	03/02/2025	1	1,777.00	0.00	1,777.00
12-2900	OR GLIDE SCOPE	03/02/2025	1	264.00	0.00	264.00
12-2956	OR MEGA NEEDLE DRIVER ✔	03/02/2025	1	1,954.00	0.00	1,954.00
12-2951	OR MONOPOLAR SCISSORS (HOT SHEARS) ✔	03/02/2025	1	2,842.00	0.00	2,842.00
7-130000004	4617207V OMNIFIX 20ML SYRINGE	03/02/2025	1	9.70	0.96	8.74
7-160000005	470015 ARM DRAPE ✔	03/02/2025	1	1,582.55	158.25	1,406.30
7-160000008	470341 COLUMN DRAPE ✔	03/02/2025	1	185.70	18.57	167.13
SURGICAL SUPPLIES						
7-251000251	1005/2458 VLOCM604 V-LOC 90 3-0 15CM V-20 (26MM 1/2 CIRCLE TAPER POINT)	03/02/2025	1	218.60	21.86	196.74
7-310300018	400169 HOT SHEARS TIP COVER ACCESSORY ✔	03/02/2025	1	226.70	22.67	204.03
7-280100007	4388991B IV CANNULA WITH INJECTION PORT & FIXATION WING - VASOFIX G22 X 25MM FEP	03/02/2025	1	8.15	0.81	7.34
7-280100006	4388113B IV CANNULA WITH INJECTION PORT & FIXATION WING - VASOFIX G20 X 33MM FEP	03/02/2025	1	8.15	0.81	7.34
7-273300010	4350 INTERCEDE 6X10CM	03/02/2025	2	2,080.80	208.08	1,872.72
7-373000022	470339 XI 8MM BLADELESS OBTURATOR (OPTICAL) ✔	03/02/2025	1	283.80	28.38	255.42
7-320300043	470351 UNIVERSAL SEAL 5MM - 8MM ✔	03/02/2025	3	517.80	51.78	466.02
7-254000023	C0023286 MONOSYN UNDYED 3/0 (2) 70MM CE60M) DDP	03/02/2025	1	100.55	10.05	90.50
7-280000031	(ABS-120) FAIRSEAL ACCESS PORT LOW PROFILE OBTURATOR WITH BLADELESS OPTICAL TIP 8MM, 120MM LENGTH	03/02/2025	1	1,381.69	138.10	1,243.59
7-251000131	MCP336H MONOCRYL PLUS UND 70CM 3/0 PS-1 PRIME	03/02/2025	1	115.45	11.54	103.91
7-251000033	POUCH ENDOPOUCH 3"X5" WITH INTRODUCER	03/02/2025	1	988.39	98.82	889.57
7-315200006	SHS4-STD-3M SUCTION TUBE 300CM-UNWRAPPED SIZE 5.30 X 6.3MM	03/02/2025	1	17.80	1.78	16.02
7-270200004	SWAN MORTON SURGICAL BLADES SZ 11	03/02/2025	1	7.10	0.71	6.39
7-270200006	SWAN MORTON SURGICAL BLADES SZ 15	03/02/2025	1	7.10	0.71	6.39
7-285000008	UM8678 RUMI TIPS BLUE 0.7MM X 9CM	03/02/2025	1	607.70	60.77	546.93
7-251000060	VLOCL0309 V-LOC 180 DEVICE 0 15CM GS-21	03/02/2025	1	209.70	20.97	188.73
7-221000238	VLOCL0316 V-LOC 180 0 30CM GS-21 (37MM 1/2 CIRCLE TAPER POINT)	03/02/2025	1	243.86	24.38	219.42
7-251000246	VLOCM0614 V-LOC 90 3-0 VIO 90CM V20	03/02/2025	1	261.60	26.16	235.44
SURGICAL SUPPLIES - CONSIGNMENT						
7-251500001	OBSTETRIC/GYNAE PACKAGE	03/02/2025	2	5,390.00	0.00	5,390.00
Total HOSPITAL MEDICAL SERVICES				50,484.95	3,739.05	53,671.65
Total HOSPITAL CHARGES				37,199.62	2,992.03	34,196.65

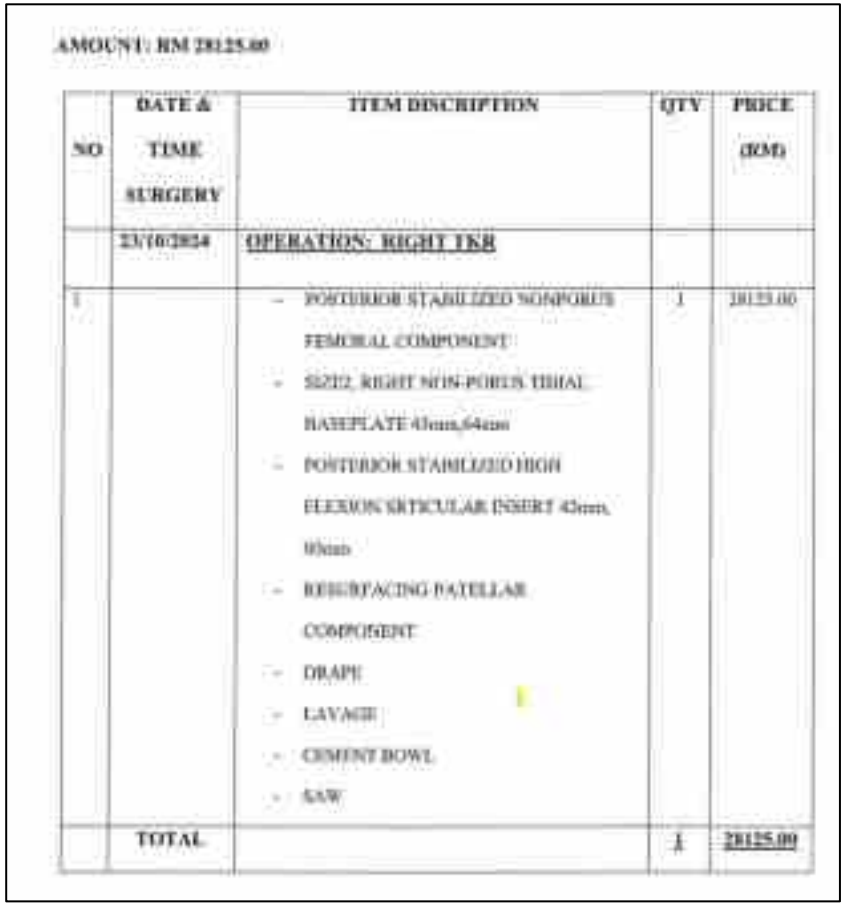
Kos peralatan pembedahan “robotic myomectomy”: RM30,324

Allianz

Peralatan Konsainan

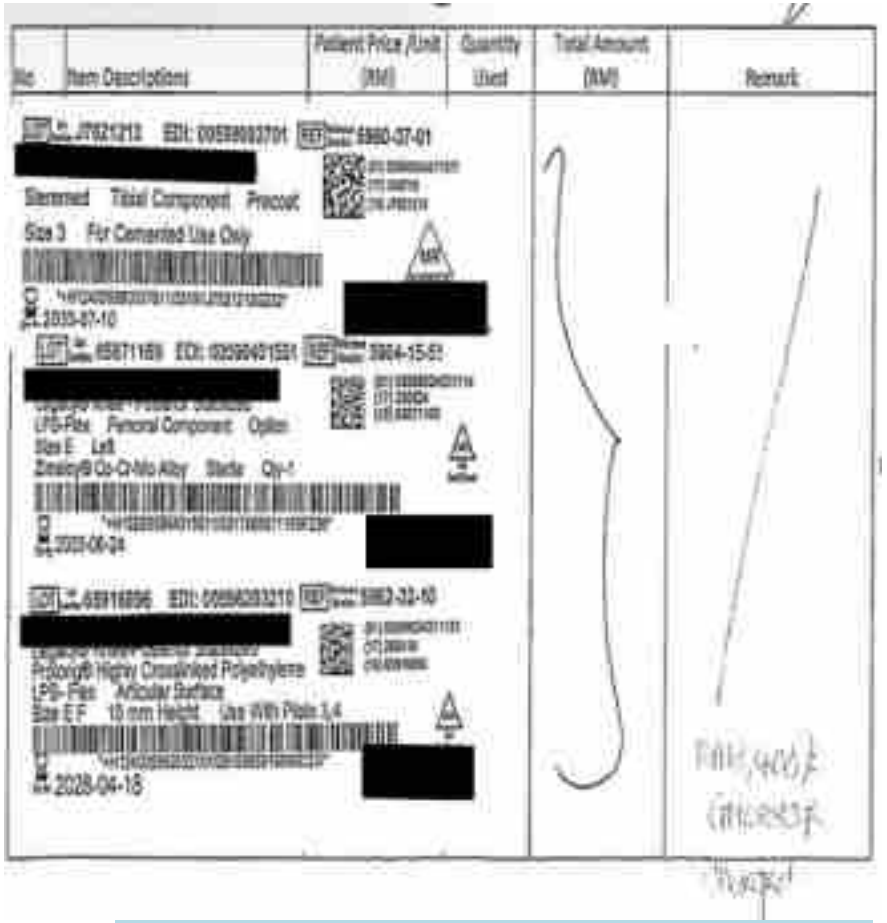
Peralatan perubatan / konsainan merupakan komponen besar dalam kos perubatan

- Variasi harga yang luas, bergantung pada jenis, jenama etc
- Pilihan peralatan oleh pengamal perubatan memberi impak besar terhadap kos rawatan keseluruhan



AMOUNT: RM 28125.00

NO	DATE & TIME SURGERY	ITEM DISCRIPTION	QTY	PRICE (RM)
	23/10/2024	OPERATION: RIGHT TKR		
1		- POSTERIOR STABILIZED NONPORUS FEMORAL COMPONENT - SIZE2, RIGHT NON-PORUS TIBIAL BASEPLATE 43mm,64mm - POSTERIOR STABILIZED HIGH FLEXION ARTICULAR INSERT 43mm, 10mm - RESURFACING PATELLAR COMPONENT - DRAPE - LAVAGE - CEMENT BOWL - SAW	1	28125.00
	TOTAL		1	28125.00



No.	Item Description	Patient Price /Unit (RM)	Quantity Unit	Total Amount (RM)	Remark

Implan : RM28,125
Jumlah Bil: RM 47,000

Implan: RM8,400
Jumlah Bil: RM 27,000

Perbandingan harga Implan penggantian lutut – (kumpulan hospital yang sama)

Allianz

Peralatan Perubatan

Peralatan perubatan merupakan komponen besar dalam kos perubatan

- Perbandingan harga sukar dibuat kerana perbezaan jenis peralatan, jenama, pengilang

NURSING	921.93	0.00	0.00	921.93
				921.93
OR IMPLANTS - OTHERS	80,142.20	0.00	0.00	80,142.20
				80,142.20
OR UTILISATION & RECOVERY	6,437.06	0.00	0.00	6,437.06
				6,437.06
PHARMACY	3,215.34	0.00	0.00	3,215.34
				3,215.34
ROOM CHARGES	750.00	75.00	0.00	675.00
				675.00
REHABILITATION	725.36	0.00	0.00	725.36
				725.36
PHYSIOTHERAPY SUPPLIES	162.53	0.00	0.00	162.53
				162.53

Pembedahan tulang belakang

Allianz

Peralatan Perubatan

Peralatan perubatan merupakan komponen besar dalam kos perubatan

- Perbandingan harga sukar dibuat kerana perbezaan jenis peralatan, jenama, pengilang



HOSPITAL			
4 BEDDED (WITH AIR-COND) @ 3 DAYS	300.00	0.00	300.00
A&E PACKAGE A CHARGES - NEW PATIENT	120.00	0.00	120.00
DIAGNOSTIC IMAGING	4,958.00	0.00	4,958.00
DISCOUNT/ADJUSTMENT	-15,363.00	0.00	-15,363.00
DOUBLE BEDDED (NEW) @ 1 DAYS	120.00	0.00	120.00
ECG - LONG LEAD (PKG)	70.00	0.00	70.00
HDU-IN ROOM (HDU7,HDU8 / ISOLATION)	205.00	0.00	205.00
ICU 1 (OUTSIDE) @ 1 DAYS	220.00	0.00	220.00
INJECTIONS	15.30	0.00	15.30
LABORATORY	2,895.78	0.00	2,895.78
MEDICAL EQUIPMENT	1,529.00	0.00	1,529.00
NURSING PROCEDURE	1,903.80	0.00	1,903.80
OPERATION THEATRE	1,480.00	0.00	[illegible]
PACKAGE DEAL	126,000.00	0.00	126,000.00
PHARMACY	36.30	0.00	36.30
PHARMACY ITEM	6,512.90	0.00	6,512.90
REGISTRATION-INSURANCE	121.00	0.00	121.00
ROOM DISCOUNT	-229.00	0.00	-229.00
SINGLE ROOM (522 & LEVEL 4) @ 5 DAY	1,025.00	0.00	1,025.00
SPECIAL DIAGNOSTIC	1,815.00	0.00	1,815.00

	AMOUNT (RM)	TAX AMT (RM)	PAYABLE AMT (RM)
SURGICAL/MEDICAL SUPPLIES	5,293.61	0.00	5,293.61
PHAR TAKE AWAY	415.62	0.00	415.62
SUB TOTAL	139,444.51	0.00	139,444.51

Pembedahan “mechanical thrombectomy”

Presentation to the PAC on the rising cost of health insurance premium

Mark O'Dell, CEO LIAM on behalf of LIAM, MTA and PIAM

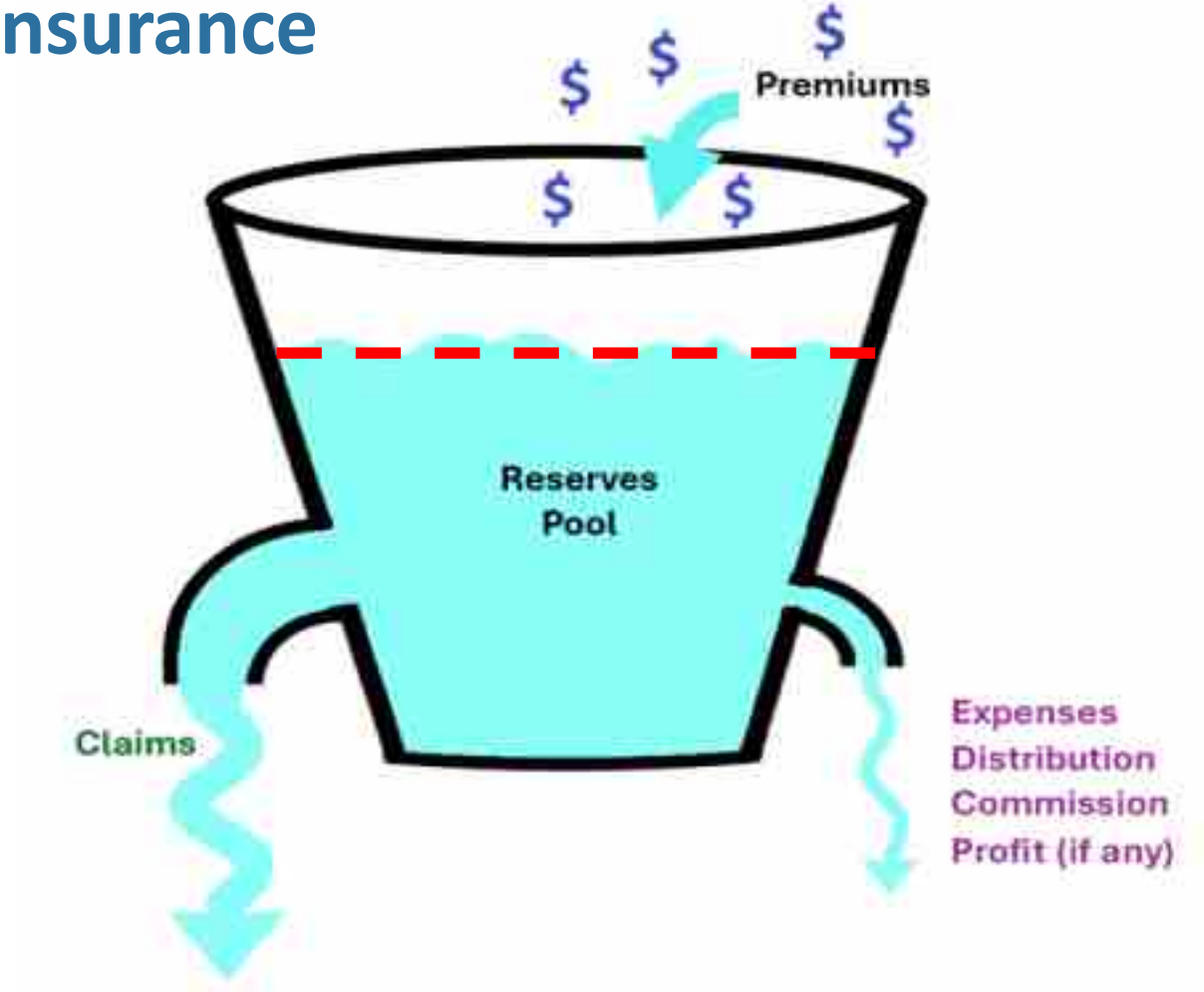
26 February 2025

Persatuan Insurans Hayat Malaysia
Life Insurance Association of Malaysia

Malaysian Takaful Association

PIAM

Medical Insurance

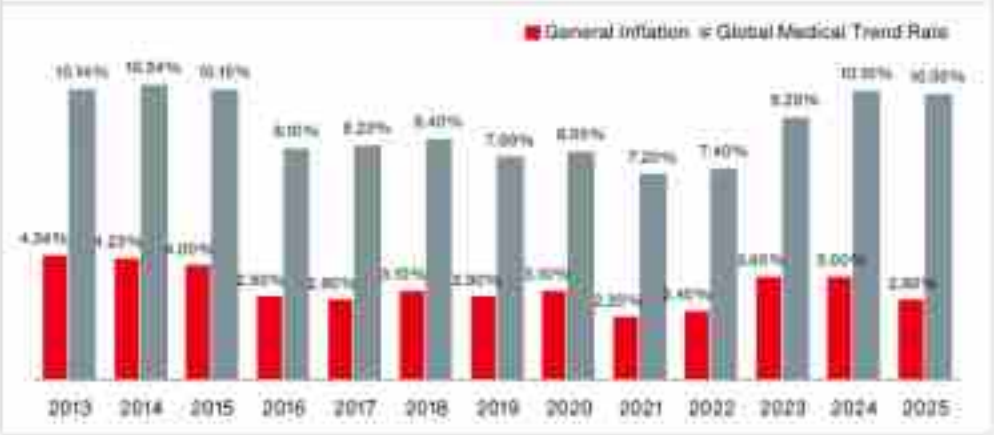


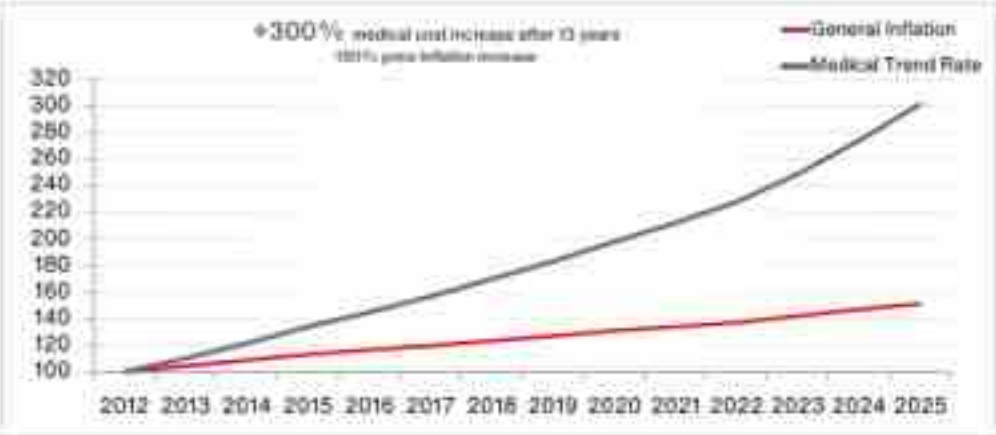
- Expenses, distribution costs and profit are quite steady and generally fluctuate very little.
- The biggest variable is claims. When the fund is depleting, premiums must be raised.

Standalone Only (LIAM only)	2020	2021	2022	2023	2024
Premiums	100.00%	100.00%	100.00%	100.00%	100.00%
Claims	76.60%	71.02%	80.66%	92.96%	93.82%
Expenses	20.20%	24.30%	25.70%	22.80%	22.80%
Profit / (Loss)	3.20%	4.68%	(6.36%)	(15.76%)	(16.62%)

SULIT

2025 Global Medical Trend – The Medical Trend Challenge





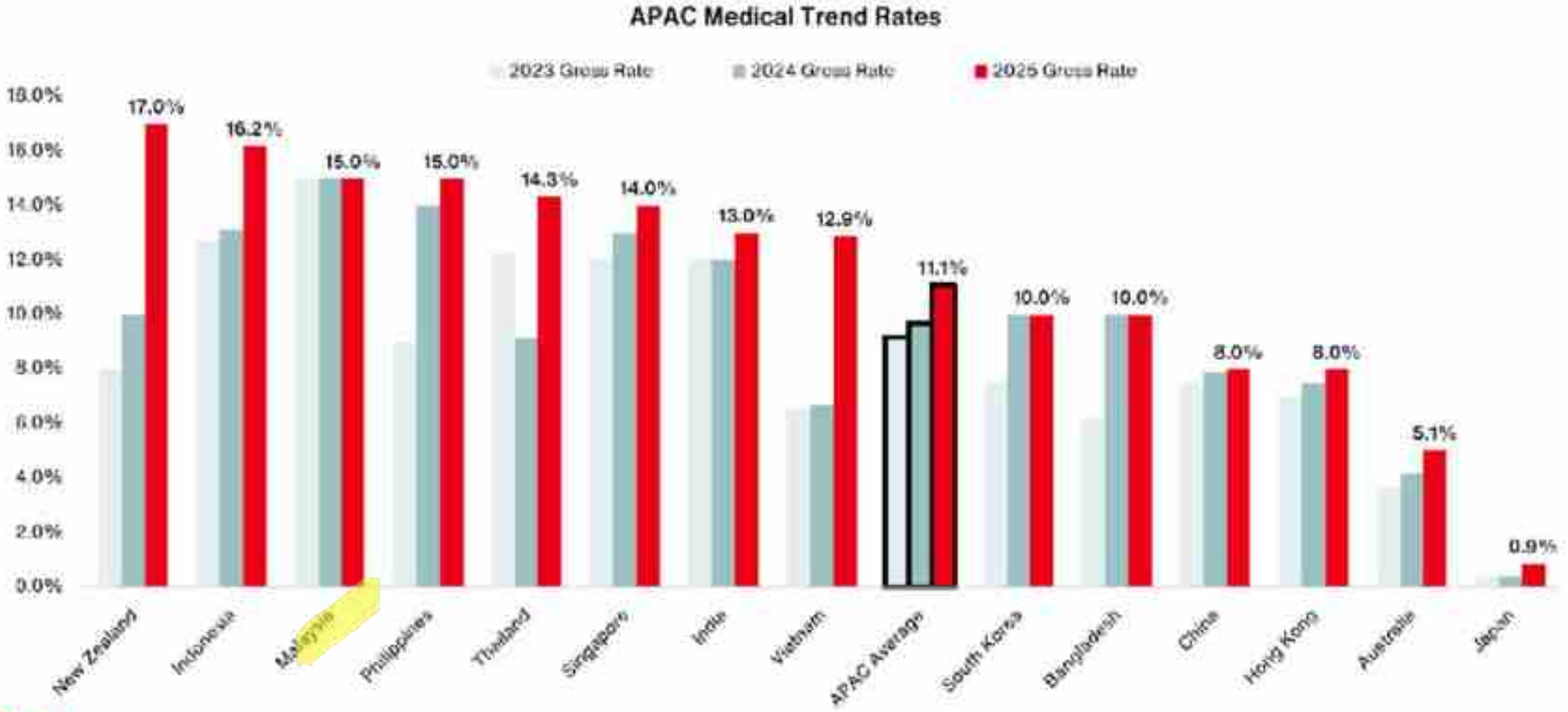
Region	2023			2024			2025		
	Annual General Inflation Rate (%)	Annual Medical Trend Rates		Annual General Inflation Rate (%)	Annual Medical Trend Rates		Annual General Inflation Rate (%)	Annual Medical Trend Rates	
		Gross (%)	Net (%)		Gross (%)	Net (%)		Gross (%)	Net (%)
Global	**3.6**	**9.2**	**5.6**	**3.6**	**10.1**	**6.5**	**2.8**	**10.0**	**7.2**
North America	2.8	6.6	3.8	2.3	7.6	5.3	2.0	8.8	6.9
Asia-Pacific (APAC)	3.0	9.2	6.2	3.6	9.7	6.1	2.8	11.1	8.3
Europe	3.8	9.1	5.3	3.7	10.4	6.7	2.2	8.9	6.7
Latin America & Caribbean (LAC)	4.3	11.6	7.3	4.1	11.7	7.6	3.0	10.7	7.7
Middle East & Africa (MEA)	6.4	14.5	8.1	7.4	15.1	7.7	6.2	15.5	7.3

General Inflation Rate is the 2025 projected domestic general inflation published by the International Monetary Fund (IMF World Economic Outlook Database April 2024). All information is as reported as of September 2024.

Source: *Aon 2025 Global Medical Trends Survey*

2025 Medical Trend - APAC

Managing medical cost is our clients' top priority



AON

Source: Aon 2025 Global Medical Trends Survey

SULIT

A look at claims inflation Post COVID-19

- Industry claims study done on 4 million claims from 2013-2018 showed a bit more than 8% annualized increase in total claims.
- Since the end of Covid, claims have escalated (figures below are for LIAM members only representing 75% of all MHI). The average increase in claims over the last 7 years has been 14.34%.

Year	Medical Claims (RM)	+/-
2018	4,088m	+11.7%
2019	4,940m	+20.8%
2020	4,508m	-8.7%
2021	4,611m	+2.3%
2022	6,164m	+33.7%
2023	7,781m	+26.2%
2024	8,898m	+14.4%

Claims Ratio (%)- Reimbursements				
Year	Individual	+/-	ILP Unitized Riders	+/-
2018	83.27	+9.17	85.44	+17.46
2019	88.28	+5.01	91.68	+6.24
2020	76.6	-11.68	74.57	-17.11
2021	71.02	-5.58	67.69	-6.88
2022	80.66	+9.64	87.51	+19.82
2023	92.96	+12.30	102.3	+14.79
2024	93.82	+0.86	97.66	-4.64

- Insurers report increase in cost of claims along with significant increase in frequency of claims in 2022 and 2023.
- The number of claims and volume have nearly doubled post COVID.
- Claims ratios have grown at a slower pace than claims due to premium revisions along the way.
- Many insurers have claims ratios above 100%, while the large hospital groups have enjoyed EBITDA (earnings before interest taxes, depreciation and amortization) margins of +20% to +25%
- The cost of operating standalone MHIT have averaged 20% to 25% the last 5 years pushing the entire line of business into loss making territory.

SULIT

Among the Major Drivers of Medical and Premium/Contribution Inflation

The Actuarial Partners study identified a number of drivers contributing to the yearly increase in private medical costs and claims. Major Drivers are:

1. Advances in Medical Treatment
2. Imported Equipment, Supplies and Medicines
3. High Prevalance of Non-communicable Diseases
4. **Aging Population**
5. **Increasing Benefits and Policy Design Influence Behavior**
6. **Lack of information**
7. **Waste, Fraud and Abuse**



Among the Drivers of Medical Cost and Premium/Contribution Inflation

1. Advances in Medical Treatment

- Advances in our understanding of disease and the costs of new procedures, diagnostic equipment and newer and better medicine are a major driver of medical cost inflation.
- Minimally invasive surgeries, interventional procedures (neuro, cardio, vascular), transcatheter aortic valve implantation (TAVI), bariatric surgery, oncology (immunotherapy), robotic surgery are just some of the new procedures introduced in recent years.
- Malaysians seeking treatment by a private doctor through a private hospital expect the latest in technology and treatment.



Among the Drivers of Medical and Premium/Contribution Inflation

2. Imported Equipment, Supplies and Medicines

- Private Hospitals and doctors need to import much of the equipment, supplies and medicine needed to provide the best treatment.
- There is little control over the price of needed imported items. Especially pharmaceuticals, which make up nearly half of private hospital profit.(1)
- Imported equipment, supplies and medicine are subject to the rise and fall of the Ringgit versus foreign currency.
- In 2012 to 2024 the Ringgit depreciated significantly versus major foreign currencies. With the exception of the recent Ringgit strengthening, the Ringgit depreciation has averaged nearly 4% per year.

(1) APHM Factbook page 46

Among the Drivers of Medical and Premium/Contribution Inflation

3. Non-communicable Diseases

- Unhealthy lifestyles and eating preferences have resulted in a high prevalence level of diabetes, high blood pressure, high cholesterol and obesity.
- Non-communicable diseases include obesity, diabetes mellitus, cardiovascular diseases smoking related conditions and psychosomatic conditions (i.e stress related) which result in worsening of cardiovascular diseases, hypertension, eczemas, psoriasis .These non-communicable diseases require long term care, hospitalization and interventions.
- In 2023, the National Health and Morbidity Survey showed the following prevalence amongst the Malaysian population:

Diabetes	15.6%
High Blood Pressure	29.2%
High Cholesterol	33.3%
Overweight	54.4%



Among the Drivers of Medical and Premium/Contribution Inflation

4. Aging

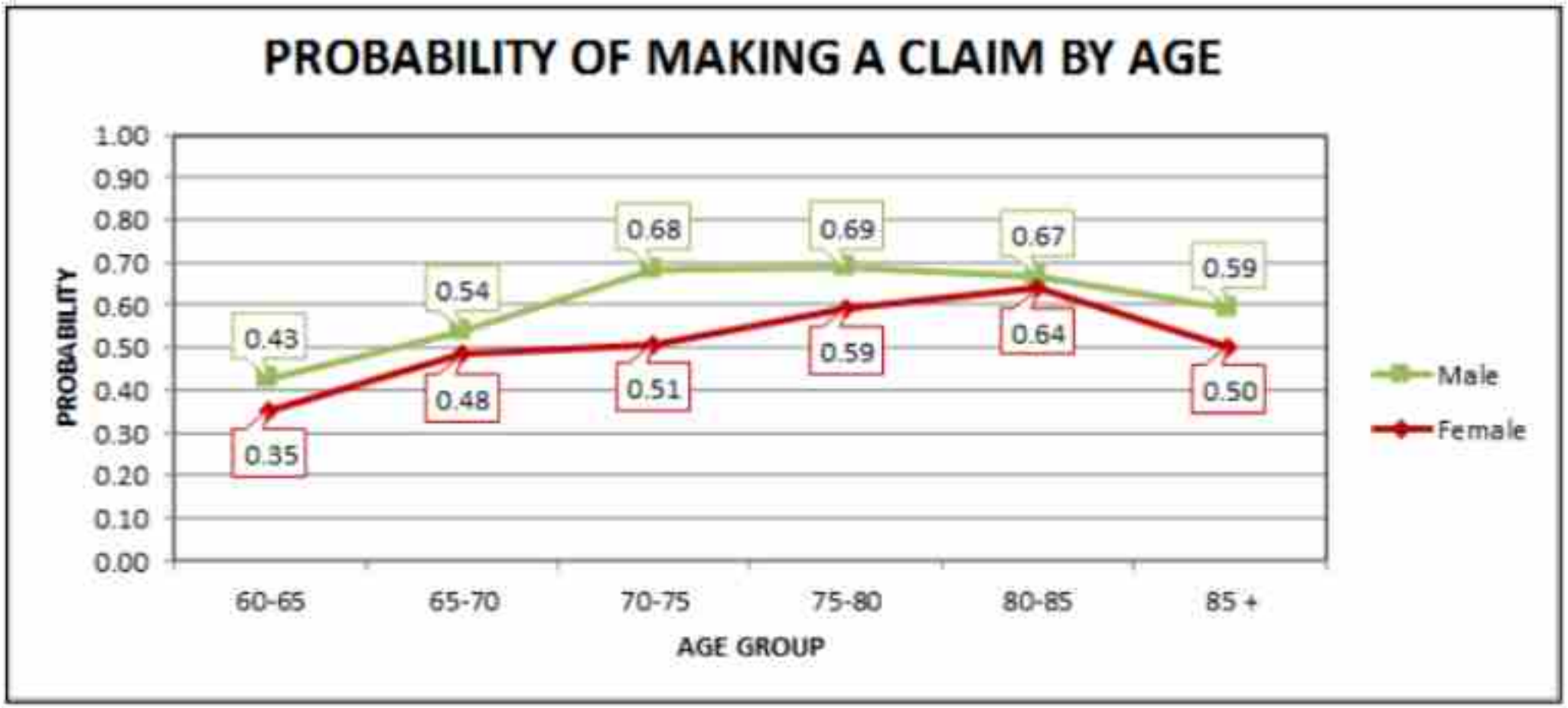
- Malaysia is an aging country with more than 9.5% of the population over 60 in 2016. This is projected to increase to 14% by 2030 and 23.5% by 2050(1).
- As an individual ages the increase incident rate and higher average claims cost threaten policy sustainability. (see table).
- Rising incident rates and claims, and the resulting higher premiums, will burden many policyholders and overburden the public healthcare system.

(1) *UN Economics and Social Commission for Asia and the Pacific.*

Annual Premium Rates for Male & Female Standard Life – Insured and Spouse Typical 100% cashless card cover

Age Next Birthday	Annual Premiums	8% inflation 10 years later
1 - 5	-	-
6 - 17	-	-
18 - 30	3,064	6,615
31 - 40	3,716	8,023
41 - 45	4,820(1)	10,406
46 - 50	6,262	13,519
51 - 55	7,980	17,228(1)
56 - 60	10,795	23,306
61 - 65	12,689(2)	27,395
70*	22,942	49,530
75*	31,078	67,095(2)
80*	42,050	90,783
85*	54,794	118,296
90*	66,962	144,566
95*	80,327	173,420

Claims Frequency Rise with Age

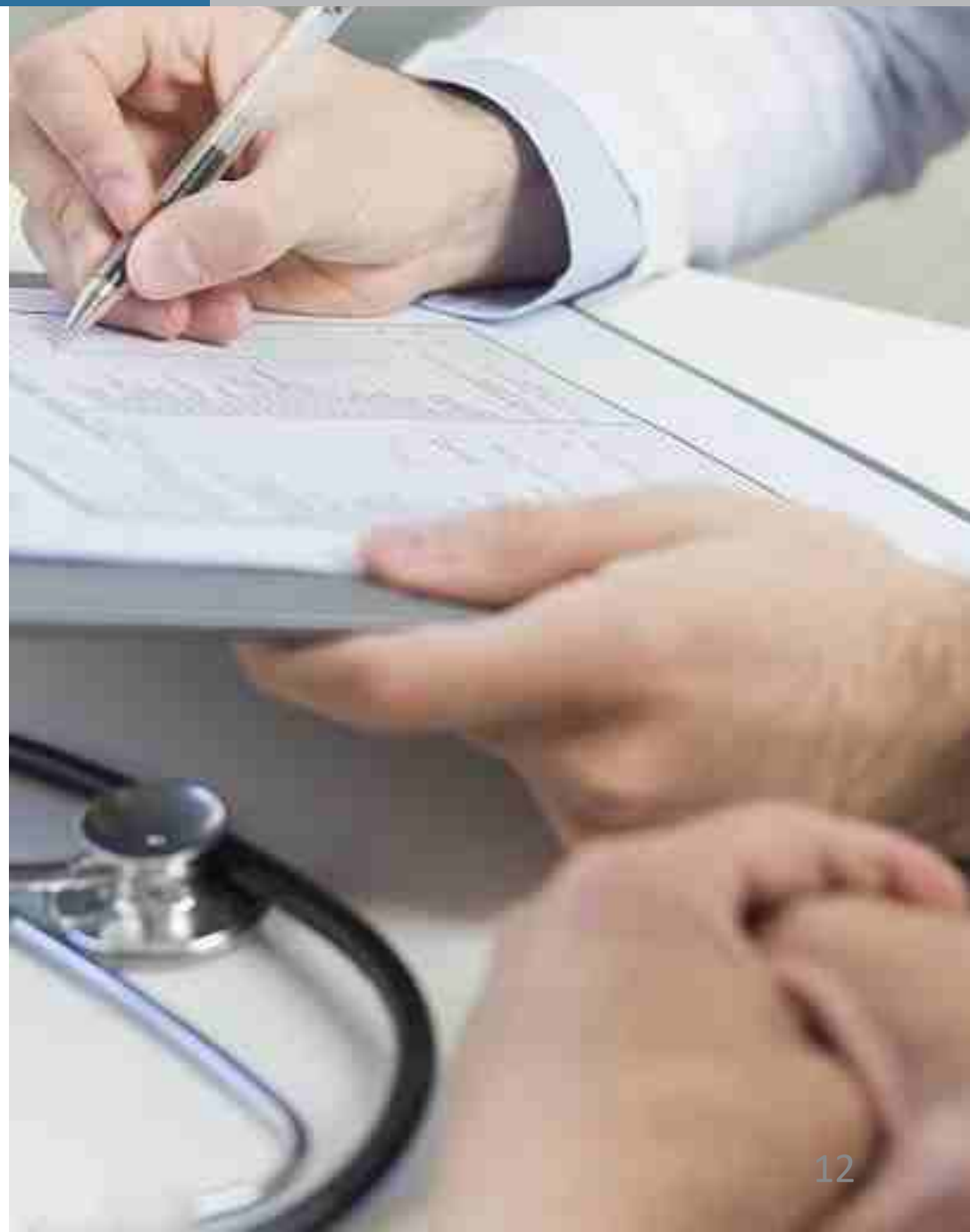


- The probability of a hospital admission is > 50% in a year above age 70.

Among the Drivers of Medical and Premium/Contribution Inflation

5. Increasing Benefits and Policy Design

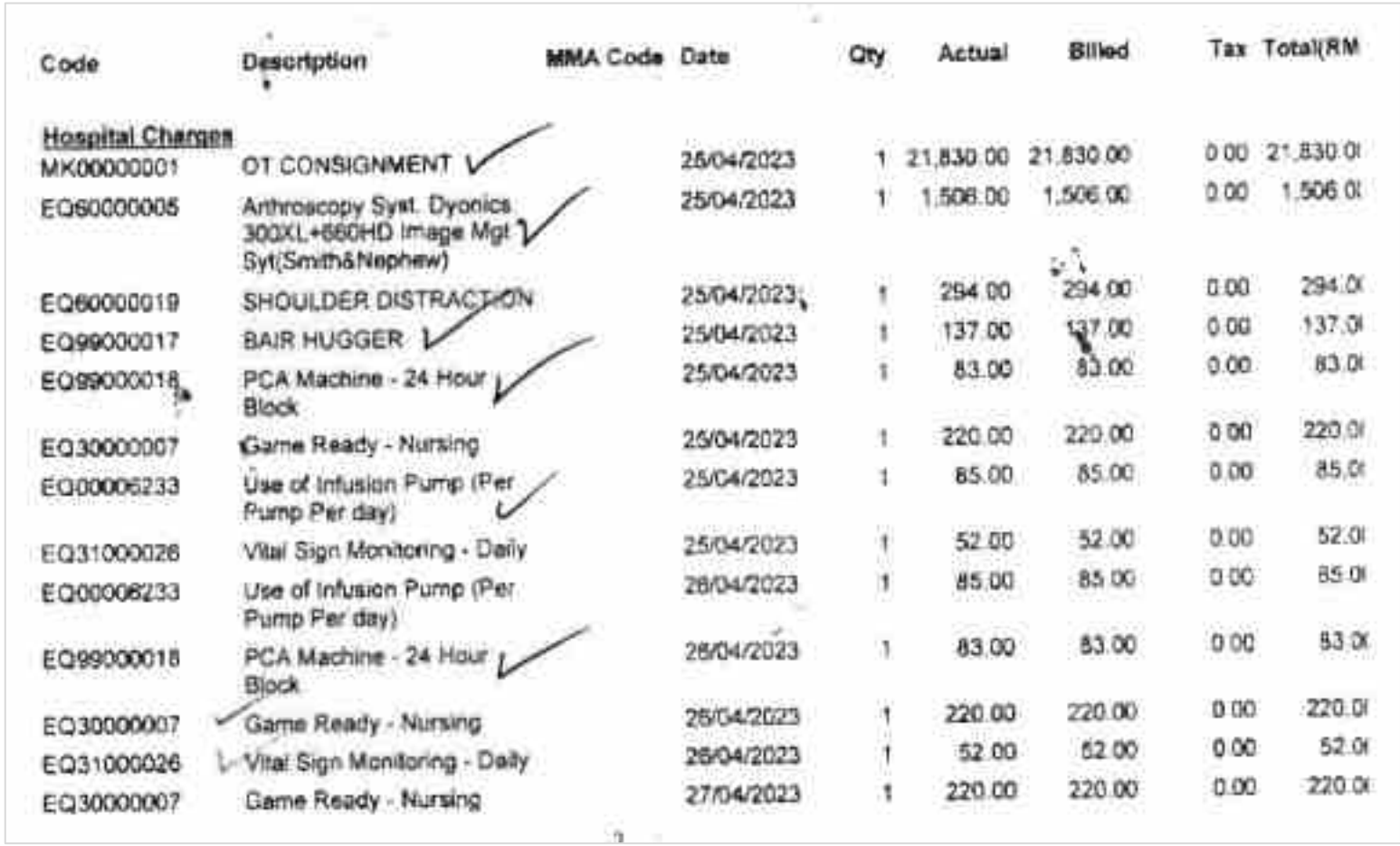
- Insurers and takaful operators have regularly increased benefits and liberalized conditions within MHIT policies/certificates often leading to higher claims. The most significant change being the introduction of the “cashless card” where a policyholder can get a pre authorized guarantee letter and be admitted with no out of pocket expense.
- Today’s MHIT policies/certificates often pay for 100% of the cost of a hospitalization. This can result in the “buffet syndrome” where policyholders seek to maximise the value of premiums paid. Hence, they tend to utilise medical services with little incentive to consider the associated costs.
- Additional expensive diagnostics are often seen with insured patients.
- Policy/certificate holders lack the technical knowledge and incentive to question the necessity and costs of procedures.



Among the Drivers of Medical and Premium/Contribution Inflation

6. Lack of Information

- Patients, almost always, lack information needed and have to rely on practitioner advice. Costs of procedures are often not disclosed up front
- Comparing costs and quality of outcomes is impossible to compare between providers due to lack of public information.
- With the lack of good data, patients are left to assume that higher costs providers results provide better health outcomes.
- Detailed Hospital bills contain too much medical jargon, making it hard for policyholders to raise questions.



Code	Description	MMA Code	Date	Qty	Actual	Billed	Tax	Total(RM
Hospital Charges								
MK00000001	OT CONSIGNMENT		25/04/2023	1	21,830.00	21,830.00	0.00	21,830.0
EQ60000005	Arthroscopy Syst. Dyonics 300XL+660HD Image Mgt Syt(Smith&Nephew)		25/04/2023	1	1,506.00	1,506.00	0.00	1,506.0
EQ60000019	SHOULDER DISTRACTION		25/04/2023	1	294.00	294.00	0.00	294.0
EQ99000017	BAIR HUGGER		25/04/2023	1	137.00	137.00	0.00	137.0
EQ99000018	PCA Machine - 24 Hour Block		25/04/2023	1	83.00	83.00	0.00	83.0
EQ30000007	Game Ready - Nursing		25/04/2023	1	220.00	220.00	0.00	220.0
EQ00006233	Use of Infusion Pump (Per Pump Per day)		25/04/2023	1	85.00	85.00	0.00	85.0
EQ31000026	Vital Sign Monitoring - Daily		25/04/2023	1	52.00	52.00	0.00	52.0
EQ00006233	Use of Infusion Pump (Per Pump Per day)		26/04/2023	1	85.00	85.00	0.00	85.0
EQ99000018	PCA Machine - 24 Hour Block		26/04/2023	1	83.00	83.00	0.00	83.0
EQ30000007	Game Ready - Nursing		26/04/2023	1	220.00	220.00	0.00	220.0
EQ31000026	Vital Sign Monitoring - Daily		26/04/2023	1	52.00	52.00	0.00	52.0
EQ30000007	Game Ready - Nursing		27/04/2023	1	220.00	220.00	0.00	220.0

SULIT

Among the Drivers of Medical and Premium/Contribution Inflation

7. Waste, Fraud and Abuse

- Abuse from all stakeholders making unnecessary claims to the system. An insured patient is much more likely to undergo additional and often unnecessary diagnostic tests vs. non-insured patients.
- Types of abuse include: identity fraud, provider abuse, agent abuse.
- Anti-selection occurs when an insurance applicant fails to disclose pre-existing conditions when taking out new cover. These situations can often go undetected and contribute to higher claims and the resulting higher premiums when claims are made for conditions that may not have been insurable had they been disclosed.







Options for Policyholders/ Certificateholders

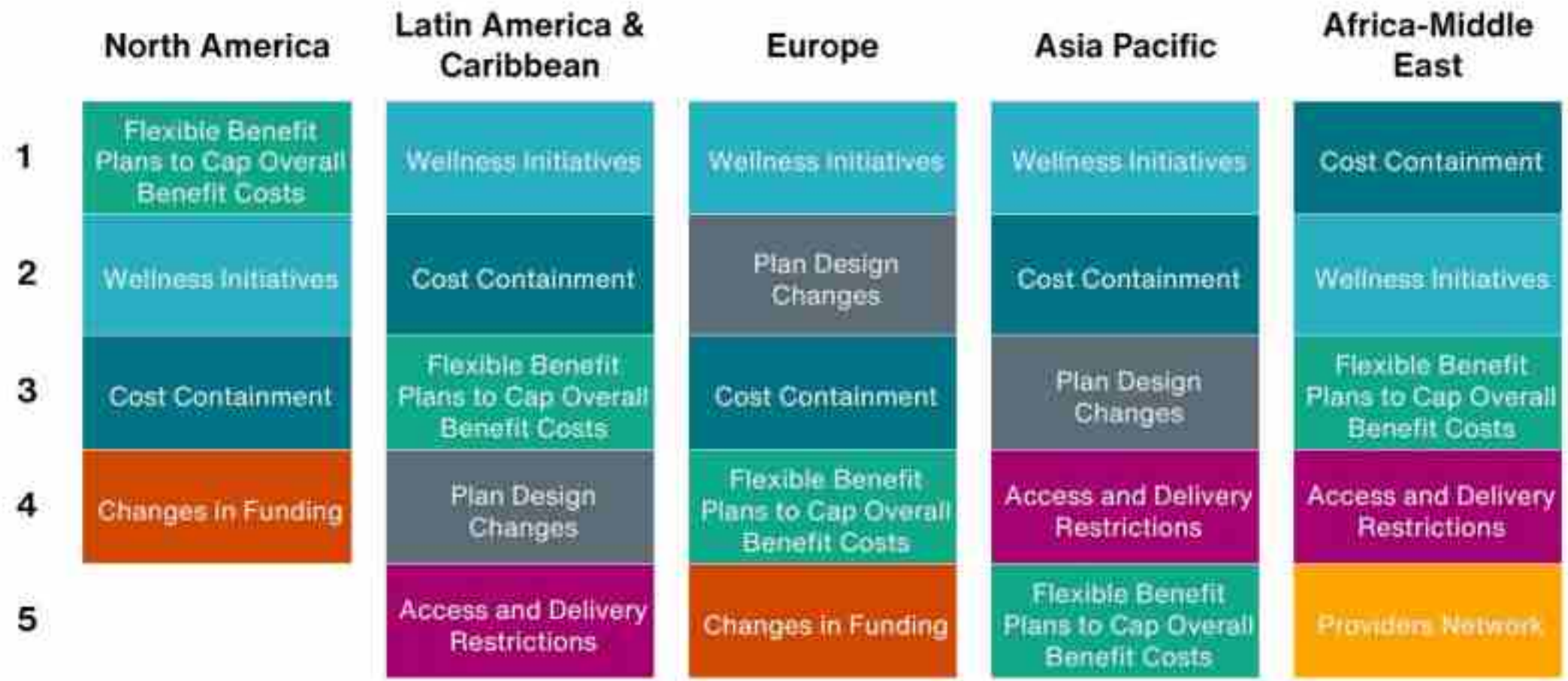






- Review of medical plans to choose more affordable option e.g. reduce the annual limit or select plans with lower benefits
- Introduce co-pay plans which can be less expensive (depending on level of co-pay) than plan without
- Review of policy or certificate e.g. to reduce level of sum assured/ covered for life plans or reduce the term of the certificate (where shorter term will have lower premium or contribution)

2025 Global Medical Trend – Top Mitigation Initiatives By Region



Top 5 mitigation initiatives expected to be undertaken by employers to arrest medical cost escalation and promote a health workforce. North America considering Canada & US only with list identifying the top 2/3 for each country

AON

Source: Aon 2025 Global Medical Trends Survey

SULIT

Industry and Regulatory Response and Recommendations

1. **Appoint an independent consultant, paid by the insurers and hospitals**, to analyze and recommend stakeholder actions to reduce claims inflation.

2. **Offer assistance to customers at risk of losing financial protection** due to the inability to cope with repriced solutions. **Strengthen sales and disclosure practices** and **improve communication** and transparency around re-pricing. **(issue 7)**

3. **Policyholder co-payments** needed to align interests and reduce over consumption. Co-Payment, especially co-insurance, can encourage more responsible consumptions of health services**. (issue 5)**

4. **Encourage and incentivise healthier lifestyles through no claim bonuses.**

5. **Establishment of industrywide claims database (an all admissions database would be even better)** for better claims analysis and reducing abuse. Greater transparency by **publishing the average costs of common procedures/treatment across private hospitals as well as annual medical costs inflation. (issue 7)**

6. **Develop** a basic **long term sustainable medical product** together with BNM. **(issues 4 & 5) Allow ITOs to insure top up schemes** for those who can afford it.

7. **Exempt Group Insurance from 8% SST** to encourage more employers to take up. Currently approximately 4 million employees get coverage through work, including many B40 members.

SULIT

Industry and Regulatory Response and Recommendations

8. **Insurers to consider to develop suitable and streamlined, re-pricing framework(annual re-pricing)** to reduce rate increase shock by spreading out the impact of large increases and incidents of healthy insureds leaving for premiums that are temporarily cheaper. **(issue 6)**

9. **Providers and insurers/TPAs** need to better align regarding cost and consumption of healthcare services. **Cost containment measures must be adopted by providers.** The insurance and takaful industry supports **the adoption of DRG (diagnostic-related grouping) pricing going forward. (Issues 8 & 5)**

10. **Work with MOH to require the use of generic drugs and control pricing of all drugs**. APHM's own report states that 48% of private hospital profits come from pharma**. (issue 2)**

11. **Request private hospitals to freeze costs** for the same period that insurers/takaful operators are asked to cap premium increases.

12. **Rakan KKM** can help serve as a pricing benchmark for private care DRGs.

13. **All stakeholders**, including insurers/takaful operators, private hospitals, doctors, regulators and policyholders must work together in an **all of nation approach** to address the challenges contributing to rising costs and premiums.

SULIT

Thank you.



PROPOSED PRESENTATION BY NAMLIFA

President's Welcome Remark's

MR. A.KRISHNAN



MAKLUMBALAS BERSABIT LANGKAH INTERIM OLEH BNM

1. Kenaikan 10% setiap tahun dari 2024 – 2026 (compound interest)

CONTOH

Premium sebelum kenaikan : RM1000

- Kenaikan 10% - 2024 : RM 100 (Total RM1,100)
- Kenaikan 10% - 2025 : RM 100 (Total RM1,210)
- Kenaikan 10% - 2026 : RM 100 (Total RM1,331)

Kenaikan sebenar : 33.1% dalam masa 3 tahun

2. Ketidakpastian tentang kadar kenaikan caruman yang bakal dikenakan pasca 2026

3. Angka pesakit di hospital Kerajaan meningkat sebab ketidakmampuan ramai pemegang polisi

4. Kos penjagaan kesihatan awam dijangka naik

5. Keyakinan Masyarakat terhadap pengurusan Kesihatan secara umum adalah tidak memuaskan

6. Bukan semua pemilik polisi yang berumur 60 tahun ke atas dapat menikmati moratorium1 tahun yang diberikan. Setiap syarikat mengenakan syarat berlainan mengikut ciri-ciri produk masing masing.

7. Pihak actuarial serta pengurunan tertinggi Syarikat Insurans haruslah dipertanggungjawab kerana menjual produk yang tidak mampu bertahan kepada Masyarakat umum.

8. Had tahunan perlindungan medikal yang tidak terkawal menyebabkan perlumbaan yang tidak sihat di kalangan syarikat insurans yang menyumbang kepada kenaikan bil hospital.

9. Hospital yang disenarai hitam oleh mana mana Syarikat insurans haruslah disenarai hitam oleh semua.

10. Caj caj bukan professional yang tidak dikawal haruslah diaudit

11. Kos ubat serta farmasutikal haruslah diseragamkan

12. Fasiliti Tanpa Tunai harus ditawarkan kepada hospital awam jugak seperti hospital swasta.

SARANAN DARIPADA NAMLIFA

INSURANS/TAKAFUL PERUBATAN SOCIAL

1. Skim Perlindungan Perubatan untuk setiap rakyat Malaysia

2. Had perlindungan rawatan kemasukan wad tahunan harus mampu menampung kos jenis rawatan standard MOH

3. Perlindungan ini sah digunakan di hospital awam dan swasta

4. Mekenisma caruman premium/sumbangan ditentukan oleh pihak Kerajaan.

5. Had umur maksima kelayakan memasuki skim ini boleh ditentukan oleh pihak pengunderit yang dipertanggungjawabkan.

6. Kelayakan memasuki skim ini adalah tanpa pengesahan kesihatan serta melindungi penyakit dan status kesihatan semasa.

7. Semua Hospital Swasta wajib menyediakan jumlah katil mengikut kapasiti masing masing untuk peserta skim ini dengan kos rawatan yang telah ditetapkan.

HASRAT NAMLIFA UNTUK RAKYAT MALAYSIA

1. Komitmen Kerajaan untuk menjayakan yang dibentangkan oleh MOH pada tahun 2024

2. Meningkatkan kapasiti serta mutu perkhidmatan penjagaan kesihatan di setiap hospital awam

3. Membina hospital awam baru berkapasiti tinggi.

4. Menaik taraf hospital sedia ada.

5. Rakyat mendapat khidmat penjagaan kesihatan bermutu tinggi di hospital awam

6. Khidmat Penjagaan Kesihatan Awam yang mampan dengan gandingan Khidmat Penjagaan Kesihatan Swasta dengan kos yang munasabah untuk seluruh rakyat Malaysia.


Thank you

3rd March 2025, Monday

MALAYSIAN MEDICAL ASSOCIATION

PENINGKATAN BAYARAN PREMIUM INSURANS KESIHATAN, CAJ HOSPITAL SWASTA DAN IMPAK KEPADA KESIHATAN AWAM

INTRODUCTION MMA DELEGATION

NAME	POST	QUALIFICATION
Dato Dr Kalwinder Singh Khaira	President	Physician
Datuk Dr Thirunavukarasu Rajoo	President-Elect	General Practice
Dr Vasu Pillai Letchumanan	Honorary General Secretary	Hepatobiliary Surgeon
Dr Sivanaesan Letchumanan	Honorary Deputy Secretary	General Practice
Dr Timothy Cheng Tsin Jien	Chairman, SCHOMOS	Orthopaedic Surgeon
Dr Gunalan Palari	Life Member/Taskforce on Specialist Affairs	Anaesthesiologist
Dr Mohamed Namazie Ibrahim	Life Member, former President	Anaesthesiologist
Dr Mastura Md Yusof	Life Member	Oncologist
Dato’ Dr Venugopal Balchand	Life Member	Cardiothoracic Surgeon
Dr Kuharaj Balasubramaniam	Life Member	Obstetrician & Gynaecologist
Dr Liew Shan Fap	Life Member	Gastroenterologist

ISSUES

MEDICAL INFLATION LEADING TO HIGHER PREMIUMS BY THE ITO

WHO’S AT FAULT ?

SOLUTION?

FEE FOR SERVICE VS DRG

WILL IT SOLVE THE PROBLEM OR MAKE THE EXISTING PROBLEM WORSE?

ARE WE LIKELY TO CREATE NEW ONES?

MMA’S PROPOSAL

PRIVATE HEALTHCARE/ITO RELATIONSHIP

1. Worked well together since the mid-1980s ever since the introduction of health and medical insurance plans
2. During Covid-19, drop in claims (MCO , deferment of elective surgeries)
3. Post Covid-19, increase in utilization coupled with rise in medical inflation necessitated repricing

4. Irrespective of the causes, MMA believes in making the entire ecosystem work better for all
5. Correct misconceptions and share the realities of private healthcare
6. Stop finger pointing and look at solutions
7. Anecdotal experiences are not necessarily representative of the overall picture
    i. Cash pay more/cash pay less vs insurance
    ii. Ask got insurance or not before starting treatment





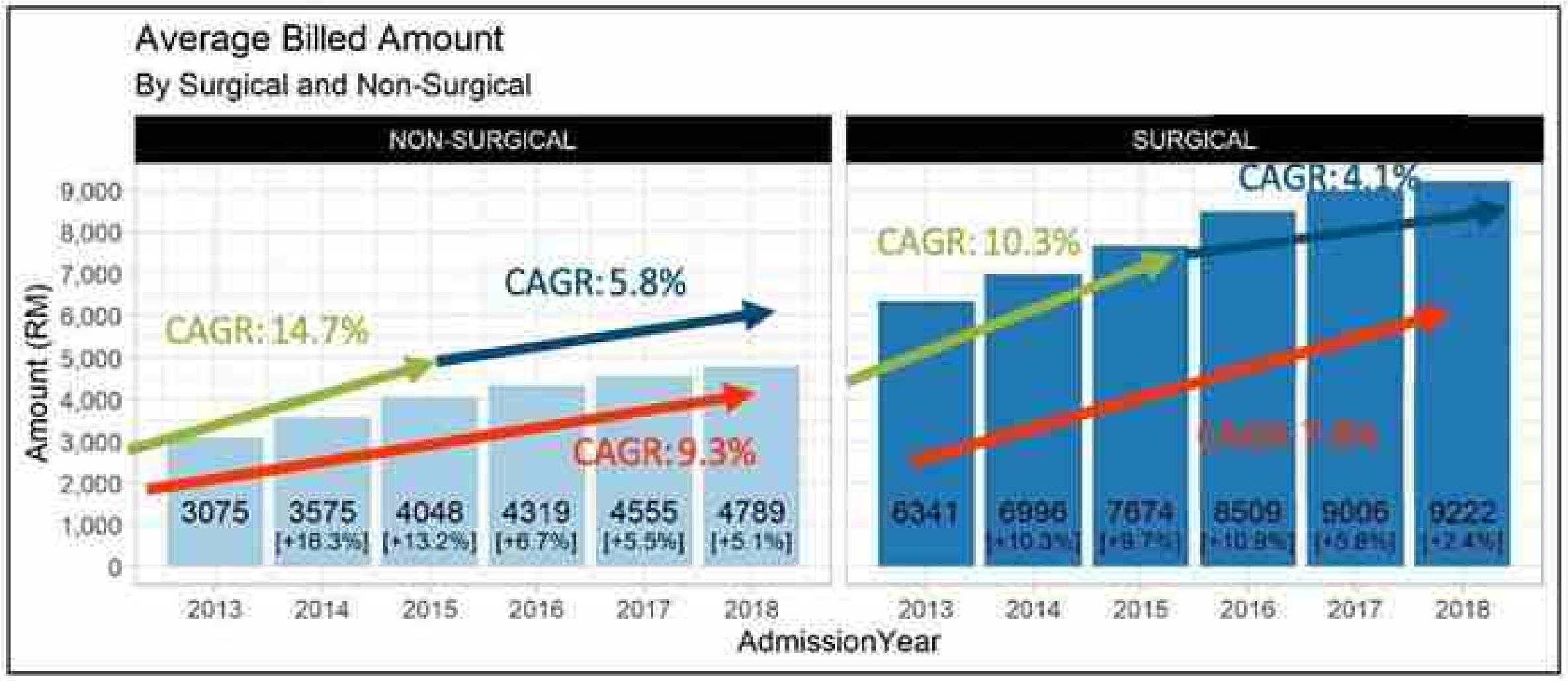


MMA has been at work together with the stakeholders to make

PRIVATE HEALTHCARE SUSTAINABLE FOR ALL

Insurance and Takaful Industry Medical Cost Containment Task Force Study on the

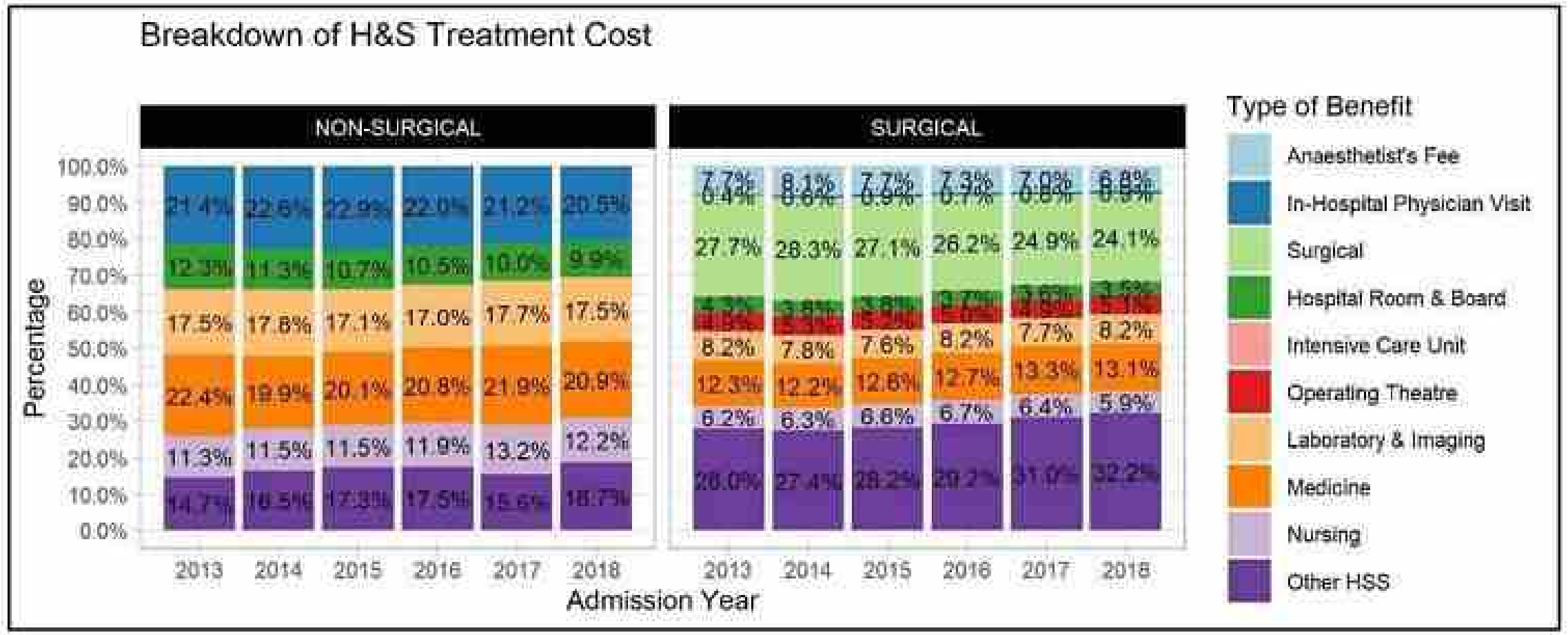
Drivers of Medical Costs and Medical Insurance Premium Inflation 2020



Between non-surgical and surgical treatments, the CAGR of the average billed amount for HSS ranges between 5.7% and 11.8% from 2013 to 2018.

Insurance and Takaful Industry Medical Cost Containment Task Force Study on the

Drivers of Medical Costs and Medical Insurance Premium Inflation 2020



Biggest contributor to the cost of care in a private hospital is the Hospital Supplies and Services(HSS)
70% and 59% of the total bill for non-surgical and surgical treatments
HSS annual increase is also higher than the other components of the bill.

The 13th Schedule has, to an extent, helped control doctors' and surgical fees(plateau since 2016)
In fact, may soon drop to 20-25% of total bill size.
However, the overall medical cost is still on the rise, contributed by the HSS component.

DOCTORS IN PRIVATE HEALTHCARE

DOCTORS FEES NOT THE MAIN DRIVER FOR RISE IN COST

AMENDED 13TH SCHEDULE OF THE PHFSA (ACT 586) WORKED ON SINCE 2020,STILL NOT ADOPTED AS YET

DOCTORS ROLE IN UTILIZATION OF HOSPITAL SERVICES AND SUPPLIES

MEDICAL NECESSITY VS BUFFET SYNDROME

IMPACT OF REGULATIONS/ACCREDITATION: PHFSA/MEDICAL DEVICES ACT/JCI/MSQH

IMPACT OF RISING MEDICOLEGAL CLAIMS: DEFENSIVE MEDICINE

Insurance industry data

The total claims payout in 2023 increased by 14.9% to RM15.4 billion in 2023 compared to RM13.4 billion in 2022. The increase was driven by the hike of 41.4% in disability payment and 26.2% in medical claims.

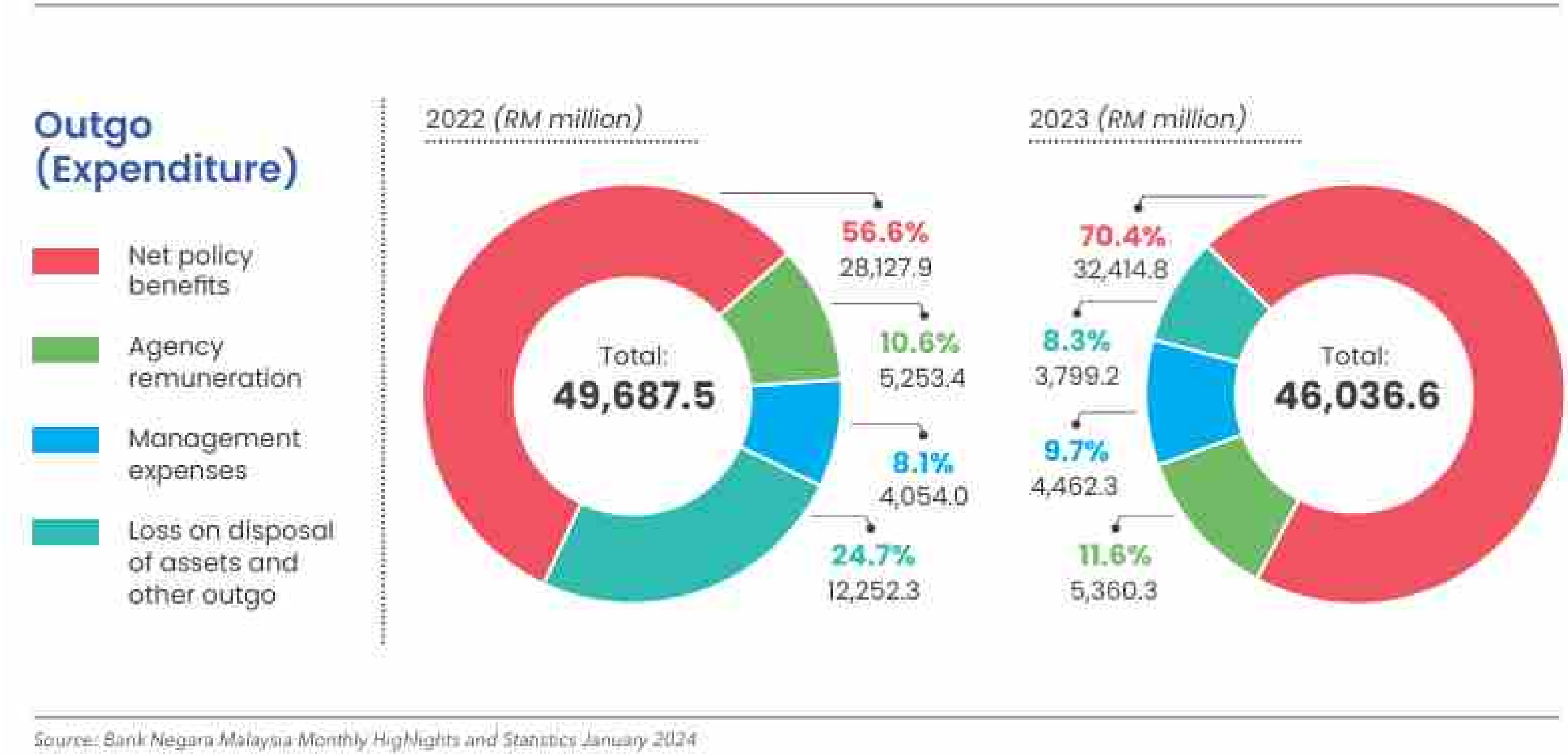
RM / Benefit	January to December			
	2022	2023	Difference	Growth
Death	1,814,532,683	1,727,050,751	-87,481,932	-4.8
Disability	107,946,280	152,662,549	44,716,269	41.4
Medical	6,163,799,351	7,780,606,751	1,616,807,400	26.2
Bonuses	3,162,473,293	3,306,450,789	143,977,496	4.6
Others	2,144,558,651	2,423,393,443	278,834,792	13.0
Total	**13,393,310,258**	**15,390,164,283**	**1,996,854,025**	**14.9**

In 2023, the Life Insurance Association of Malaysia (LIAM) Annual report highlighted that the total medical claims payout increased

26.2%(RM7.7b compared with RM6.1b in 2022)

About 6000 Drs and about 100k strong workforce

Insurance industry data



In the same report, the **agency remuneration was stated as RM5.3b and management expenses were RM4.4b.**

The role of licensed financial planners or agents (more than 80,000 strong) are important as they are the patients advocate as well but at the same time RM 5.3b represents almost 2/3 of the cost for medical claims.

SUGGESTIONS FOR THE INDUSTRY

Direct Purchased Insurance(In 2022 accounted for about 40 per cent of insurance policies sold in Singapore)

Adoption of Digitalization and Simplification of the Claims Process

Friendly clearer products for those with no preexisting illness

Transparent underwriting terms and conditions

Appropriate lifetime or annual limits

Regular discussion with medical societies on what’s the most current guidelines to ensure standard of care

SUGGESTIONS FOR THE INDUSTRY

Stop squeezing hospitals and indirectly doctors to give huge discounts

Stop threats of moving business away

Respect the clinical decision-making process of both the patient and the doctors

Respect the patient’s choice to decide what’s best for them which includes the choice of doctor and hospital

Stop incessant questions that are sent to approve a claim ie pre-authorization process which adds on to cost

Doctors in the industry must work together with the clinicians in understanding the disease process and management plans

Explain and own the process of declinatures properly so that we can understand why

PRIVATE HEALTH CARE FACILITIES AND SERVICES ACT 1998

(i) “The licensee of a private healthcare facility or service shall ensure that the medical and dental management of patients vests in a registered medical practitioner and a registered dental practitioner respectively.” (Section 78a)

(ii) “where the facility or service is a private hospital, private ambulatory care centre, private hospice or private psychiatric hospital, there is established a Medical Advisory Committee whose members shall be registered medical practitioners representing all medical practitioners practicing in the facility or service to advise the Board of Management, the licensee and person in charge on all aspects relating to medical practice.” (Section 78b)

PRIVATE HEALTH CARE FACILITIES AND SERVICES ACT 1998

The licensee of a private healthcare facility or service or the holder of a certificate of registration shall not enter into a contract or make any arrangement with any managed care organization that results in- (a) a change in the powers of the registered medical practitioner or dental practitioner over the medical or dental management of patients as vested in paragraph 78(a), and a change in the powers of the registered medical practitioner or visiting registered medical practitioner over the medical care management of patients as vested in paragraphs 79(a) and 80(a);

PRIVATE HEALTH CARE FACILITIES AND SERVICES ACT 1998

Section 78b : Advice on all aspects relating to medical practice should include

i. Ethical conduct of doctors

ii. Billing/coding practices of doctors

iii. Prices of equipment and medications

MMC position on the 13TH Schedule

Fees are accepted as the maximum professional fees chargeable.

MCO/TPA request for discounts on the professional fees by private arrangement with the private hospitals as an inducement to refer corporate patients.

MCO/TPA sometimes restrict a patient's right of choice of a registered medical practitioner or health care facility.

The MMC's position is that both these practices: Unethical.

Fee Splitting : Any form of kickbacks or arrangements made between practitioners, healthcare facilities, organisations or individuals as an inducement to refer or to receive a patient to or from another practitioner, healthcare facility, organisation or individual

The MMC's position: Unethical.

MMC position on RMPs

Pursuant to the Acts and Regulations, Guidelines issued by the Ministry of Health (Practice Division), and MMC Code of Professional Conduct and guidelines and directives, the Registered Medical Practitioners who enters into any contract with a MCO is bound to adhere strictly to these regulatory stipulations and ethical requirements, and is liable to disciplinary procedures in the event of any breach of these, if complaints are submitted to the Ministry of Health or the Malaysian Medical Council.

Diagnosis Related Group(DRG)

DRG-based payment systems in low- and middle-income countries: Implementation experiences and challenges by Inke Mathauer and Friedrich Wittenbecher WHO 2012

Several success factors for DRG payment system implementation are identified:

1) mandatory application to the widest range of providers
2) purchaser capacity
3) regulation relating to balance-billing
4) inclusion of the private sector in the DRG-based remuneration
5) piloting and incremental introduction, particularly in larger countries
6) definition of expenditure ceilings
7) instruments to promote provider cooperation and patient acceptance

DRG

Advantages

- Reimbursement fixed are specified for each DRG case
- Strong incentive for cost containment per case
- Service delivered cost effectively
- Shortest possible length of stay

Disadvantage

- Under provision of care esp. when payment tariffs are low
- Even at rate that covers cost, patients are discharged early
- Higher rates of readmission
- Select only low-cost patients and rejecting high-cost patients
- Admit patient unnecessarily (Cylus and Irwin 2010, Park et al 2007)
- Upcoding for higher DRG rates (Silverman and Skinner, 2004)
- Need for increased quality and monitoring measures adding to overall costs

?DRG in Malaysia

Public expenditure on health care is funded by general tax revenue.

Restructuring of health financing being discussed in Malaysia, with the introduction of National Healthcare Financing (NHF) as one of the options

Currently, budgets are allocated to public providers of inpatient care

Private providers are reimbursed on a fee-for service basis

The introduction of case-based reimbursement for inpatient care has been researched in Malaysia for more than a decade already

DRGs piloted as a recording tool in 6 hospitals in Malaysia in 2010 to 149 MOH hospitals (MYCMX) but mainly used for budgeting purpose.

DRG payment system is closely connected to social health insurance/NHF

There has to be a national DRG system applicable to both public and private hospitals

Table 2: Summary of country DRG design aspects

	1) Purchaser(s) paying via DRG; 2) Other health financing agents	*Year of introduction of DRG-based payment*
Mexico	1) Contribution-based social health insurance	Late 1990s
Croatia	1) Contribution-based social health insurance	2002: Introduction for limited set of diagnoses 2005: Extension to 118 diagnoses 2006: Introduction of adopted AR-DRGs in four pilot hospitals 2007-2009: Implementation of the new DRGs in all hospitals as shadow billing method.
Estonia	1) Contribution-based social health insurance	2000: Adjustment of NordDRGs for national use 2003: Introduction as coding tool 2004: Implementation as payment method
Hungary	1) Contribution-based social health insurance	1987: Pilot 1993: National implementation
Kyrgyzstan	1) Contribution-based social health insurance	1997: Introduction 2001: All hospitals incorporated into the scheme 2003: Major revision and refinement, introduction of ICD-10 coding
Macedonia	1) Contribution-based social health insurance, state subsidies for those who cannot pay	2009: Implementation in 51 hospitals 2010: Extension to 56 hospitals
Poland	1) Contribution-based social health insurance	First half 2008: Pilot in 44 hospital Second half 2008: National implementation of DRGs for coding purposes 2009: Use of DRGs as payment method

How successful is DRG worldwide

Need to have Social health insurance in place
Not 100% tax funded or 100% private insurance
Reality is that many advanced health financing systems apply and combine several provider payment mechanisms

DRG experience in Germany (Dr Otmar Kloiber, Sec Gen WMA)

1. Complex administratively and technically
2. Clinical data needed to group patients
3. Cost data was not available and varies according to size of hospital
4. Did not reduce cost
5. Ratio of administrative staff: healthcare staff (7:3)
6. Smaller remote hospital were eventually closed or merged
7. Risk selection, avoid high risk or difficult cases as not profitable
8. Need ambulatory centres to manage as outpatient

Adoption issues

1. Significant data worldwide that it did not reduce cost

2. DRG own its own is not going to solve the current private medical insurance premium hikes

3. Will it work for private hospital?

4. Is DRG considered collusion/price fixing and whether would be compliant with the Competition Act?

MMA view on DRG

In principle we are not rejecting DRG wholesale, but few issues need to be considered

1. Private hospitals are not funded by taxes but investments
2. Operational costs of private hospitals have to come from somewhere
3. External Factors are hard to control
    - Supply chain disruption
    - Currency exchange
    - Costly new drugs and technology
4. Internal factors can be controlled
    - Doctors charge code
    - Profit margins for all players
    - Abide to highest standards of care to reduce adverse events
    - Adoption of technology and AI/automation to increase efficiency
    - Cap litigation payouts
    - Madani Mediation Centre for dispute resolution

Issues Faced by Doctors

1. Threat of litigation is real
2. No one likes readmission, keep patients until we are sure no issues (control of DM, healing of wounds)
3. BOR typically is at 80-100%, we are discharging as fast as we can
4. Moving elective surgeries moving towards Daycare and DOSA reduces the need for admission and monitoring.
    i. Insurance companies must help to support and look at providing cashless for these admissions (not all are doing)
    ii. Quick turnaround time for approval so that cases can be done within office hours, reducing after hours costs
5. Involvement of primary care is key
    i. early discharge to home GP for further care
    ii. GPs need the 7th schedule approved urgently for adequate reimbursement
6. Hospitals can focus on purely inpatient care and GPs can manage patients as an outpatient.

MMA proposal for “DRG/negotiated price”

1. DRs fees are exempt from DRG, we are already regulated by the 13th schedule

2. DRG only for certain categories
    1. Below RM 10k which mainly medical admission(about 65%) : exempt
    2. Surgeries that cost RM 10-50k (30%): predictable, possible to be included for negotiated price
    3. Surgeries above RM 50k(5%): too many variables in terms of complexities(exempt)

3. Example of straightforward and predictable surgeries
    Lap Cholecystectomy, Lap appendicectomy, ACL reconstruction, FESS ,TKR

    Philippines: 11 case-based payments for medical cases and 12 for surgical cases in place, i.e. a total of 23. These cover about 50% of claims
    Korea has only 7 (cataract, appendix, haemorrhoids, tonsil, hernia, LSCS and uterine surgery)

Exempt patients with co-morbidities(DM/HPT/IHD/Asthma) in phase 1 as we collect the data

3. Propose soft cap vs hard cap budgeting for the initial phase, let’s get the data first and then we can decide the adoptability

MMA proposal if “DRG” is implemented

Government to:

1. Support investments in electronic medical records
2. Support start-up costs of introducing a DRG system, such as the training of coders, the information technology, the implementation phase, as well as for the ongoing costs such as the regular review of the DRG system,
3. Support the additional costs of administrative procedures of monitoring coding practices and quality assurance.
4. Look into current regulatory burden, E –invoicing , Medical Device Act that are already adding costs
5. Form a DRG monitoring agency

    Phase by phase approach

    Allow for further fine-tuning of groups and for corrections in costing and tariff setting.

    Review processes, address up-coding and to decrease the scope for up-coding.

    Outcome parameters such as costs or length of stay need to be collected

    Assess the impact of adjustments to the DRG system

?Cancer Care under DRG

At present, cancer care is a problem dealing with the Insurance industry

Cancer patients don’t have a second shot

Significant barriers especially with definitions, exclusions, latest therapies, targeted therapy

Generic medication vs Original, Patent Issues, Pharmaceutical Costs(CDR) , Medical Devices Prices (stents/RFA/Microwave ablation)

Hybrid convoluted process of cancer care

- Surgery and follow up done in private hospital
- For the purpose of medication that are not covered they go to government side
- Central procurement method of purchasing the medications and given to the private sector for use in patients with limited coverage/no coverage

Allow access to treatment and purchase of certain services from the private sector

Patient care should be with the experts and underwriters/claims teams should work together with doctors

Exempt Cancer Care from DRG

Conclusion

MMA felt that a frank open discussion needs to take place between all stakeholders in the private healthcare ecosystem

In 2020 itself, we knew what we are seeing today was eventually going to happen

“Grievance Mechanism Committee ” with BNM and MOH as the regulatory parties with discussions to be focused on finding common grounds among MMA, APHM, LIAM, PIAM and MTA.

Unfortunately, at first Covid-19 and then some concerns about the Competition Act disrupted the meetings

With support of the parliamentarians, we hope we can get back on track to meet again and discuss all our issues in a meaningful objective manner

Set frequency of meetings with clear outcomes and report to Parliament Committee

Let’s not rush without getting all the stakeholders views on the table at the same time

MOH and BNM being the regulators need to play an active role in this.

Interests of policyholders, patients, and healthcare providers must be looked into.

MALAYSIAN MEDICAL ASSOCIATION

Thank You!

The truth about Healthcare Inflation

- According to Aon's 2022 Global Medical Trend Rates Report, Malaysia's estimated medical inflation rate is **12%**, increasing on an average of 10%–15% annually. In contrast, the general inflation rate of Malaysia for goods and services is only estimated to be at approximately 2% in 2022.

https://www.prudential.com.my/en/insurance-101/all-stories/medical-inflation-rate-in-malaysia/

- What is **Aon's 2022 Global Medical Trend Rates Report**?

"Aon surveyed 108 of its offices that broker, administer, or advise on employer-sponsored medical plans to understand the average medical trend rates from countries worldwide."

Aon's 2022 Global Medical Trend Rates Report

https://insights-north-america.aon.com/research/2022-global-medical-trend-rates-report

Exhibit 14: Region/Country (Avg %)

Regional & Country Averages	2021			2022		
	Annual General Inflation Rate	Annual Medical Trend Rates		Annual General Inflation Rate	Annual Medical Trend Rates	
		Gross	Net		Gross	Net
North America	**2.1**	**7.0**	**4.9**	**2.3**	**6.6**	**4.3**
Canada	1.3	7.0	5.7	2.0	7.0	5.0
United States	2.2	7.0	4.8	2.4	6.5	4.1
Asia-Pacific	**2.5**	**8.0**	**5.5**	**2.4**	**8.2**	**5.8**
Australia	1.8	2.5	0.7	1.6	3.1	1.5
Bangladesh	5.6	7.7	2.1	5.6	8.0	2.4
China	2.6	7.0	4.4	1.9	7.0	5.1
Hong Kong	2.5	5.3	2.8	1.9	5.6	3.7
India	3.6	9.0	5.4	4.1	13.0	8.9
Indonesia	2.9	13.0	10.1	3.1	12.2	9.1
Japan	0.4	0.0	(0.4)	0.7	0.0	(0.7)
Kazakhstan	6.8	15.0	8.2	5.0	15.0	10.0
Malaysia	2.8	14.0	11.2	2.0	12.0	10.0

2022 Global Medical Trend Rates Report

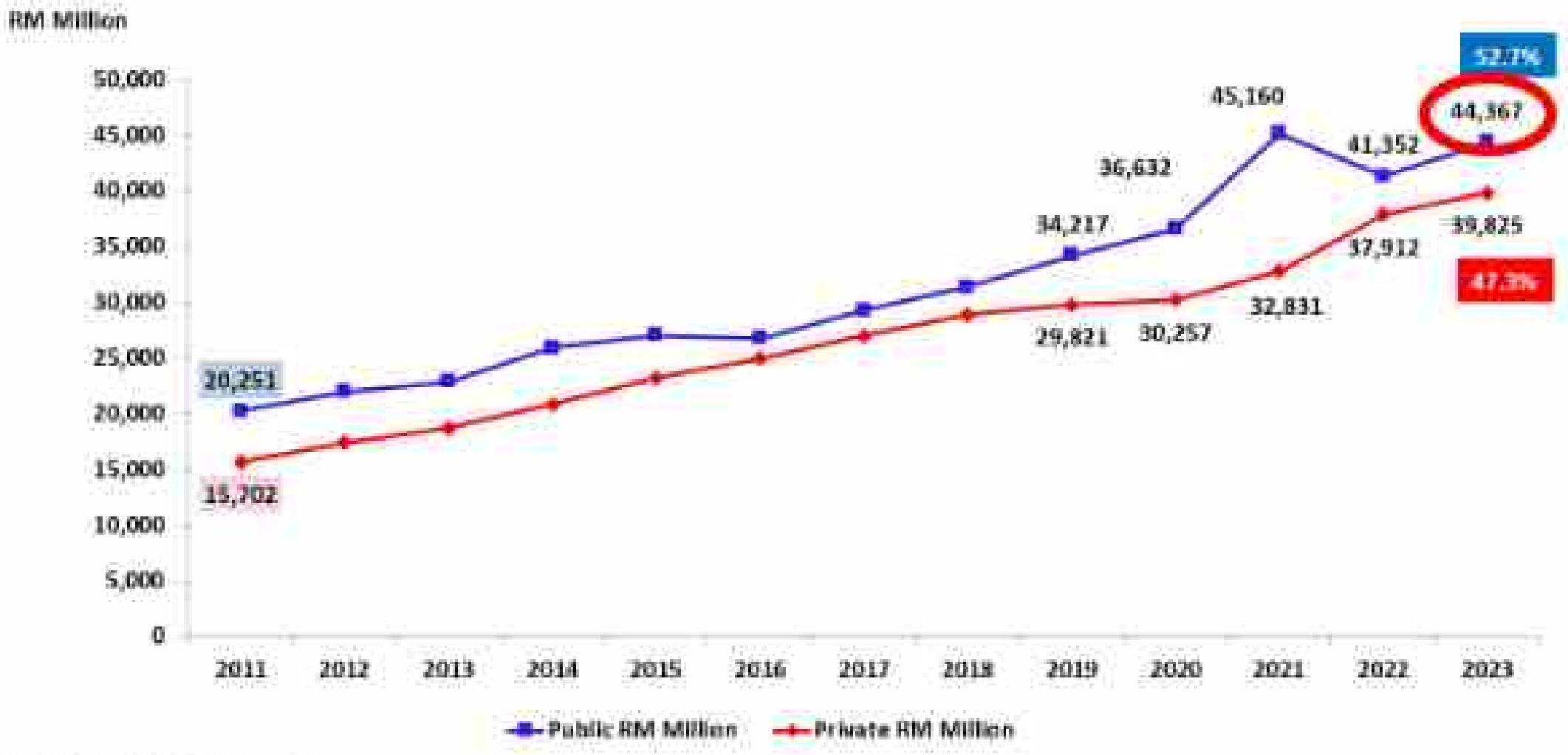
- The trend rate figures shown in this report represent the **percentage increases in medical plan (insured and self-insured) unit costs** that are anticipated to be technically required to address **projected price inflation, technology advances in the medical field, plan utilization patterns, and cost shifting** from social programs in each covered country
- Care should be taken in interpreting the information presented here . The Medical Trend Rates provided are **not meant to represent an overview of each country's health care costs** as a whole .

Malaysia National Health Accounts (MNHA):
NATIONAL HEALTH EXPENDITURE 2011-2023

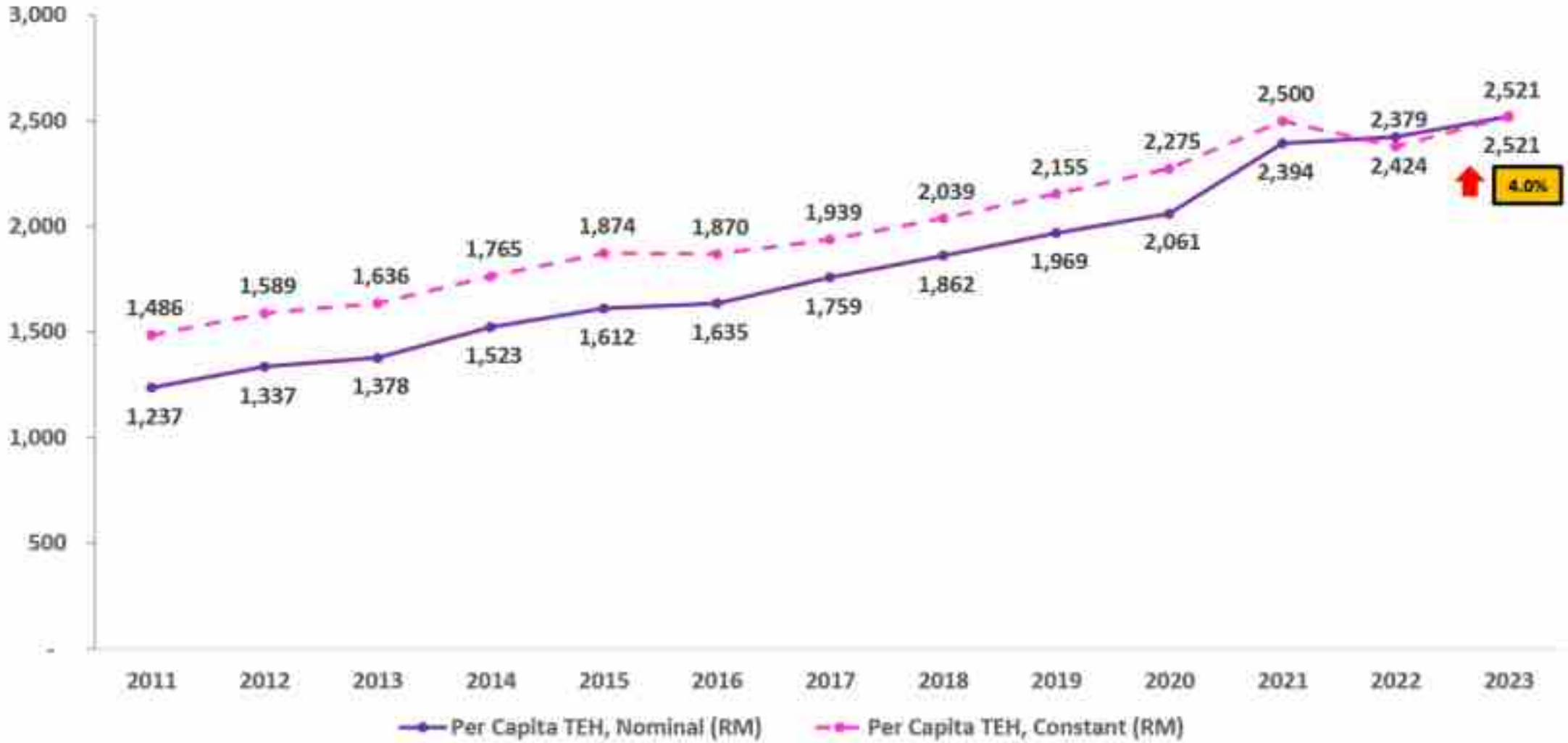
Mesyuarat Pemandu MNHA Bil. 2/2024
24 Disember 2024

Seksyen MNHA, Bahagian Perancangan, KKM – 2024

TEH by Sources of Financing, Public & Private Sources, 2011-2023

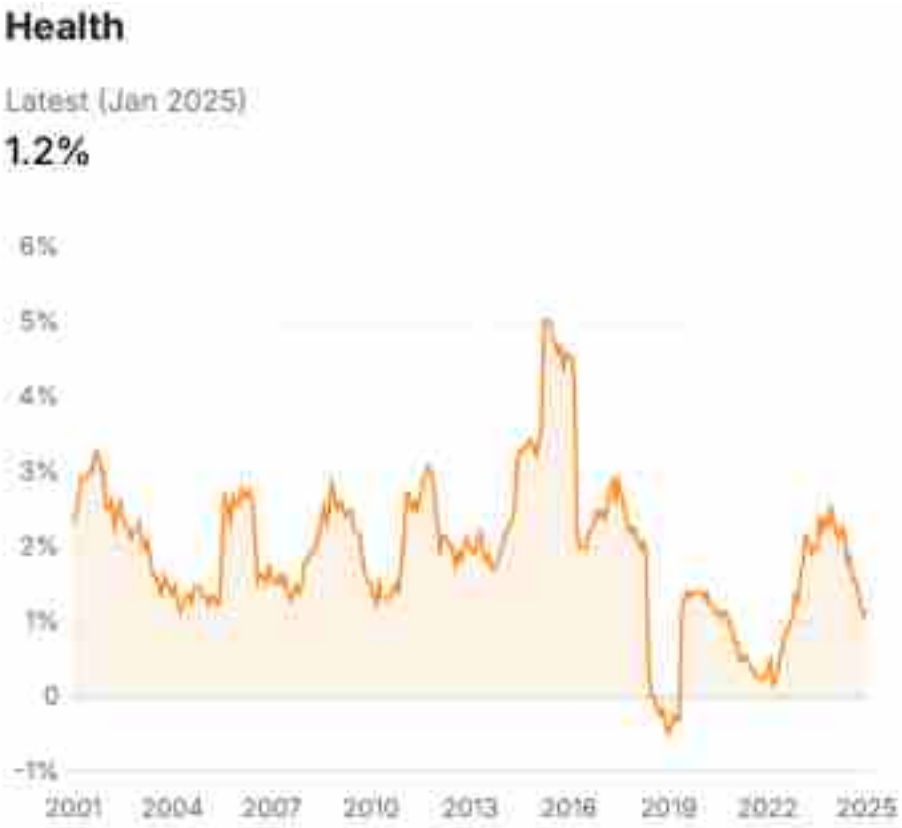


Per Capita Expenditure on Health, 2011-2023

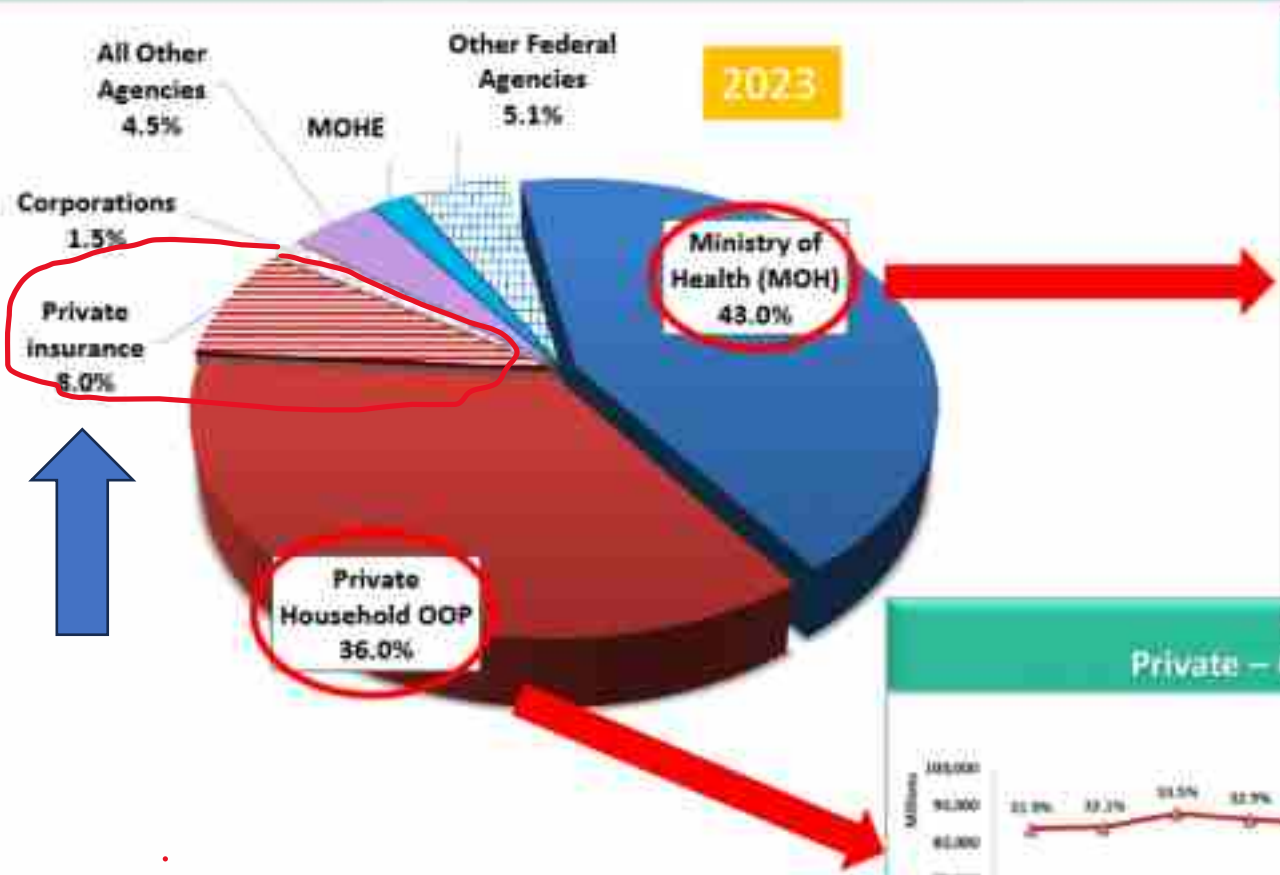


Inflation in Malaysia-DOSM





TEH by Sources of Financing, Public & Private Sources, 2011-2023



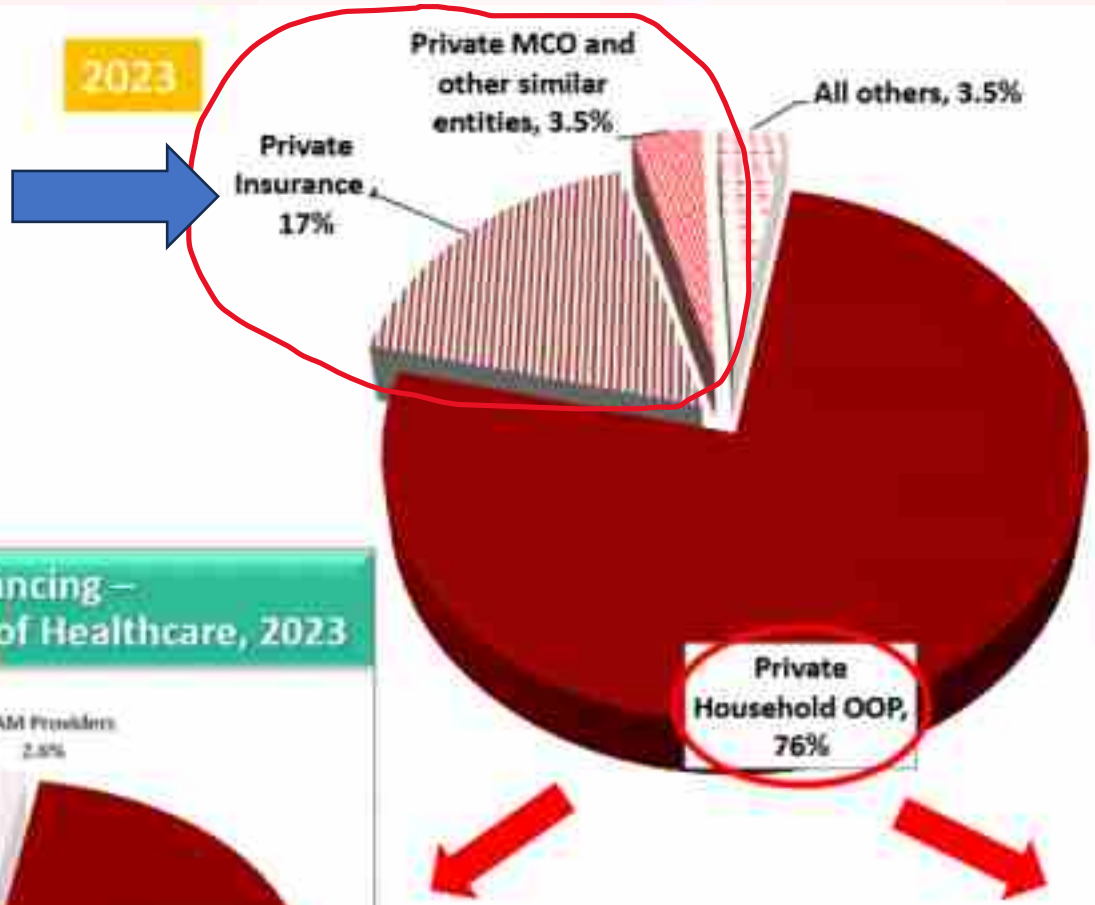
Sources of Financing – Ministry of Health (MOH), 2011-2023



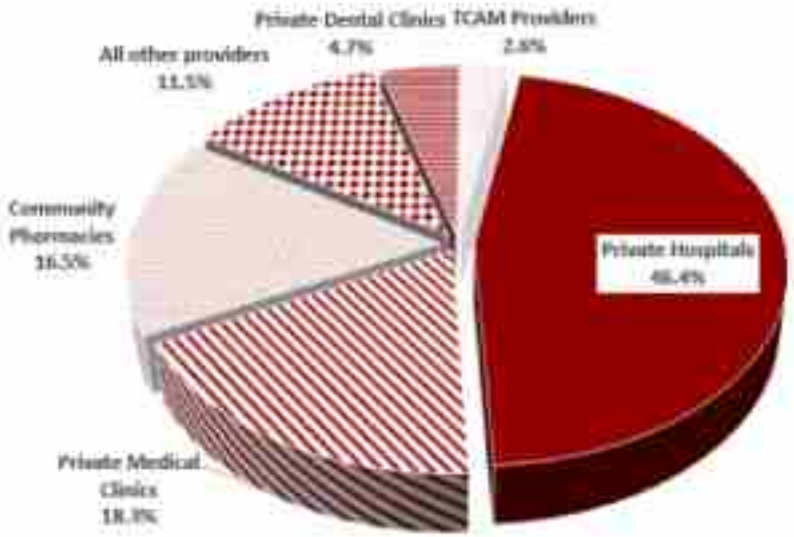
Sources of Financing – Private – Out-of-pocket (OOP), 2011-2023



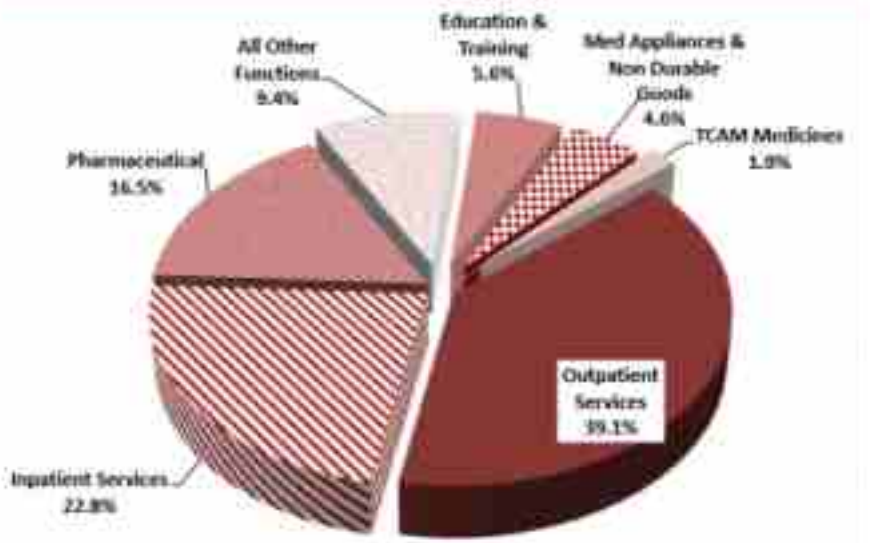
Sources of Financing – Private Source, 2023



Sources of Financing – Private – OOP – Providers of Healthcare, 2023



Sources of Financing – Private – OOP – Functions of Healthcare, 2023

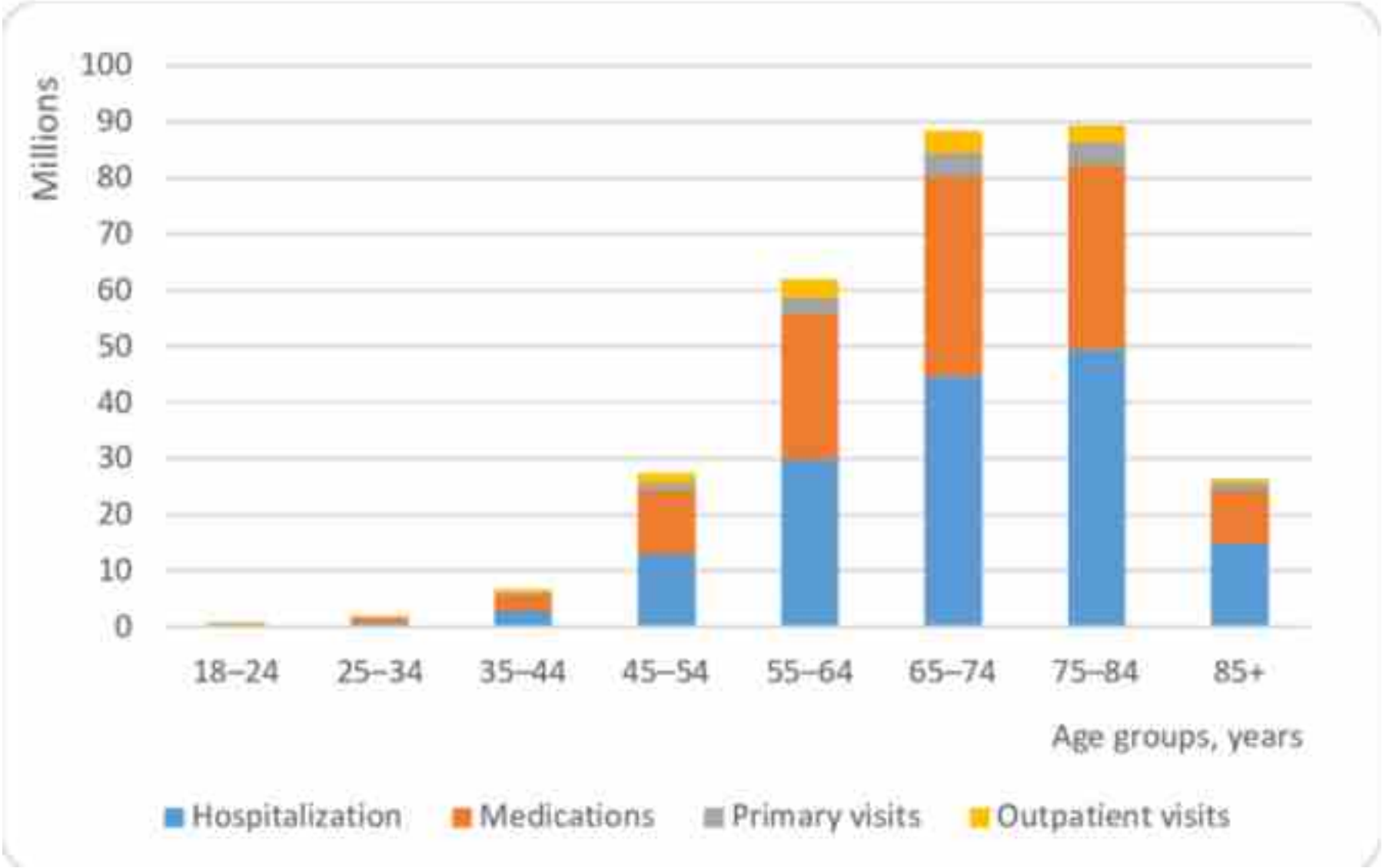


1.Even though Healthcare cost inflation is real, but the often-quoted figure of 10-15% yearly inflation refers to the healthcare insurance premium inflation (which is about 10% of the total expenditure for Health) AND not the overall healthcare cost inflation (due to aging population, new technology, increased cost and LITIGATION)!

2.MOH and the Public Healthcare providers mitigated much of the inflationary factors.

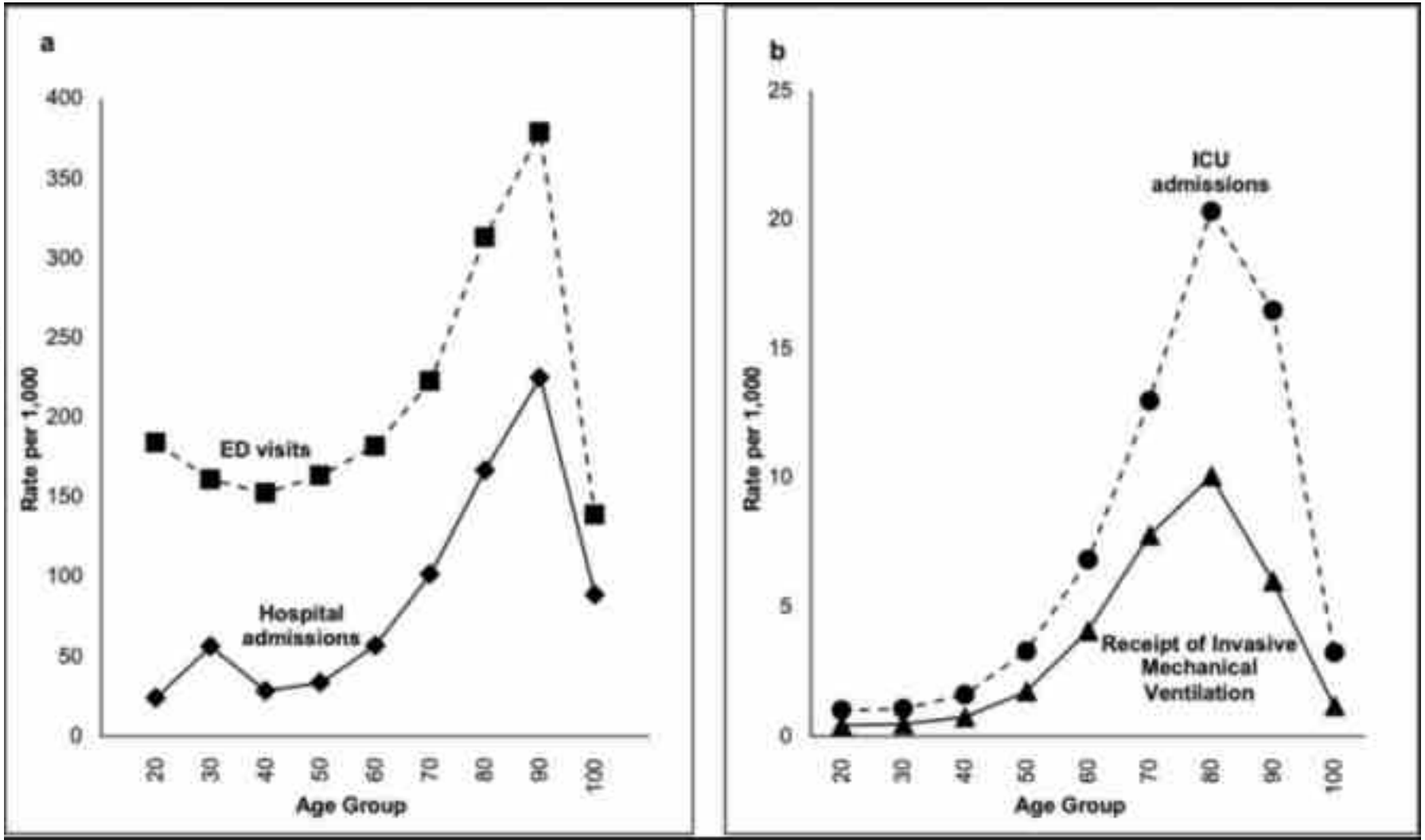
3.Why does the healthcare insurance premium keep increasing by 10-15% every year?

Structure and Distribution of Health Care Costs across Age Groups of Patients with Multimorbidity in Lithuania



Ontario Canada

Acute healthcare resource utilization by age: A cohort study

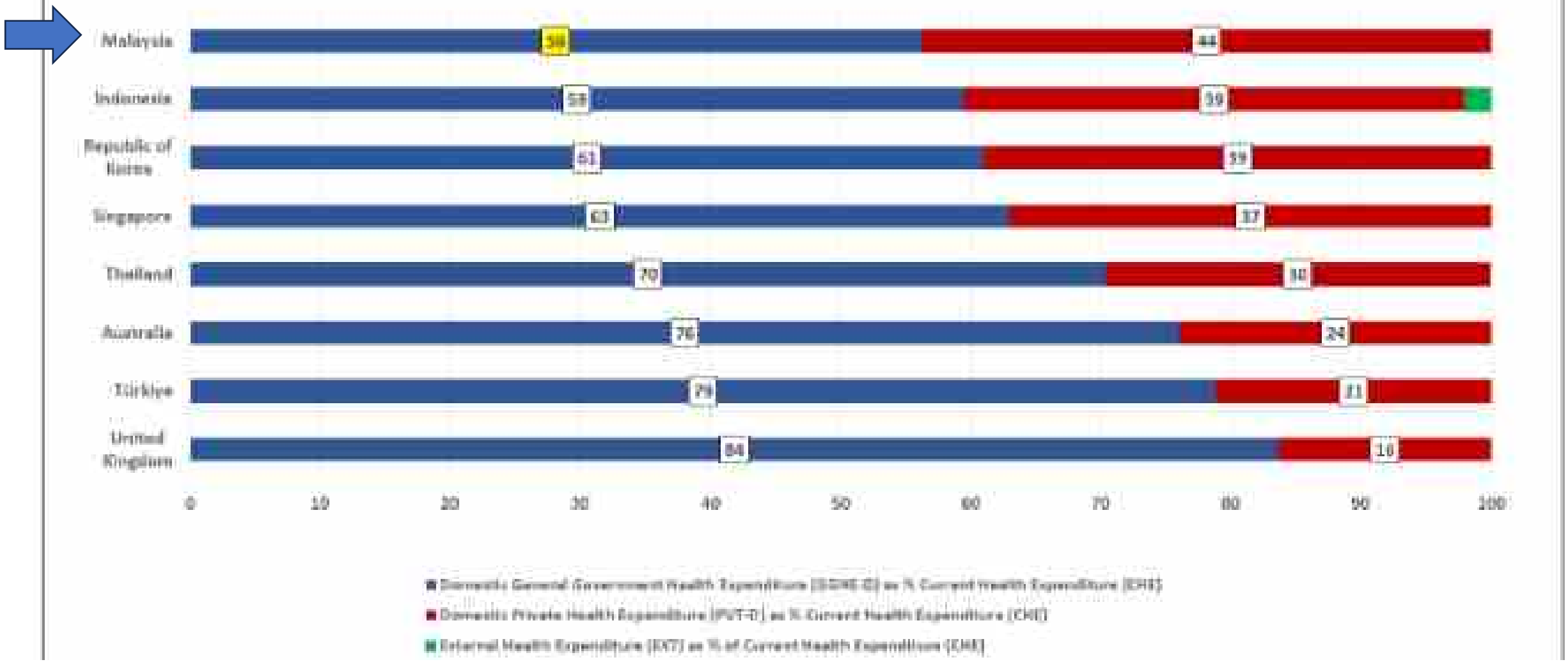


See this image and copyright information in PMC

Fig 1 Age stratified trends in overall rates of: a) acute healthcare encounters; and b) critical care encounters, and overall volume of: c) acute healthcare encounters; and d) critical care encounters.

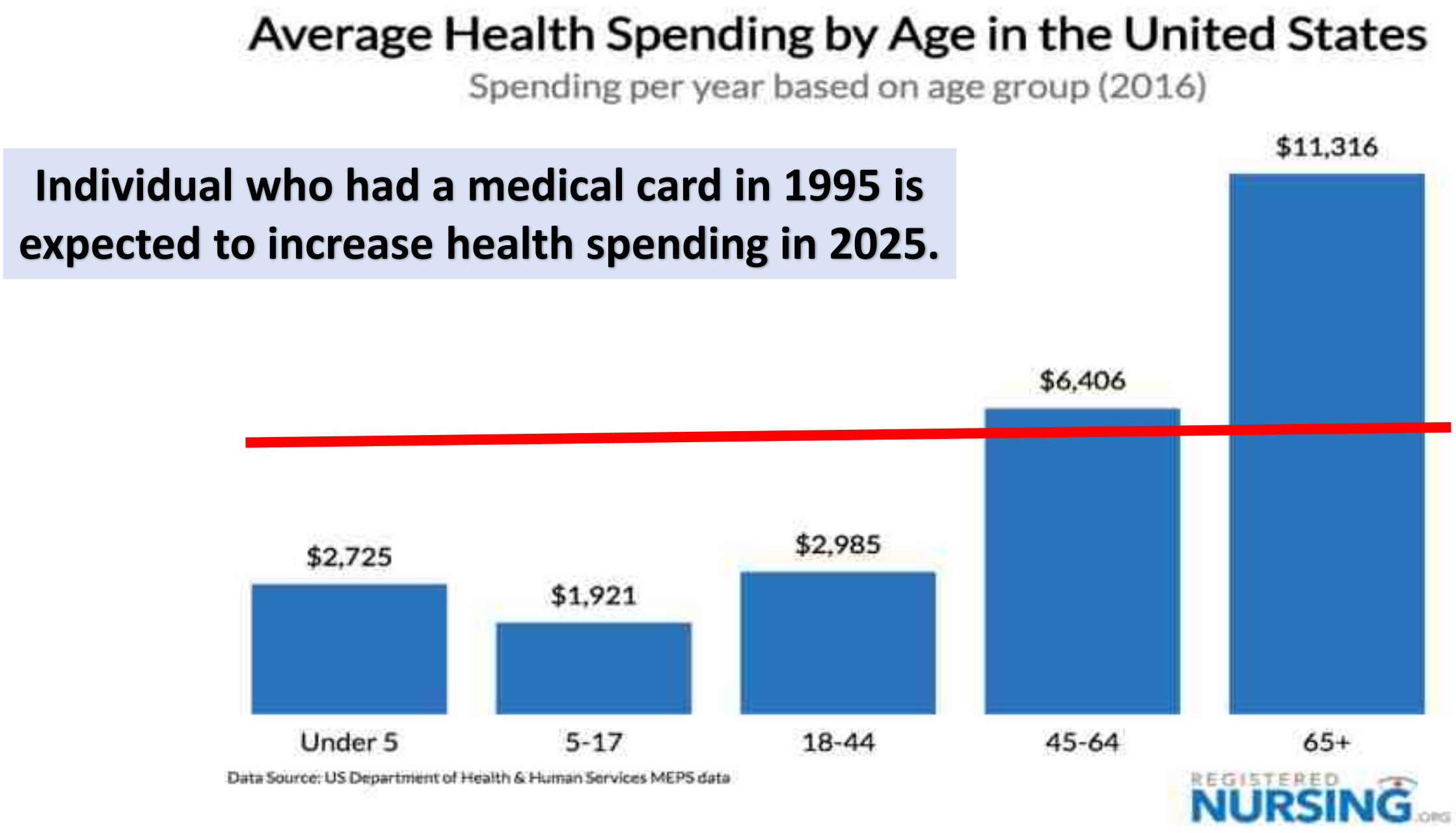
Public-Private Share in Health Expenditure, 2021 (%)

Selected Country Comparison*



While private healthcare sector provides CHOICE for the people, the public healthcare sector must expand because public sector had the ability to RATION healthcare consumption. Public sector can also run at a lower cost and hence it will help to dampen the overall healthcare cost inflation.

Health Spending Average by Age



Individual who had a medical card in 1995 is expected to increase health spending in 2025.

The need for a Universal National Health Insurance Scheme to cover from cradle to death.

- Public healthcare facilities had a dampening effect on healthcare cost inflation.
- Important to strengthen public healthcare facilities before implementation of a National Health Insurance Scheme
- Internal review to make it more efficient
- Instill and solidify patient centric culture
- More $$$$$$ to MOH and other public healthcare facilities

The ultimate objectives of national healthcare policy

- Universal, Equitable, Accessible and Quality
- Should look at TOTAL EXPENDITURE for HEALTH (TEH) rather than sectoral approach (such as medical cards).
- Then decided of how to fund the THE-eg National Health Insurance.

THANK YOU

ADDENDUM

Record-Breaking Medical Negligence Compensation

- In **Thaqif Asyraf v Government of Malaysia** [2023] 1 LNS 2261, the Court of Appeal awarded **RM9.45 million**, the highest recorded medical negligence compensation in Malaysia. Thaqif, a 10-year-old boy, suffered irreversible brain injuries at birth due to negligent treatment at Penang Hospital.
- In **Nur Adeena v Government of Malaysia** & Ors [2023] MLJU 1400, the Court of Appeal increased medical negligence compensation in Malaysia to **RM8.6 million** for a minor who suffered tetraplegia due to spinal cord injury caused by medical negligence at Hospital Selayang.
- ***Fareed Reezal bin Arund v Pantai Medical Centre Sdn. Bhd. & 4 Ors:*** The total award sum was **RM7.5 million**
- **Siow Ching Yee v Columbia Asia Sdn Bhd: RM 4.5 million** compensation by the Hospital and **RM 2.0 million** by the Doctor. **The private hospital was found liable.**

Siow Ching Yee v Columbia Asia Sdn Bhd:2024

- **Quantum – Director's Fees and Allowances as Earnings**
- The Federal Court allowed the claim regarding the director's fees and allowances, on top of the plaintiff's salary and the provident fund contributions.
- **The Judgment Sum**
- Following the judgment of the Federal Court, the judgment sum, including costs, is now RM 4.5 million (from Columbia Asia Sdn Bhd).

For reference : The highest remuneration as CEO of a public listed company in Malaysia is RM113 million per year!

Session with the Public Accounts Committee regarding Health Insurance



4 March 2025

[Lim Teng Chyuan, B Pharm(Hons), MBA(TQM), RPh 1489, MMPS]

Who are we

- Malaysian Association of Pharmaceutical Suppliers (MAPS)
- 37 ordinary members comprising companies involved in the marketing, sales and distribution of pharmaceuticals in Malaysia
- Products are mainly affordable generics imported from sources that meet the standards required by and registered with the NPRA

MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Healthcare cost components vs medicines cost

- Hospital charges
- Fees
- Medicines
- Disposables
- Tests
- Imaging
- Procedures

- Medical goods make up 15% to total healthcare costs [1 (p.43)] in the private market
  - Pharmaceuticals, appliances, western medicines, TCM, etc. [1 (p.110)]
- This % is measured at the health care provider level, ie after mark-ups
- Markups range from 24 to 402% depending on outlets [2]
  - markup of medicine prices was generally higher in private hospitals than community pharmacies
- Markups for generics generally higher [2]
  - generic medicine was 31%–402%
  - innovator medicine was 24%–86%

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Theoretical impact of medicine price increase towards health care cost

Before

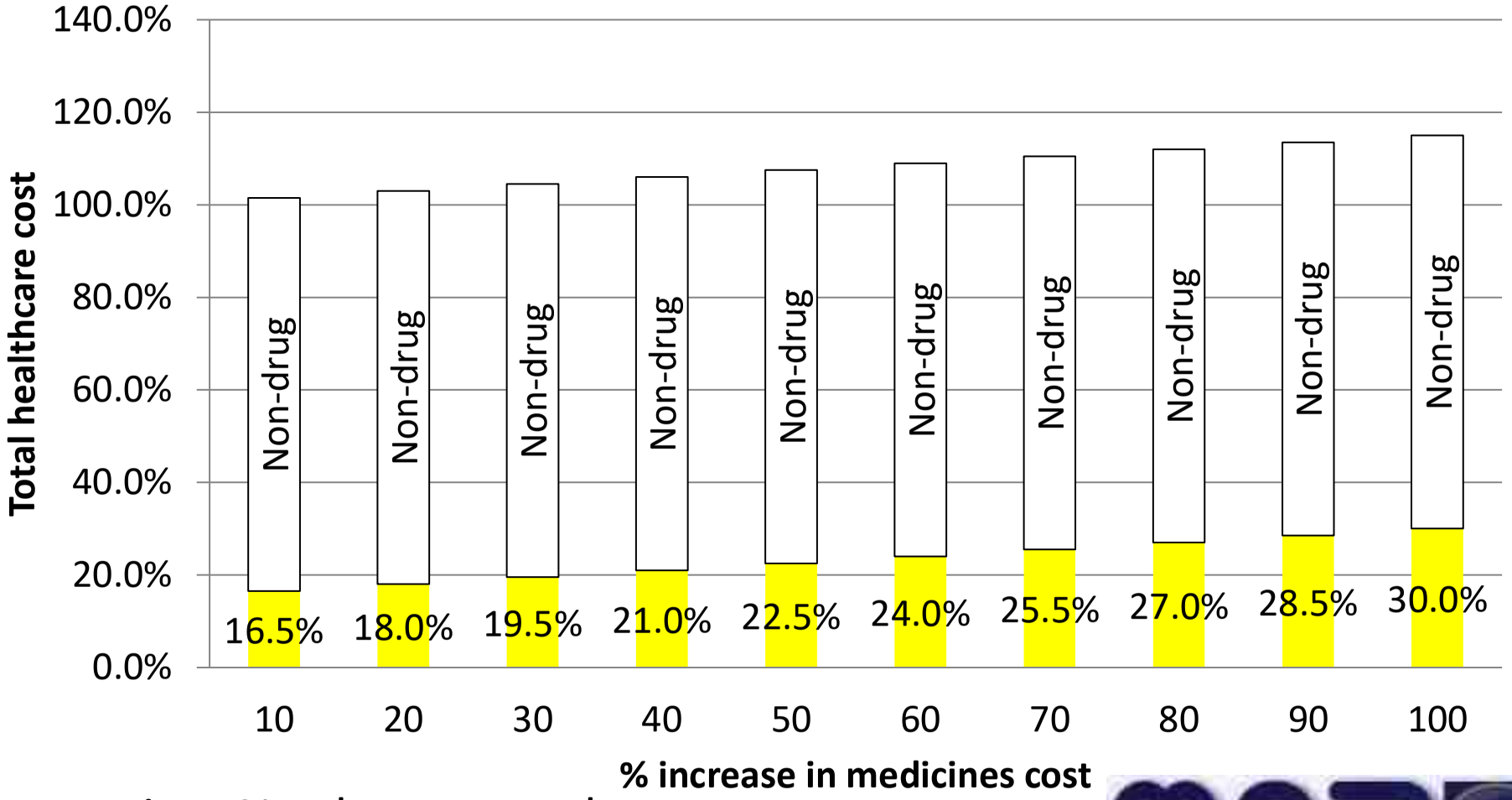
- Total bill is RM10,000
- Medicine component is RM1,500
- Non-medicine costs = RM8500

After

- 10% rise in medicine cost =RM1,650
- Assuming non-medicine costs unchanged = RM8500
- Total bill = RM10,150
- 10% rise in medicine costs only causes a 1.5% rise in total health care costs, if all else is maintained

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Theoretical impact to total costs based on % of medicine price increase



Assumption: No change to other costs

MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

HCP paid by Insurance

Personal

- Impacts patients directly as patients have to pay the premiums themselves

Employer

- Premium paid by employers but impacts patients via company profitability

Caveats:

1) Limits due to coverage plan
2) Premiums may rise depending on history of claims and age
3) Unfortunately, having health insurance will not always result in lower out-of-pocket expenditure [3(p.104)]

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Payment Direct to HCP

Out of Pocket

- Impacts patients directly as patients have to pay the HCP
- Big problems when catastrophic events occur, may not get the care required
- Malaysia has a higher rate of OOP (35%) [1 (p.xvi)] compared to Thailand (9%) and Brunei (6%) [1 (p.88),3(p.103)]

Employer

- Rarely practised, usually on a reimbursement basis

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Impacts of rising premiums

OOP

- Under-insurance [3 (p.112)]
- Cancellation of coverage
- Diversion to public facilities
  - Overwhelming public facilities
  - Government expenses increased
- Sub-optimal intervention in Private HCP intervention

Employers

- Under-insurance
- Cancellation of coverage
- Resort to reimbursement model

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Role of Insurance

- Accessibility to medical services
- Improve life expectancy
- Transfer risks
- Pooling of resources
- Investment income

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

What is reasonable premium?

- Per capita expenditure on health was RM1,974 in 2019. [1 (p.14)]
- How much higher than RM1,974/yr as premium is reasonable?

Claims ratio?

- Assuming no increase in premiums from 2018 – 2023 => paid RM42K
- Total claimed RM23K from 2023 - 2024
- Claims ratio 47%, ignoring premiums paid thereafter

	Insured Comp	Type of Insurance	Name Insured	Commencement Date
	HLA	Medical	[redacted]	27-Mar-18
	DATE	27-Mar-18	28-Apr-24	28-Mar-25
Premium Paid (RM)	Monthly	583.00	683.00	1,047.00
	Yearly	6,996.00	8,196.00	12,564.00
	% Increased YoY		17.2%	53.3%
	% Increased since 2024 (> 2 years)			80%

Event	Hospital	Event Date	Claim Status	Claim Status	Claimed Amount (RM)	Diagnosis
HOSPITAL & SURGICAL	KPJ Ipoh	19/4/2023	Full Settlement	Full Settlement	5583	Bilateral Knee Osteoarthritis
HOSPITAL & SURGICAL	KPJ Ipoh	23/5/2023	Full Settlement	Full Settlement	400	Follow Up
HOSPITAL & SURGICAL	KPJ Ipoh	13/3/2024	Full Settlement	Full Settlement	5919.65	Bilateral Knee Osteoarthritis
HOSPITAL & SURGICAL	KPJ Ipoh	8/5/2024	Full Settlement	Full Settlement	400	Follow Up
HOSPITAL & SURGICAL	KPJ Ipoh	5/6/2024	Full Settlement	Full Settlement	400	Follow Up
HOSPITAL & SURGICAL	Columbia Asia Taiping	18/7/2024	Full Settlement	Full Settlement	9742.6	Coronary Artery Disease
HOSPITAL & SURGICAL	Columbia Asia Taiping	2/8/2024	Full Settlement	Full Settlement	159.6	Follow Up
HOSPITAL & SURGICAL	Columbia Asia Taiping	13/9/2024	Full Settlement	Full Settlement	159.6	Follow Up
HOSPITAL & SURGICAL	Columbia Asia Taiping	11/10/2024	Full Settlement	Full Settlement	273.45	Follow Up
				TOTAL Claimed	23,[illegible]90	

- What is justification for the increments from 2024 onwards?

MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

How about this?

	Insured Comp	Type of Insurance	Name Insured	Commencement Date	Original Mature Date
	HLA	Medical	LIM GAIK ENG	18-Mar-19	18-Feb-67
	DATE	18-Mar-19	19-Mar-24	19-Mar-25	
Premium Paid (RM)	Monthly	356.00	526.00	774.00	
	Yearly	4,272.00	6,312.00	9,288.00	
	% Increased YoY		47.8%	47.1%	
	% Increased since 2024 (> 2 years)			117%	
			TOTAL CLAIMED INCURED	NIL	

- With no claims since inception, what is justification for the increments from 2024 onwards?

MAPS
MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Is it worth paying premiums?

From: [redacted]
Sent: Tuesday, October 1, 2024 1:58 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Insurance Renewal Quotation for 2024/2025 - Someplace Sdn Bhd

Dear Cassie,

Enclosed herewith the 5 years medical record for your attention.

Year	Premium Paid	Claim Incurred	Loss Ratio
2019-2020	64,068.49	30,000.00	47%
2020-2021	58,295.89	43,385.99	74%
2021-2022	51,475.64	18,803.66	37%
2022-2023	49,119.00	37,256.00	76%
2023-2024	50,749.17	47,777.25	94%
Total	273,707.99	177,222.90	65%

Thank you.



1. GHS Claim History



	2016	2017	2018	2019	2020	Total
Premium (RM)	14,096	34,684	53,507	64,068	58,295	224,651
Claim (RM)	28,747	40,344	35,260	30,000	26,962	161,313
L/R	203.9%	116.3%	65.9%	46.8%	46.3%	71.8%

MALAYSIAN ASSOCIATION of PHARMACEUTICAL SUPPLIERS

Medical suppliers profitability - example

- Somedico profits RM456k on RM17m sales in 2017[4]
- Somedico profits RM225k on RM22.5m sales in 2023[5]
- Almost a halving of profits despite a 32% increase in sales

Conclusion

- It may seem like the insurance pays but finally we pay, either OOP or via employers to the insurance companies
- Insurance companies gain very much via annual hikes and claims-based history justification for hikes
- BNM need to regulate such hikes

References

1. Ministry of Health Malaysia. Malaysia national health accounts: Health expenditure report 1997-2019. Putrajaya: Malaysia National Health Accounts Section, Planning Division, Ministry of Health Malaysia; 2021
2. Nur Sufiza, Patient Preference and Adherence 2018:12 1231–1237
3. Norfatihah Isamail, Rusmawati Said, Mal J Med Health Sci 21(1): 103-114, Jan 2025
4. MARKET REVIEW ON PRIORITY SECTOR UNDER COMPETITION ACT 2010 PHARMACEUTICAL SECTOR p48
5. Directors Reports and Audited Financial Statements for the Year ended Sep 2023 (filed with the SSM)

PRESENTATION FOR MALAYSIAN PARLIAMENT ACCOUNTS COMMITTEE (PAC)

INSURANCE PREMIUM INCREASE
A REFLECTION OF RISING HEALTHCARE COSTS

4 March 2025

FEDERATION OF PRIVATE MEDICAL PRACTITIONERS ASSOCIATIONS MALAYSIA (FPMPAM)

FPMPAM Introduction & Team

- We are a national body representing private practitioners, both GPs and Specialists via our sister state societies, namely : Kedah-Perlis, Penang, Perak, Selangor-Wilayah Persekutuan Kuala Lumpur, Pahang, Sarawak, Sabah
- 5000 members

Our Team today:

- Dr Shanmuganathan Ganeson MD UKM, President
- Dr Steven Chow Kim Weng, MBBS (Mal), MRCPI,FAADV, FAMM, FRCPI Hon. FRACP. FRCP(London), Dip Derm (Hons), Dip Ven (London) Hon Treasurer, Founder & Immediate Past President
- Dr Lim Kuan Joo, AMN,KMN, MBBS (UM), MPH (Antwerp), AM Malaysia, Adviser, Ex-officio
- Dr Chang Chee Seong, MD (KSMU), OHD (NIOSH), Committee Member, Past President PMPASKL

Rise in healthcare costs

KUALA LUMPUR, Dec 10 — Malaysia's healthcare sector is facing a medical cost inflation rate that poses significant challenges for both healthcare providers and patients requiring long-term care.

According to Bank Negara Malaysia, the country recorded a 12.6 per cent medical cost inflation rate in 2023—more than double the global average of 5.6 per cent and an increase from 12 per cent in 2022.

Rise in healthcare costs …..Insurers

Insurers groups asserted that price adjustment is inevitable.

But
Allianz General Insurance Company:
In 2019 Profit before tax : RM365 million. In 2023 it was RM577 million

Prudential Assurance Malaysia Berhad: 2019: RM573 million. In 2023, it was RM1.42 billion……147% increase

Chia Chu Hang of EMIR research

Rise in healthcare costs…..Hospital groups

APHM explained that private hospitals are, by design, **business entities** that allow patients to make voluntary choices regarding their treatment.

The rising costs are too great for private hospitals to absorb unless they increase their prices.

But financial reports suggests otherwise:
IHH Healthcare Berhad, operator of 18 private hospitals made RM1.04 billion in 2019 to RM4.05 billion in 2024
KPJ Healthcare Berhad made profit before tax in 2019 : RM270 million In 2023, RM378 million

Chia Chu Hang Emir Research

Causes of medical inflation

1. Pandemic
2. Higher over cost
3. Under-utilisation of primary healthcare
4. Insurance Claims policy
5. Practice of defensive medicine
6. Moral hazards

Causes of medical inflation

1. **Pandemic:**
   Medical inflation was very high during Covid 19
   Logistical challenges
   Demand outstripped supply
   Hysteria

2. **Higher over costs**
   Medical and Non-medical, Currency exchange issues with lower RM

Causes of medical inflation

3. Under-utilisation of primary healthcare

Primary healthcare is more cost-effective.
However,
KKM policies, Insurers policies, Public perspective and current Malaysian culture is to make the Specialist or sub-specialiost the first line of visit.

Causes of medical inflation

4. **Insurance Claims policies**
Most Insurers here allow claims only with admission
Out-patient or day care procedures reduce cost
Procedures at the GP cost lower
Rise in premiums is also attributed to extended coverage, pandemic coverage, post-covid syndrome, critical illnesses

5. Practice of defensive medicine
This is overly good medical practice. Multidisciplinary approach, multiple diagnostic imaging and laboratory investigations

Causes of medical inflation

6. Moral hazards

Insured: admissions for investigations without medical indication (self-justification already paid for many years)

Providers: for the insured, over investigate

Rise in healthcare costs…..Health care workers, GP Clinics

- **Source**
  - 1. Healthcare –related cost: HCWs' wages, price of medications, disposables, devices
    2. Mandatory or regulation related cost – medical indemnity, minimum wages
    3. Non-Healthcare related cost – General wages, Logistic costs, Rentals, Housing
- **Is HCWs' wages or fees the main contributor of rise?**
  - Definitely not, thanks to the Fee Schedules that has not kept up with the times
  - GP and Specialists fees **not** reviewed from time to time to adjust for inflation
- **Inflation**
  - Unless the government is able to control inflation in other areas, one cannot expect cost of healthcare to remain unchanged when everything else is on the rise.

Questions

- **1. Malaysia healthcare –Dual system**
  Public is almost free,
  Private : Price variation: premium, standard, low
  What are we paying for?
  Comfort? Expertise? State pof the art equipment
- **2. Real cost of medical inflation**
  Specialist fee is regulated, GP fees stagnant do not account for the steep inflation
- **3. Insurance Premium increase**
  Is it over-utilization? Claims ratio increase?

Open Letter to YAB Perdana Menteri

16 September 2023

Government must regulate the Managed care Organisation to ensure patient safety and quality of care

Some ways to reduce health cost:

1. Compel Insureds to see a GP first
2. Co-payment to reduce overuse
3: Extending Insurance Coverage for Older Adults
4. Regulations & the cost of compliance

1: Compel Insureds to see a GP first but support the GP

- **Problem**
  - Direct Specialist access drives up cost and leads to over-utilisation
- **Recommendation**
  - Insurers should mandate non-emergency GP Consultations before specialist access. The GP as a gate-keeper.
  - Price display mandate is being touted to solve medical inflation. This mandate will annihilate current GP Clinics. If we want gatekeepers, stop this pathway to dispensing separation.

2: Co-payment to reduce overuse

- **Problem**
  - Lack of Co-payment
    Co-payment discourages unnecessary specialist and hospital visits
- **Recommendation**
  - A tiered co-payment system for out-patient and in-patient care should be developed

3: Extending Insurance Coverage for Older Adults

- **Problem**
  - Those above 60 years are generally uninsurable, creating a financial burden on the public sector
- **Recommendation**
  - Introduce risk-based premiums for those aged 60 to 70
  - Is this doable? Looking at the insurers' profits, it should be.

4: Regulations & the cost of compliance

- **Problem**
  - Regulations when made should compute the cost it imposes on providers and to the patient
- **Recommendation**
  - Take a re-look at the recommendations of the Malaysia Productivity Corporation book on deregulating unnecessary regulations in Healthcare

Regulatory gaps

- **1. Lack of Insurer accountability**
  - No clear oversight on how insurers set premiums or deny coverage
- **2. No mandate for fair GP/SP reimbursement/unregulated Hospital charges**
  - The PHFSA dictates low rates for GPs
  - Hospital administrators have a free hand on fee imposition, unregulated, unlike specialist fees
- **3. No co-payment requirement**
  - Patients have no financial stake, leading to overuse of secondary and or tertiary care
- **4. Minimal standardized insurance framework for those aged 60+**
  - Insurers exclude older adults instead of offering risk based coverage

PRESENTATION FOR MALAYSIAN PARLIAMENT SPECIAL SELECT COMMITTEE ON HEALTH

Challenges Faced by Private Medical Practitioners in Malaysia

25 February 2025

FEDERATION OF PRIVATE MEDICAL PRACTITIONERS ASSOCIATIONS MALAYSIA (FPMPAM)

Overview of Issues

1. GP Fee Schedule stagnation
2. Foreign equity in primary care
3. Dispensing Separation: Price display requirements
4. MCOs unregulated
5. Micro-regulation via PHFSA1998
6. Rising costs of medical negligence cases
7. Repeal of Pathology Laboratory Act without replacement
8. National Health Financing Scheme engagement

Recommendations

1. Immediate revision of consultation fee schedules.
2. Flexibility on price display requirements.
3. Establish clear TPA regulations.
4. Protect local ownership in primary care.
5. Streamline PHFSA 1998 regulations.
6. Introduce alternative dispute resolution for medical negligence cases.
7. Maintain regulatory oversight of the Pathology Laboratory Act
8. Actively involve private practitioners in the National Health Financing Scheme.

THANK YOU

Rise in healthcare costs

MNHA: Total (TEH) and Current (CHE) Expenditure on Health Data as of 2022

Malaysia's national health accounts are based on the Malaysian National Health Accounts (MNHA) framework, which is consistent with international NHA classifications but with minor modifications to suit local policy needs.

For this dataset specifically, **total expenditure on health (TEH)** comprises 'health expenditure' and 'health-related' expenditure from both public and private sectors.

- *Health expenditure* consists of all expenditures or outlays of medical care, prevention, promotion, rehabilitation, community health activities, health administration and regulation with the predominant objective to improve health.

- *Health-related expenditure* covers capital formation of healthcare provider institutions, education and training of health personnel, research and development, and all other health-related expenditures.

Current expenditure on health (CEH) is conceptually similar, but covers only health expenditure, i.e. it excludes *health-related* expenditure.

Conclusion and next steps

Key Takeaways

- **Health Insurance premiums** are rising steeply, affecting accessibility and affordability
- **A GP first approach** is a logical cost-effective strategy for controlling costs but policies should sustain the GP clinic
- **Co-payment mechanisms** are needed to curb overutilization and ensure sustainability
- **Fairer remuneration structures** are essential to balance GP, procedural and non-procedural specialist incomes
- **Extending coverage for those above 60+** should be explored with risk-based models

Rise in healthcare costs

MNHA: Total (TEH) and Current (CHE) Expenditure on Health
Data as of 2022

Total and current expenditure on health in Malaysia, with a breakdown into public and private sectors.

In general, national health accounts (NHA) seek to answer 4 questions pertaining to healthcare spending:

1. How much is spent?
2. Who spent it? (sources of financing)
3. Where was it spent? (providers of healthcare)
4. What was it spent for?(functions)

Purpose

- Identifying healthcare costs
- Share ideas on curbing healthcare costs

HIGH PRIVATE HEALTHCARE COSTS



"VIEWPOINTS & SUGGESTIONS"
from The Private Specialists
We speak for the industry, the patients & the nation

Presentation by

The Association of Specialists in Private Medical Practice (ASPMP) for the

Parliamentary Accounts Committee

Jawatankuasa Kira-Kira Wang Negara

HIGH PRIVATE HEALTHCARE COSTS

Firstly,

A BIG THANK YOU for hearing us.

RIBUAN TERIMA KASIH, atas jumputan ini daripada JKKKWN

Kami, The Association of Specialists in Private Medical Practice (ASPMP)
(Persatuan Pakar Amalan Perubatan Swasta Malaysia)...
Dr Sng Kim Hock dan Dato' Dr Ahmad Faisal

HIGH PRIVATE HEALTHCARE COSTS

The Association of Specialists in Private Medical Practice (ASPMP) is the main focused voice that represents all private medical specialists

We work alongside MMA (all doctors, government & private) &
FPMPAM (all private doctors, mainly GPs)

We really appreciate being heard, as we are the frontliners. We know what is happening, and we believe we have some suggestions as to what can be done.

HIGH PRIVATE HEALTHCARE COSTS

Private Medical Centres began 51 years ago in 1974 when a group of specialists started Pantai Medical Centre

The Association of Specialists in Private Medical Practice (ASPMP) was formed in 2001, when the founders realized that we are not represented and our issues are often not heard.

HIGH PRIVATE HEALTHCARE COSTS

“Recent high private healthcare costs”

We agree that the escalation of private healthcare costs is real and unacceptable.

We also agree that something must be done.

On our part, we are listening to the public, to the ministry of health, and most important to our members... Penang, Klang Valley, Johor, Melaka, and Ipoh, and in discussion with MMA, FPMPAM
After speaking to PAC, we will meet APHM, maybe the Insurance bodies before we meet MOH.

HIGH PRIVATE HEALTHCARE COSTS



Malaysia's Dual Complimentary Healthcare System
(2023 data)

149 Government Hospitals
(45,964 beds) 71%
212 Private Health Care Centres
(18,779 beds) 29%

HIGH PRIVATE HEALTHCARE COSTS

Current numbers:

Total Registered Doctors – 82,227
(MMC -2023) 1:406 population

All Specialists – 18,211
Private Specialists – 6,110
(National Specialist Register, 31.12.2024)

HIGH PRIVATE HEALTHCARE COSTS

Private Health Care has grown into a multibillion dollar industry, playing a crucial role for the nation, and at the same time a national pride and asset.

212 centres
18,779 beds (29%)
6,110 specialists (34%)

1999 – 10% of patients insured
2024 – 50-70% patients insured

HIGH PRIVATE HEALTHCARE COSTS

Therefore, as leaders, planners and law makers...

We must protect, nurture and support the Private Health Care industry, (similar to the Hotel, tourism industry, the private educational institutions, from kindergarten to Universities, the private banking industry, the private transportation, air and other supporting industries) and not to crush and constrict it with harmful rules and regulations

HIGH PRIVATE HEALTHCARE COSTS

ASPMP fully agree and supports the principles and concepts that

Healthcare is a right for everyone, both citizens, residents and others, and that is why no hospital/doctor has ever turned away from treating the sick.

However, we strongly believe in a free market, free choice and hence payment is unavoidable ie fee for service currently.

However, the public healthcare system has to be universal, as there will always be the poor, and the millions who cannot afford private health care.

National Health Expenditure

Parameter	2020	2022
Total National Health Expenditure	67.05 Billion	79.94 Billion
% GDP	4.73%	4.41%
Private Healthcare Contribution	30.45 Billion (46%)	37. 69 Billion (48%)

Health Tourism

In 2023, the healthcare tourism sector posted RM2.25 billion in revenue.

MHTC recorded health tourist arrivals:
2022: 850,000
2023: 1 million
First half 2024: 584,468

MALAYSIA

Best Healthcare in the World 2019 International Living Annual Global Retirement Index.

- 13 private hospitals accredited by the JCI
- Almost all doctors — trained in UK, US or Australia & fluent in English
- Easy access to see a private specialist
- Referral from GP not required
- Just register at any private hospital, wait in queue & see specialist of your choice

ROADMAP TO HEALTHCARE REFORMS

YOUR OPINION

THE STAR, FRIDAY 27 DECEMBER 2024

EMAIL editor@thestar.com.my or MAIL The Editor, Menara Star, 15, Jalan 13/11, Section 13, 46350 Petaling Jaya. Letters must carry the sender's full name, address and telephone number. A pseudonym may be included.

Alarming state of healthcare system



DRG, the diagnosis-related group system, has become a very fashionable abbreviation after insurance providers announced yet another spike in excess of 40%-70% in medical insurance premiums.

This increase in premiums is against the backdrop of RM963mil in RM1.41bil profit after tax for the year ending 2023 for medical insurance providers. Dividends paid out in 2023 amounted to between RM451mil and RM972mil.

The medical insurance providers have, however, pointed their fingers at exorbitant bills in private hospitals.

A letter by a group of MPs and a senator alleges that, "Bank Negara Malaysia also highlighted the charges for hospital supplies and services which they said are 59% to 70% higher than drug bills, as well as the lack of government regulation over consumable items such as syringes, gloves and gauze in hospitals".

Not unlike the medical insurance providers, private hospitals reaped net earnings of RM263.4mil to RM2.95bil for the year ending 2023. This represented private hospital group profit surges of between 58% and 98%.

Therefore, it is of utmost importance for MPs, Bank Negara Malaysia, the Health Ministry (MOH), and – most crucially – the lay public to note that the medical specialist is a minor player in the billion-ringgit corporatisation of the healthcare industry in Malaysia.

Why? This is because the specialist's fee is only a tiny fraction of the itemised hospital bill. That fee is strictly regulated by the 12th Schedule of the Private Healthcare Facilities and Services (Amendment) Order 2012, and published by the Attorney General's Chambers.

This means that the specialist fees in the hospital's itemised bill has not been reviewed or revised for 11 long inflationary years.

Specialist fees by and large (with the rare exception of the very few black sheep in this "most trusted professional group as voted by Malaysians and the global public") have not significantly contributed to medical inflation in Malaysia for the last decade.

This contrasts sharply with the laissez-faire and virtually unregulated business of medicine as conducted by private hospital groups and medical insurance providers. These two groups have been allowed to do as they choose with minimal government interference.

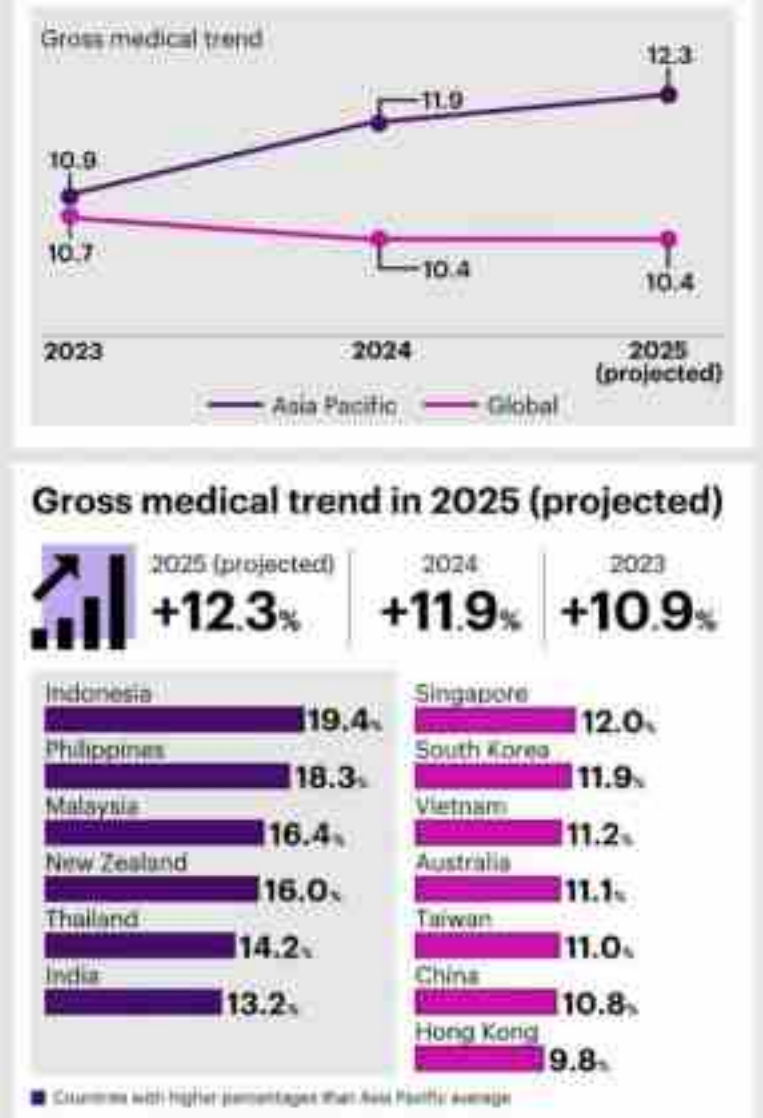
This alarming state of healthcare affairs – apparently only recently realised by Bank Negara and the MOH – has unfortunately fuelled medical inflation in excess of 12%, and this is expected to rise to 16.4% in 2025, well above the global average of 10.4%.

Now that we have all the chips on the table, we next need to discuss whether the DRG system is the right way forward to transform our healthcare ecosystem.

DR MUSA MOHD NORDIN
Paediatrician
DR AHMAD FAIZAL MOHD PERDAUS
Chest physician
DR RAJENTHERAN SUNTHERALINGAM
Urologist

Medical Inflation

- Rate at which healthcare costs have risen due to new trends & developments.
- Global medical trend in 2025 = 10.4%
- Asia Pacific = 12.3%
- Malaysia = 16.4%



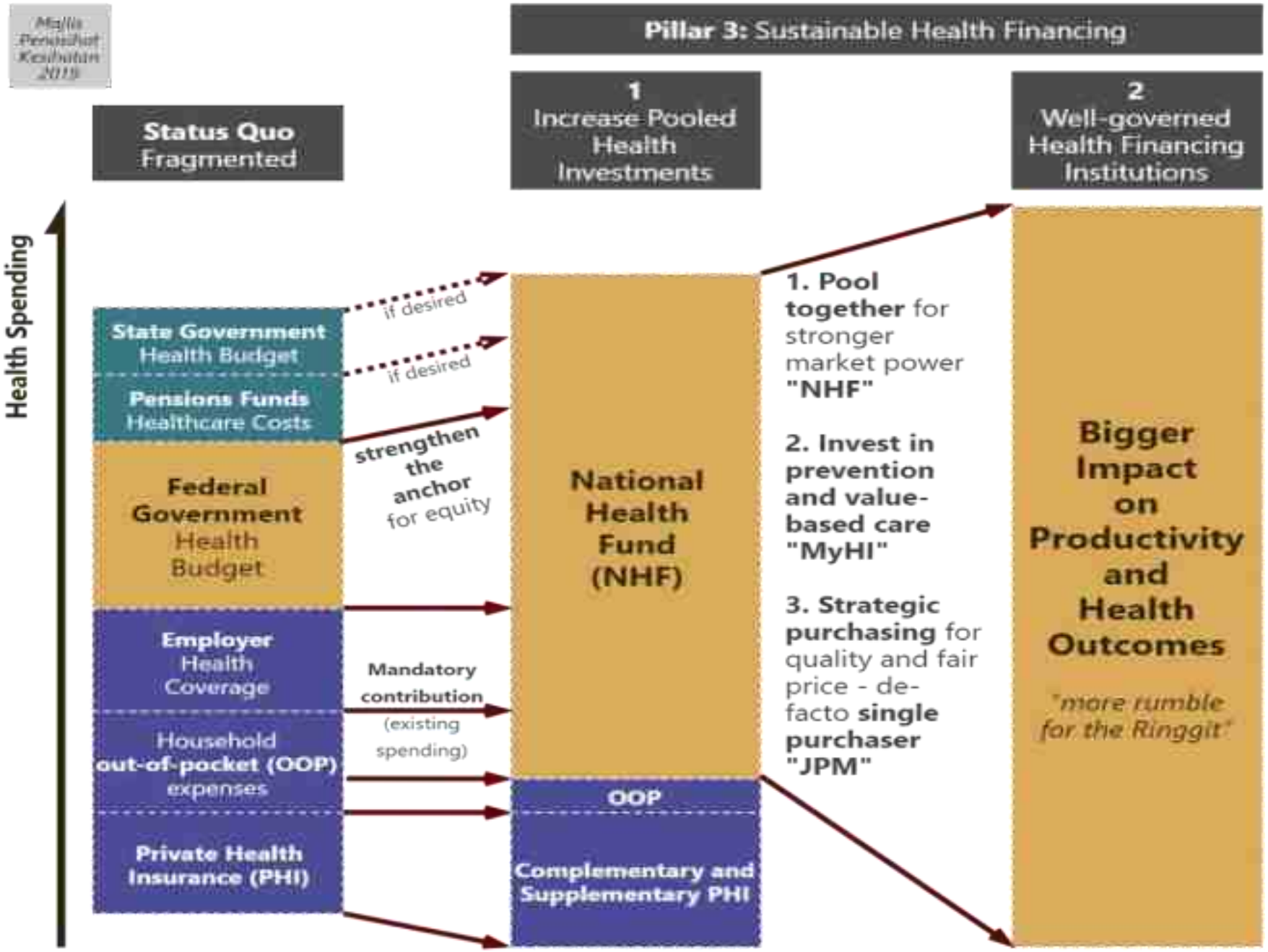
Rising Healthcare Costs

1. Inflated Insurance Premiums
2. Escalating Private Hospital Bills
3. New technology: Diagnostics-Therapeutics
5. ROI on Equipment
6. Drugs & devices mark up
7. Doctors Bill (capped since 2013)
8. Higher Remunerations: Executives, Marketing
9. Corporate demands:BOD
10. Returns to Shareholder
11. Higher Salaries of Skilled Staff: Nurses, Paramedics
12. Patient factors: Age-NCD

Inflated Insurance Premiums

- BNM's directive: Cap premium increases to 10% a year for the next 3 years.
- Infringements: 10-50% increases issued to clients. Action by BNM!
- Co-payments to discourage unnecessary admissions & investigations.
- Ambulatory care, surgeries
- National Health Fund

Majlis Penasihat Kesihatan 2019



Unbridled Private Hospital Charges

- Corporatization of medicine by private healthcare groups
- Investors paid top dollar-Expect high returns
- Lofty valuations-Higher bills-Higher medical inflation
- 70-80% of bills
- Cannot continue unchecked
- PAC-MOF-MOH must check this profiteering
- Regulate private hospital fees

How much is the cost per Hospital?

Pricey valuations for private hospitals risk escalating healthcare costs

When the acquisition of a 16% stake in Sunway Bhd's (KL:SUNWAY) healthcare arm by Singapore's GIC Pte Ltd was announced in June 2021, the valuations ascribed to the healthcare group were considered mighty lofty.

At RM750 million for 16%, Sunway Healthcare was valued at around RM4.7 billion with an implied enterprise value-to-earnings before interest, taxes, depreciation and amortisation (EV/Ebitda) of 31.3 times, based on the group's then Ebitda of RM130 million.

That was not the only deal involving a major private hospital or healthcare group in Malaysia over the last six years. Except for 2022, there has been at least one major healthcare deal a year since 2019.

These transactions were largely concluded at EV/Ebitda multiples that were higher than those ascribed by the market to the only two pure-play private healthcare groups listed on Bursa Malaysia — IHH Healthcare Bhd (KL:IHH) and KPJ Healthcare Bhd (KL:KPJ).

Valuations of the acquisitions of private healthcare groups and hospitals

TARGET	YEAR OF ACQUISITION	ACQUIRER	CONSIDERATION PAID (RM MIL)	ENTERPRISE VALUE (RM MIL)	NO OF BEDS	VALUATION PER BED (RM)	EV/EBITDA (TIMES)
Columbia Asia's Southeast Asian hospitals	2019	Hong Leong-TPG	5,010	NA	1,494	3.35 million	NA
Prince Court Medical Centre	2020	IHH Healthcare Bhd	1,020	963.6	277	3.48 million	21.9
16% of Sunway Healthcare Group	2021	GIC Pte Ltd	750	4,688	*800	5.86 million	31.3
Ramsay Sime Darby Health Care	2023	Columbia Asia Healthcare Sdn Bhd	5,700	6,050	1,530	3.95 million	20.10
Island Hospital	2024	IHH Healthcare Bhd	3,923	4,200	500	8.4 million	24.6

Note: * in excess of 800 beds

EV/Ebitda multiples are based on analysts' estimates, except for IHH Healthcare's acquisitions of Prince Court Medical Centre and Island Hospital

Influence of New Technology

- New technologies do not = standard treatment or are effective.
- Many new technologies in past decade
- Most not better than the standard treatment currently available.
- e.g. Prostate treatment: TURP is still the gold standard.
- Robots: Not better but spiraled cost – MI
- Better technologies: Latest MRIs, PET scans

Drugs and Devices

- Mark up in excess of 50-100%
- Generic drugs registered and regulated can contain MI
- e.g. Novel hormonal agents for metastatic prostate cancer cost RM10-15K per month. Regulated generics RM600 per month
- Expiry date versus Shelf Life Extension Program

Suggested Hospital Fees Act based on ROI on Equipment

Purpose: A value based approach

Principle: Payers pay for the exact value of services that are provided

Unlike DRG which averages cost or limits cost of treatment

[ROI : Return of Investment]

Suggested Hospital Fees Act based on ROI on Equipment

Basic Approach

1. Hospitals must declare exact ROI of all instruments and machines

2. ROI must have declaration of average life span of that machine during ROI calculation. **Eg. ESWL will last even more than 15-20 yrs, but ROI has now been calculated for 5-8 yrs during current ROI calculation.**

3. The cost of services charged and billed must be based on the calculated ROI

4. Once ROI achieved, subsequent charges

Suggested Hospital Fees Act based on ROI on Equipment

Final bill includes : miscellaneous mark-ups by the hospital, which includes staff salary, maintenance of building, etc as one single billing item.

This final bill will be transparent to everyone, so payers can compare this mark-ups amongst all other hospitals and decide where they wish to go.

Suggested Hospital Fees Act based on ROI on Equipment

Regulatory Enforcement:

For this ROI billing to be transparent, govt **MUST enforce the Anti-Competition Act** to make sure hospital groups don't discuss to give same mark-ups for all hospitals. This defeats the purpose of this billing system.

Enforcement of ROI declaration with hefty penalties for failure to do so

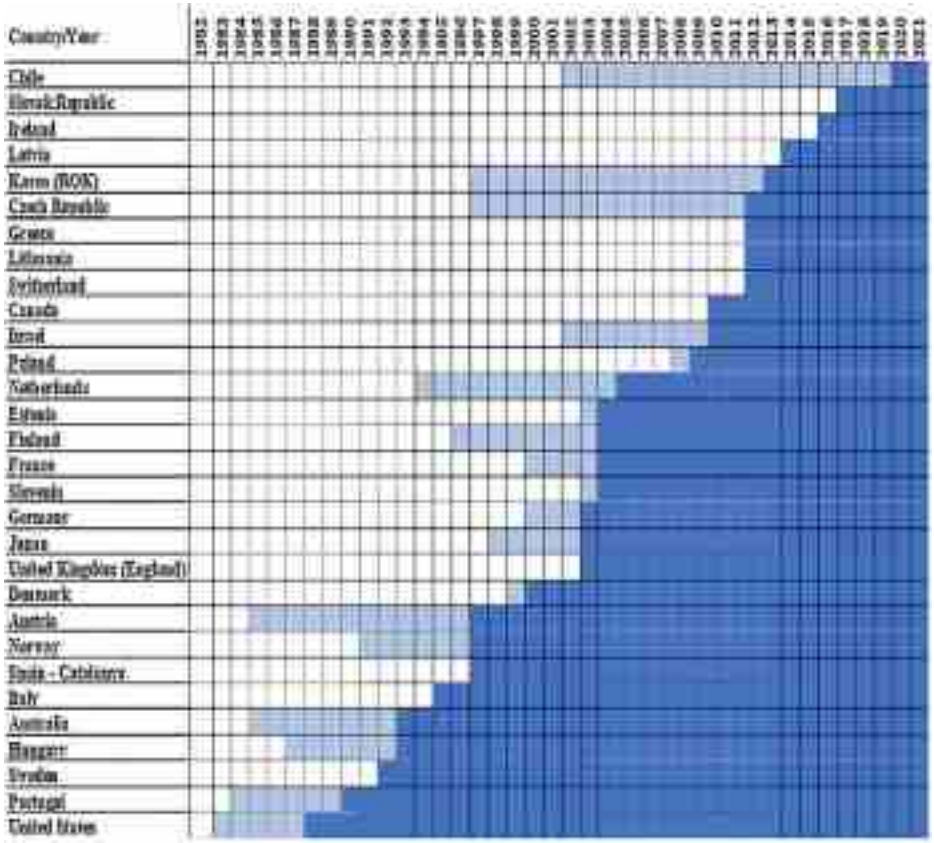
ROI vs DRG

ROI	DRG
1. Value based approach	Averaging of costs/limiting costs of treatment
1. Exact value of services that is provided	Results in inadequate/ incomplete value of treatment
2. No 3rd party involvement; directly declared by the hospital	3rd party involvement, rise in costs
1. No 3rd party conflicts of interest	Conflict of interest of parties involved with DRG / Case Mixed Solutions

OECD: DRG LESSONS FOR MALAYSIA

18 nations piloted DRG
Poland: 1 year
Chile: 18 years
Average: 7.4 years

Tan Sri Abu Bakar:
Implement DRG
gradually. Not
in a "BIG BANG"



Diagnosis Related Groups
A STEPWISE APPROACH

DRG:

•Good tool to manage rising medical costs.
•Requires further analysis for practical implementation involving people, process and technology.

PILOT:

•Select MOH hospitals
•Rakan KKM program
•University hospitals
•Voluntary private hospitals
•Each major hospital group volunteer 1-2 of their hospitals

Hybridisation:

•May be necessary
•Combination of different tools including
•Value-Based Care, for a healthcare system that truly leaves no one behind.

Why Must Pilot DRG

TO ENSURE NO LIMITATION OF ESSENTIAL/NECESSARY /PROVEN TREATMENT TO PATIENTS

TO ENSURE NO 'cherry-picking' of patients by private hospitals

TO ENSURE COMPLEX & COMPLICATED patients are covered for appropriate treatment

TO PREVENT half-treated patients from being untimely transferred to government hospitals

TO ENSURE no systemic un-necessary up-coding or down –coding

TO ENSURE no systemic loss financially (e.g. Indonesia & UMMC)

Whatever the Government/MOH Imposes ie Regulations/Rules/Capping Please Study All Options Let Stakeholders Be Involved

If DRG: Pilot studies, exclusions, inclusions and in stages eg IJN Corporatization stopped just there

Seriously consider ROI for expensive equipments

Insurance & Hospitals & Specialists/Family Practitioners/Pharmaceuticals with Bank Negara/MOH must be there

Private Dr Specialist Fees must NOT be further unfairly cut as it's the only factor/line item that is ALREADY regulated

A Look at the National Healthcare Budget

CONFIDENTIAL



Data sources:
1. 2015-2023b MOH OE + DE (MOF 2023 Budget)
2. 2015-2022 GDP (DOSM)
3. 2023-2028p GDP and GSR projections (IMF WEO April 2023)

Note:
Data and trend reflect only expenditure on health, and federal government expenditure on health allocated via other ministries, such as MOHE and MinDef not included.

RM 1 per visit is NOT sustainable

Prepare the nation to realise that RM1 per visit since many2 years is not sustainable!

Apart from quality & safe healthcare services, MOH must have best fiscal services to ensure financial sustainability

In private hospitals, the financial department:

- most prominent
- top notch IT infrastructure
- fully staffed including “bouncers to chase for late dues””
- legally proficient to issue summons for unpaid dues
- administration fee for first visit= RM30.00
- admission fee = RM60.00
- follow up visit = RM5.00

RM 5 per visit except B 40

MOH collection

RM2.6 Billion

6.2% of MOH allocation in 2024 Budget

ITEM	RM1.00	RM5.00	RM10.00
Hospital Admissions 2,613,161	2,613,161	13,065,805	26,11,610
Special Medical Institution 131,520	131,520	657,600	1,315,200
Day Care Hospital 1,792,748	1,792,748	8,963,740	17,927,480
Outpatient Hospital 18,956,999	18,956,999	94,784,995	1,895,699,900
Special Medical Institution 647,578	647,578	3,237,890	6,475,780
Public Health Facility 43,944,325	43,944,325	2,197,216,200	4,394,432,500
Antenatal Clinics 5,765,379	5,765,379	11,530,758	23,061516
Postnatal Clinics	455,358	22,767,790	4,553,580
Child Clinics	9,580,855	47,904,275	95,808,550
Total	83,887,923	4,194,396,108	8,388,792,300
Less 40% for BAO		2,520,000,000	5,040,000,800
		83,887,923	83,887,923
Total Collection		2,603,887,923	5,123,887,923
Non MOH Hospital Admissions 182,639	182,639	913,195	1,826,390
Non MOH Hospitals Outpatients 2,879,666	2,879,666	14,398,330	28,796,660
Total	3,062,305	15,311,525	30,623,050
Less 40% for BAO		9,186,915	18,373,839
		3,062,305	3,062,305
Total Collection for Non MOH Hospitals		12,249,220	21,436,144

UNIVERSITI MALAYA

PUSAT PERUBATAN
Medical Centre

How to Curb the Increase in Health Insurance Premiums

Strategies for Sustainable and Affordable Healthcare

Professor Dr. Maznah Dahlui
Health Economics
Health Economic Research and Case-mix Unit
UMMC

Introduction

Rising health insurance premiums are a global concern.

Affects affordability, accessibility, and financial protection.

Need for reforms to ensure sustainable health coverage.

Factors Increases HI Premium

- Rising medical costs and inflation.
- Increased demand for healthcare services.
- Aging population and chronic diseases.
- Administrative and operational expenses.
- Risk pooling inefficiencies in private insurance.

Strategies to Control Increases in HI Premium

1. Strengthening Social Health Insurance (SHI)

2. Expanding Risk Pooling & Cross-Subsidization

3. Promoting Preventive Healthcare & Wellness Programs

4. Regulating Insurance Industry Practices

5. Encouraging Public-Private Partnerships

6. Leveraging Technology & Data Analytics

1. Strengthening Social Health Insurance (SHI)

- Shift towards universal health coverage (UHC).
- Reduce reliance on private insurance for essential services.
- Government subsidies for vulnerable groups.
- Bundle payment to healthcare providers (use of DRGs for standardization and cost transparency)

2. Expanding Risk Pooling & Cross-Subsidization

- Mandating broader participation in insurance schemes.
- Risk-sharing between low-risk and high-risk populations.
- Integration of employer-based and government-sponsored plans.
- Example: Singapore's MediShield Life & Germany's SHI model.

3. Promoting Preventive Healthcare & Wellness Programs

- Early disease detection reduces treatment costs.
- Encouraging healthier lifestyles through incentives.
- Insurance premium discounts for healthy behaviors.
- Example: Malaysia’s PeKa B40 & corporate wellness initiatives.

4. Regulating Insurance Industry Practices

- Government intervention in premium pricing.
- Standardizing benefit packages to prevent excessive markups.
- Ensuring transparency in policy pricing and claims processes.
- Example: Japan’s fee schedule regulation.

5. Encourage Public-Private Partnerships (PPPs)

- Collaboration to improve efficiency and reduce costs.
- Government subsidies for private providers offering affordable plans.
- Joint initiatives for chronic disease management.
- Example: UK’s National Health Service (NHS) partnerships.

6. Leverage on Technology & Data Analytics

- AI-driven cost prediction and fraud prevention.
- Telemedicine reducing hospital visits and expenses.
- Blockchain for secure and efficient claims processing.
- Example: InsurTech innovations in developed countries.

Conclusion & Call to Action

- Need for multi-faceted approach to control premium hikes.
- Role of government, insurers, and individuals in sustainability.
- Policy reforms and stakeholder collaboration are crucial.
- Affordable healthcare should be a right, not a privilege.

3rd January 2025

Rising Healthcare Costs in Malaysia
Healthcare for Whom?
Implications of Increasing Private Health Insurance Charges on the National Healthcare System

Dr Tharani Loganathan

Public Health Medical Specialist and Associate Professor in Global Health

Health Policy and Management Unit,
Department of Social and Preventive Medicine,
Faculty of Medicine, University of Malaya

Contents


UHC and the Malaysian healthcare system


Rising Healthcare Costs in Malaysia


Implications on the healthcare system

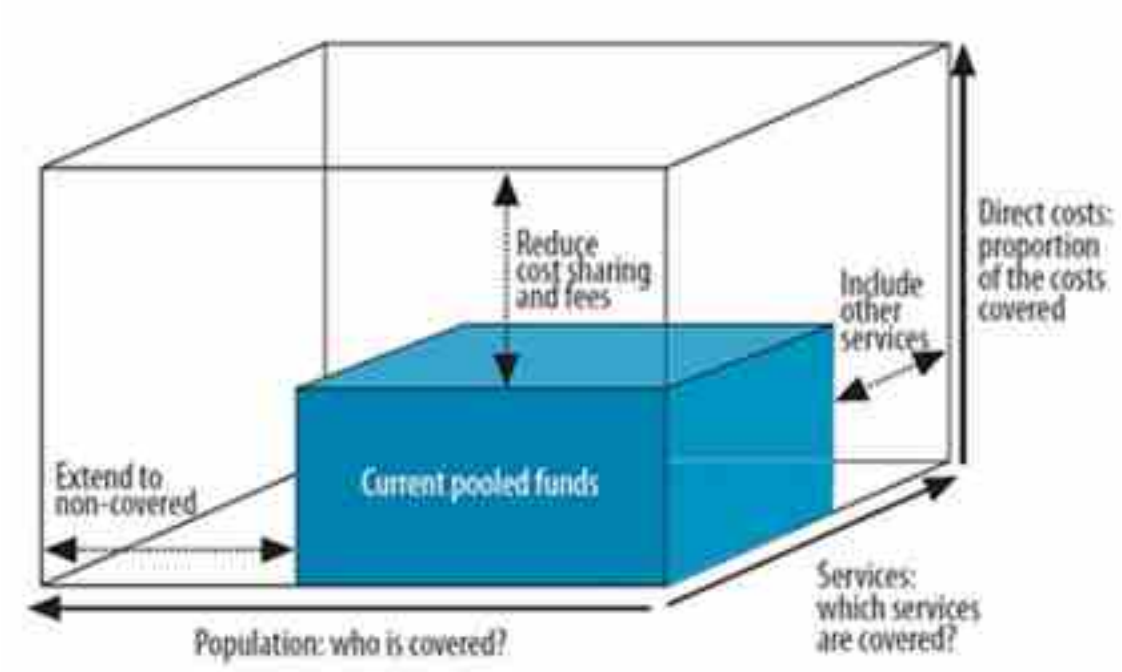

Policy Solutions

What is UHC?

"Universal health coverage is defined as ensuring that ***all people have access to needed health services*** *(including prevention, promotion, treatment, rehabilitation and palliation)* ***of sufficient quality to be effective*** *while also ensuring that the use of these services does not expose the user the* ***financial hardship.****"*

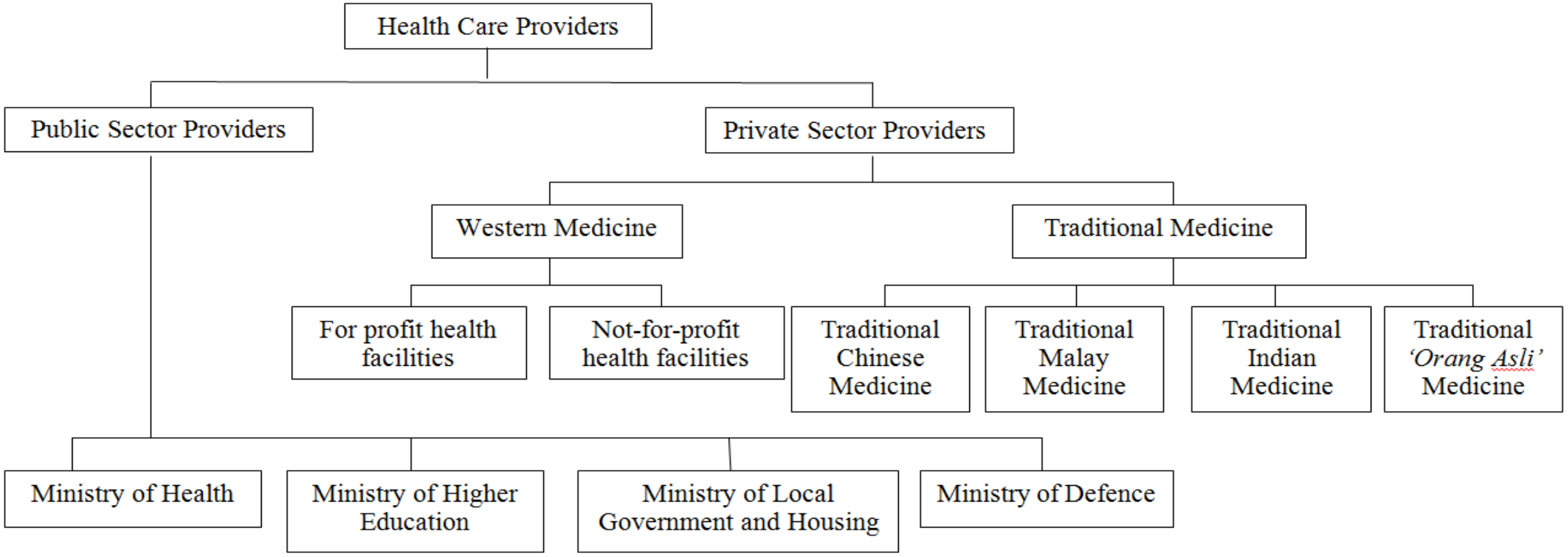
World Health Organization

- UHC is an aspirational concept
- UHC has become a major goal for health reform in many countries and a primary objective of WHO



Three dimensions to consider when moving towards universal coverage

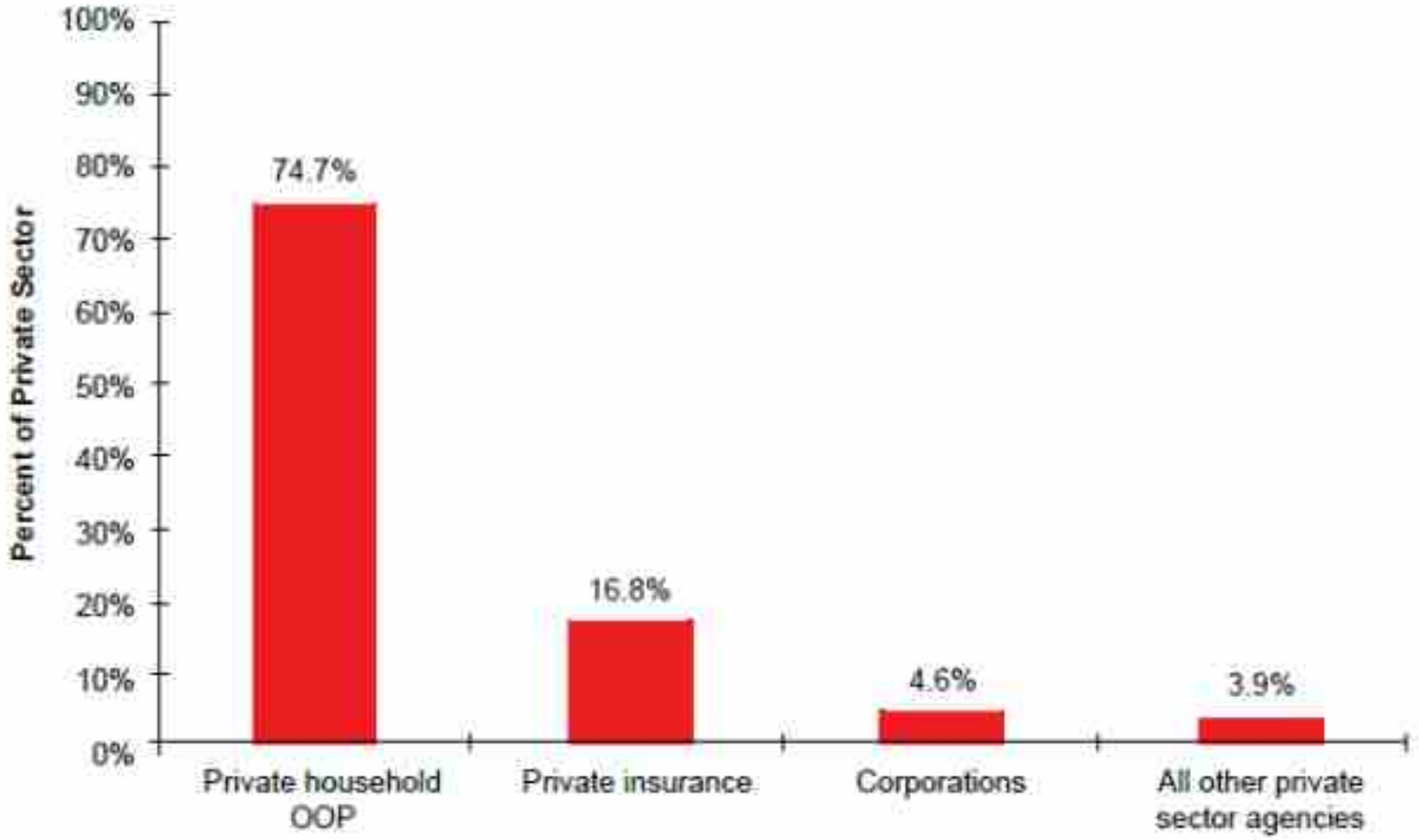
Malaysian Healthcare System



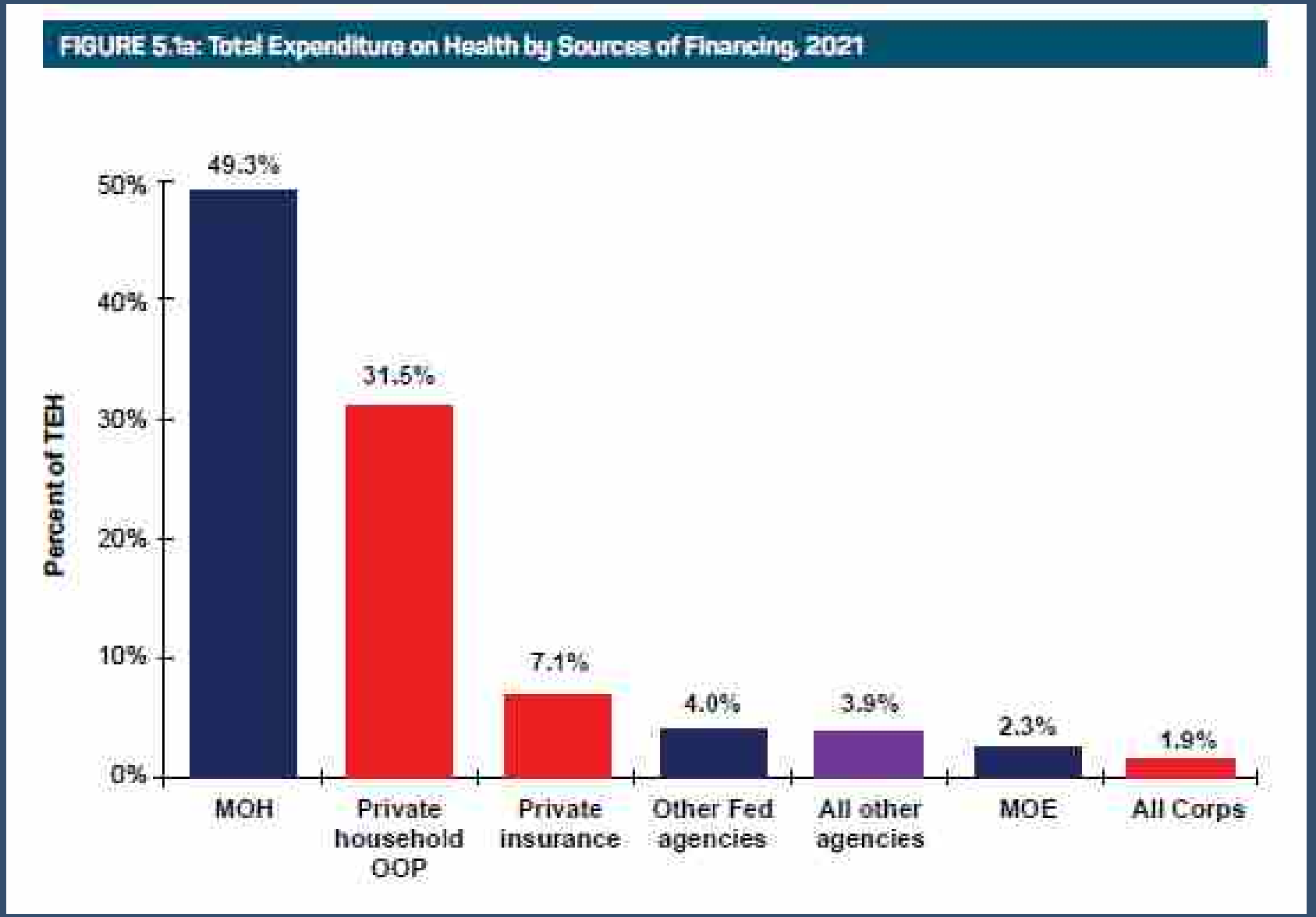
Modified from Noor Ghani, S., & Yadav, H. (2008). *Health Care in Malaysia*. Kuala Lumpur, Malaysia: University of Malaya Press.

Health Expenditure by Private Sources of Financing, 2021

FIGURE 5.3.1: Health Expenditure by Private Sources of Financing, 2021



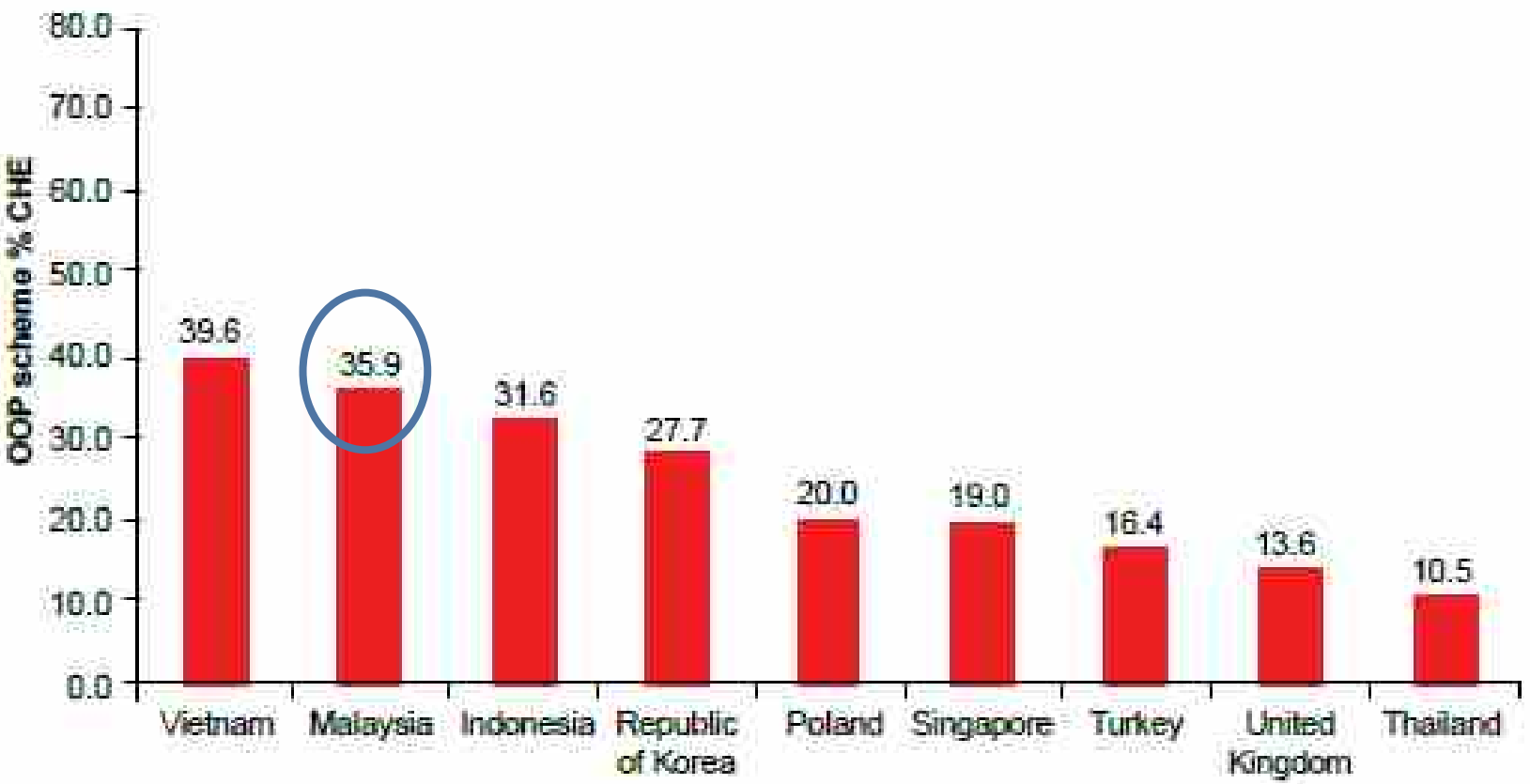
Total Expenditure on Health by Sources of Financing, 2021



MALAYSIA NATIONAL HEALTH ACCOUNTS HEALTH EXPENDITURE REPORT 2011-2021

International Comparison of Out-of-pocket Health Financing as Percent of Current Health Expenditure, 2020

FIGURE 10.3: International Comparison of Out-of-Pocket Health Financing Scheme as Percent of Current Health Expenditure, 2020



Source: Global Health Expenditure Database (GHED) WHO NHA on 27th December 2022



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Original Article

OXFORD

Effect of supplementary private health insurance on out-of-pocket inpatient medical expenditure: evidence from Malaysia

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Abstract

The vital role of healthcare financing in achieving universal health coverage is indisputable. However, most countries, including Malaysia, face challenges in establishing an equitable and sustainable healthcare financing system due to escalating healthcare costs, an ageing population and a growing disease burden. With desirable pre-payment and risk pooling features, private health insurance (PHI) is considered an alternative financing option to reduce out-of-pocket (OOP) medical expenditure. However, ongoing theoretical and empirical debates persist regarding the adequacy of financial risk protection provided by PHI largely because it depends on its role, the benefit design and the regulations in place. Our study aimed to investigate the effect of supplementary PHI on OOP inpatient medical expenditure in Malaysia. Secondary data analysis was conducted using the Malaysian National Health and Morbidity Survey 2019 dataset. A total of 960 respondents with a history of inpatient hospitalization in the past 12 months were included in the study. Instrumental variable analysis using a two-stage residual inclusion was performed to address endogeneity bias, with wealth status and education level as the instrumental variables. Tobit regression model was used in the second stage considering the censored distribution of the outcome variable. Missing data were handled using multiple imputation. About one-fifth of the respondents had PHI. In this study, we found that having PHI significantly increased OOP inpatient medical expenditure in all three marginal effects. Additionally, age, residential location, ethnicity (citizenship), being covered by government guarantee letter, government funding and employer sponsored health insurance were other significant factors associated with OOP inpatient medical expenditure. Our findings undermine a key justification to advocate PHI uptake among the population, with a need for the Malaysian government to reassess the role of PHI in healthcare financing and reconsider PHI subsidization policy. Regulations should also be strengthened to enhance the financial risk protection provided by PHI.

Keywords: Malaysia, private health insurance, out-of-pocket expenditure, financial risk protection, instrumental variable analysis, inpatient care

Key Messages

- Private health insurance (PHI) significantly increased out-of-pocket inpatient medical expenditure.
- Raising fundamental questions about the quality of benefit packages and the adequacy of financial risk protection provided by PHI.
- The Malaysian government should re-examine the rationale of the ongoing subsidization of PHI purchases and the explicit encouragement of population-wide enrolment.
- The current governance and regulatory framework for PHI should be reviewed and strengthened to enhance its financial protective effect.
- Despite facing fiscal constraints, the quest to achieve universal health coverage relying on PHI remains contentious and warrants careful consideration.

Ng, R. J., Choo, W. Y., Ng, C.-W., & Hairi, N. N. (2024). Effect of supplementary private health insurance on out-of-pocket inpatient medical expenditure: evidence from Malaysia. Health policy and planning, 39(3), 268-280.



Rising Healthcare Costs in Malaysia





Bank Negara Orders Insurance Industry To Publish Private Hospitals' Charges For Procedures

By CodeBlue | 4 December 2024

Interim measures to assist policyholders and to promote continued access to suitable medical and health insurance/takaful products

Embargo : For immediate release

Bank Negara Malaysia (BNM) today announced interim measures agreed with the insurance and takaful industry to assist policyholders who experienced premium revisions of their medical and health insurance/takaful (MHIT) products. These interim measures have been introduced to alleviate the immediate financial impact to policyholders and preserve MHIT coverage. However, broader measures to address the rising medical cost in Malaysia are urgently needed to manage future premium adjustments and ensure that MHIT products continue to be affordable for the Malaysian public.

Average Medical Inflation Trend Rates

Global/Region (Average Percentage):

Global/Region (Average percentage):

	2024			2025		
	Annual General Inflation Rate	Annual Medical Trend Rates		Annual General Inflation Rate	Annual Medical Trend Rates	
		Gross	Net		Gross	Net
Global	3.6	10.1	6.5	2.8	10.0	7.2
North America	2.3	7.8	5.3	2.0	8.8	6.8
Asia-Pacific	3.6	9.7	6.1	2.8	11.1	8.3
Europe	3.7	10.4	6.7	2.2	8.9	6.7
Latin America & Caribbean	4.1	11.7	7.6	3.0	10.7	7.7
Middle East & Africa	7.4	15.1	7.7	6.2	15.5	7.3

Regional/ Country (Average Percentage

	2024			2025		
	Annual General Inflation Rate	Annual Medical Trend Rates		Annual General Inflation Rate	Annual Medical Trend Rates	
		Gross	Net		Gross	Net
Asia-Pacific	3.6	9.7	6.1	2.8	11.1	8.3
Australia	3.3	6.2	1.0	3.0	5.1	2.1
Bangladesh	6.5	10.0	3.5	6.1	10.0	3.8
China	2.2	7.9	5.7	2.0	8.0	6.0
Hong Kong	2.4	7.5	5.1	2.3	8.0	5.7
India	4.4	12.0	7.6	4.2	15.0	6.8
Indonesia	3.5	13.1	10.1	2.8	16.2	13.4
Japan	2.2	0.4	(1.8)	2.1	0.9	(1.2)
Kazakhstan	8.5	30.0	21.5	7.0	29.0	22.0
Malaysia	3.1	15.0	11.9	2.5	15.0	12.5
Mongolia	8.8	15.0	6.2	10.0	n/a	n/a

The global average medical trend rate for 2025 is expected to be **10.0 percent.**
The forecasted rate for Malaysia is **15.0 percent**

AON. (2024). 2025 Global Medical Trend Rates Report Global: Overview and Data Tables. https://www.aon.com/en/insights/reports/the-global-medical-trend-rates-report

Driving Factors

1

Medical inflation and the rising cost of advanced technology.

2

Ageing population leading to increased chronic disease burden.

3

Profit driven model and insurance driven pricing of private healthcare

4

Limited competition among private insurers.

Implications on the healthcare system

For Patients:

Access Inequality:
More cannot afford private care & are forced into public facilities, worsening overcrowding.

Out-of-Pocket Payments:
increased financial hardship.

For Public Healthcare:

Strain on Public Hospitals:
Rising reliance on subsidised care.

Workforce Challenges:
Migration of specialists to private practice, exacerbating shortages in public systems.

For the Private Sector:

Risk of Exclusion:
High insurance charges may reduce client pools, leading to further price hikes—a vicious cycle.

Policy Solutions

- **Strengthen Regulatory Oversight:**
  Enforce price caps & transparency on private sector fees.
- **Monitor Insurance premiums:**
  Enforce stricter regulations to control private health insurance premium hikes, ensuring affordability.
- **Expand Public-Private Partnerships:**
  Outsource non-critical services to reduce strain on public hospitals.
- **Promote Preventive Health:**
  Reduce long-term costs by targeting preventable diseases. Incentivised well-being initiatives
- **Universal Health Coverage:**
  Reform health financing towards social health insurance.

A healthcare system should serve everyone—not just the privileged few.

Together, we can reshape Malaysia's healthcare landscape...

UNIVERSITI MALAYA

PUSAT PERUBATAN

Medical Centre

PENGENALAN
Introduction

KEMENTERIAN INDUK | *Parent Ministry*

KEMENTERIAN PENDIDIKAN TINGGI
Ministry of Higher Education

UNIVERSITI INDUK | *Parent University*

UNIVERSITI MALAYA
Universiti Malaya

TARIKH PENUBUHAN | Date of *Establishment*

5 OGOS1968
5 August 1968

SEKTOR PERKHIDMATAN | *Service Sector*



SEKTOR AWAM
(HOSPITAL PENGAJAR UNIVERSITI AWAM)
Public Sector
(Public University Teaching Hospital)

KATEGORI HOSPITAL | *Hospital Category*



TERTIARI
Tertiary

VISI | MISI | NILAI TERAS
Vision | Mission | Core Values

VISI | *Vision*

PPUM sebagai hospital pengajar yang terunggul dan bertaraf antarabangsa
To establish UMMC as a leading teaching hospital with international repute

MISI | *Mission*

- **Memperkasakan modal insan yang berwibawa dan berkompetensi tinggi**

  To empower human capital with high competency

- **Memacu kecemerlangan dalam penyelidikan klinikal**

  To drive excellence in clinical research

- **Melestarikan kedudukan kewangan yang mampan**

  To sustain a strong financial standing

- **Memartabatkan institusi melalui pengiktirafan dan akreditasi pendidikan dan penjagaan kesihatan**

  To uphold the constitution standard with education and healthcare-related recognitions and accreditations

NILAI TERAS | *Core Values*



KECEMERLANGAN
Excellence



EFISIEN
Efficiency



EMPATI
Empathy



BERETIKA
Ethical



BERPUSATKAN PESAKIT
Patient-Centredness



KEMESRAAN
Friendliness

LEMBAGA PENGURUS
Board of Management

PENGERUSI | Chairman	**PROFESSOR DATO' SERI IR. DR. NOOR AZUAN BIN ABU OSMAN**
WAKIL LEMBAGA PENGARAH UNIVERSITI MALAYA | ***Representative of the Board of Directors of Universiti Malaya***	**DATO' MOHD ZAHIR BIN ZAHUR HUSSAIN**
WAKIL KETUA SETIAUSAHA, KEMENTERIAN PENDIDIKAN TINGGI | ***Reperesentative of the Secretary General, Ministry of Higher Education***	**KOSONG**
WAKIL KETUA SETIAUSAHA, KEMENTERIAN KEWANGAN | ***Reperesentative of the Secretary General, Ministry of Finance***	**PUAN SHAMILI POONMALAR A/P VELLAPANDIAN**
WAKIL KETUA PENGARAH KESIHATAN, KEMENTERIAN KESIHATAN | ***Reperesentative of the Director General, Ministry of Health***	**DATO' DR. MOHD AZMAN BIN YACOB**
DEKAN, FAKULTI PERUBATAN UNIVERSITI MALAYA | ***Dean, Faculty of Medicine, Universiti Malaya***	**PROFESSOR DATO' DR. YANG FARIDAH BINTI ABDUL AZIZ**
PENGARAH, PUSAT PERUBATAN UNIVERSITI MALAYA | ***Director, Universiti Malaya Medical Centre***	**PROFESSOR DR. NAZIRAH BINTI HASNAN**
SETIAUSAHA | ***Secretary***	**ENCIK KHAIRUL ANUAR BIN YAHYA**



PUSAT PERUBATAN UNIVERSITI MALAYA

STRUKTUR ORGANISASI PUSAT PERUBATAN UNIVERSITI MALAYA

- JABATAN PENGURUSAN TERTINGGI
- JABATAN AUDIT DALAM
- JABATAN PERKEMBANGAN DAN AMALAN PERUBATAN
- JABATAN PERHUBUNGAN KORPORAT
- JABATAN PENYELIDIKAN, PEMBANGUNAN & INOVASI
- JABATAN PERUNDANGAN
- JABATAN INTEGRITI
- JABATAN KESELAMATAN



PROF. DR. NAZIRAH BINTI HASNAN

PENGARAH



CHEW YEE YEAN

TIMBALAN PENGARAH IKHTISAS



DR. MOHMMAD SALLEH BIN YAHYA

TIMBALAN PENGARAH KLINIKAL (PERUBATAN)



PROF. MADYA. DR. AZURA BINTI MANSOR

TIMBALAN PENGARAH KLINIKAL (SURGIKAL)



KHAIRUL ANUAR BIN YAHYA

TIMBALAN PENGARAH PENGURUSAN

SOKONGAN KLINIKAL

- JABATAN FARMASI
- JABATAN MAKLUMAT PESAKIT
- JABATAN DIETETIK
- JABATAN KERJA SOSIAL PERUBATAN
- JABATAN FIZIK PERUBATAN
- JABATAN PERKHIDMATAN MAKMAL DIAGNOSTIK

KLINIKAL

- JABATAN PERUBATAN
- JABATAN PEDIATRIK
- JABATAN PERUBATAN PSIKOLOGI
- JABATAN PERUBATAN RAWATAN UTAMA
- JABATAN PERUBATAN PEMULIHAN
- JABATAN MIKROBIOLOGI PERUBATAN
- JABATAN PERUBATAN KECEMASAN
- JABATAN PERUBATAN KESUKANAN
- JABATAN PERUBATAN TRANSFUSI
- JABATAN PENGIMEJAN BIOPERUBATAN
- JABATAN KAWALAN JANGKITAN
- JABATAN KEJURURAWATAN (PERUBATAN)
- JABATAN KESIHATAN AWAM
- UNIT KESIHATAN STAF DAN PELAJAR
- UNIT PENJAGAAN DIABETES
- UNIT GENETIK PERUBATAN
- UNIT MAKMAL KARDIOLOGI
- UNIT MAKMAL NEUROLOGI

KLINIKAL

- JABATAN SURGERI
- JABATAN SURGERI ORTOPEDIK
- JABATAN ANESTESIOLOGI
- JABATAN ONKOLOGI KLINIKAL
- JABATAN OBSTETRIK & GINEKOLOGI
- JABATAN OTORINOLARINGOLOGI
- JABATAN OFTALMOLOGI
- JABATAN ORAL MAKSILOFASIAL
- JABATAN PATOLOGI
- JABATAN PATOLOGI FORENSIK
- JABATAN KEJURURAWATAN (SURGIKAL)
- UNIT PERKHIDMATAN RAWATAN KRITIKAL
- UNIT MAKMAL ENDOSKOPI
- PERKHIDMATAN DEWAN BEDAH
- PERKHIDMATAN KRITIKAL

BUKAN KLINIKAL

- JABATAN SUMBER MANUSIA
- JABATAN KEJURUTERAAN
- JABATAN PEROLEHAN
- JABATAN TEKNOLOGI MAKLUMAT
- JABATAN PEMBANGUNAN PERNIAGAAN
- JABATAN KEWANGAN
- JABATAN GOVERNAN, PERANCANGAN & DASAR
- JABATAN PENGURUSAN FASILITI
- JABATAN PENGURUSAN PSIKOLOGI & KAUNSELING
- JABATAN KEJURUTERAAN BIOMEDIKAL
- KOLEJ SAINS KESIHATAN
- JABATAN HAL EHWAL ISLAM

- PERKHIDMATAN PENSWASTAAN

TARIKH KEMASKINI : 04 Disember 2023

FUNGSI UTAMA
Main Functions

1



Education & Training

2



Research & Innovation

3

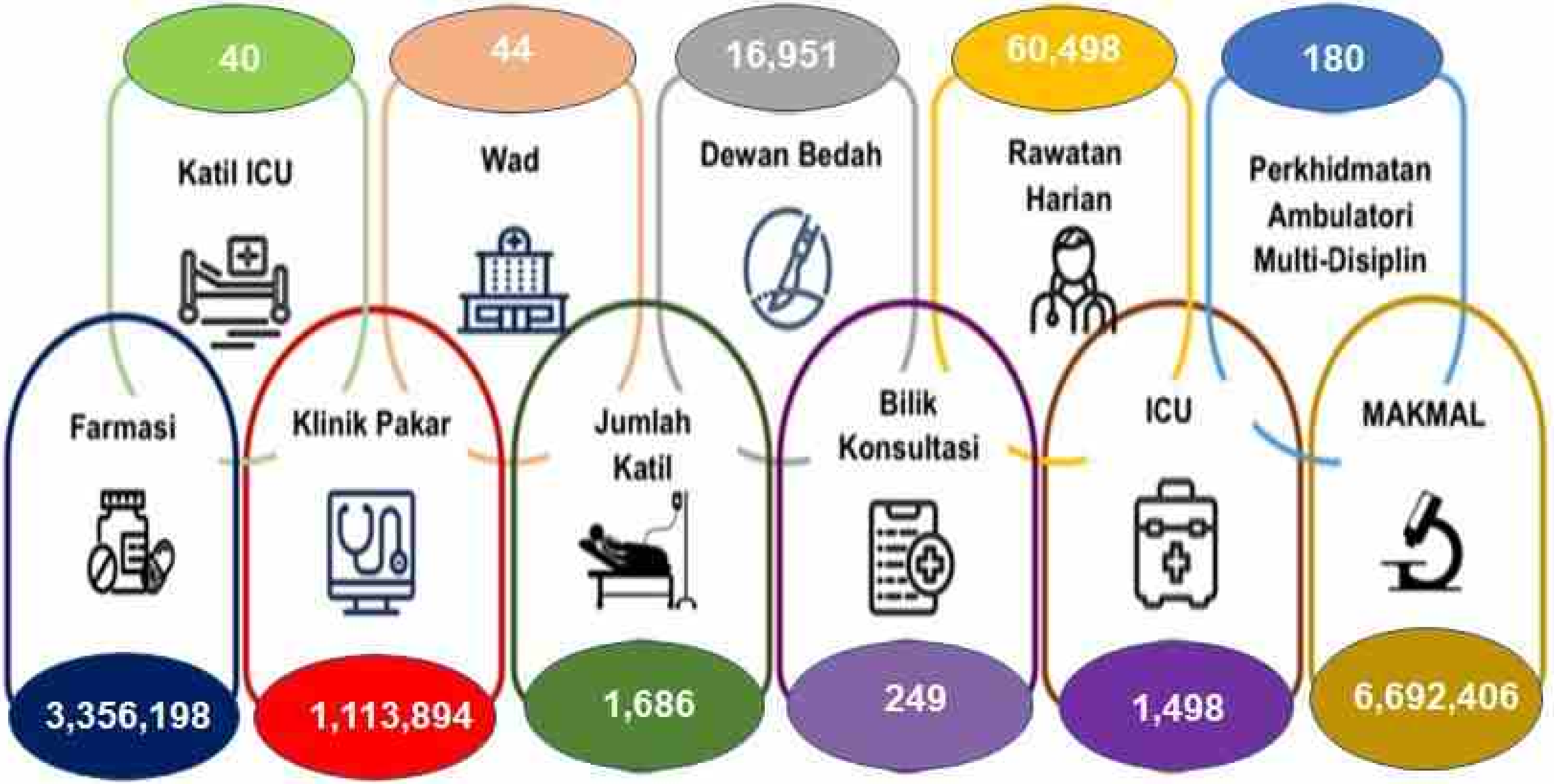


Clinical Services

RINGKASAN INFO
Summarised Info

1,681 Jumlah Katil	**44** Jumlah Wad	**40** Jumlah Katil ICU	**5,899** Staf	**134** Pegawai Perubatan **2,246** Jururawat	**419** Staf Akademik Klinikal FPUM
1,113,894 Jumlah Pesakit Luar			**92** Pakar Klinikal **21** Pakar Perunding		**4** Tahun Akreditasi Penuh MSQH
	**48,411** Jumlah Pesakit Dalam	**36** Dewan Bedah		**51** Bidang Sub-Kepakaran dan Fellowship	

PERKHIDMATAN & FASILITI KLINIKAL



PERKHIDMATAN & FASILITI KLINIKAL
Clinical Facilities & Services

15
Klinik Pakar

249
Bilik Konsultasi

18
Pusat Rawatan Harian

Perkhidmatan Ambulatori

Perkhidmatan Makmal Diagnostik Komprehensif

Department of Medicine
Department of Surgery
Department of Orthopaedic Surgery
Department of Paediatrics
Department of Anaesthesiology
Department of Obstetrics & Gynaecology
Department of Otorhinolaryngology
Department of Ophthalmology
Department of Biomedical Imaging
Department of Psychological Medicine
Department of Primary Care Medicine
Department of Rehabilitation Medicine
Department of Pathology
Department of Medical Microbiology
Department of Emergency Medicine
Department of Clinical Oncology
Department of Sports Medicine
Department of Forensic Pathology
Department of Transfusion Medicine
Department of Nursing
Department of Infection Control
Department of Public Health
Department of Oral Maxillofacial
Department of Clinical Investigation
Staff Health Clinic Unit
Diabetes Care Unit
Medical Genetics Unit
Neurology Laboratory Unit
Endoscopy Laboratory Unit
Cardiology Laboratory Unit
Critical Care Services Unit

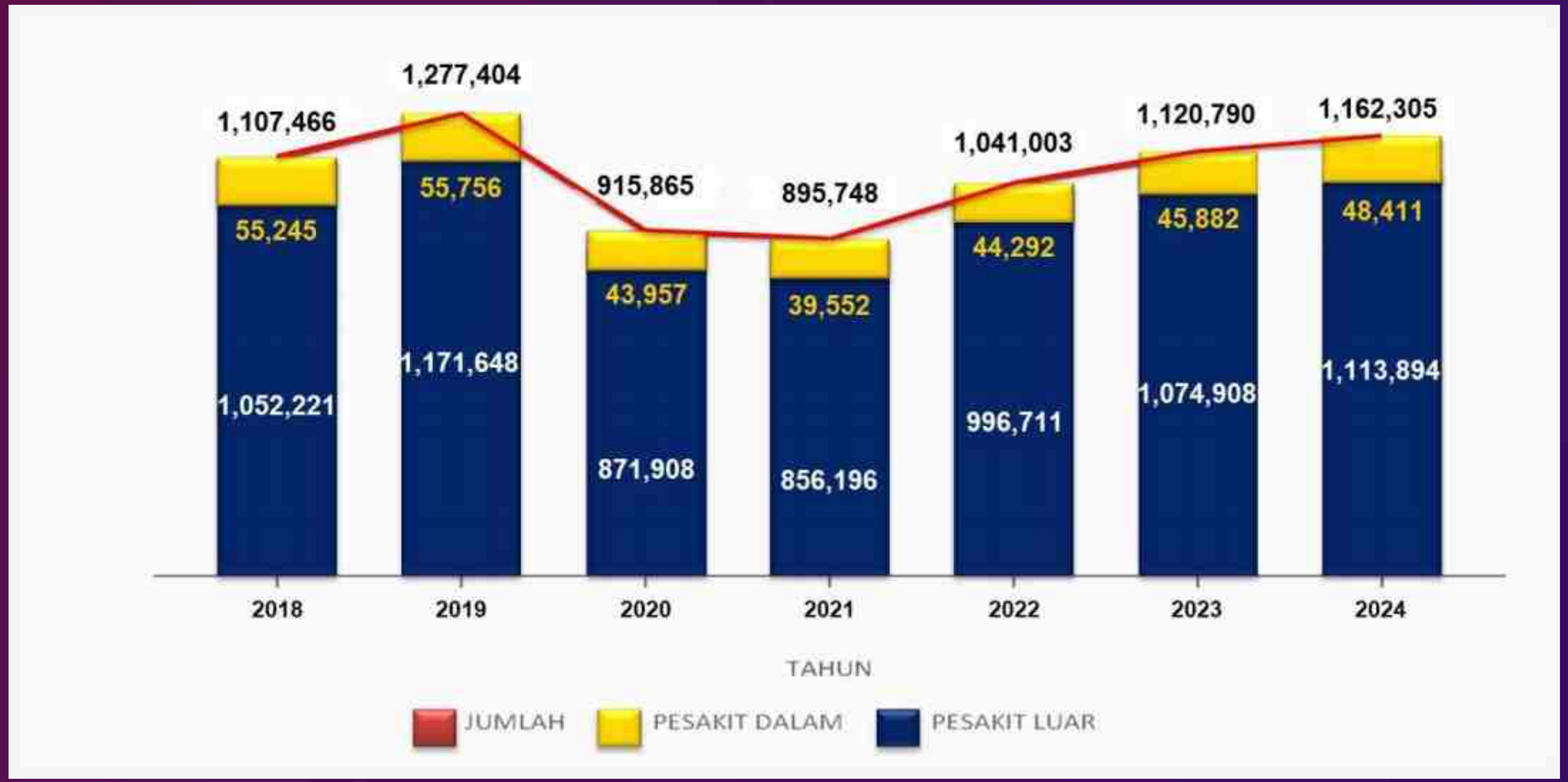






STATISTIK KEHADIRAN PESAKIT

Statistic of Patients' Visit



PERUNTUKAN & PERBELANJAAN



TAHUN	Peruntukan	Perbelanjaan
	RM	RM
2021	460,068,750.00	596,114,389.84
2022	460,660,540.00	627,286,272.14
2023	429,029,000.00	656,401,540.16
2024	474,940,000.00	672,701,921.16

UNIVERSITI MALAYA

PUSAT PERUBATAN
Medical Centre

Sekian | Terima kasih

Sesi Perbincangan bersama Jawatankuasa Kira-Kira Wang Negara (PAC)



Malaysian Organisation of Pharmaceutical Industries (MOPI)

Ubat Berkualiti dan Berpatutan untuk Semua



Bilik Jawatankuasa 1, Tingkat 2, Blok Utama, Parlimen Malaysia

06 Mac 2025

SUMBANGAN

Pembuatan Farmaseutikal Tempatan

2023

Industri pembuatan produk farmaseutikal telah diiktiraf sebagai satu industri keperluan dan strategik untuk negara oleh kerajaan.



1 daripada 2 rakyat Malaysia mengambil ubat-ubatan yang dihasilkan oleh pengeluar tempatan

64%

daripada jumlah kesuluruhan ubatan generik yang digunakan dalam negara adalah produk pengeluar tempatan

47%

daripada Senarai Ubat-ubatan Penting Kebangsaan (NEML) dihasilkan dari pengeluar tempatan

RM 623 mil

pada 2023, sejumlah RM 623 JUTA dilaburkan oleh pengeluar tempatan

15,572

15,572 perkerjaan pada 2023, dimana 50% daripada jumlah ini adalah graduan

Tentang MOPI

Industri pembuatan farmaseutikal tempatan diiktiraf oleh Kerajaan sebagai industri yang penting dan strategik untuk negara.

01 Keahlian MOPI terus berkembang.

52 ahli pada tahun 2025, mewakili semua pengeluar utama di Malaysia.

02 Ahli MOPI mempunyai kemampuan untuk menghasilkan pelbagai jenis produk dengan kualiti yang tinggi.

Selaras dengan keperluan PIC/s, EU, TGA, dan USFDA.

03 Ahli MOPI terlibat dalam pelbagai aktiviti farmaseutikal

Terdiri daripada pengeluar farmaseutikal tempatan, pengeluar Bahan Aktif Farmaseutikal (API), syarikat pembungkusan dan percetakan.

Tentang MOPI

Industri pembuatan farmaseutikal tempatan diiktiraf oleh Kerajaan sebagai industri yang penting dan strategik untuk negara.

04 Penghubung antara industri dan penggubal dasar

MOPI juga menyediakan latihan GMP dan Regulatori kepada industri farmaseutikal tempatan.

05 Ahli MOPI membekalkan hampir separuh daripada ubat preskripsi.

Industri pembuatan farmaseutikal tempatan adalah teras kepada kesihatan negara kita.

06 Ahli MOPI telah menceburi industri teknologi tinggi sepanjang tahun.

Seperti vaksin, ubat biosimilar seperti inhaler dos bermeter dan ubat rawatan kanser.

Persatuan Industri Farmaseutikal di Malaysia

Pharmaceutical Association of Malaysia

Mewakili Innovator - kebanyakan pengedar/pengeluar dalam Malaysia.

1972

45 ahli

Malaysian Organisation of Pharmaceutical Industry

Mewakili pengeluar generik dan biosimilar yang beroperasi di Malaysia.

1981

52 ahli

Malaysian Association of Pharmaceutical Suppliers

Mewakili pengimport generik yang beroperasi di Malaysia.

2011

39 ahli

Persatuan industri memainkan peranan penting sebagai penghubung antara industri dan penggubal dasar, menyuarakan kepentingan industri, menyampaikan maklumat mengenai undang-undang baharu, serta menyediakan sokongan dan panduan amalan terbaik yang relevan.

ORDINARY MEMBERS

ORDINARY MEMBERS

AHLI MOPI: TREND R&D (2019-2023)

Jumlah pelaburan R&D dari 2019 - 2023
RM 1.16 bil

Bajet R&D yang dijangkakan dari 2024 - 2027:
RM 1.06 bil

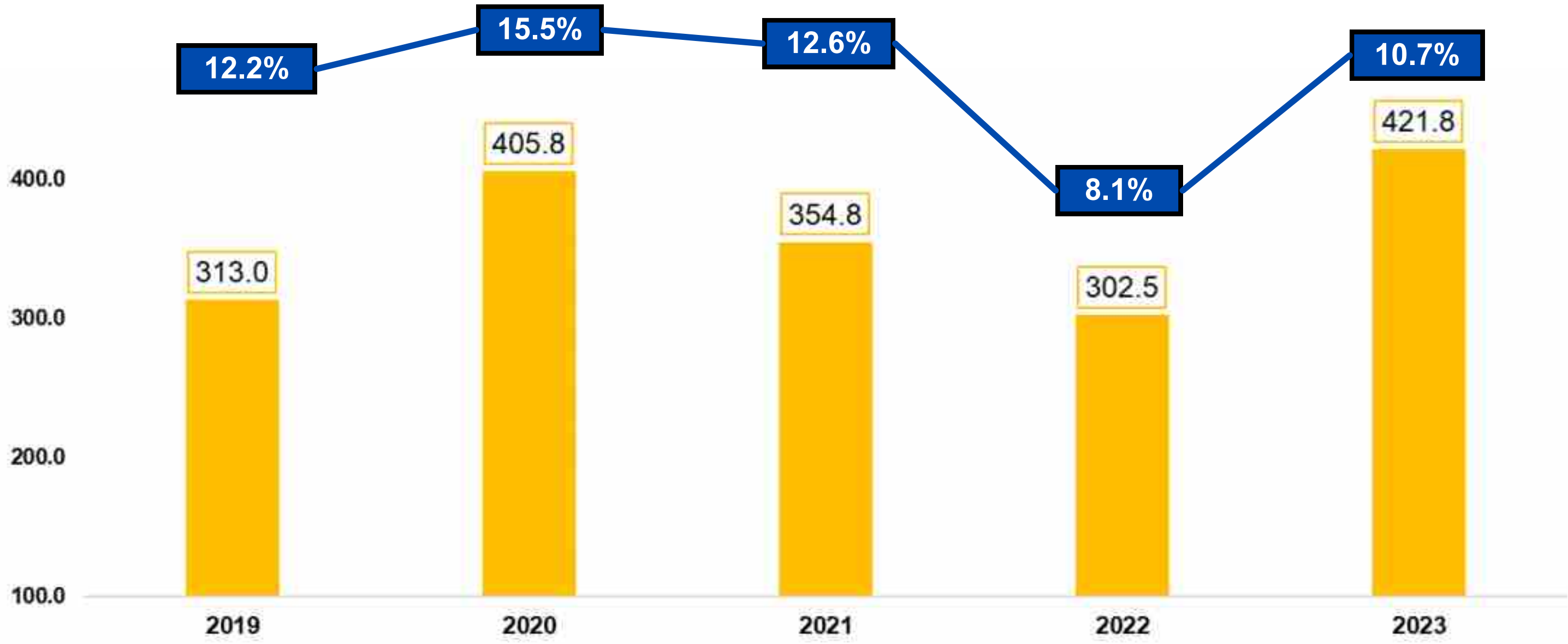


Nilai mewakili % R&D berbanding Jumlah Pendapatan (tempatan + eksport) untuk tahun tersebut.
Nota: Nilai dalam RM (juta) dan ahli MOPI mewakili pengeluar farmaseutikal tempatan.

AHLI MOPI: TREND PERBELANJAAN MODAL (2019-2023)

Jumlah pelaburan Capex dari 2019 - 2023:
RM 1.79 bil

Belanjawan Capex yang diramalkan dari 2024 - 2027:
RM 2.32 bil

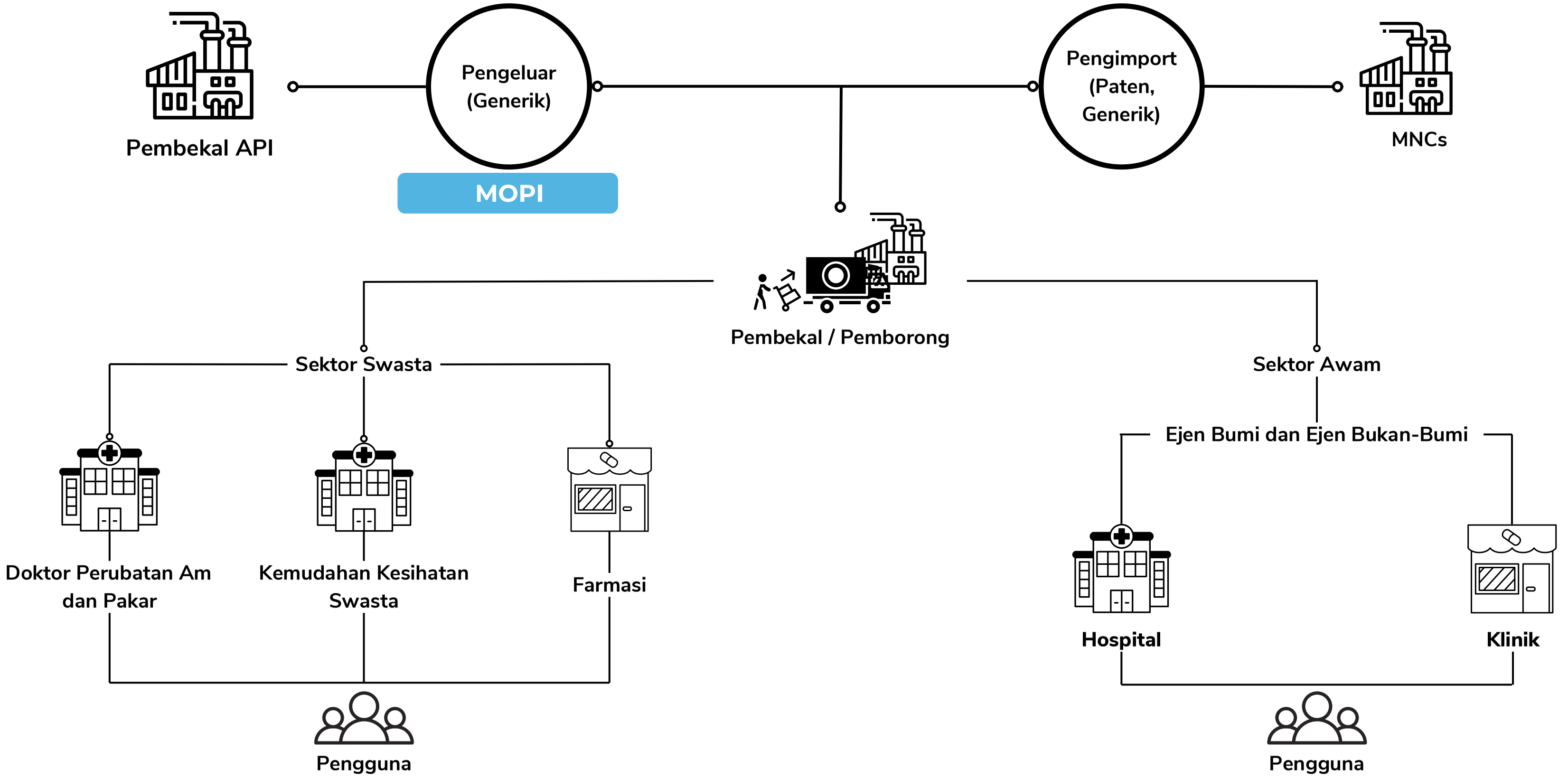


Nilai mewakili % daripada CAPEX terhadap Jumlah Pendapatan (tempatan + eksport) untuk tahun tersebut.

Purata % CAPEX berbanding Jumlah Hasil: 11.8%.

Nota: Nilai dalam RM (juta) dan ahli MOPI mewakili pengeluar farmaseutikal tempatan.

Peta Rantaian Bekalan Pasaran Farmaseutikal Malaysia



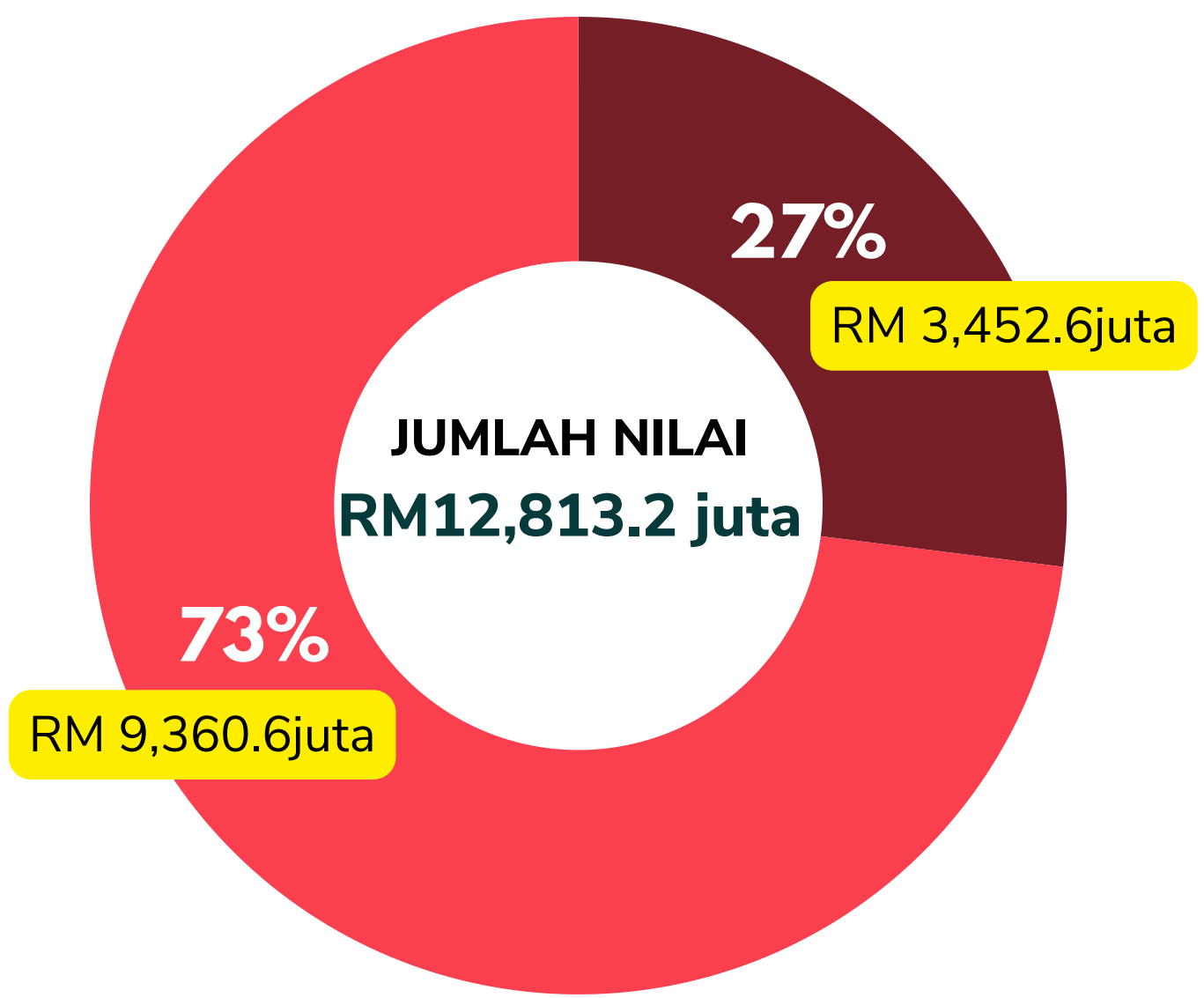
Tahap 1

Tahap 2

Tahap 3

Pecahan Pasaran Sektor Kerajaan dan Swasta pada Tahun 2024

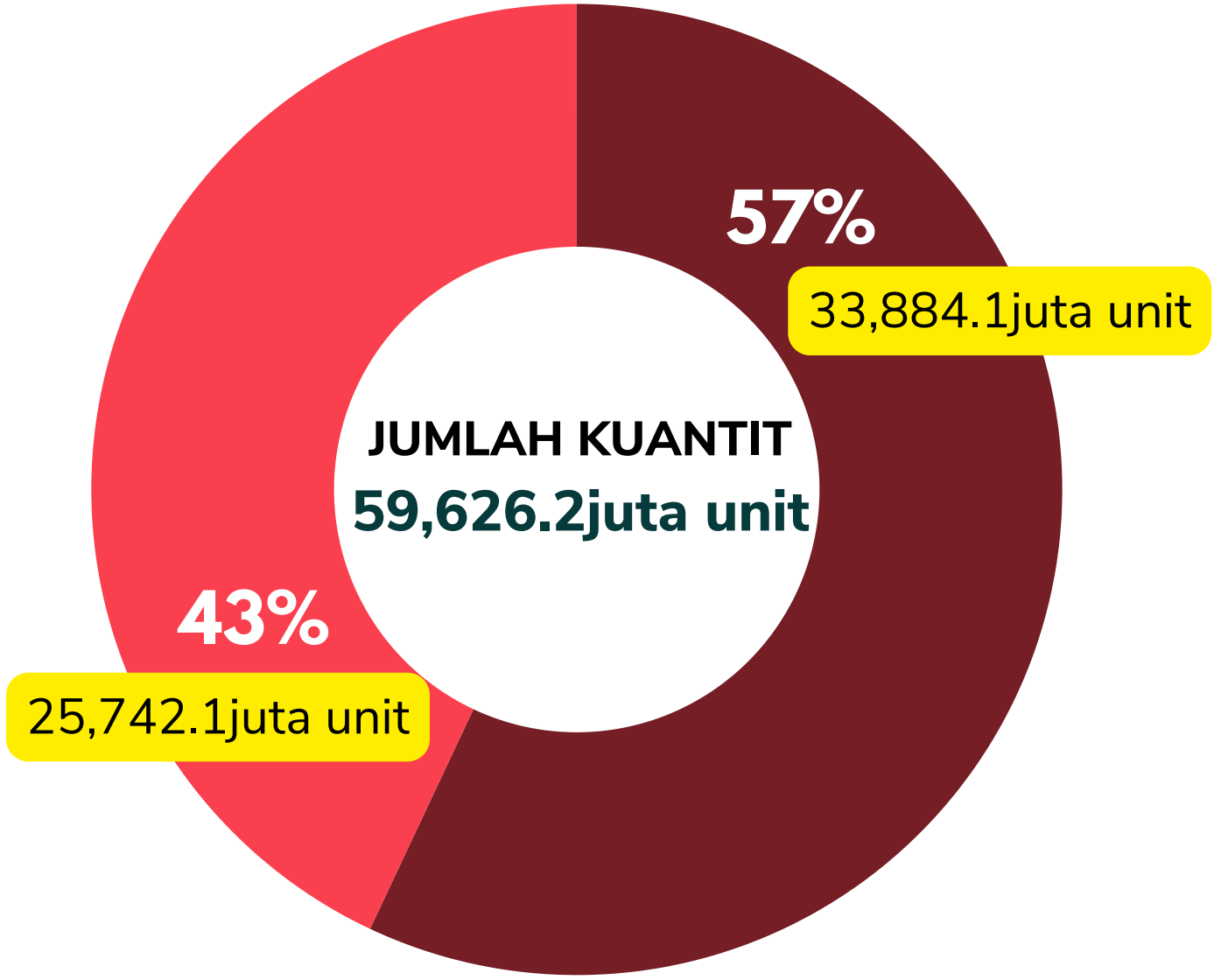
Nilai (Value)



Kerajaan

Swasta

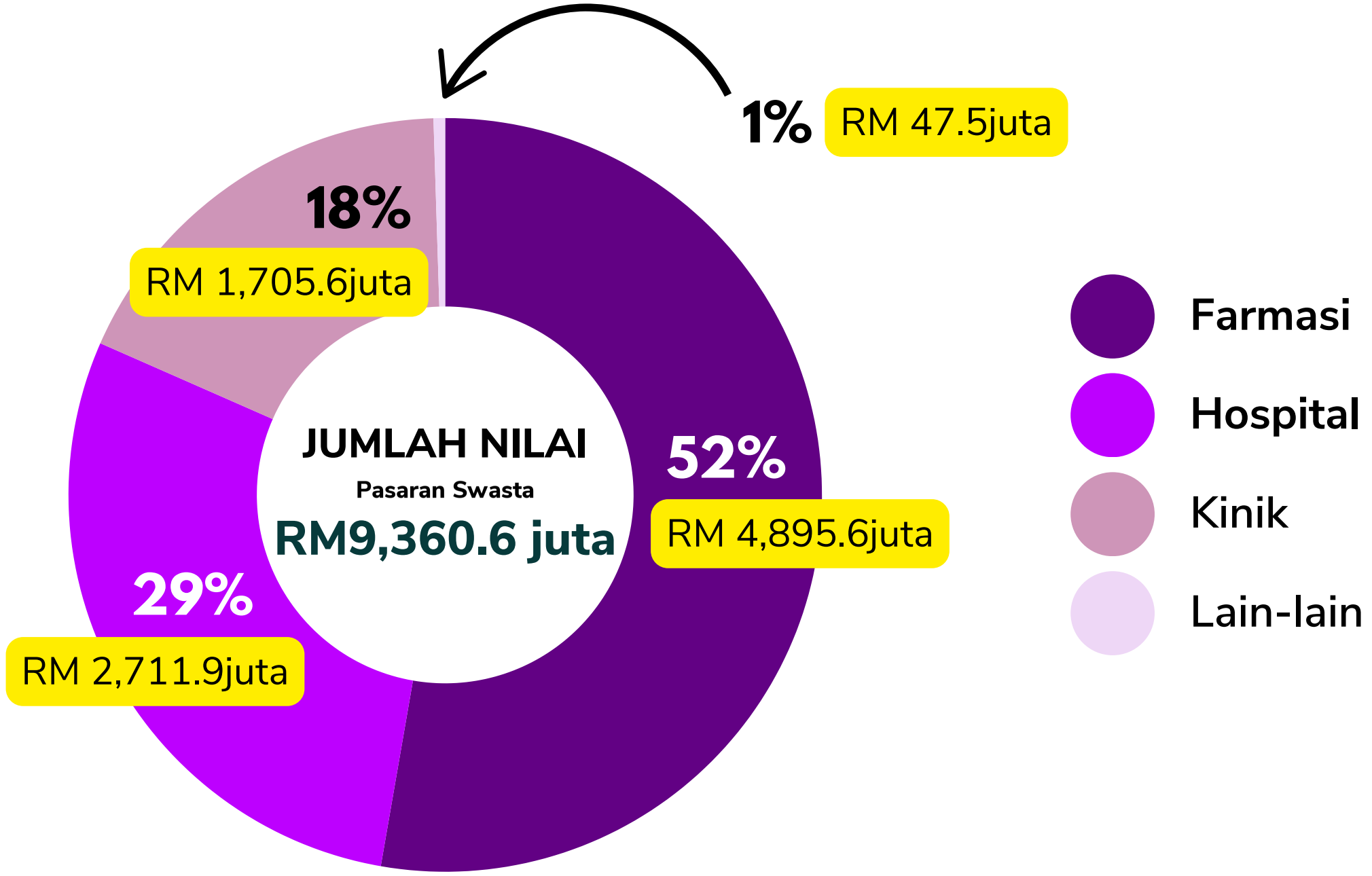
Kuantiti (Volume)



Sumber: IQVIA

Pecahan Pasaran Sektor Swasta pada Tahun 2024

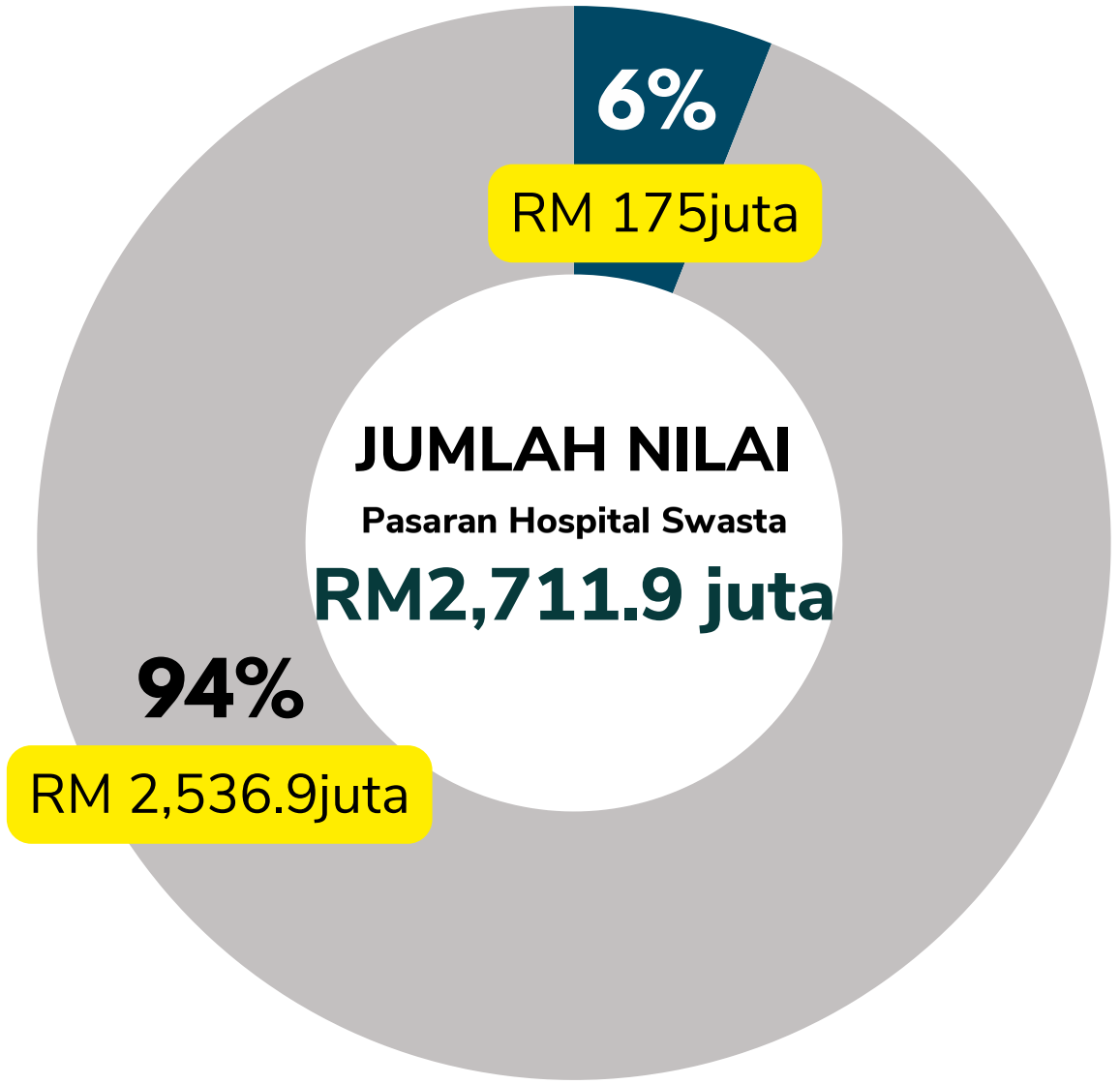
Nilai (Value)



Sumber: IQVIA

Sumbangan Ahli MOPI - Nilai dan Kuanititi Bekalan Ubat Generik kepada Hospital Swasta pada Tahun 2024

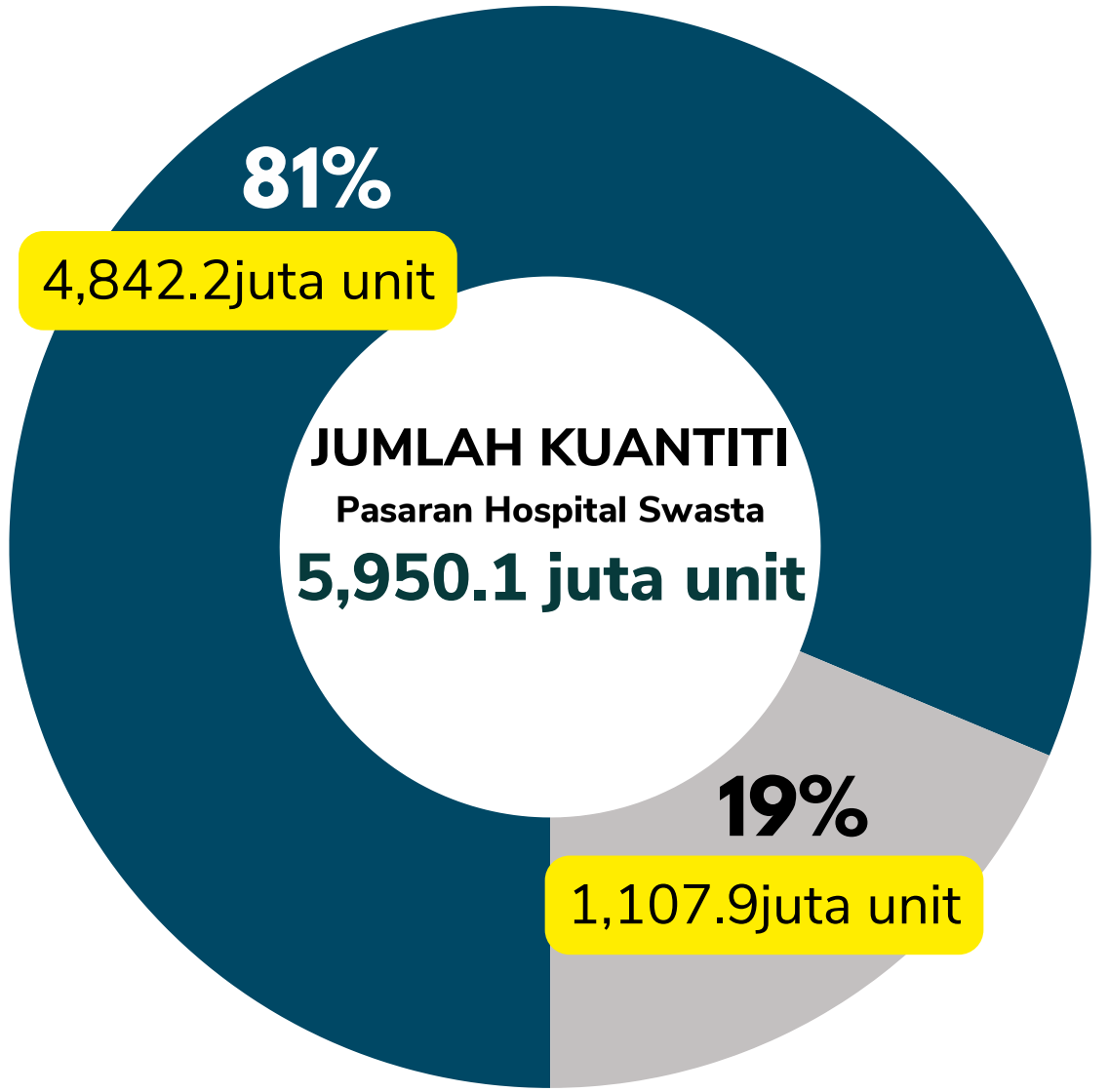
Nilai (Value)



Ubat import

Ubat generik daripada pengeluar tempatan - AHLI MOPI

Kuantiti (Volume)

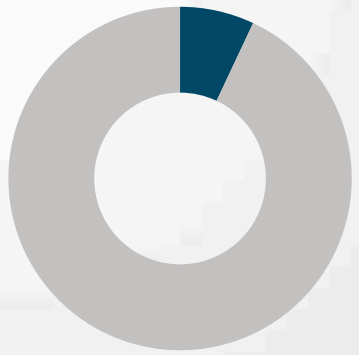


Sumber: IQVIA

Pegangan Pasaran dan Kenaikan Harga Ahli MOPI dalam Bidang Terapi Utama

UBAT KANSER





7%

Pegangan Pasaran Ahli MOPI

KENAIKAN HARGA

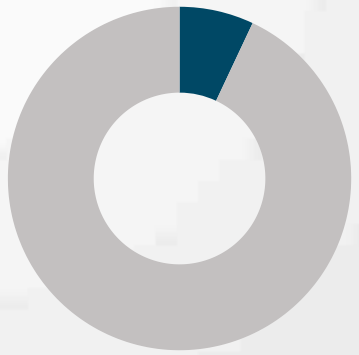
▲ **22%** Di Pasaran

▲ **4%** Ahli MOPI

KENAIKAN LEBIH RENDAH DARIPADA PASARAN

ANTIBIOTIK (SUNTIKAN)





7%

Pegangan Pasaran Ahli MOPI

KENAIKAN HARGA

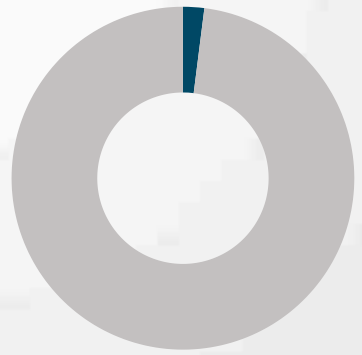
▲ **9%** Di Pasaran

▼ **-30%** Ahli MOPI

HARGA MENURUN LEBIH RENDAH BERBANDING KENAIKAN PASARAN

ANTIBIOTIK (TABLET)





2%

Pegangan Pasaran Ahli MOPI

KENAIKAN HARGA

▲ **17%** Di Pasaran

▲ **4%** Ahli MOPI

KENAIKAN LEBIH RENDAH DARIPADA PASARAN

Sumber: IQVIA

PUNCA PENINGKATAN HARGA

Depresiasi RM berbanding USD. Untuk tahun 2022, purata ROE RM berbanding USD adalah 4.41 berbanding 2023 yang adalah 4.56, peningkatan sebanyak 3.4%.

Kadar inflasi umum yang lebih tinggi menyebabkan peningkatan dalam gaji dan kos logistik. (Kadar inflasi pada 2023 - 2.5% dan 2024 - 1.8%)

Kos bahan mentah import meningkat, terutamanya API.

Kenaikan kadar siling kerja lebih masa untuk pekerja kilang.

Kenaikan tarif elektrik

Sumber kadar inflasi

Monetary Policy Statement - https://www.bnm.gov.my/-/monetary-policy-statement-22012025

Analysis of Annual Consumer Price Index, Malaysia, 2023 - http://www.dosm.gov.my/portal-main/release-content/analysis-of-annual-consumer-price-index-malaysia-2023-



Terima Kasih

https://mopi.org.my/

+603-7931 9003
+603-7932 2730

Medical Cost Inflation

Presentation to Public Accounts Committee (PAC)

6 Mac 2025 | Bilik Jawatankuasa 1, Tingkat 2, Blok Utama,
Parlimen Malaysia, Kuala Lumpur

Agenda

No	Topics
1	Introduction to PhAMA
2	Overview: Healthcare System in Malaysia
3	Healthcare Expenditure & Statistics
4	Way Forward

About Pharmaceutical Association of Malaysia

ABOUT US

- Established **53** years ago in 1972
- A non-profit organization representing local and multinational companies
- Members are involved in the import, distribution and manufacturing of pharmaceutical products.

MEMBERS

- **45** member companies
- Majority international innovative companies based in MY
- Since its inception in 1972, PhAMA today is recognized as the backbone of the innovative medicines industry in the country.









Contribution to Nation Building

	**Foreign Direct Investments**	RM720m investment as total direct investment	Drive medical tourism through quality treatment and access to innovative medicines
	**Gross Domestic Product**	RM6.8bn contributed by the industry (2020), and projected to grow to RM9.8bn (2024) to RM13.4bn (2027) at a CAGR of 7%	RM42 million annual investment by MNCs for medical professionals (CMEs)
	**Employment**	Generate job opportunities for over 15,000 individuals, with zero layoffs during the COVID-19 pandemic.	A further 80,000 individuals employed indirectly as support services.
	**Healthcare Advancement**	PhAMA members contributed significantly to the clinical trial landscape in Malaysia, accounting for 80% of the total investment in this sector.	From 2020-2024, RM 700m investment in clinical trials carried out in Malaysia was driven by Pharmaceutical MNCs

Source: Phama Fact Book 2022, IQVIA Analysis, Media reports

Supporting MOH In Healthcare Delivery

COVID-19 MANAGEMENT

- Effective management of COVID-19 with timely and ample access to life-saving vaccines to curb COVID-19 transmission.
- Ensuring continued supply of medicines in a sustainable manner throughout Movement Control Order



MEDICINE ACCESS SCHEMES

No.	Categories	2018	2019	2020	2021	2022	June 2023	Total
1	Number of patients who benefitted from PAP in Private Sector	2401	4242	13497	13812	18943	20939	73834
2	Number of patients who benefitted from PAP in Public Sector	1827	2980	4596	4640	5700	1617	21360
3	Number of programmes in Private Sector	31	43	32	55	65	61	311
4	Number of programmes in Public Sector	15	18	20	34	28	29	134

SUPPORTING CANCER PREVENTION

1) AstraZeneca collaborated with Lung Cancer Network Malaysia (LCNM) to launch Free Lung Cancer Screening Campaign to broaden access to lung cancer diagnosis utilising advanced technologies in Sept 2022.



2) MSD donated HPV vaccines valued at RM90 million to the National Cancer Society of Malaysia (NCSM) to provide FREE HPV vaccinations to girls in vulnerable communities to accelerate the elimination of Cervical Cancer in Malaysia. Zuellig Pharma contributed to the distribution channel ensuring timely delivery.



INVESTING IN CLINICAL TRIALS

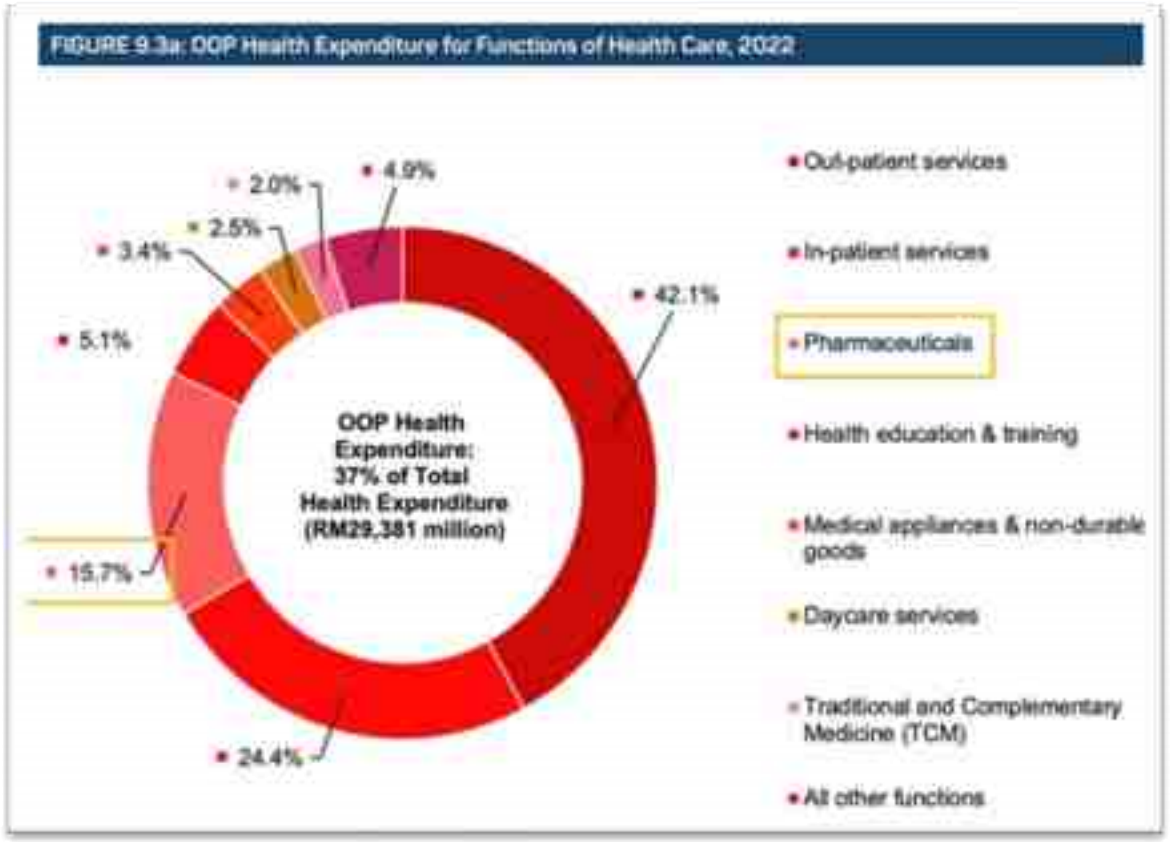
- Launch of 2 First-in-human (FIH)clinical trials in Sarawak from 2022-2024 with Roche and Astra Zeneca
- MOU signed with Clinical Research Malaysia in January 2024 to support talent development and expand interest in scientific study.





Medicines only contribute to a fraction of the entire cost of treatment

Medicines only contribute **16% to the entire cost** of treatment as per MNHA Report



Source: Malaysia National Health Accounts 2021

Medicines only contribute **12% to the entire cost** structure of Hospital Services in Taiwan (statistic as reference).

Item		Percentage (%)
Medical Costs		100%
Variable Costs	Attending Physicians' Salaries	18.3
	Drug Costs	13.3
	Medical Material Costs	11.4
	Social Assistance Subsidies	2.5
	Education & Training Expenses	3.4
	Water & Electricity Fees	2
	Fuel & Gas Costs	0.5
	Subtotal	56.9%
Fixed Costs	Direct Labor Costs	29.2
	Indirect Labor Costs	4.5
	Depreciation	3.2
	Maintenance Expenses	2.9
	Tax Losses	0.6
	Equipment Purchases	0.8
	Consumables	0.3
	Office Expenses	0.8
	Other Expenses	0.3
	Subtotal	44.1%
Administrative Expenses		5.6%

Source: Cost Structure of Linkou Chang Gung Memorial Hospital, Taiwan (3400-beds)

Medication Costs are largely flat within the public sector

Based on the Malaysia National Health Accounts (MNHA) framework report, Malaysia's expenditure on health in 2022 only **10% of the MOH's expenditure was allocated to pharmaceuticals.**

Table 3.1 Percentage and total estimated medicine expenditure (MYR million) 2018-2022 by sector

Sector	Expenditure (MYR million)				
	2018	2019	2020	2021	2022
Private	4143.39 (61.6%)	4556.92 (61.7%)	4252.17 (60.1%)	4699.12 (62.5%)	5833.84 (66.5%)
Public	2581.86 (38.4%)	2831.84 (38.3%)	2824.82 (39.9%)	2818.61 (37.5%)	2936.01 (33.5%)
Total	6725.25	7388.76	7076.99	7517.73	8769.85



Figure 3.1 Estimated total medicines expenditure (MYR million) from 2017 to 2022

Source: National Medicine Utilisation Study 2023/ Malaysian Statistics on Medicine 2018-2022, NHMS 2023, MHNA 2022

Increasing costs of healthcare due to a mix of social and economic factor

Causes of rising medicines cost:

- Ageing population
- Lifestyles of population
- Rising prevalence of NCDs
- Introduction of new and more effective medications
- Weakening RM
- Rising production costs and cost of doing business

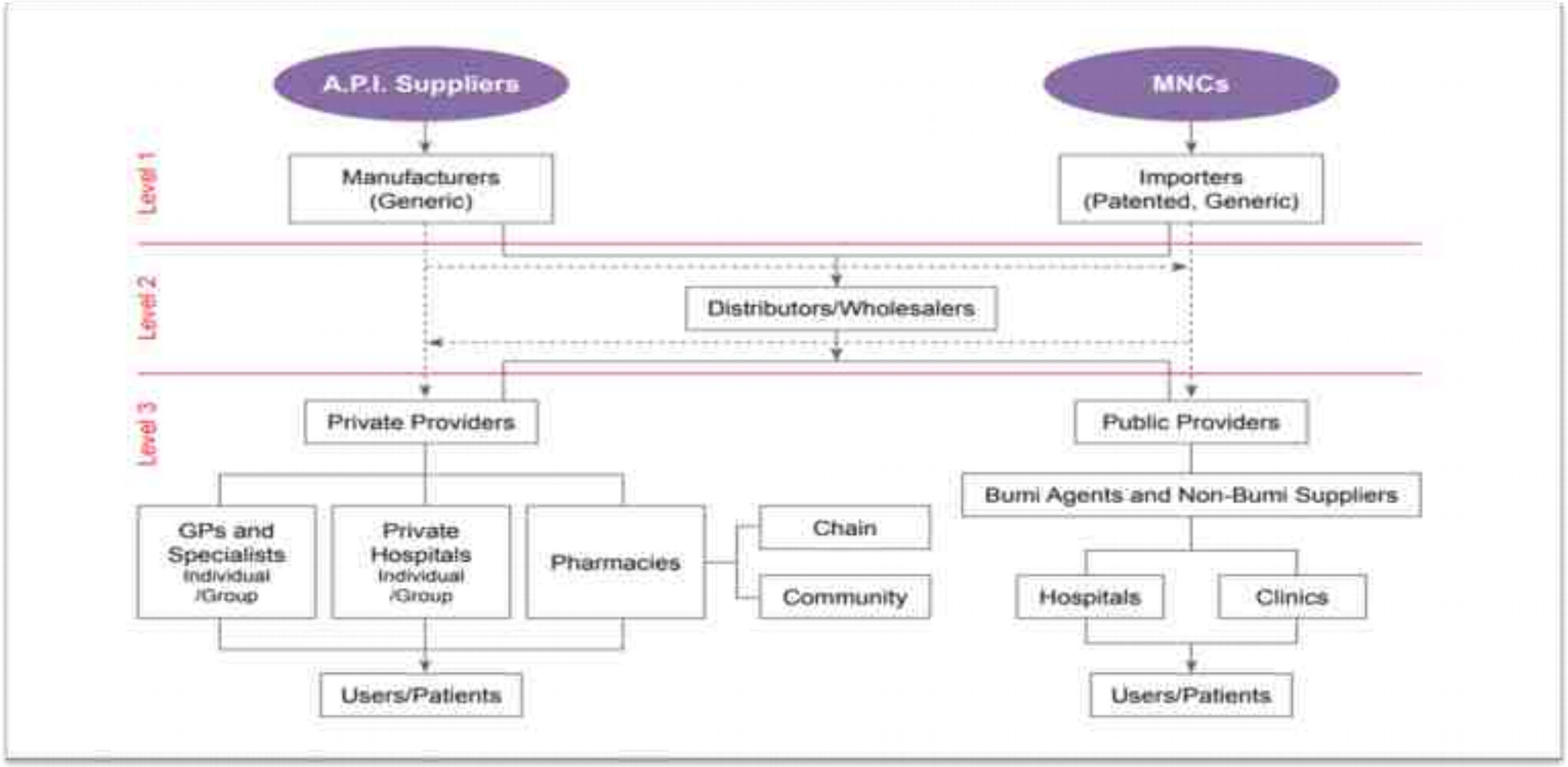


Macro indicators		Energy & Utilities		Transportation & Logistics		Commodities	
Indices	*Forecast*	*Indices*	*Forecast*	*Indices*	*Forecast*	*Indices*	*Forecast*
GDP growth	↑ +2 to 3%	Electricity	↑ +2 to 4%	Sea freight	↑ +2 to 4%	Aluminum	↑ +2 to 3%
Labor	↑ +3 to 5%	Natural Gas	↑ +1.5 to 3%	Air freight	↑ +3 to 5%	Carton board	↑ +1.5 to 3%
Exchange rate	Fluctuation of 2 to 3%	Crude oil	↑ +2 to 4%	Road freight	↑ +2 to 4%	HDPE Blow Moulding	↑ +2 to 3.5%
Interest rate	↓ -1 to 2%	Renewables	↑ +1.5 to 3%	Diesel	↑ +2 to 4%	PVC PVC suspension	↑ +1.5 to 3%
Inflation	↓ -2 to 3%			Warehouses	↑ +4 to 6%	Lactose	↑ +2.5 to 4%
Pharma market size	↑ +4 to 6%					Gelatine	↑ +3 to 5%
						Wheat	↑ +1.5 to 3%

1. Sources: International Monetary Fund (IMF), International Energy Agency (IEA), World Bank, Statista, Bloomberg NEF, U.S. Energy Information Administration (EIA), OPEC, OECD and Market reports (2023/2024)

Supply chain complexity adds to the mix

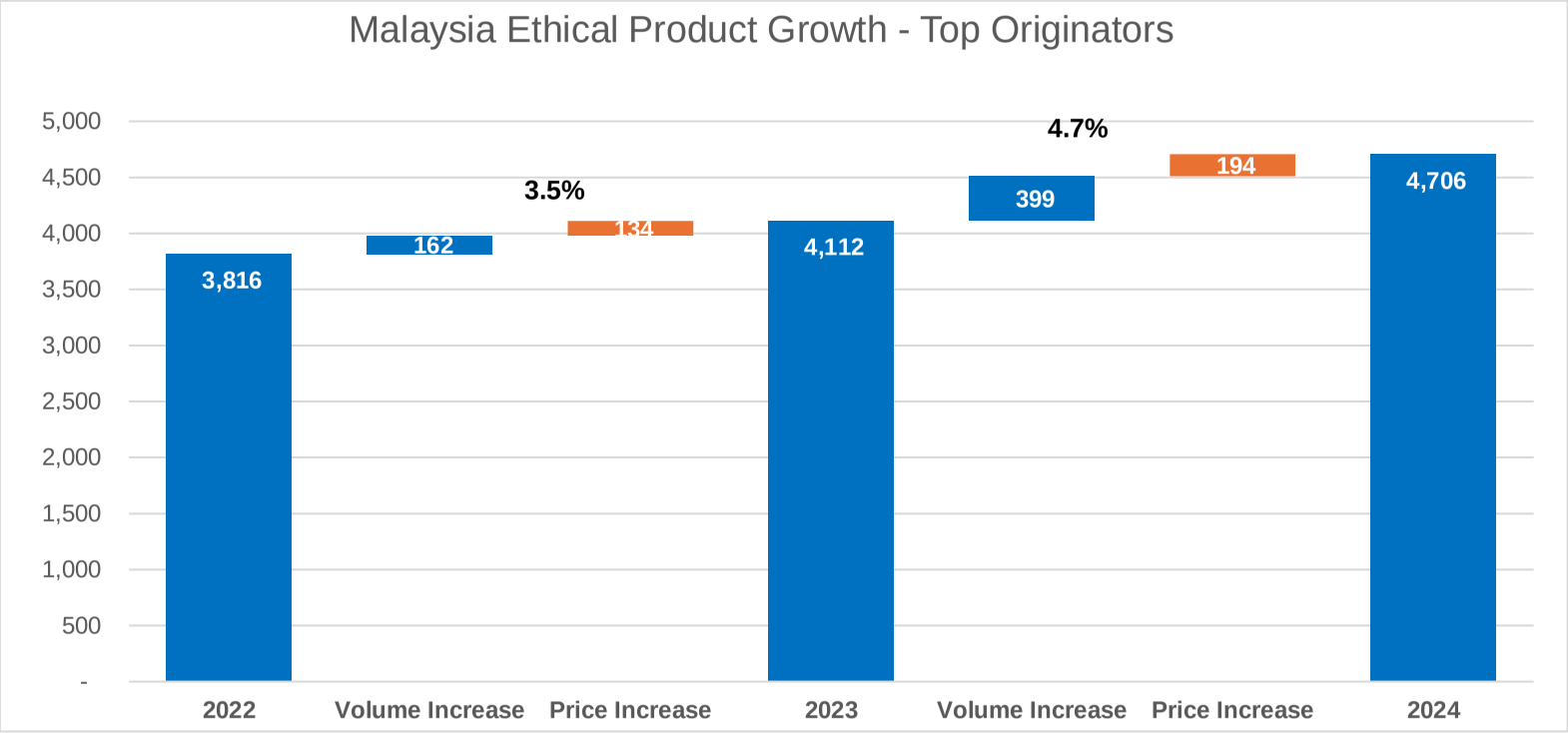
The pharmaceutical supply chain in Malaysia involves a series of interconnected stages that ensure the safe and efficient delivery of medicines from manufacturers to patients



Source: https://www.mycc.gov.my/sites/default/files/pdf/newsroom/Market%20Review%20on%20Pharmaceutical%20Sector.pdf

Top innovators prices are not the primary driver of medical inflation

Price increase in line with inflation, includes new innovation launches



Manufacturer
NOVARTIS, ASTRAZENECA, B.INGELHEIM, PFIZER BIOPHARMA, ROCHE PHARMA RX, GLAXOSMITHKLINE PH, MERCK SHARP&DOHME, SANOFI-AVENTIS, ORGANON, NOVO NORDISK, SANOFI-PASTEUR, BAYER PHARMA, SERVIER, ABBOTT PHARMA, TAKEDA, MERCK SDN BHD

Current existing laws are in place to ensure companies don't make unreasonable profit

Current existing laws under Malaysian Price Control & Anti-Profiteering Act 2011 (PCAP) under KPDN are in place to ensure companies don't make unreasonable profits.

Source: IQVIA IMS Data 2025

Socio economic impact of innovator medicines

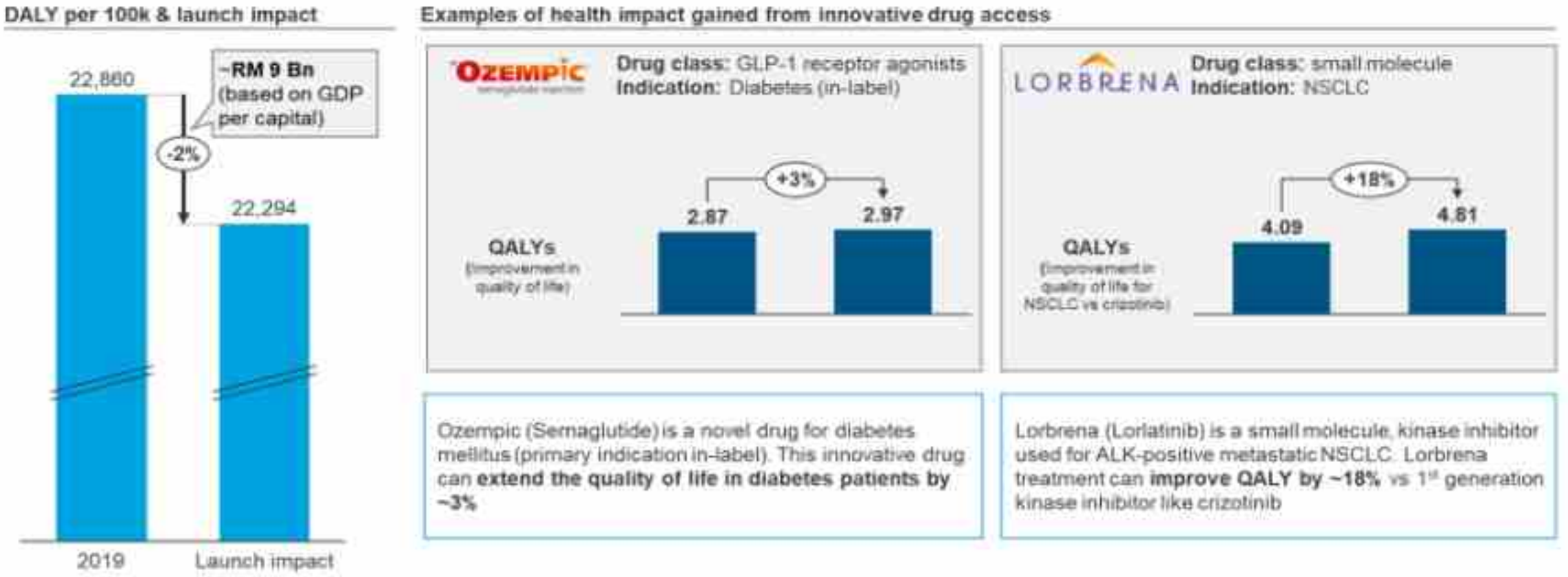
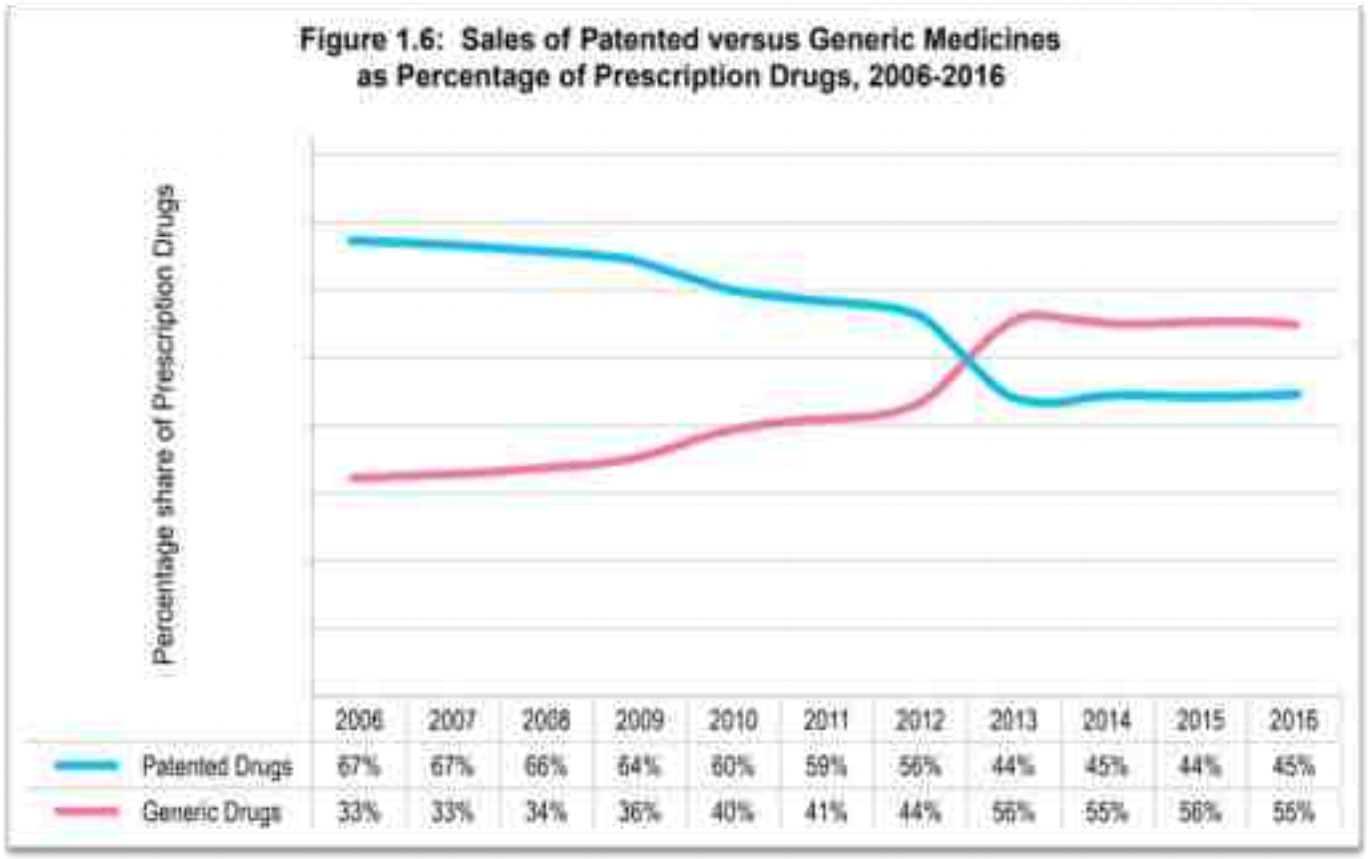
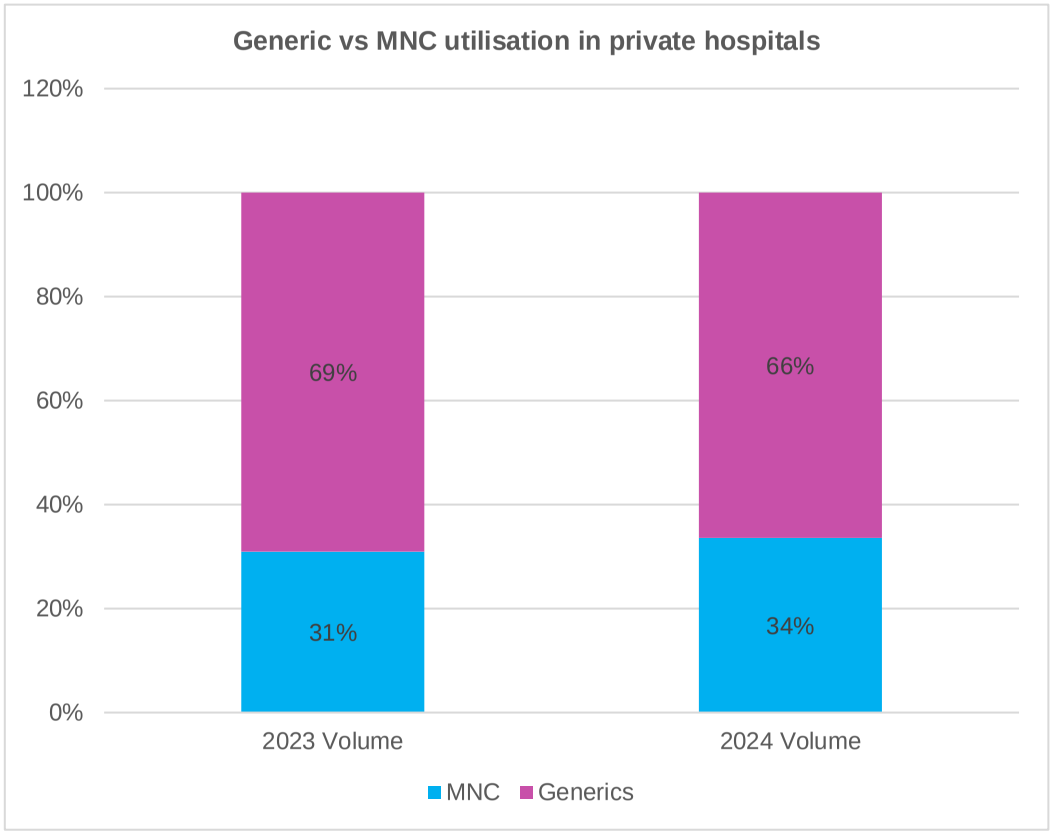


Figure 15: Averted DALY - Disease burden potential reduction from launched drugs in private hospital
Source: IQVIA MIDAS, IHME-WHO, cost-effectiveness analysis reports per drug [26, 32, 33]

Source: Association Of Private Hospitals, Malaysia (APHM) Factbook 2024

Increased utilization of generics in line with Generics first policy

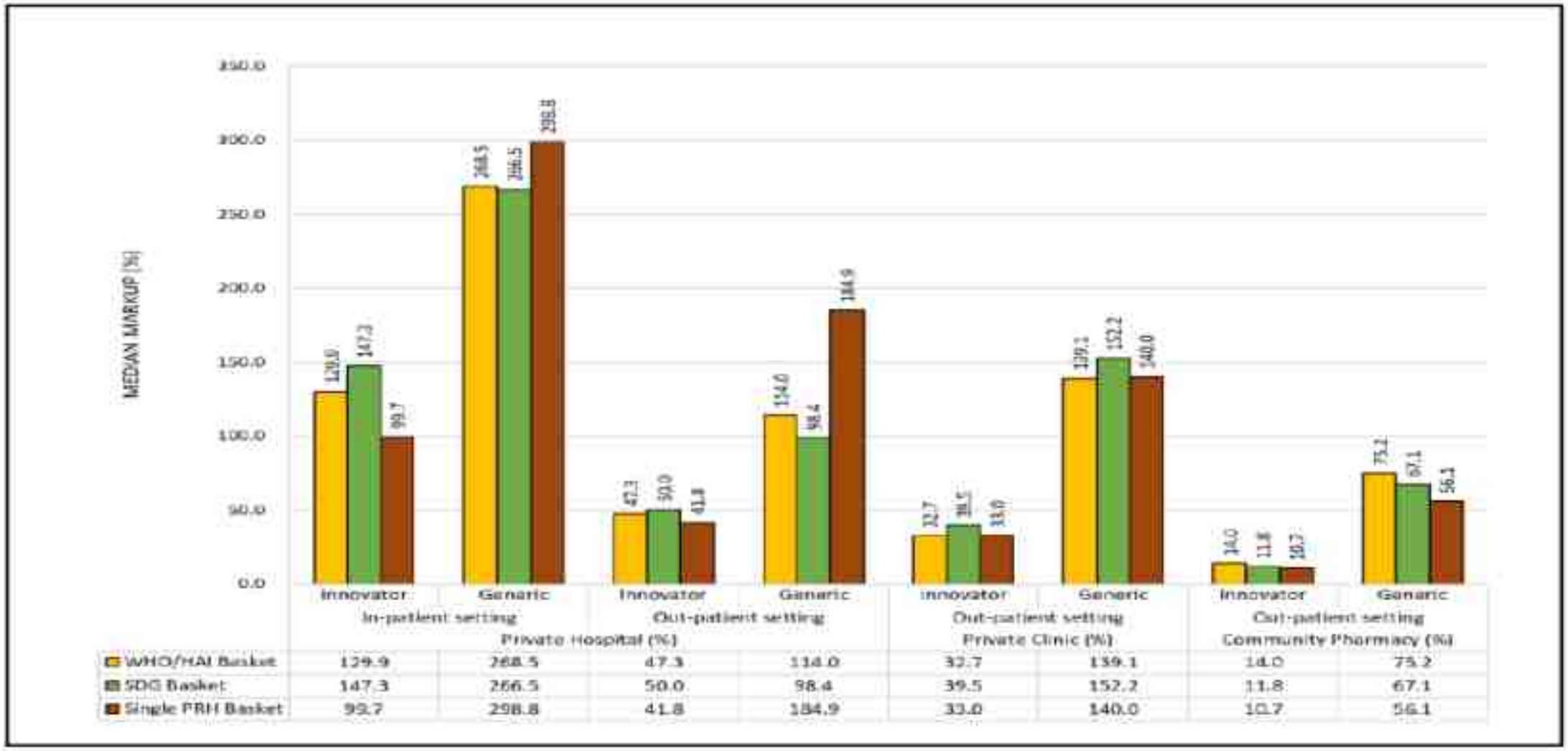




Source: IQVIA 2025

Source: BMI (2011). Malaysia: Pharmaceuticals & Healthcare Report, Q1, 2011; BMI (2013). Malaysia: Pharmaceuticals & Healthcare Report, Q4, 2013; BMI (2017). Malaysia: Pharmaceuticals & Healthcare Report, Q3, 2017 - Market Review on Priority Sector under Competition Act 2010 (Pharmaceutical Sector)

Procurement price to selling price median markup in private sector are high



Source: Medicine Prices Monitoring in Malaysia – Survey Report 2022, Ministry of Health

The Way Forward

Preventive health to reduce sick care

- Strengthen Primary Care for prevent health services eg. early screenings and diagnosis, adult vaccinations to empower public and manage rising NCDs amidst ageing population
- Expand PekaB40 and SOCSO to incentivize healthy behaviour - Redirect taxes for unhealthy food to incentives for healthy food using traffic light labelling
- Raise awareness of social determinants of health from young at schools

Innovative Healthcare Financing

- Increase innovative healthcare financing (i.e. co-payment) and micro-insurance
- Contributory Care Model in public facilities –minimal charge to patients for costly medicines to avoid wastage and increase compliance
- Strengthen public sector infrastructure to contain healthcare costs

Invest in public health data to enable value based procurement

- To promote patient health data via 1Rakyat, 1Record
- Improve resource efficiency using data-driven decision-making
- Enable Value-Based Healthcare and utilization of Societal Impact through healthcare data

THANK YOU

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APHM
Persatuan Hospital Swasta Malaysia
Association of Private Hospitals of Malaysia

APHM Proceeding with Public Accounts Committee (PAC)

10 March 2025

Agenda

1. Study on Profitability & Billing and Cost Structure of Private Hospitals
2. Results from Medical Inflation Study (Utilization Rate)
3. Results from Medical Inflation Study (Medical costs Increase and Drivers in Medical Inflation)
4. Data Discrepancy for Insurance and Cash Payment for Dengue & Pneumonia
5. List of Measures and Actions to be undertaken by Private Hospitals during 3-year interim measure period
6. Longer-term Measures and Solutions to be undertaken by Private Hospitals contributing

Profitability of Private Hospitals

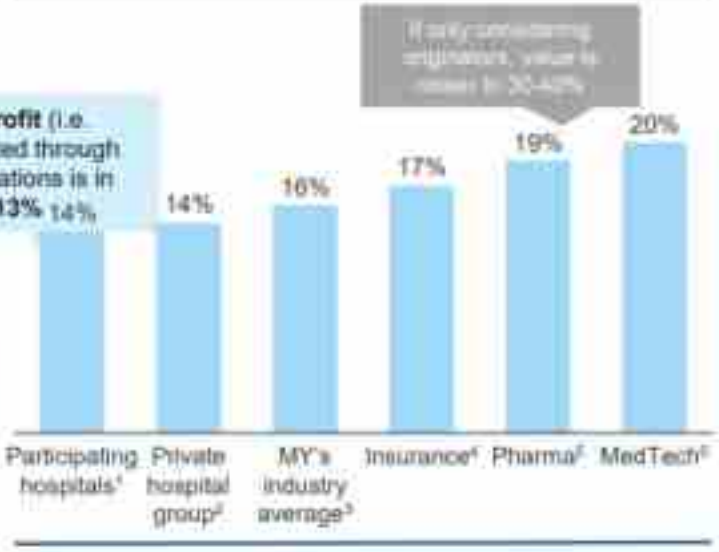
Profit margins for private hospitals are slim, with direct and staff costs representing the largest expense at ~63% of revenue

Revenue breakdown of private hospitals

Breakdown of every RM 1,000 revenue generated by Participating Hospitals[1]



PBT across selected healthcare industries, *2023*



PAT						
	9-11%	12%	12%	13%	15%	16%

Note: GL – Guarantee Letter; PBT – Profit before tax; PAT – Profit after tax; 1. Basket of participating hospitals; 2. 2 biggest private hospitals groups in Malaysia; 3. Across 5 capital intensive sectors and 26 publicly listed companies (telecommunication services, semiconductors and semiconductor equipment, transportation infrastructure, and automobiles); 4. 3 biggest publicly listed insurance companies (AIA, Prudential, and Great Eastern); 5. Global average; 6. Aon: Global Medical Trend Rates Report

Source: Capital IQ (retrieved August 2024), Third Party Consultant Analysis, Expert Interviews

Please refer to the 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.10) for details.

Profitability of Private Hospitals

Profit margins have normalized post-COVID at 10.8%, direct and staff costs remains the largest expense at ~63% of revenue

Revenue breakdown of private hospitals

Breakdown of every RM 1,000 revenue generated by Participating Hospitals[1]



Note: 1. Basket of participating hospitals; 2. Profit before tax; 3. Profit after tax; 4. Varies according to hospital size and planned investment expenditures for the year
Source: Participating hospitals, Team analysis
Profitability analyses across the Malaysian healthcare ecosystem | October 2024 | Confidential: Not for circulation

Please refer to the 'Profitability analyses across the Malaysian Healthcare Ecosystem – Discussion Document' (p.21) for details.

Billing & Cost Structure for Private Hospitals

Line Items Appearing in Patient's Bill

- Consumable drugs
- Medical Supplies
- Rehab charges
- Operating Theatre
- Rehab charges
- Medical Officer fees

Line Items Appearing in Patient's Bill at Subsidised Rate

- Ward charges
- ICU Charges
- Nursing Care
- Emergency equipment

Items NOT listed in Patient's Bill

- Non-nursing staff cost
- Allied Health Staff Cost
- Building cost / rental
- General Plant & Equipment
- Land cost
- Maintenance of general plant and equipment
- IT Costs / cyber security
- Utilities

Redundancies & Preparedness

- **Ambulances**
  - 24/7, 3 shifts staff cost
  - Equipment & maintenance
- **Emergency Department**
  - Emergency Equipment
  - Emergency OT
  - 24/7, 3 shifts staff cost
  - On Call Team

Please refer to the APHM Drug Price Control : Impact Assessment & Potential Implications (2019) ' (p.13) for details.

Billing & Cost Structure for Private Hospitals

Categories	Description	Patient Bill
Direct Charges (Some are cross subsidized as elaboration below)	Consumable drugs & Medical Supplies	Appear in Patient Bill
	Use of Facilities (e.g Room charges, Operating Theatre Fee and others)	
	Use of Medical Equipment (e.g X-Ray, MRI, CT Scan, Defibrillator, Radiotherapy machine and others)	
	Service Costs in Patient Care (e.g Nursing care, Rehab charges, MO fee and others)	
Cross Subsidization ⊕	Nursing care	Appear in Patient Bill at Subsidized Rate
	Room charges	
	Emergency equipment (e.g IABP* machine, Defibrillator and others)	
Non-Chargeable Costs	Half of hospitals' staff cost are non-nursing which are non-chargeable	Items that do not typically appear in the patient bill but essential in facilitating delivery of high-quality medical services
	Utilities (e.g high electricity bill due to high requirements for air-cond system and medical equipment which consume high electricity power and others)	
	Land cost, building cost, rental, general plant and equipment	
	Maintenance of general plant and equipment	
	IT Costs (e.g HIS, PACS, servers, data centres, cybersecurity, hardware & software)	
Redundancies & Preparedness	Standby facilities and resources (e.g ambulances, staff and equipment at emergency department, emergency OT, emergency medicines, on-call teams and others)	

Please refer to the APHM Drug Price Control : Impact Assessment & Potential Implications (2019) ' (p.13) for details.

Cross Subsidization Sample

Room Charges



- Typical room charges is RM 200 - 300 per day (Single occupancy)
- Actual cost for hospital rooms / per bed is significantly more **- build and maintain**, between RM1mil – RM1.5mil per bed cost.
- Actual cost per room/ per bed/ per day is between 3X to 5X, which is not charged to patients.
- High **maintenance cost** – regulatory standards on air exchange, infection control, medical gas, nurse call systems, etc.

To accommodate product design of insurance policy, where if charged are at the appropriate and fair cost, it will result in direct cost burden to patients *(co-payment / excess charges)*

Please refer to the APHM Drug Price Control : Impact Assessment & Potential Implications (2019) ' (p.10 and p.11) for details.

Cross Subsidization Sample

Equipment – Example : Intra Aortic Balloon Pump

Purchase Price	Average RM300,000 x 2 units
Frequency of Use	Average 10 per year
Typical Charge per Use	Average RM1,500

- To breakeven, the charge should be RM15,000 per use.
- Breakeven = RM600,000 x 1.25 [5% cost of capital per annum]

  ---

  5 years x 10 cases per year

  = RM15,000
- Hence, the **SUBSIDY** per use is RM13,500.



IABP is a crucial piece of device that increases myocardial oxygen perfusion and indirectly increase cardiac output through afterload reduction.

It is used for temporary circulatory support in critically ill patients with cardiac diseases.

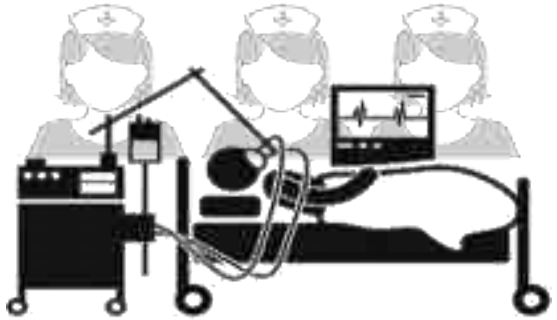
Please refer to the APHM Drug Price Control : Impact Assessment & Potential Implications (2019) ' (p.10 and p.11) for details.

Cross Subsidization Sample

Nursing Care in Intensive Care Unit (ICU)



- 1:1 Nursing (as per MOH requirement)
- RM 6000/staff
- 3 shifts X RM 6K = RM 18,000 per bed



- Typical Nursing Care Charge – **RM 300/ day**
- Assuming 100% occupancy – **RM 300 X 30 = RM 9,000**
- Revenue **DEFICIT of RM 9,000**
- If Typical occupancy of 70%, ONLY **RM 6,300 revenue**

These few examples point to the systemic issue of why items like drugs and consumables, including examples like gloves appear to be charged above what maybe deemed fair, as a significant portion of hospital costs is undercharged or not charged to the patient.

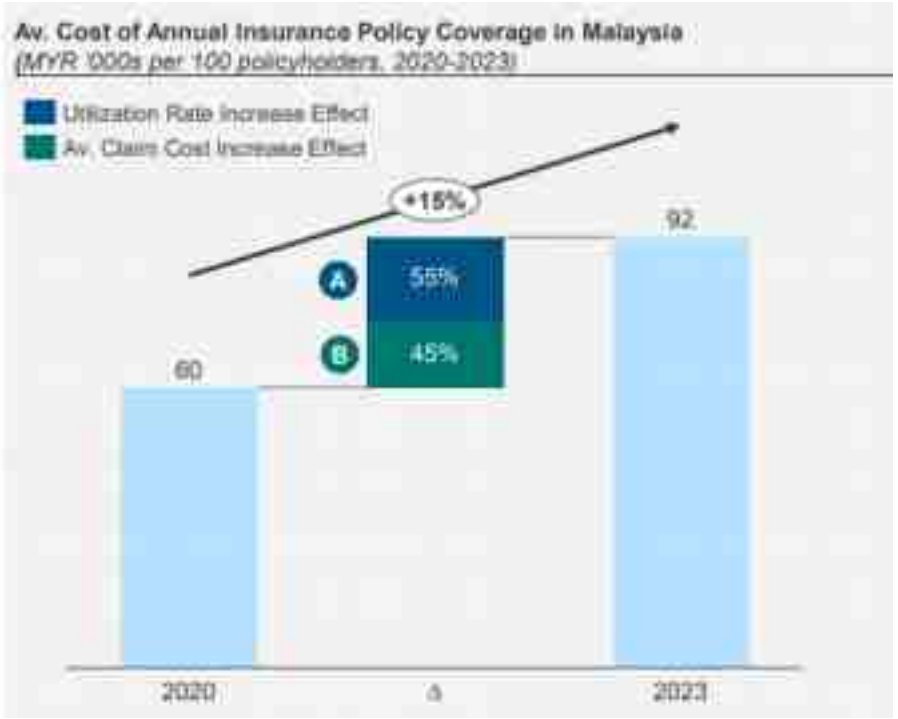
This potentially causes confusion, especially since hospitals are very transparent in billing, as required by law and current request by payors.

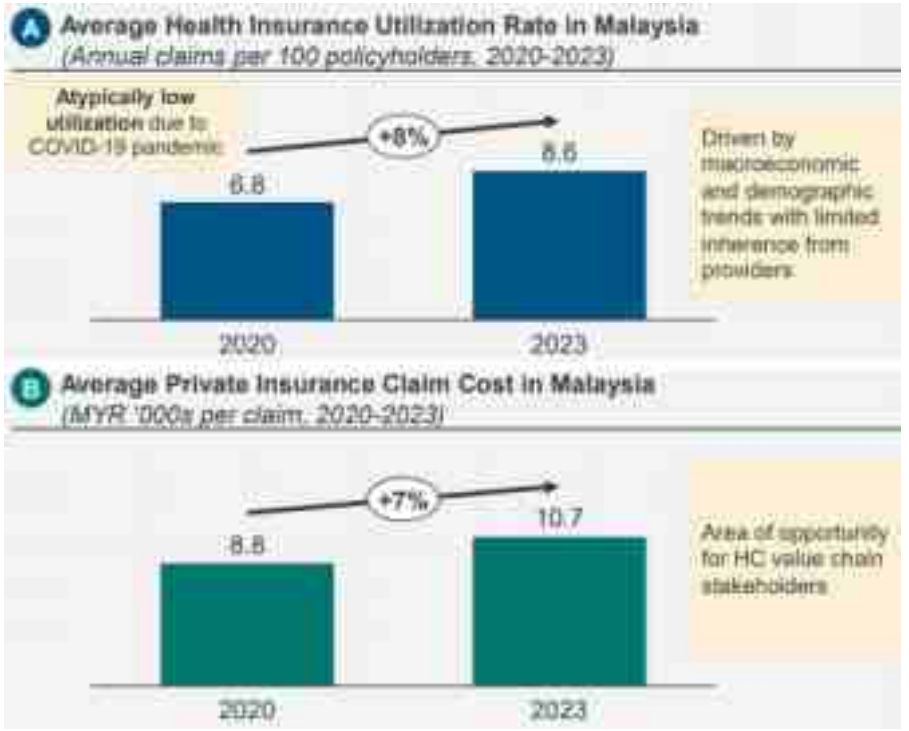
A comprehensive review of this matter, in alignment with payors is needed to ensure appropriate allocation of cost and charging structure

Please refer to the APHM Drug Price Control : Impact Assessment & Potential Implications (2019) ' (p.10 and p.11) for details.

Results from Medical Inflation Study (Utilization Rate)

Increased utilization rate has higher contribution to insurance policy costs compared to claim costs





Please refer to 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.7) for details.

Results from Medical Inflation Study (Utilization Rate)

Rise in utilization rate driven by combination of macroeonomic and behavioral factors



Ageing Population & Rise in NCD Incidence:
Older population with NCD's typically require increased frequency of care



Increased Adoption of Private Healthcare :
Malaysians have been seeking private care more due to rising affordability and public healthcare limitations



Ongoing Expansion of Private Healthcare:
Rise in claim numbers following steep uptake in private health insurance in recent years

Please refer to the 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.10) for details.

Results from Medical Inflation Study (Variance in Reported Medical Trend Rate)

Further noted on variance of Medical Trend Rates reported and circulated, published by different groups



- **No correlation** between the **Medical Trending Rates (MTR)** published by different leading insurance firms.
- MTR's are **subjective**, based on specific **insurer's policy terms** and their **market expectations.**
- Hence, utilization of MTR in estimating future medical inflation or comparable benchmark amongst countries **might not be an accurate characterization** of true medical inflation

Note : (1) – Mercer Marsh Benefits
Please refer to 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.5) for details.

Results from Medical Inflation Study (Variance in Reported Medical Trend Rate)

Several terms are often used interchangeably when referring to Medical Inflation, with different definitions

	Medical Trend Rate	Δ Medical Consumer Price Index (M-CPI)	Δ Private Health Expenditure (PHE) per Capita
Definition	Cost of medical plan costs per insured patient to insurers	OOP spending on medical care by household	Private health expenditure as a ratio of population
Stakeholder In Focus	Insurance companies	Household (OOP)	Household, private insurance, direct payments by private corporations
Published by	• Insurance companies / brokers	• Government economic ministries	• WHO (Global Health Expenditure Database)
Key Drivers	• Average claim amount (unit cost) • Policy utilization rate (claims / policyholder)	• OOP medical expenses • Insurance premiums; deductible, co-payments	• Cost of private HC goods and services • Healthcare services demand
Limitations	• Inaccurate proxy of actual rise in costs, as it's merged with policy utilization	• Excludes all healthcare spend disbursed by other healthcare payers (public, private)	• Limited disaggregation of components available

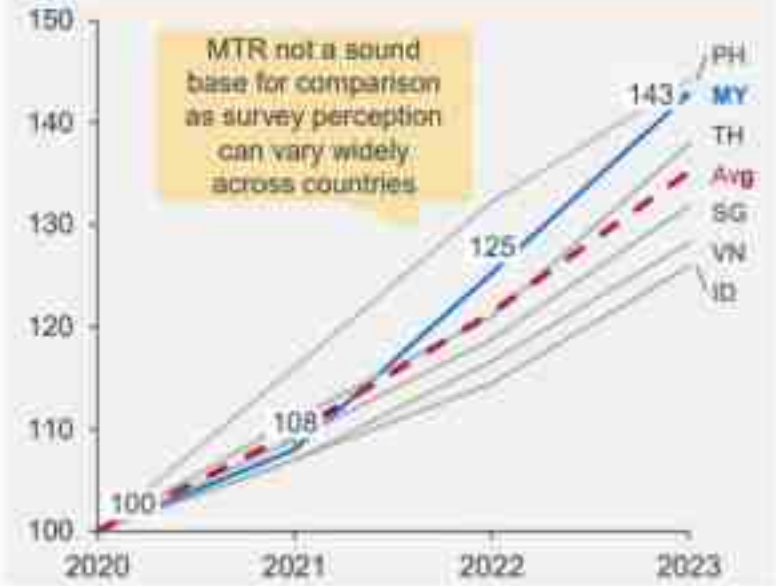
Medical inflation refers to the change in the cost of healthcare goods and services, but different stakeholders experience these costs differently

Notes: OOP – Out of pocket expenditure;
Source: Aon Medical trend rates reports, Bank Negara Malaysia, Department of Statistics Malaysia, WHO GHED, Third Party Consultant analysis

Please refer to 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.3) for details.

Other Matrices for Representation of Medical Inflation

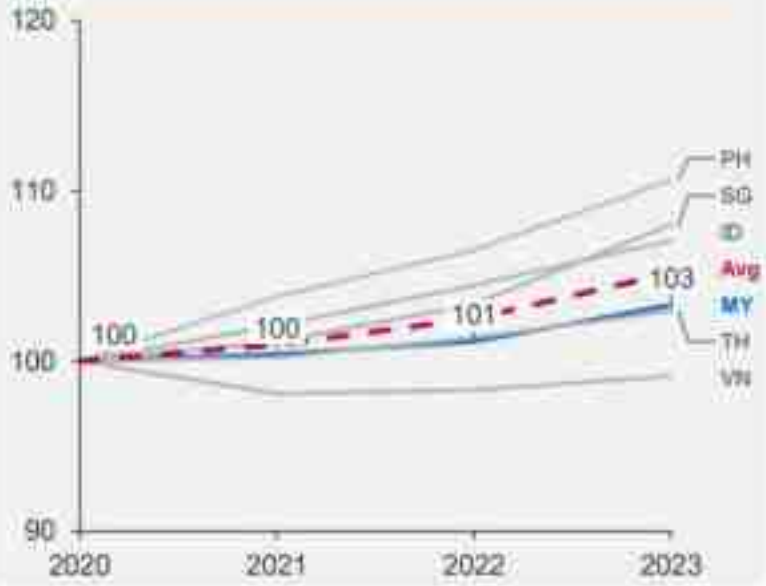
Medical Trend Rate (MTR)



Insights

- Increase in policy utilization rate has accounted for ~55% of the medical trend rate growth since 2020 in MY, driven by higher awareness and rising NCDs

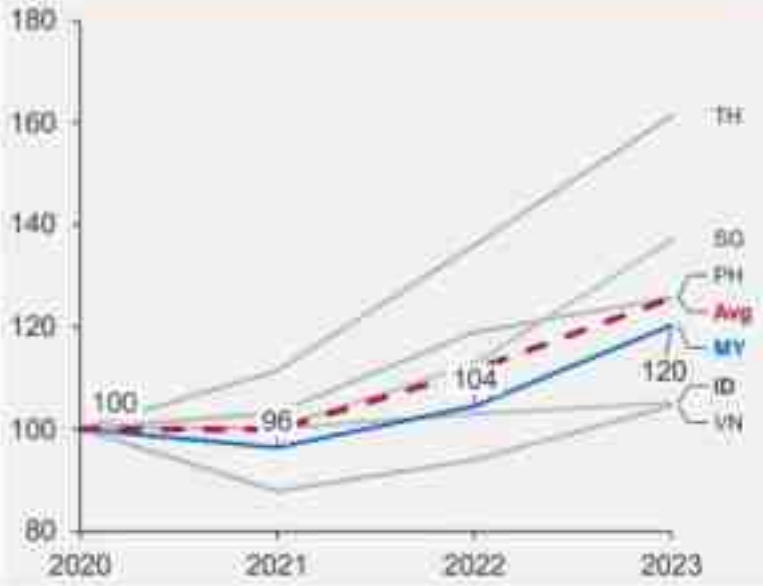
Δ Medical Consumer Price Index (M-CPI)



Insights

- M-CPI growth in MY has been driven by private insurance premium hikes and the adoption of more advanced treatments

Δ Private Health Expenditure (PHE) per Capita



Insights

- Increased demand for private healthcare services due to limited public infrastructure capacity in MY

Notes: NCDs – Non-Communicable Diseases
Source: Aon Medical trend rates reports, Bank Negara Malaysia, Department of Statistics Malaysia, WHO GHED, Third Party Consultant analysis
APHM | Medical Inflation in Malaysia | Discussion Document | February 2024 | Confidential

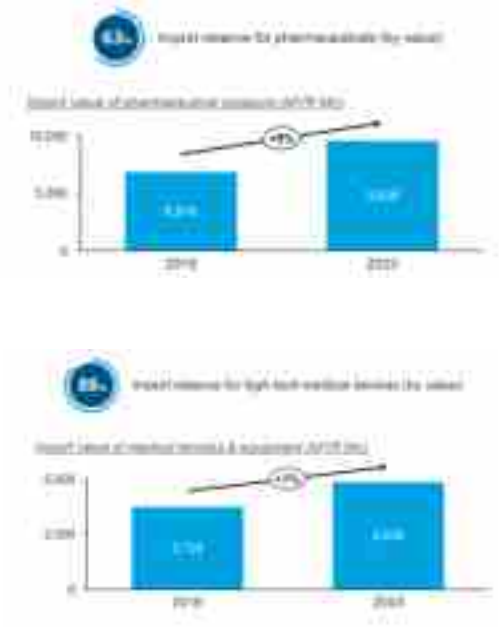
Please refer to 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.6) for details.

Results from Medical Inflation Study (Four Key Drivers in Rising Medical Costs)

1. **Pharma price increase due to innovation in different areas such as biologics market and Ox and Bx products**

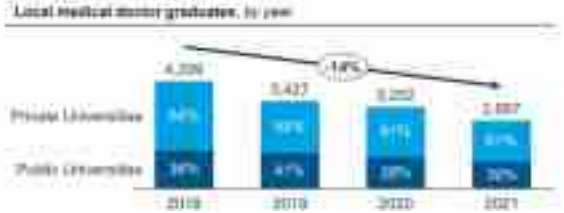


2. **63% increase in import value for pharmaceuticals and 88% for medical devices**

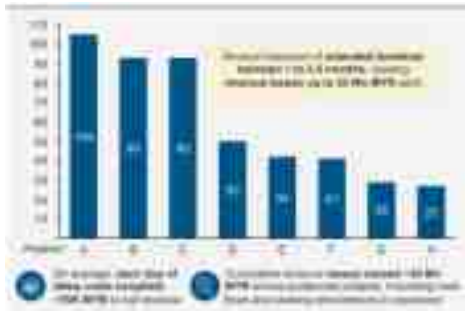


3. **Medical Staff decrease for nurses and local medical graduates resulting in Salary Increases up to 7%**



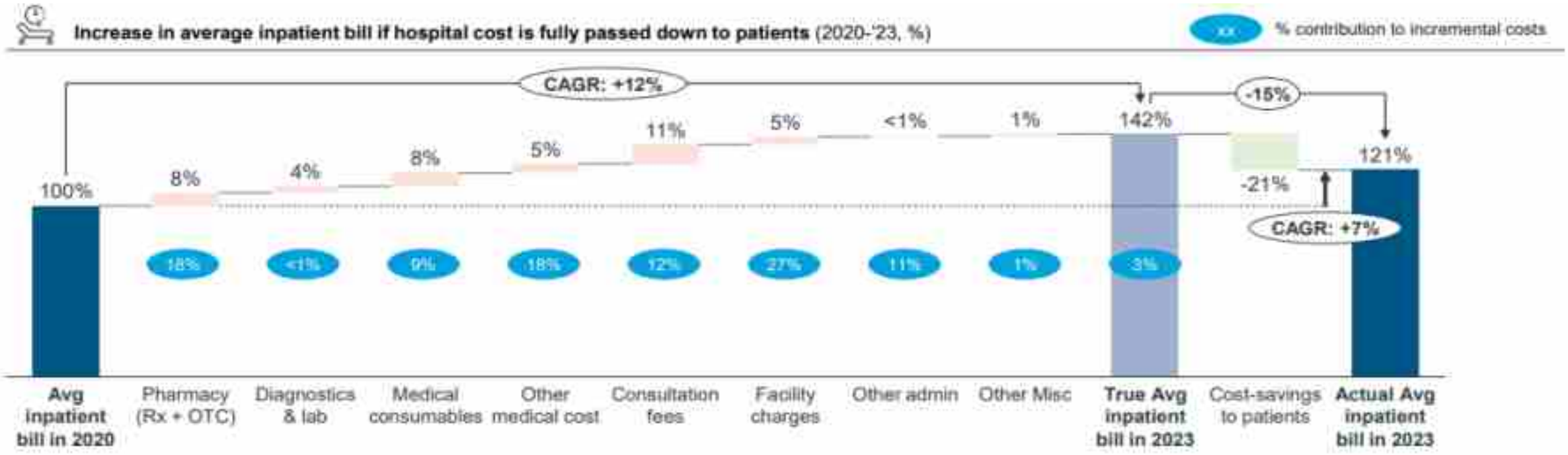


4. **Delay in Regulatory Compliance Approvals between 1 to 3.5 months**



Please refer to 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.15-20) for details.

Ongoing Cost Containment Measures and Efforts by Private Hospitals



Economies of scale and efficiency improvements have enabled private hospitals to counter cost increase

Please refer to 'Medical Inflation in Malaysia : Drivers and Recommendations – Discussion Document ' (p.22) for details.

Insurance vs Cash Payment

Data Presented to Government (2020 – 2023)

Disease	'Guarantee Letter' Utilization (RM)	Pay-and-Claim (RM)	Multiple
Dengue	4,978	1,288	**4x**
Pneumonia	6,859	2,654	**3x**

Source : Insurance & Takaful Industry Medical Cost Containment Task Force Study on Drivers of Medical Costs & Medical Insurance Premium Inflation with sample size of 33,185 for dengue and 53,188 for pneumonia.

Note: No indication of sample size especially for Pay-&-claim (which as per hospitals is low volume), length of stay for treatment of disease, and whether the charges are for inpatient or outpatient bills.

No indication as well if the comparison is within the same basket of facilities, or different facilities between GL and Pay-and-claim

Available Data from APHM (2024)

Disease	Insurance (RM)	Cash (RM)	Multiple
Dengue	6,889	7,421	**0.07x**
Pneumonia	9,337	10,659	**0.14x**

Source : A sample size of 10,000 cases of dengue and pneumonia combined from APHM Participating Hospitals under IHH, SMC, KPJ & A1Health

Note: Inpatient data with average length of stay between 3-5 days. All for admission cases, without complication / critical care. .

List of Measures and Actions Private Hospitals will Continue to Take in the 3-year interim measure period

Cost Optimization and Efficiency	• Cost-effective medication use • Operational cost reduction
Price Transparency	• Implement Drug Price Transparency for Out-Patient Departments (OPD) in all APHM hospitals by 1 April 2025 according to MOH directive • Regulatory and Policy advocacy
Long-term, Sustainable Pricing Systems	• Commitment in exploring alternative reimbursement models, aligned with development of accessible national healthcare system
Improve Insurance Products and Optimize Benefits for Policyholders through Close Cooperation with Insurance Companies	• Tiered insurance products • Mandatory co-payments
Raising Public Awareness on Insurance Policies and Claims	• Educating policyholders • Unified Public Relations Strategy

Long-Term Measures for a Sustainable Healthcare Ecosystem

Integrated Care Models

Strengthen collaboration with GPs and clinics to enhance chronic disease management and prioritize outpatient-first care

Value-Based Healthcare

Adopt a new reimbursement model aligned to a National Healthcare Financing Scheme allowing Malaysians access to both public and private facilities, enhancing overall healthcare

Gradual Discount Elimination

APHM plans to advocate for phasing out unsustainable discounts while ensuring fair contract negotiation with insurers to ensure the sustainability of quality of healthcare services.

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APPENDIX

Potential Timelines and Pathways to Proposed Initiatives

	2025	2026	2027	Long Term
Short & Medium Term	• Q2 : APHM Short Term Initiative • Q2 : Drug Price Display • Q3 : Joint taskforce on study and design for tiered Value Driven ITO Product (VDP) • Q4 : Study on reducing regulatory & operating cost *(above in addition to premium cap and enhanced discounts by hospital)*	• Q1 : Launch of new VDPs (if approved) • Q2 : Drug Price Display (IPD) • Q2 : Tabling of regulatory & operating cost containments • Q3 : Taskforce on reducing medico-legal burden	• Q1 : Recommendations on medico-legal changes	
Long Term (>3 years)	• Q2 : WG on alternative payment models • Q2 : Data parameter setting • Q3 : Alignment of timelines to National Healthcare Scheme • Q3 : Training & roadshow for data submission to MOH • Q4 : Roll out of data template and system	• Q1 : Report on key direction for new payment model • Q1 : Submission of private hospital data based on agreed parameters • Q2 : Launch of Coder training program (if DRG) • Q2 : Joint system evaluation • Q3 : Launch of pilot payment model • Q4 : Primary care pathway	• Q1 : Analysis report on data • Q2 : Expansion of data parameters and submission • Q3 : Review of pilot program • Q4 : Recommendation on payment model to adopt • Q4 : Alignment of National Healthcare Scheme to payment model • Q4 : Activation of primary care into patient pathway	Assuming the aggressive timelines and steps are followed – a new payment model, aligned to a national scheme can be launched, with phased roll-out as part of the transformation and next stage of Malaysian Healthcare

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APHM Proceeding with Public Accounts Committee (PAC)

17 June 2025

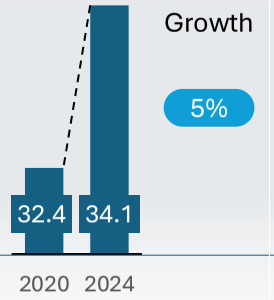
Agenda

1. Key Cost Drivers In Private Healthcare
2. APHM's 8 Commitments / Measures to Contain Medical Inflation
3. Diagnosis – Related Groups (DRG)
4. Other Government Initiatives APHM has contributed to or supported in 2025
5. APHM's Request: Three (3) Key Areas for the Public Accounts Committee's (PAC) Attention

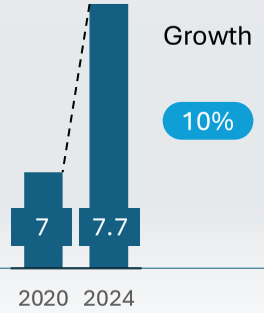
Key Cost Drivers In Private Healthcare

A Combination of Macroeconomic and Behavioral Factors

Population Growth ('million)

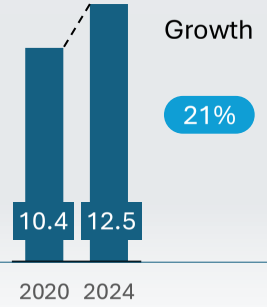


Population Aged 65+ ('% of population)

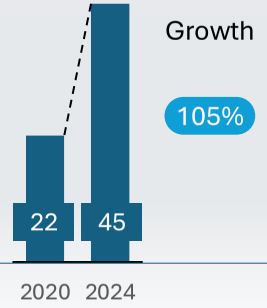


Source: DOSM

GDP per capita ('000 US Dollars)

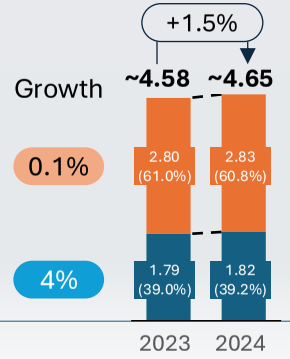


Medically insured ('% of population)

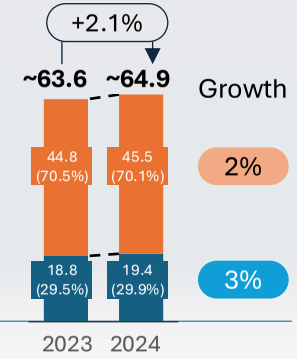


Source: Statista, NHMS 2019, LIAM 2024

Inpatient admissions ('million)



Licensed beds ('000)



Source: Roland Berger

Ageing Population & Rise in NCD Incidence:

Growing number of older population with NCD's requiring increased volume and frequency of care

Post- Pandemic Economic Growth & Increased Personal Medical Insurance:

Malaysians have increasingly been seeking private care due to rising affordability & increased medical insurance penetration rate

Public Hospital Capacity Issues & Investments by Private Hospitals:

Exponential growth of inpatient admissions to private hospitals (40x) driven by lack of capacity in public hospitals.

APHM's 8 Commitments / Measures to Contain Medical Inflation

published on 17 March 2025

1 Establish a Working Committee For Review of Billing Structure & Fair Pricing

- Review & change billing structure to reduce cross-subsidization, aligning charges with cost of services & supplies.
- Collaborate with Insurance & Takaful Operators (ITOs) to create a fair pricing model for drugs & supplies, balancing affordability with procurement costs and ensuring reimbursement rates reflect the market.

2 Establish Industry Communication Workgroup

- Develop communication strategies and tools to promote the proper use of medical policies by all parties, including patients and insurance agents.
- ITOs and hospitals should work together on public education to help policyholders make informed healthcare decisions and understand their coverage.

3 Form An Independent Healthcare Cost & Reimbursement Committee Review Body

- Oversee fair pricing and reimbursements, with regular reviews of premiums and reimbursement structures.
- Align with actual healthcare costs and market conditions, encouraging data-driven negotiations between hospitals and ITOs for transparency and sustainability.

4 Improve Transparency Of Health Claims Volume And Cost

- Enable industry discussions by breaking down total premiums, with ITOs publishing operating costs, agency fees, distribution costs, and provider payments.
- Help Malaysia set fair claims payouts, review premium costs, and manage agency and acquisition expenses.



The Minister of Finance II, in agreement with the Minister of Health, has established a **National Committee to Address Medical Inflation**, including both ministries. A working committee led by Bank Negara Malaysia will oversee a consultative committee with industry representatives, including APHM.



APHM's 8 Commitments/Measures to Contain Medical Inflation (cont.)

published on 17 March 2025

5 Establishment Of National Medico-legal Committee

- Review and recommend measures to control medico-legal claims and payouts, including mandatory arbitration
- Help reduce defensive medicine, legal, and insurance costs, which contribute to rising healthcare expenses.

6 Review & Adopt Recommendations on Reducing Regulatory Burden

- Review recommendations on the regulatory burden faced by providers/hospitals, including those from the MPC initiative.
- Develop a plan for self-regulation while maintaining high standards under MOH oversight, akin to neighboring countries, and align with a National Healthcare Financing Scheme.

7 Expansion & Inclusion of Primary Care as part of The Patient Pathway

- APHM members are keen and willing to play a role in training and co-managing patients to allow primary care to provide basic procedures in the primary care level, which will reduce cost and increase the appropriateness of seeking hospital services.

8 Improve Healthcare Policy Holder Enrolment Process

- Review and enhance screening of potential policy holders, to reduce under declaration of health status, which poses a significant challenge for clinicians in ensuring fair and transparent diagnosis, reporting and processing of coverage.

We have not yet received support for these initiatives. Given their importance in tackling medical cost inflation and their impact on healthcare affordability, we urge the PAC and government to create a formal platform for their implementation.

Overview of APHM's Key Activities and Engagements

Since Previous PAC Session

Date	Workgroup / Meeting / Event	Key Stakeholders	Description
April–June 2025	Multiple meetings with Minister of Finance II	Ministry of Finance (MoF)	Discussed key issues affecting private hospital operations, ITO relations, and DRG planning.
Pending Invitation for First Meeting	Joint Ministerial Committee	MoF and MoH	APHM is included as a stakeholder in a new inter-ministerial committee focused on DRG development.
April–June 2025	Working Committee and Consultative Committee for DRG	BNM and MoF	Participating in technical and consultative efforts to shape Malaysia's DRG framework.
April–June 2025	Technical meetings with HTA, Medical Development Division, and HTO	MoH	Provided input on clinical and policy frameworks needed for DRG implementation.
29–30 May 2025	Policy Delphi Workshop on NHB	HTA Section, MoH	Workshop to develop a national framework for prioritizing healthcare services under NHB.
23–25 June 2025	Technical Workshop on Clinical Data Needs for DRG	MoH	Focused on identifying key clinical data required for a DRG-based payment system.
April–June 2025	Meetings with BNM Governor and Technical Advisor	BNM	Provided industry insights on DRG feasibility and medical cost inflation challenges.
Ongoing	Policy feedback on medicine price transparency	MoH	Submitted comments and industry input on new medicine pricing transparency policies.
9–11 June 2025	APHM Conference and Exhibition 2025	APHM	Featured discussions on DRGs, reimbursement models, AI, cost control, and regional case studies.
April–June 2025	Articles published in local newspapers on healthcare	APHM Board Members	Shared expert perspectives to improve public health literacy and encourage informed discourse.

Diagnosis – Related Groups (DRG)

Lessons from Thailand's experience

Background

- Thailand introduced the Diagnosis Related Group (DRG) system in 1993 to improve hospital payments by linking them to case type and complexity.
- After the 1997 Asian financial crisis, health financing reforms were accelerated to ensure system sustainability.
- In 2002, the Universal Health Coverage (UHC) scheme was launched, expanding DRG use across public hospitals.
- DRGs were adapted from the U.S. model and are funded through general taxation.

1977
Yale-DRG Development

1983
HCFA-DRG Implementation

1988
AP-DRG Enhancement

USA

1996
AN-DRG Adaptation

1999
AR-DRG Refined

Australia

1993 – 1997
Thai-DRG R&D

1998
Thai-DRG V1
(511 groups)

2001
Thai-DRG V2
(511 groups)

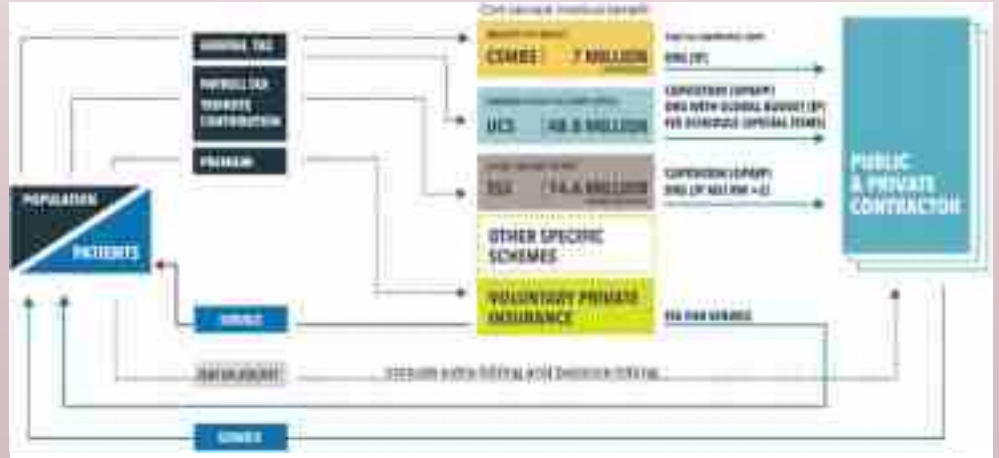
Thai 2003
Thai-DRG V3
(1,283 groups)

2007
Thai-DRG V4
(1,920 groups)

2012
Thai-DRG V5
(2,450 groups)

2017
Thai-DRG V6.2
(1,543 groups)

Thailand

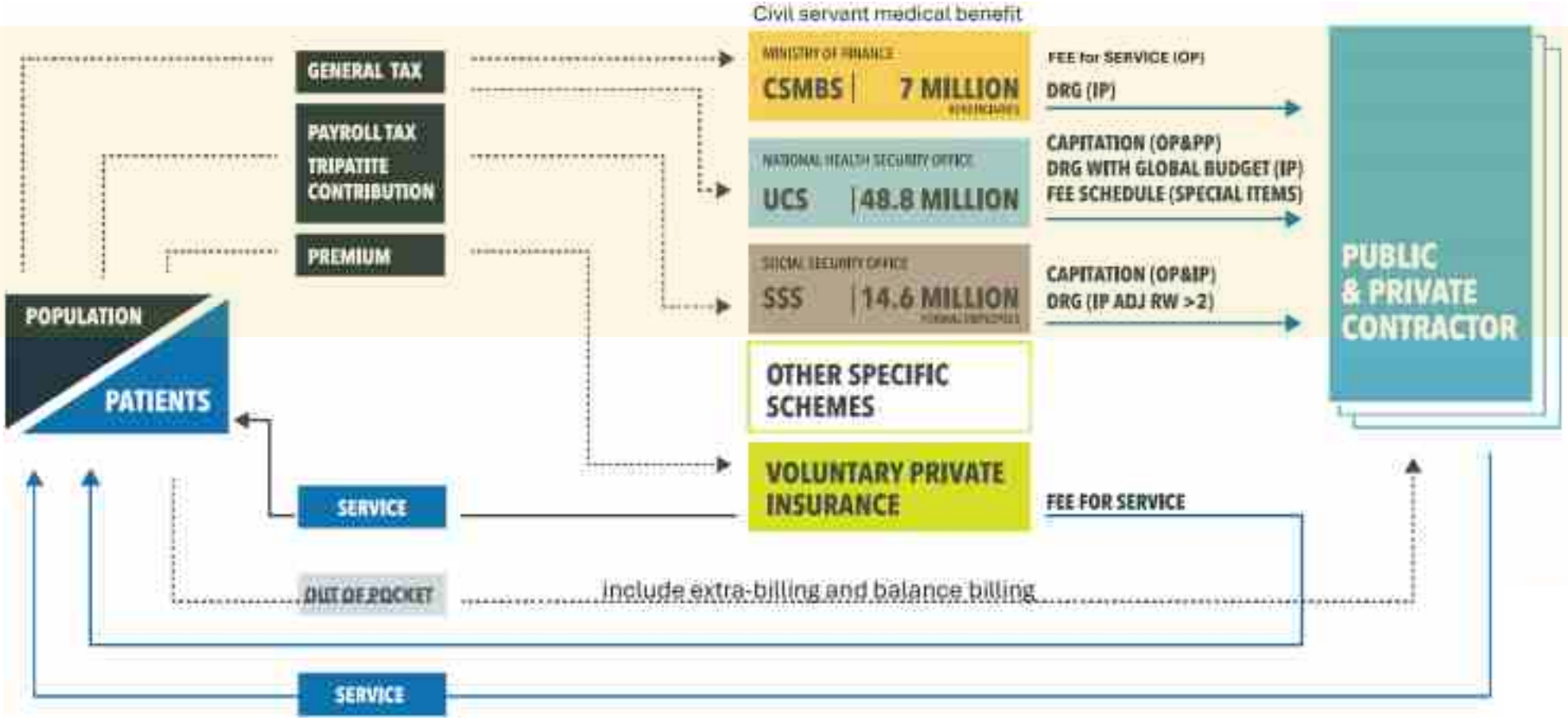


More Than 30 Years to Establish DRG and Reach Current Frameworks

- The UHC scheme is funded by general taxation and managed by the National Health Security Office (NHSO).
- Hospitals receive prospective capitation payments for outpatient and preventive services. Inpatient care is reimbursed using a DRG-based retrospective payment system.
- Hospitals can appeal audits and request DRG reclassification or recalibration. An outlier reimbursement scheme covers exceptional high-cost cases.

Diagnosis – Related Groups (DRG) cont.

Lessons from Thailand's experience



DRG system under the UHC

Thailand's public healthcare system uses DRG to pay hospitals under its Universal Health Coverage (UHC) scheme, funded by taxpayers.

Private insurance and self-pay patients are still billed per service using a fee-for-service model.

This results in two payment systems, bundled payments in the public sector and itemized billing in the private sector.

Diagnosis – Related Groups (DRG) cont.

Expert Opinions on Malaysia Implementation



Prof. Emeritus Dato' Dr. Syed Mohamed Aljunid
Department of Public Health and Community Medicine, International Medical University, Malaysia and Founder/President of Casemix Solutions

Prof outlined four (4) main challenges that needs to be addressed immediately for DRG to be realistically implemented:

1. Ensuring accurate and consistent coding standards
2. Technical barriers such as data infrastructure
3. Resistance from staff due to workflow changes
4. Need for ongoing training and system refinement

APHM ADVOCATES FOR AND SUPPORTS THE IMPLEMENTATION OF DRG IN THE PUBLIC HEALTHCARE SYSTEM

- APHM member hospitals have offered to share the necessary data for setting up DRG with the MOH and MOF but haven't received details on how or where to submit it.
- In a recent meeting with the Health Transformation Office (HTO) of MOH, the HTO mentioned that it will take about **three (3)** years to gather data, analyze it, and pilot a DRG system for Malaysia.



I personally think it is very difficult to implement DRG by this year, but what we can do is to develop the DRG grouper first. Right now there's one being used by MOH, and one used by teaching hospitals. It is time for us to have a "national grouper". There is another group under the Health Ministry that looks at developing the health benefits package and the healthcare payment model for Malaysia, in preparation towards National Health Insurance (NHI). So, DRG is only part of and not necessarily only for NHI.

Prof. Dr. Maznah Dahlui
Public Health Medicine Specialist (Health Economics), Health Economic Research and Case-mix Unit, Dept. of Research Development and Innovation, University of Malaya Medical Centre



Any DRG implementation should take 5 to 10 years, and it happens in phases. This has been the experience in other countries that have launched their DRGs, which started in 1983 in the United States.

Dr Khor Swee Kheng
Health systems specialist and CEO of Angsana Health

Other Government Initiatives APHM has contributed to or supported in 2025

Private Hospitals Have Actively Supported Government Healthcare Policy

INITITAIVES	Basic MHIT at Fixed Prices	Medicine Price Display	Sales & Service Tax (SST)	Public & Industry Outreach
	MOH is developing a basic MHIT product for common procedure packages, as announced by Deputy Prime Minister Datuk Seri Dr Ahmad Zahid Hamidi on 11 March 2025	*MOH and the Ministry of Domestic Trade and Cost of Living (MDTCL) issued a gazette requiring private hospitals, clinics, and pharmacies to begin displaying medicine prices from 1 May 2025.*	*MOF announced the expansion of the 6% SST to private healthcare services provided to non-Malaysian patients, effective 1 July 2025, with mandatory compliance by 31 December 2025.*	*APHM has been promoting health literacy to elevate the quality of healthcare discourse in the country*
DETAILS & ACVITIVIES	• These packages should not be confused with the DRG system, as they differ in scope and structure. • ITOs may be reluctant due to low profit potential. • BNM and MOF should encourage ITOs to adopt the basic MHIT product by incentivizing them to support it.	• A 3-month grace period is in place for feedback, during which no fines will be imposed for non-compliance. APHM will collate feedback from member hospitals to share with MOH at the end of the grace period. • APHM continues to have concerns regarding the display of inpatient medicine prices. These concerns include potential clinical and medico-legal implications that may arise from these new requirement.	• APHM requested the MOF extend the 1st July deadline. • In addition, the 31st December mandatory compliance deadline must also be deferred. • This is to allow private hospitals sufficient time to adjust their administrative systems, billing processes, and compliance procedures.	• In addition to engaging stakeholders, APHM board members have published articles on healthcare matters to elevate the quality of discourse on healthcare. • The APHM Conference and Exhibition 2025, held from 9-11 June, gathered local and international healthcare experts to discuss reimbursement models, DRGs, AI/Data Analytics, case studies from India and Thailand, cost containment, and digitalization

We've made significant efforts in a short time to address the issue, but there are still **three (3)** key areas that need attention

APHM's Request

Three (3) Key Areas for PAC's Attention

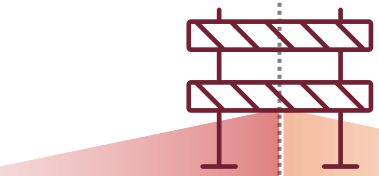
1 Equitable Approach Towards Transparency

Two (2) key issues

ISSUE: Fixed Insurance Rates

The current system forces hospitals to allocate costs such as technology and services to unrelated categories, including consumables like gloves, syringes and masks.

- *This practice has led to confusion and mistrust from patients, prompting recurring questions and scrutiny on perceived overcharging on gloves, swabs etc.*





ISSUE: Underfunded Segment

Insurance companies have different business lines, such as life, critical illness & medical insurance. Profits mainly come from non-medical lines while the medical insurance block often operates at a loss or low margins.

- *Unlike private hospitals and other sustainably run businesses, ITOs do not cross-subsidise between business lines, choosing to continuously increase premiums instead*
- *This issue also impacts long-time, claim-free policyholders, particularly the elderly, who are struggling with rising premiums.*
- *Requiring insurers to disclose financial details could help identify fair solutions such as extending coverage, offering no-claim benefits or creating more affordable plans for the elderly*

REVIEW AND REVISE BILLING STRUCTURE

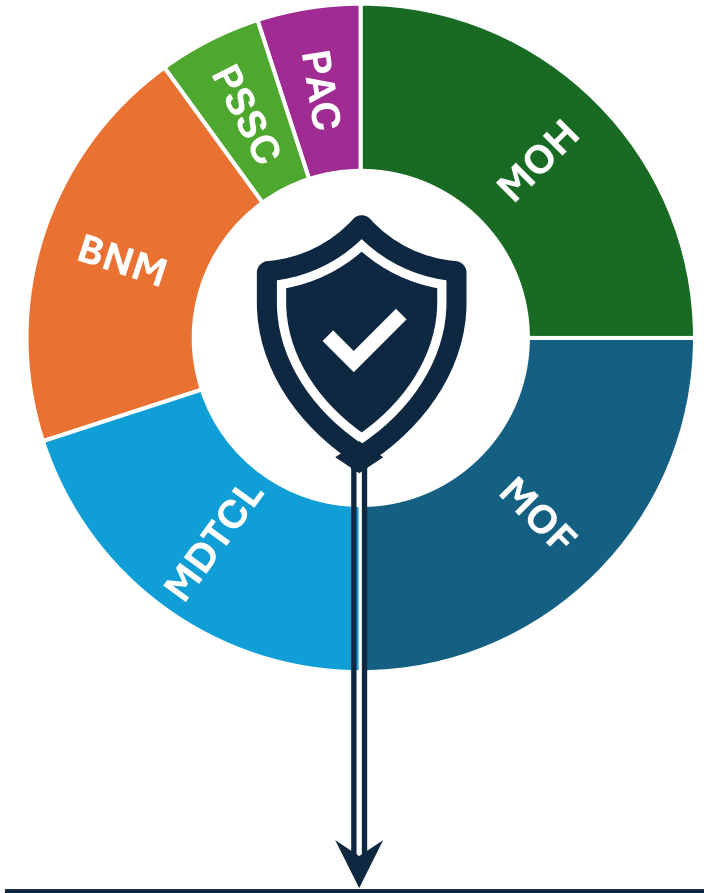
We urge the government to support a review and revision of the billing framework, fostering collaboration between private hospitals, government, and insurers to ensure transparency and fairness for all stakeholders, especially patients.

TRANSPARENCY IN INSURANCE PREMIUMS

We urge the government to mandate that insurance companies publicly disclose the breakdown of premiums, operating costs, agency fees, and payments to providers. This transparency will help establish fair claims payouts, review premium costs, and improve the management of agency and acquisition expenses

2 Protective Guidelines, Policies & Regulation

Unilateral Pressures Harm Stakeholders Across the Healthcare Value Chain



- For many years, private hospitals already offer up to 10% discounts to insurers but demands for aggressive discounts are increasing at an alarming rate.
- Insurers threaten de-empanelment of hospitals that don't comply, with several hospitals already removed. Excessive discounts disrupt hospital operations, leading to higher costs for patients.
- Many private hospitals in Malaysia are also owned by government-linked investment companies (GLICs), which provide returns to the government, ultimately for the benefit of the rakyat. Excessive discounting erodes shareholder value and reduces these returns, particularly when insurers are foreign-owned. APHM has raised concerns with Bank Negara Malaysia, but no clear resolution has been made.

KHAZANAH NASIONAL · JCORP Johor Corporation · PNB · KWSP EPF · KWAP · TABUNG HAJI

- Implementing a benchmarking system for ITOs would enhance service standards in B2B healthcare. For example, Singapore's IP Providers Survey evaluates performance on inclusiveness, transparency, and timeliness, helping identify strengths and service gaps for continuous improvement.

We urge the PAC and the government to address the detrimental impact on patient care and healthcare costs caused by **excessive discount demands** and **de-empanelment threats**.
We call for the introduction of regulations to prevent further harm to the healthcare system and ensure sustainable practices.

3 Strong Institutional Support for Industry-led Initiatives

Official Channels Needed

APHM is keen to support the following initiatives

INITITAIVES	National Medico-Legal Committee	Regulatory Burden Review	Primary Healthcare Expansion	Improving Policyholder Enrolment
PROPOSED ACTIVITY	• Establish a committee to recommend measures like mandatory arbitration to reduce medico-legal claims, defensive medicine, and insurance costs, which drive up healthcare expenses.	• Review of the regulatory challenges faced by providers and hospitals, to enable industry self-regulation under the Ministry of Health (MOH) and support a National Healthcare Financing Scheme.	• Expand primary healthcare, enabling more basic procedures at this level. This will reduce costs and help patients avoid unnecessary hospital visits.	• Enhance the screening process for potential policyholders, reducing the issue of under-declared health statuses, which impacts the accuracy of diagnoses and insurance coverage.

We need **institutional support** and official channels to implement these initiatives. We ask PAC to urge the government to provide APHM with a platform to drive these efforts, which will directly help combat healthcare inflation in Malaysia.

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- End -

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Appendix

APHM's Response to ITOs' Proposed Recommendations

No	ITO Proposed Measure	APHM Response	APHM Position (Brief)
1	Implementation of DRG (diagnostic-related grouping) pricing to enhance transparency in healthcare services chargers and billings. Aligning cost structures between healthcare providers, ITOs and Third-Party Administrators (TPAs) is essential in managing healthcare expenses effectively.	APHM is supportive, however, as we have consistently stated, this MUST be aligned to a National Healthcare Financing Scheme. APHM presented to PAC a list of preliminary proposed steps and timelines to achieve this.	Supports DRG pricing but insists on alignment with National Healthcare Financing Scheme.
2	Working with BNM to develop a basic long-term sustainable insurance and takaful product while allowing ITOs to offer top up schemes for those seeking additional coverage.	APHM has been consistently suggesting this and is supportive. APHM strongly recommends that APHM and practicing clinicians are included in the development process from the onset.	Supports sustainable insurance/takaful products and calls for early APHM and clinician involvement.
3	Greater transparency by publishing the average costs of common procedures/treatments across private hospitals and annual medical costs inflation rates to empower consumers with greater financial awareness. The establishment of industry-wide claims database will improve claims analysis and help mitigate abuse.	APHM is supportive for insurers to publish the average costs of common procedures/treatements but strongly recommends that APHM is included in the analysis and format / presentation of the data, to avoid disputing the data and presentation so that it becomes a meaningful tool for the public, policy holders and patients. To ensure long term sustainability and validity of the data, it is suggested for it to be collected and publish by MOH or equivalent. This will also ensure that such data includes all patients (insured and non-insured)	Supports transparency on costs with APHM involvement; suggests MOH manages data collection for sustainability.
4	Co-Payment for MHIT products, a key long-term solution which helps policyholders /certificate holders manage costs by encouraging shared responsibility in healthcare expenses. Co-Payment, especially co-insurance, can encourage more responsible consumptions of health services.	APHM is and has been supportive of mandatory co-payment. However, its members have expressed significant concern about the use of co-payment to extract additional discounts to be included into selected panel listings where co-payment is waived, defeating the objective of co payments being a tool to introduce added patient responsibility in seeking appropriate care.	Supports mandatory co-payment but warns against misuse undermining patient responsibility.

APHM's Response to ITOs' Proposed Recommendations (cont.)

No	ITO Proposed Measure	APHM Response	APHM Position (Brief)
5	Regulating Pharmaceutical Costs – Collaborating with the Ministry of Health (MOH) to promote the use of generic drugs and regulate medication pricing. Reports indicate that pharmaceuticals account for a substantial portion of private hospital revenue, indicating the need for cost controls.	APHM has consistently supported MOH's efforts on price transparency and display especially for outpatient (OP), while stating the need to address a limited number of concerns for inpatient. APHM is prepared to start OP price display as soon as required by MOH. APHM is also supportive to promote the use of Generics. However, APHM opposes regulation on pricing partly due to the relatively small size of the Malaysian market, where such controls are very likely to reduce options and also slow or stop the introduction of new / innovative drugs.	Supports price transparency and generics; opposes strict pharmaceutical price regulation due to market and innovation concerns.
6	Calling for private hospitals to set up cost containment unit and to freeze increases during periods when insurers and takaful operators are required to cap premium hikes. This measure aims to ensure that cost containment efforts are equally distributed across the healthcare eco-system.	APHM member hospitals have consistently practiced cost containment, with group negotiated prices, review and selection of supplies for price optimization and other measures. A study* has shown that these efforts have enabled hospitals to cushion a 12% CAGR increase in cost to an effective increase of 7% (CAGR). *Study reference: 'Medical Inflation in Malaysia: Drivers and Recommendations – Discussion Document Hospitals have committed to continue doing so and increase their efforts. However, a freeze is not viable. APHM is however open to establish an industry guideline on medical inflation, based on fair and agreed parameters, such as M-CPI, or aligning to global average. This is despite the fact that the baseline cost to patients in Malaysia is significantly below global or even regional prices for comparable services, although input cost to hospitals is largely similar. Since the premium increase cap measure, insurers have demanded for 2x to 3x of the current discount, which is not viable or sustainable, although it has been agreed by some hospitals.	Supports cost containment efforts but rejects price freeze; proposes agreed industry guideline on medical inflation.

APHM's Response to ITOs' Proposed Recommendations (cont.)

No	ITO Proposed Measure	APHM Response	APHM Position (Brief)
7	Tax Exemption on Group Insurance from 8% SST to encourage more employers to provide insurance and takaful protection for employees. Currently approximately 4 million employees including those from the B40 group, receive coverage through workplace schemes.	APHM supports this request by ITOs. Similarly, APHM requests that no SST is applied to private healthcare as input cost has already increased with SST revision in SST rate.	Supports SST exemption on group insurance and removal of SST on private healthcare inputs.
8	Appoint an independent consultant to conduct a detailed study to analyze and recommend stakeholder actions to reduce claims inflation. This comprehensive study will provide data-driven insights and recommend effective stakeholder actions to control rising claims costs.	APHM is supportive and suggests that such an appointment is agreed upon by both ITOs and APHM, endorsed by MOF, MOH and BNM.	Supports joint appointment of independent consultant with official endorsements.
9	Encourage and incentivise healthier lifestyles through no claim bonuses, a reward system that benefits those who maintain good health, helps promote well-being and strengthens policyholder engagement and loyalty. This initiative will also reduce unnecessary medical claims.	APHM is supportive of such incentives. With reference to no claim bonuses and premium discounts to policyholders who maintain healthier lifestyles, APHM recommends that such rebates are not in the form of direct cash return but credited back to policy holders, to offset higher premiums post the retirement age, including the possibility of it being credited into a specific EPF Healthcare account or National Healthcare Financing account.	Supports incentives for healthy lifestyles with rebates credited back to policyholders rather than cash payments.



Strictly Private & Confidential

Agenda

1. About CompuMed
2. Role of TPA
3. TPA Reporting and Its Benefits
4. Proposed Strategies
5. New Implementation

About CompuMed

CompuMed Services Sdn. Bhd.

(470423W)

Licensed by the Ministry of Health and Ministry of Finance of Malaysia

COMPUMED

Established in **1998**

A wholly owned company of

Sumitomo Corporation

Attained certification UKAS/DMS ISO 9001:2015, and ISO/IEC 27001:2013

Currently managing more than **1 million lives**

Head Office in Kuala Lumpur with staff strength of over 100 people

24/7

Call Centre, Data Centre and Data Recovery Centre

Core System CompuMed (CHAMPS)

CHAMPS
CompuMed Core System

Proprietary core system and fully owned and operated by CompuMed

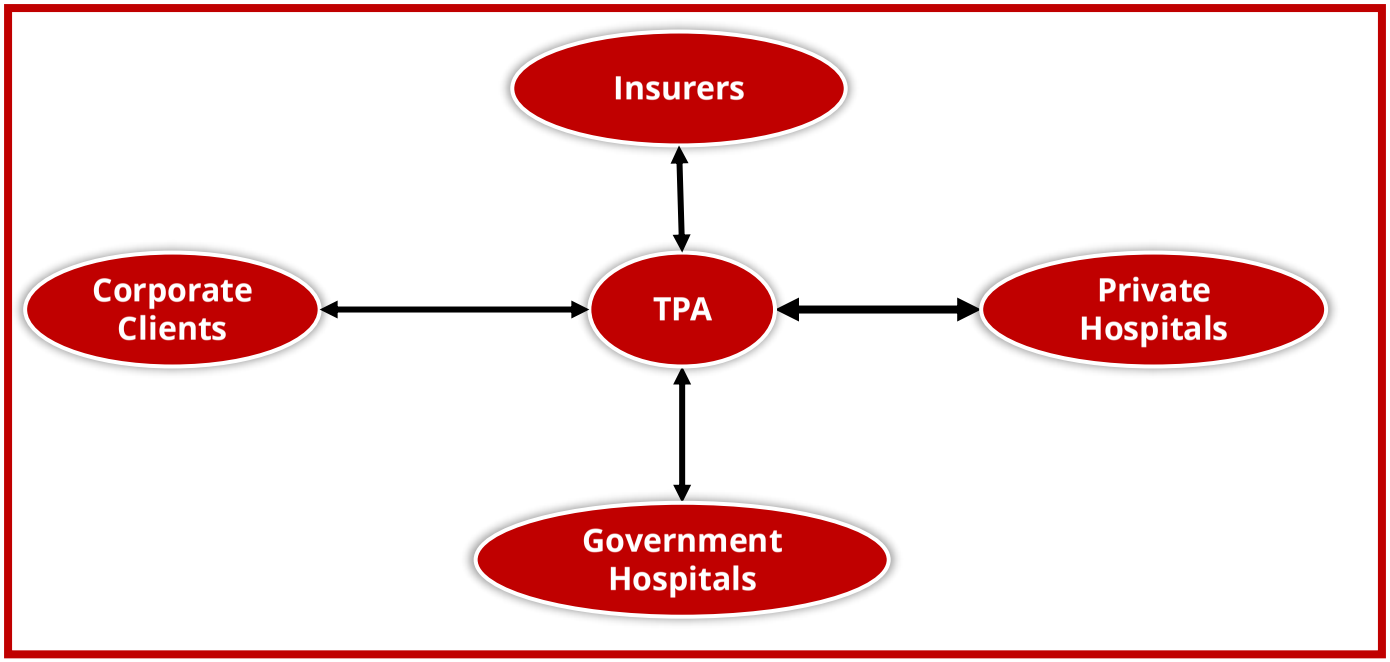
- **Multiple Claims Assessment**
  Experience in processing GHS, GPA, GTL, Funeral Expenses, Daily Hospital Cash Allowance, Critical Illness claims
- **TPA managing insurance & employee benefits**
  We are a TPA that administers, not only, employee benefits but also Insurance benefits, this includes family and individual policies
- **Solution provider**
  A solution provider in the TPA space. We provide consultancy services in the set up and sale of TPA system

Role of a TPA

Providing an Ecosystem

- Serves as an intermediary providing healthcare services to **corporate clients, insurers, healthcare providers and members**
- **Manage claims processing**, ensuring members receive cashless and reimbursement benefit treatment without delay
- **Ensuring extensive provider networks** to allow members vast access to Hospitals, Clinics, Pharmacies and other medical facilities

The ecosystem built is as per the diagram below:



Role of a TPA

Provide Access to Member

- ❑ **Provider Network Access:** Members are given access to a network of clinics and hospitals.
- ❑ **Cashless Facilities:** Members can utilize cashless services at empaneled providers (i.e., they don't have to pay upfront).
- ❑ **Corporate Discounts:** Members receive corporate discounts from empaneled providers

Cost Management

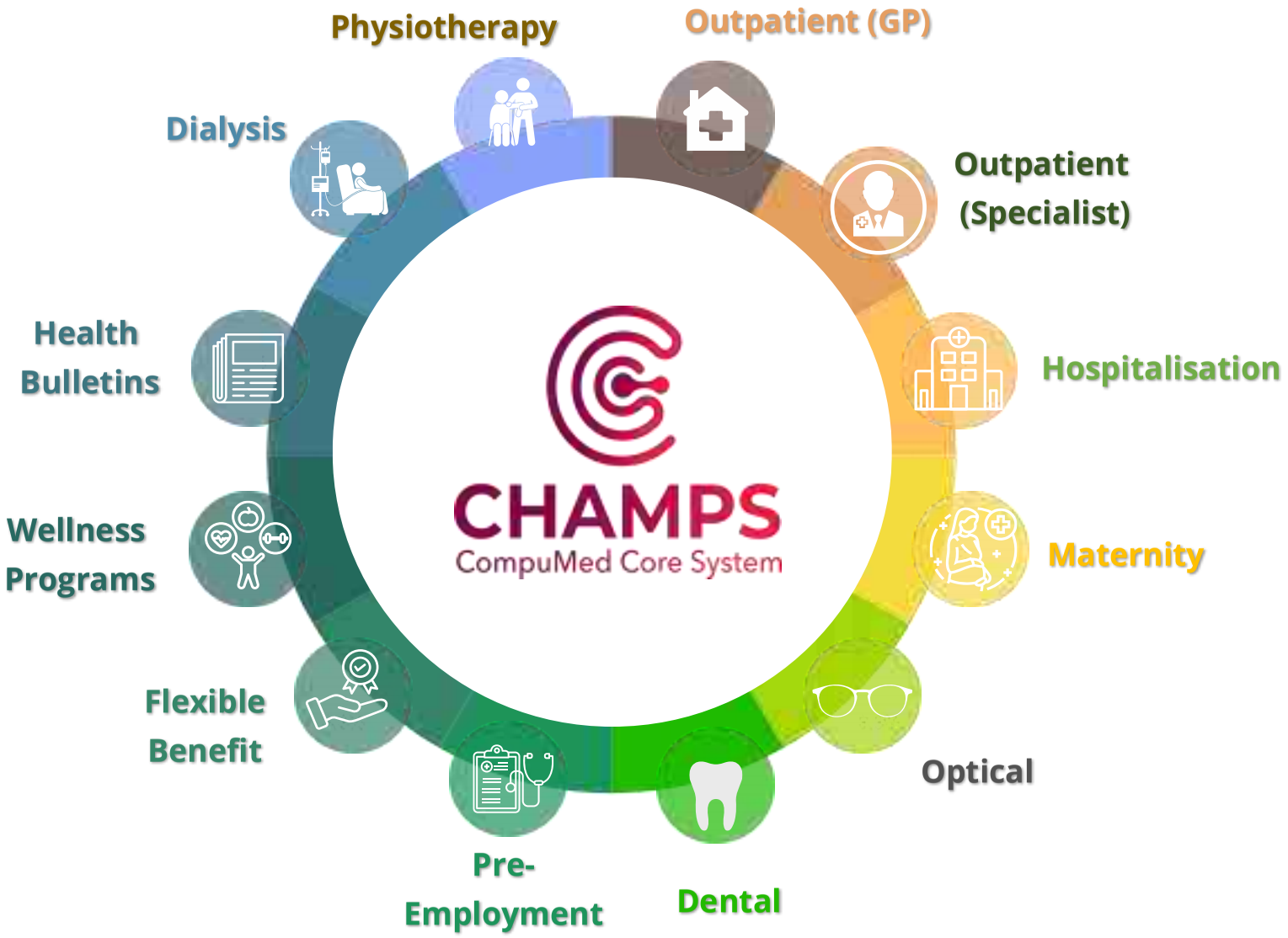
- ❑ **Negotiating rates** with healthcare providers
- ❑ **Audit of claims** to prevent overcharging, fraud and/or unnecessary procedures done
- ❑ **Provider network management** to ensure costs are standardized and offers competitive pricing for treatments
- ❑ **Promoting Preventive Cares** by encouraging companies to participate in wellness programs and preventive health measures
- ❑ **Utilisation Review** with clients to review the members' utilization and report in terms of the population's medical trends

Data Reporting

- ❑ **Monthly operational reviews**
- ❑ **Annual evaluation of the member's utilization** in collaboration with the client.
- ❑ **Enable identification of key medical trends** such as:
  - i. **Top-utilized providers**
  - ii. **Most common diagnoses**
  - iii. **Overall organizational healthcare patterns**.

Based on these insights, we propose **preventive and proactive measures** to address emerging trends effectively.

Healthcare Services



Technology & Systems



CHAMPS

CompuMed Core System

- **Enterprise TPA System called CHAMPS**
- Multi-tiered, **highly modular** operating system platform and browser agnostic web-based information system, capable of effective, efficient, and **secure service delivery to end-users encompassing several modules.**
- Policed and secure protected system as governed by **BNM's RMiT policy and ISO27001** ensuring **data protection, disaster recovery and securities are in place**

CHAMPS - *External Modules*

Member Module

- Submit personal claims
- Supporting document upload
- Track claim status

HR Module

- Medical utilisation reports
- Medical trend analysis reports
- Data cascading based on organisation company tree
- Reports can be refined to family and individual level.

Agent Module

- Dashboard summary of claims
- High-level view of claim statuses
- Tracking of claims statuses

**Due to PDPA policy, agent module is only limited to viewing of the above list*



Insurer Module

- View member information (IGL, FGL, claim status tracker);
- Update of member details
- Provider Locator
- Dashboard and reports

Dental Clinic Web Portal

- Validate Members
- Check Available limits
- Submit claims
- Check claim status
- Payment details
- View statement of accounts

Hospital Web Portal

- Validate Members
- Check members benefits and remaining limits.
- Request for Guarantee Letters
- Check claim status
- View statement of accounts

GP Clinic Web Portal

- Validate Members
- Check Available limits
- Submit claims
- Check claim status
- View statement of accounts

CHAMPS – *Internal Modules*

CRM

- Validate member
- View claim status (Cashless & Reimbursement)
- Set HR username and password
- Customise Digital Card for clients
- Update Client information

Call Centre

- Guarantee Letter Issuance
- Final Guarantee Letter issuance
- Validate members' benefits and entitlements
- View forms and exclusions
- Respond to feedback raised by members



Data Analyst

- View claims statuses
- Extract report based on requirements

Claims

- Validate Members
- Check Available limits
- Verify claims
- Process claims

Medical Management

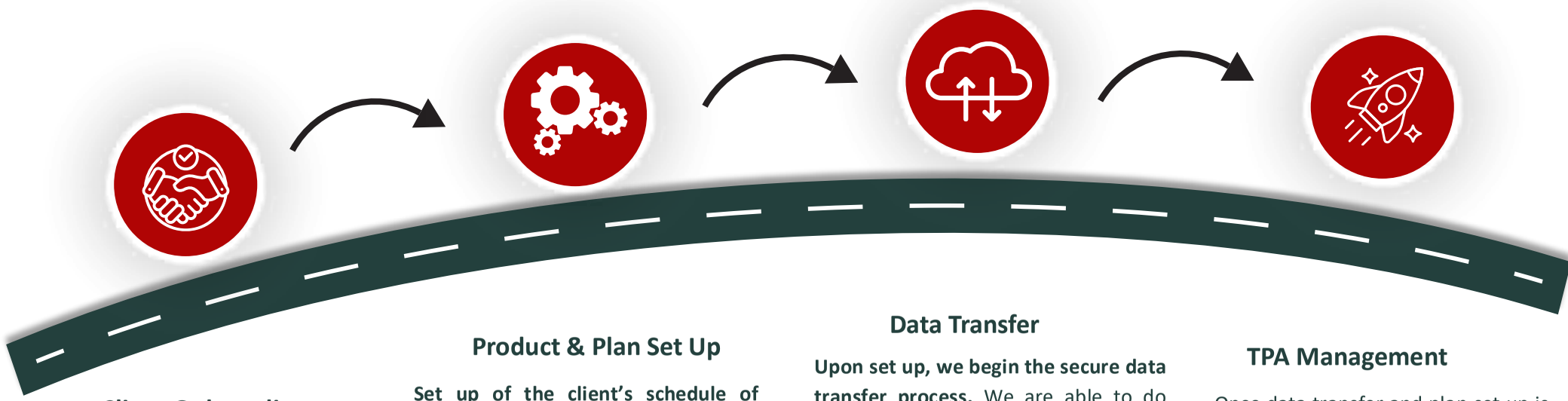
- Amend diagnosis code
- Validate member details
- View member's benefits and entitlements
- View GL & FGL for assessment

Provider Management

- View providers
- Validate their licenses and APC
- Update provider listing
- Update providers' information (i.e. Contact, Address etc.)

Reporting & Analytics

Data Journey



Client Onboarding

Upon signage of Service Level Agreements, we set the terms and conditions of the contract

**Client: Includes corporates as well as insurance companies*

Product & Plan Set Up

Set up of the client's schedule of benefits in accordance to their grades

**Differentiations of plan benefits and limits shall ensure the plan management and control of the claim utilisations*

Data Transfer

Upon set up, we begin the secure data transfer process. We are able to do this via three (3) methods:

1. SFTP (Secure File Transfer Protocol)
2. Via Manual Excel
3. Via API

TPA Management

Once data transfer and plan set up is completed and approved by the client, the TPA management shall begin

Benefits of Reporting

1 Data Collection and Analysis

- **Data on healthcare utilization, costs and patterns** are derived from the management of claims utilization
- The data can be analyzed to identify trends in medical costs, such as:
  i. Frequency of specific procedures
  ii. Average costs of treatments
  iii. Utilization of healthcare facilities
  iv. Fraudulent or over utilization of services

2 Transparency and Accountability

- Detailed TPA reports can provide insurers, regulators, and even consumers with **greater transparency into healthcare spending**
- This transparency can help to **identify areas where costs are excessive or unjustified according to regions**

3 Cost Containment Strategies

By analysing TPA data, insurers can develop strategies to contain costs, such as:

i. **Negotiating better rates** with healthcare providers
ii. **Implementing utilization management programs**
iii. Identifying and **addressing fraud and abuse**
iv. Improving **preventative care programs**
v. Work on **packaged pricing**

4 Informed Policy Decisions

- Regulators, like Bank Negara Malaysia, can use TPA data to **inform policy decisions related to healthcare financing and insurance regulation**
- This can lead to **more effective measures** to **control healthcare costs** and **ensure the sustainability of the insurance market**.

Benefits of Reporting

- How Reporting Helps Manage Premium Hikes:

Identifying Cost Drivers

TPA reporting can help **pinpoint the specific factors** that are driving up healthcare costs, which in turn lead to premium hikes.

Promoting Efficiency

By providing data on healthcare utilization and costs, TPAs can help insurers and healthcare providers **identify opportunities to improve efficiency and reduce waste.**

Combating Fraud

TPA reporting can help **detect and prevent fraudulent claims**, which can significantly **contribute to healthcare costs.**

Enabling Data Driven Regulation

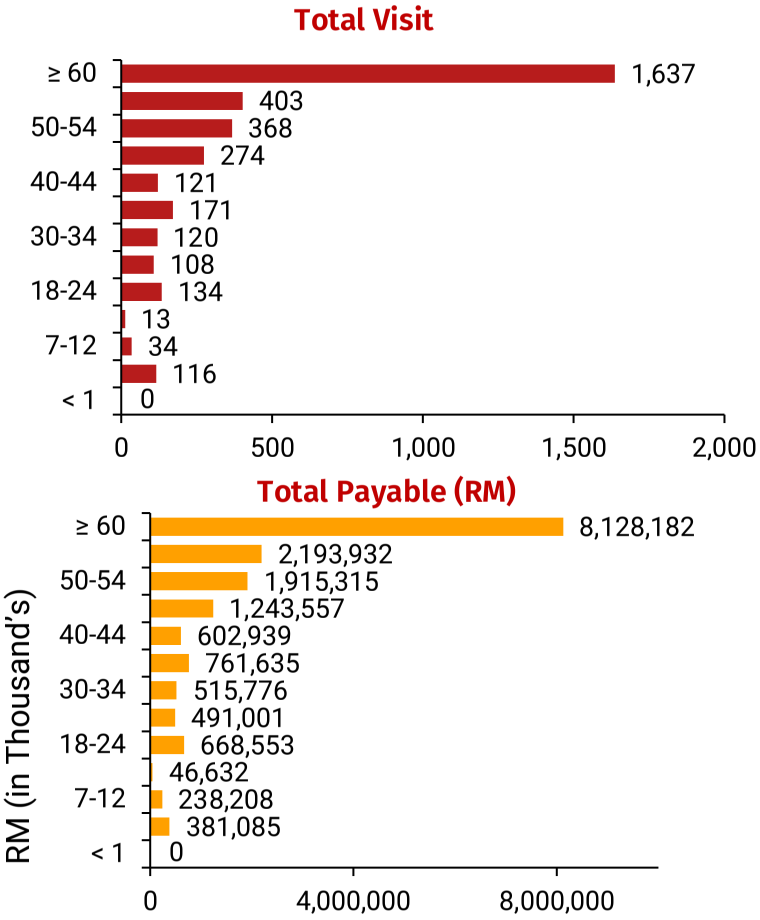
By providing **regulators with concrete data**, it allows for more **informed and effective regulation** of the insurance industry, which can lead to **better cost control**



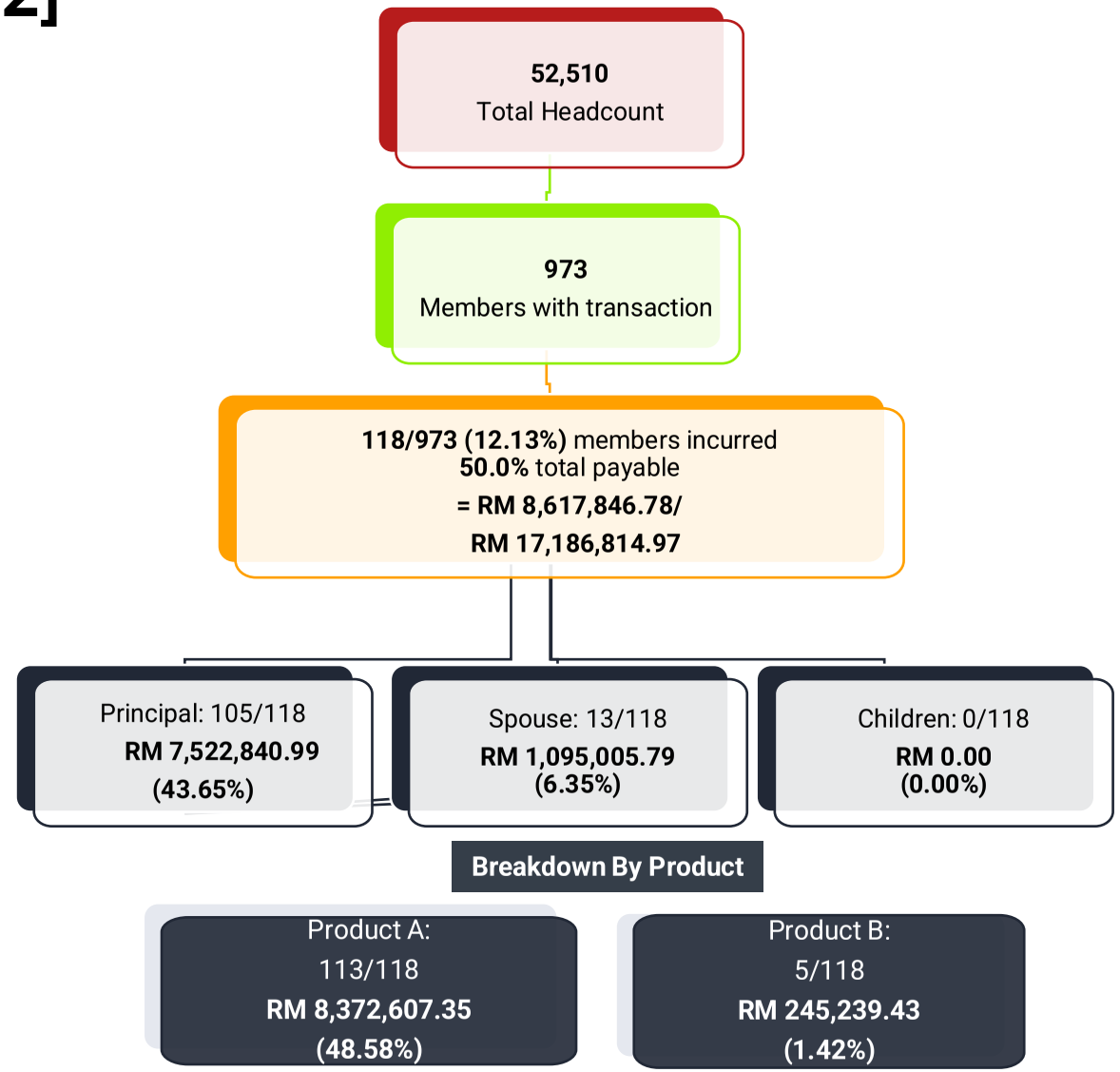
Medical Expenditure for Inpatient Benefits by Age Group

Age Group	H/C with transaction	No. of Visit	Amount Incurred (RM)	Amount Payable (RM)	Amount Uncovered (RM)	Average Payable per Visit (RM)	ALOS
< 1	0	0	0.00	0.00	0.00	0.00	0
1-6	57	116	389,917.87	381,085.27	8,832.60	3,285.22	2
7-12	18	34	239,731.76	238,207.74	1,524.02	7,006.11	2
13-17	6	13	77,369.75	46,631.55	30,738.20	3,587.04	1
18-24	61	134	692,851.77	668,552.85	24,298.92	4,989.20	1
25-29	53	108	497,791.03	491,001.49	6,789.54	4,546.31	1
30-34	48	120	520,140.63	515,776.22	4,364.41	4,298.14	1
35-39	45	171	786,043.55	761,635.19	24,408.36	4,454.01	1
40-44	43	121	615,002.73	602,939.24	12,063.49	4,982.97	1
45-49	73	274	1,307,949.61	1,243,556.57	64,393.04	4,538.53	1
50-54	99	368	1,962,110.58	1,915,315.21	46,795.37	5,204.66	1
55-59	125	403	2,334,281.43	2,193,931.98	140,349.45	5,444.00	1
≥ 60	345	1,637	8,586,329.83	8,128,181.66	458,148.17	4,965.29	1
Grand Total	**973**	**3,499**	**18,009,520.54**	**17,186,814.97**	**822,705.57**	**4,911.92**	**1**

❑ Highest payable amount for group aged ≥ 60 due to 24 surgical cases amounted more than RM50k.



Who Incurred 50% of the Total Utilization (T50 Group) in 2024? [1/2]



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Who Incurred 50% of the Total Utilization (T50 Group) in 2024? [2/2]

Age Group	No. of Member	Amount Payable (RM)	Average Payable (RM)
7-12	1	92,159.05	92,159.05
18-24	1	61,978.41	61,978.41
25.29	2	132,520.11	66,260.06
30-34	2	89,773.38	44,886.69
35-39	5	381,189.49	76,237.90
40-44	3	212,404.85	70,801.62
45-49	9	552,715.85	61,412.87
50-54	18	1,040,296.17	57,794.23
55-59	16	1,123,553.91	70,222.12
≥ 60	61	4,931,255.56	80,840.26
Grand Total	**118**	**8,617,846.78**	**73,032.60**

Branch	No. of Member	Amount Payable (RM)	Average Payable (RM)
IP	16	1,088,047.12	68,002.95
JB	17	949,097.97	55,829.29
KG	3	219,749.39	73,249.80
KJ	7	392,820.74	56,117.25
KK	3	168,944.43	56,314.81
KL	51	3,881,398.23	76,105.85
KT	6	519,704.79	86,617.47
KU	2	172,179.50	86,089.75
MR	1	267,198.10	267,198.10
PG	10	855,490.53	85,549.05
SB	1	44,534.00	44,534.00
SK	1	58,681.98	58,681.98
Grand Total	**118**	**8,617,846.78**	**73,032.60**

Highlighted rows represent highest payable.

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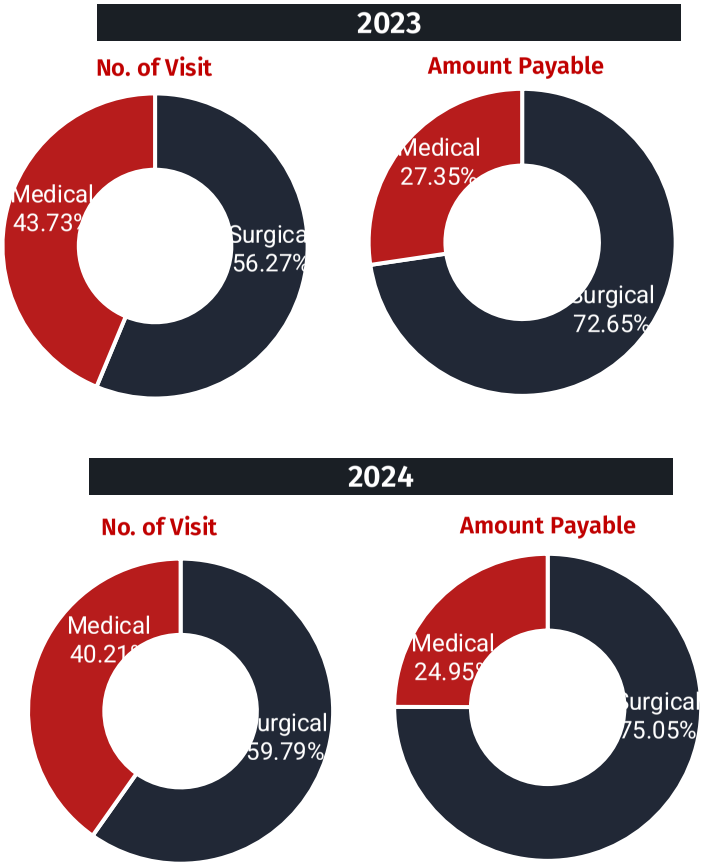
Medical Expenditure for Inpatient Benefits by Case Type

Medical Expenditure for Inpatient Benefits by Case Type in 2023

Case	H/C with transaction	No. of Visit	Amount Incurred (RM)	Amount Payable (RM)	Amount Uncovered (RM)	Average Payable per Member (RM)	ALOS
Surgical	520	1,870	11,769,691.49	11,361,398.42	408,293.07	21,848.84	2
Medical	502	1,453	4,515,844.26	4,277,135.27	238,708.99	8,520.19	2
Total	**911**	**3,323**	**16,285,535.75**	**15,638,533.69**	**647,002.06**	**17,166.34**	**2**

Medical Expenditure for Inpatient Benefits by Case Type in 2024

Case	H/C with transaction	No. of Visit	Amount Incurred (RM)	Amount Payable (RM)	Amount Uncovered (RM)	Average Payable per Member (RM)	ALOS
Surgical	647	2,092	13,390,715.28	12,898,632.16	492,083.12	19,936.06	1
Medical	499	1,407	4,618,805.26	4,288,182.81	330,622.45	8,593.55	1
Total	**973**	**3,499**	**18,009,520.54**	**17,186,814.97**	**822,705.57**	**17,663.74**	**1**



- **Inpatient Focus**: Surgical cases are the primary driver of inpatient activity, representing 59.79% of all visits.
- **Cost Burden**: Surgical cases account for an even larger share of total costs at 75.05%.
- **High Surgical Costs**: The average cost per member for surgical procedures is the highest at RM19,936.06.
- **Most Expensive Surgical Cases**: Cancer Of Liver, Gastric Ulcer: Acute With Hemorrhage, with a single visit by one member reaching RM92,916.30.
- **Most Expensive Medical Cases**: Pneumonia and Upper Gastrointestinal Bleeding with a single visit by one member reaching total payable RM111,113.75.

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COMPUMED

Medical Expenditure for Inpatient Benefits by Type of Diagnosis [2/3]

Type of Diagnosis	Chronic Diagnosis	No. of Headcount	No. of Visit	Total Cost Incurred (RM)	Total Cost Payable (RM)	Total Non-Payable (RM)	Avg. Payable per Member (RM)
Single	Cancer	50	306	2,060,988.28	1,904,662.57	156,325.71	38,093.25
	Cataract	96	400	1,088,126.38	1,020,490.11	67,636.27	10,630.11
	Diabetes	1	1	558.00	180.00	378.00	180.00
	Heart Disease	27	76	757,697.01	730,953.05	26,743.96	27,072.34
	Hypertension	2	2	5,496.20	5,411.25	84.95	2,705.63
Single Total		**170**	**785**	**3,912,865.87**	**3,661,696.98**	**251,168.89**	**21,539.39**
Multiple	Cancer	29	108	1,666,693.20	1,478,024.49	188,668.71	50,966.36
	Cataract	7	17	107,710.10	106,930.11	779.99	15,275.73
	Diabetes	18	51	350,460.09	330,944.73	19,515.36	18,385.82
	Heart Disease	26	61	648,588.08	636,014.42	12,573.66	24,462.09
	Hypertension	19	72	259,917.59	254,877.71	5,039.88	13,414.62
Multiple Total		**95**	**309**	**3,033,369.06**	**2,806,791.46**	**226,577.60**	**29,545.17**

- Cancer accounted 52.02% of total payable for single diagnosis.
- Heart Disease and diabetes took 22.66% and 11.79% respectively of total payable on multiple diagnosis.

Medical Expenditure for Inpatient Benefits by Type of Diagnosis [3/3]

Age Range	Cancer	Cataract	Diabetes Mellitus	Heart Disease	Hypertension	Grand Total
7-12	92,159.05	0.00	0.00	0.00	0.00	**92,159.05**
25-29	0.00	0.00	0.00	0.00	13,163.80	**13,163.80**
30-34	3,406.80	0.00	0.00	11,159.15	60,426.33	**74,992.28**
35-39	228,534.43	0.00	0.00	0.00	38,897.15	**267,431.58**
40-44	16,071.51	12,106.80	0.00	0.00	8,439.60	**36,617.91**
45-49	102,700.73	0.00	107,688.00	248,242.70	8,351.65	**466,983.08**
50-54	355,300.31	77,206.26	30,866.30	123,704.17	3,674.85	**590,751.89**
55-59	453,986.77	177,834.30	83,655.46	251,076.32	43,649.05	**1,010,201.90**
≥ 60	2,130,527.46	860,272.86	108,914.97	732,785.13	83,686.53	**3,916,186.95**
Grand Total	**3,382,687.06**	**1,127,420.22**	**331,124.73**	**1,366,967.47**	**260,288.96**	**6,468,488.44**

- **The age group 60 and above incurs the highest cost for chronic diagnoses**, totaling **RM 3,916,186.95** and **Cancer is the leading contributor within this age group, accounting for RM RM2,130,527.46 of those costs.**
- This five most common chronic illnesses significantly impact healthcare utilization, accounting for approximately 37.64% (RM6,468,488.44 out of RM17,186,814.97) of the total expenditure for chronic diagnoses in 2024.

Reasons in Premium Hikes

- i. Top 5 Hospitalization Cashless vs Reimbursement

Cashless	Mode of Payment	Pay and Claim (Reimbursement)
RM4,601.55 Avg length of Stay : 3 days	Acute Gastroenteritis	RM1,102.02 Avg length of Stay : 1 day
RM4,869.71 Avg length of Stay : 3 days	Viral Fever	RM1,548.76 Avg length of Stay : 1 day
RM7,822.01 Avg length of Stay : 4 days	Pneumonia/ Bronchopneumonia	RM1,669.16 Avg length of Stay : 4 days
RM6,461.83 Avg length of Stay : 4 days	Dengue Fever	RM2,288.06 Avg length of Stay : 4 days
RM6,341.69 Avg length of Stay : 4 days	Bronchitis/Bronchiolitis	RM1,925.16 Avg length of Stay : 3 days

Reasons in Premium Hikes

ii Accessibility of hospitals: KL/Selangor vs. Sabah/Sarawak

Region	Total Policy Sold	Total Headcount	Total Claims	Incident Rate
KL / Selangor	5,658	447	1,622	**7.90%**
Sabah / Sarawak	749	42	196	**5.61%**

**More claims and a higher incident rate in KL/Selangor suggest easier hospital access compared to Sabah/Sarawak.*

iii. Average medical trend rates Global vs Malaysia

Average Medical Trends	2023		2024	
	Annual General Inflation Rate	Annual Medical Trend Rate	Annual General Inflation Rate	Annual Medical Trend Rate
Global	3.6	9.2	3.6	10.1
Malaysia	2.4	15.0	3.1	15.0

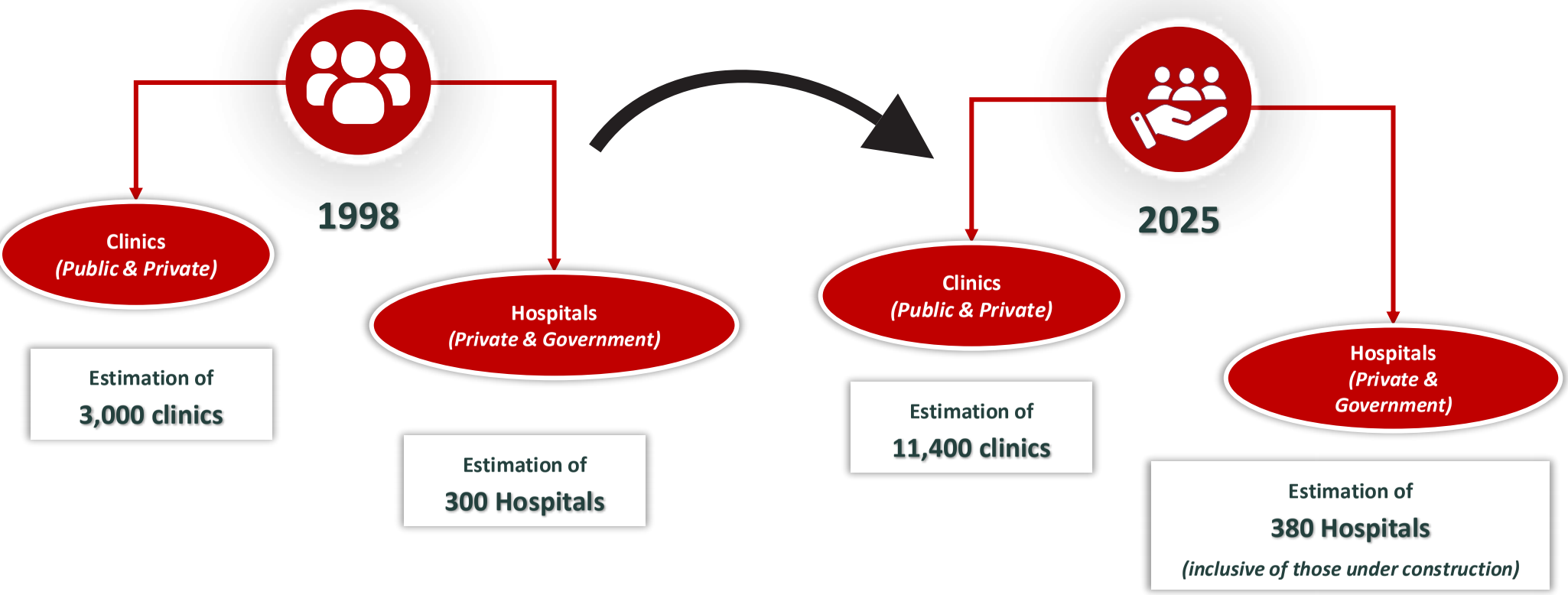
Reasons in Premium Hikes

iv.Top Non-Communicable Disease in Malaysia: Main Source NHMS 2023

	Malaysia	Global
Active Lifestyle	84% of adults are not active in sports, fitness and leisure activities	31% of adults are not active in sports, fitness and leisure activities
Hypertension	29.2% (1 in 3 adults on Malaysia have hypertension)	33% (1 in 3 adults have hypertension)
High Cholesterol	33.3% (1 in 2 adults in Malaysia have high cholesterol)	39% (2 in 5 adults have high cholesterol)
Obesity in	54.4%	16%
Malaysians that has done Medical Check-up	34.60%	

Proposed Strategies

Healthcare Journey in Malaysia



Reference:

1. State of Health: In 2025 and beyond, there are no magic solutions for healthcare
2. https://www.mof.gov.my/portal/arkib/ekonomi/1998/carta10-4_10-5.pdf
3. https://hq.moh.gov.my/medicalprac/statistik/

Proposed Strategies



01

Gatekeeping Mechanisms

- **Implementation:** Promoting **wellness programs and preventive care to reduce chronic illnesses**
- **Impact: Chronic diseases account for 70% of total healthcare costs in Malaysia**. Preventive care can significantly lower this burden by reducing hospital admissions

02

Cost-Sharing Models

- **Implementation:** Introducing co-payment or deductible systems to share medical costs between insurers and policyholders
- **Impact:** Co-payment systems have been shown to reduce unnecessary claims by **up to 15-20%,** as policyholders become more mindful of healthcare usage.

Proposed Strategies



03

Diagnostic-Related Group (DRG) Payment System

- **Implementation:** A DRG system standardizes payments for treatments based on diagnosis, ensuring cost control
- **Impact:** Countries that have adopted DRG systems, like Germany, have seen healthcare cost growth stabilize at **2-3% annually**, compared to higher rates in non-DRG systems.

04

Transparent Pricing

- **Implementation**: Standardizing fee schedules and ensuring transparent billing for medical procedures
- **Impact**: According to the Life Insurance Association of Malaysia (LIAM), medical claims rose by **26.2%** from 2022 to 2023. Transparent pricing can help control these escalating costs by preventing overcharging.



New Phase in Healthcare Management

New Phase in Healthcare Management

1 Why AI Matters?

- **Strategic Advantages of AI Adoption:**
  - **Competitive Edge:** Achieving superior operational efficiency and customer experience.
  - **Data-Driven Decision:** Developing business and servicing strategies.
  - **Scalability :** Avoiding liner growth of resources.
  - **Innovation:** Continuous improvement and technological advancement
- **Commitment to Responsible AI:**
  - Prioritizing data privacy and security
  - Focus on explainability and fairness in AI-driven decision.

New Phase in Healthcare Management

2 How Do We Utilise AI Today

I. AI-Powered Document Processing Pipeline

- Currently deployed and operational
- Automate the extraction, classifications and validation of information from various documents (Invoice, Receipts)

II. Benefits Realized:

- Accelerated turnaround times for critical business process.
- Reduced human error and improved data quality.
- Freed up employee time for more strategic, value-added tasks.

New Phase in Healthcare Management

3 Transforming Core Process – AI Tomorrow

I. Planned AI-Powered Claims Adjudication:

- Leverage AI to analyze claims data, identify patterns and automate decision-making.
- Aims to accelerate claims processing, improving consistency and reduce FWA (Fraud, Waste, Abuse)
- Expected Outcomes: Fairer assessments, faster payouts and reduced operations costs.

II. Planned AI-Powered Email Communication:

- **Intelligent Routing:** Directing inbound mails to the most appropriate department
- **Automated Responses:** Providing instant answer to common inquiries.
- **Personalized Communication:** Tailored communication based on history and needs (Integrated to core system CHAMPS)
- **Goal:** Improve member satisfaction through faster, more accurate and personalized support.

COMPUMED

Thank You



INTRODUCTION

PMCare Sdn Bhd

17 Jun 2025

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01 Executive Summary

02 Challenges Faced by Corporations

03 TPA Services

04 Medical Inflation & Cost Containment Measures

05 Medical Inflation Study

PMCare

01

Executive Summary



Company Profile & Valued Partners

PMCare

Nature

The Pioneer and Leading Third Party Administrator (TPA)

30 years

Together

A Sumitomo Corporation Group Company

100% owned by multi-national company in Japan

Fortune Global 500

Features

Digital Platform X **Big Data Analytics** X **Healthcare Solutions**

Only 1

Direction

Your **H**ealthcare **E**ssential **L**ife **P**artner

HELP

Our Valued Clients

Insurance Clients

Corporate Clients

… More

We Manage Because We Care

Key Highlight Numbers

Industry Pioneer



The Pioneer and Leading TPA in Malaysia

Employee Benefits Programmes



Servicing over 2,000+ Clients since starting the business

Largest Provider Network



Over 5,300+ GP Clinics
Over 490+ HP/SP
Over 1,100+ Dental Clinics
Over 300+ Optical

System Driven



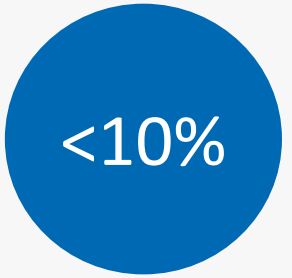
Processed more than 4.2 mil in 2024, medical claims worth more than RM2 billion per annum

Customization



100% customisation and compatible service

Managing Medical Inflation



Medical inflation trend is less than 10% as compared to the industry of more than 15%

02

Challenges Faced by Corporations



Challenges Faced by the Corporations

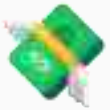
PMCare

Administrative Overload



- Manual Claims Processing
- Panel Management Hassles
- Employee Queries

Rising and Unpredictable Healthcare Costs



- Lack of Cost Control Mechanisms
- No Access to Negotiated Rates
- No Plans Advisory

Limited Data Analytics and Insights



- No Real-Time Utilisation Tracking
- No Benchmarking Tools
- Inefficient Forecasting

Challenges Faced by the Corporations

PMCare

Regulatory and Compliance Risks





PDPA/Data Protection Gaps:



Legal Exposure

Delayed or Poor Employee Experience



Slower Reimbursements



Lack of Digital Tools



Limited Access to Care

Lack of Preventive Health Programmes





No Wellness Integration



Reactive Health Spend



No Disease Management Programme

03

TPA Services



TPA Services - MAP

M

Strong Medical Management



Medical Audit

We process and adjudicate claims and conduct medical audits.

Utilization Review

Actional data & analysis through HR dashboard and comprehensive report

Wellness Initiatives

Wellness is a business strategy. Let's design your unique wellness program together

A

Efficient Administrative Services



Hassle-free Claims Adjudication

Say good-bye to endless claim processing work!

24/7 Careline

24/7 Support for you It's our hospitality and commitment

Healthcare App

Empower members to access one stop healthcare services including digital health

P

Largest Provider Network Management



Cashless Treatment

Fast and accurate transaction. Convenient.

Nationwide Provider Access

Enjoy selected nationwide provider network

Medical Cost Containment

Data analytic driven as part of medical claims adjudication and monitoring

Digital Platform X **Experienced Team**

TPA Services



Third Party Administrator (“TPA”)

- Strong Medical Management
- Efficient Administrative Service
- Largest Provider Network Management



Data-Driven Analytics

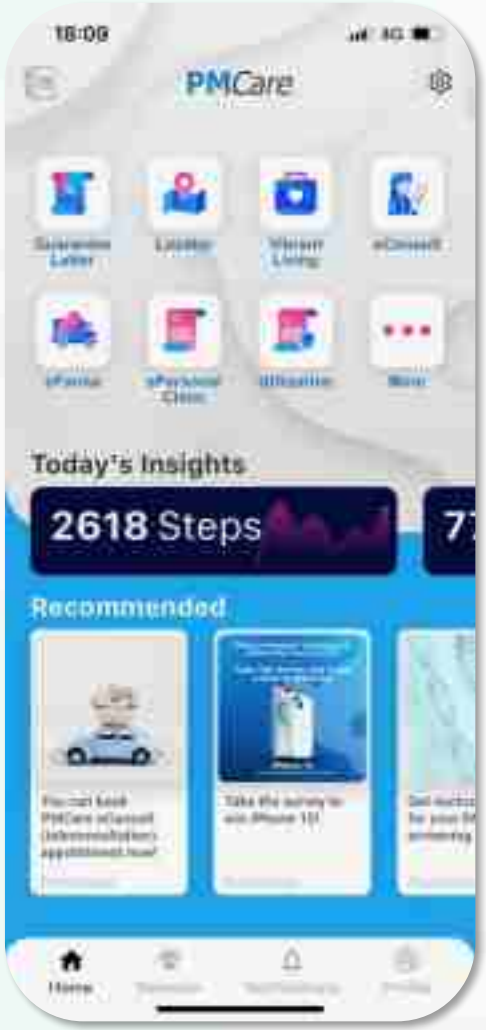
- Big Data Analytics
- Actionable Insights for Clients
- Predictive Analytics and Modeling



Healthcare Solutions

- Corporate Wellness
- Disease Management Solutions
- Digital Healthcare Solutions
- Personalised Healthcare Solutions

Member Centric Mobile App
- Empowering Members

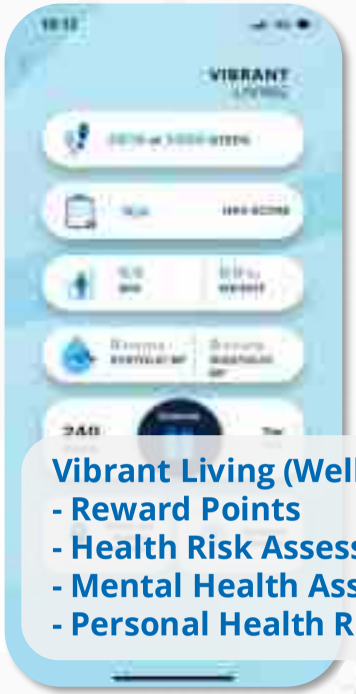




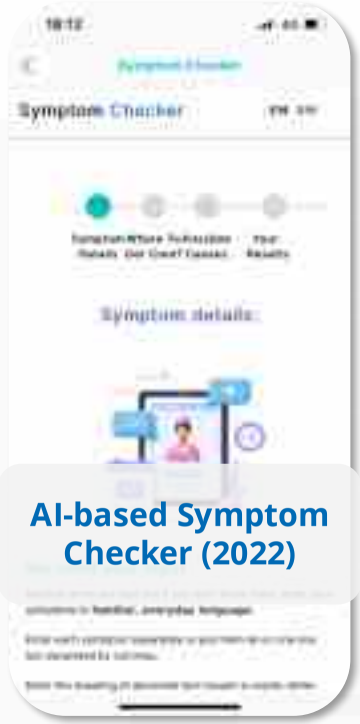




eFarma (2017)
Tele-consultation
(2020)



Vibrant Living (Wellness) 2021/2023
- Reward Points
- Health Risk Assessment
- Mental Health Assessment
- Personal Health Record (2024)



AI-based Symptom
Checker (2022)



Marketplace
(2024)





Data Driven Claims Management

- Fast Issuance of Guarantee Letter (“GL”)

- **PMCare’s Diagnosis Management Tracking (“DMT”) is a proprietary, data-driven, rule-based processing engine that evaluates claims based on diagnosis, hospital tier, and patient age**
- **Pre-authorization focused on assessing reasonableness of procedure/cost**

Reduces dependency on personnel to increase accuracy and speed

Active claims monitoring based on live data

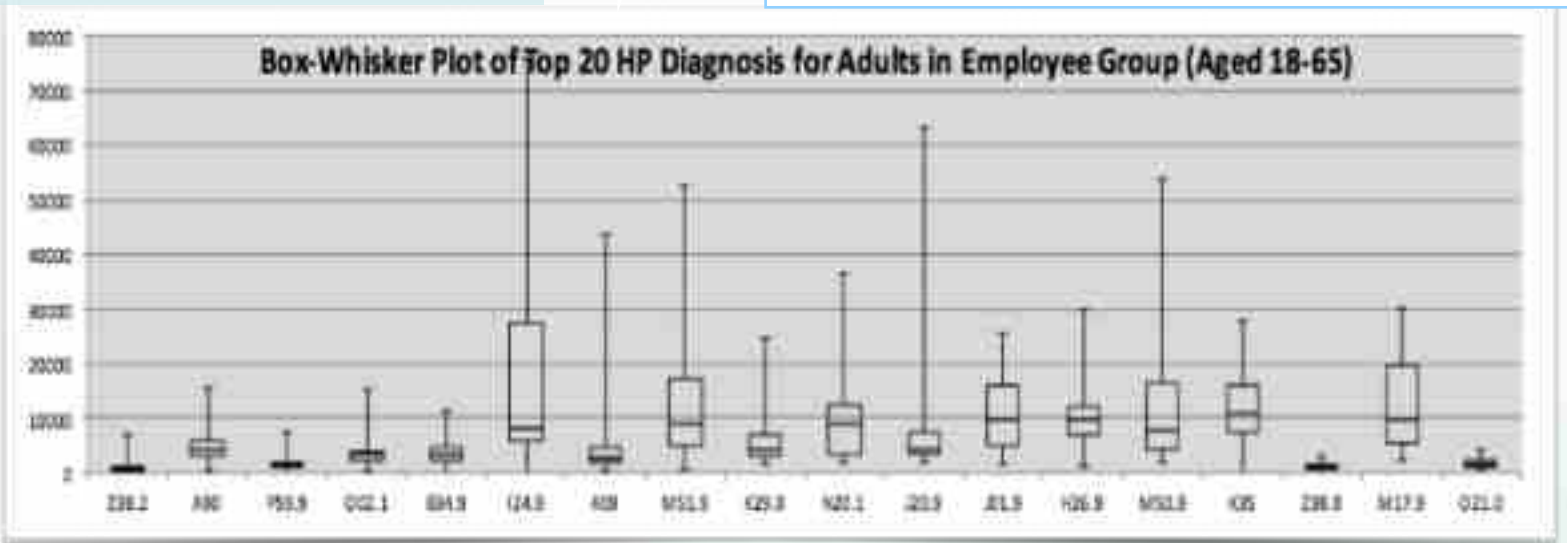
Guarantee Letter (“GL”) Issuance

Guarantees ‘within 30mins’

Claims Adjudication

Allows ‘fast tracking’ of claims that is within determined limits





Data-Driven Claims Management

–Fast Discharge by API e-Billing

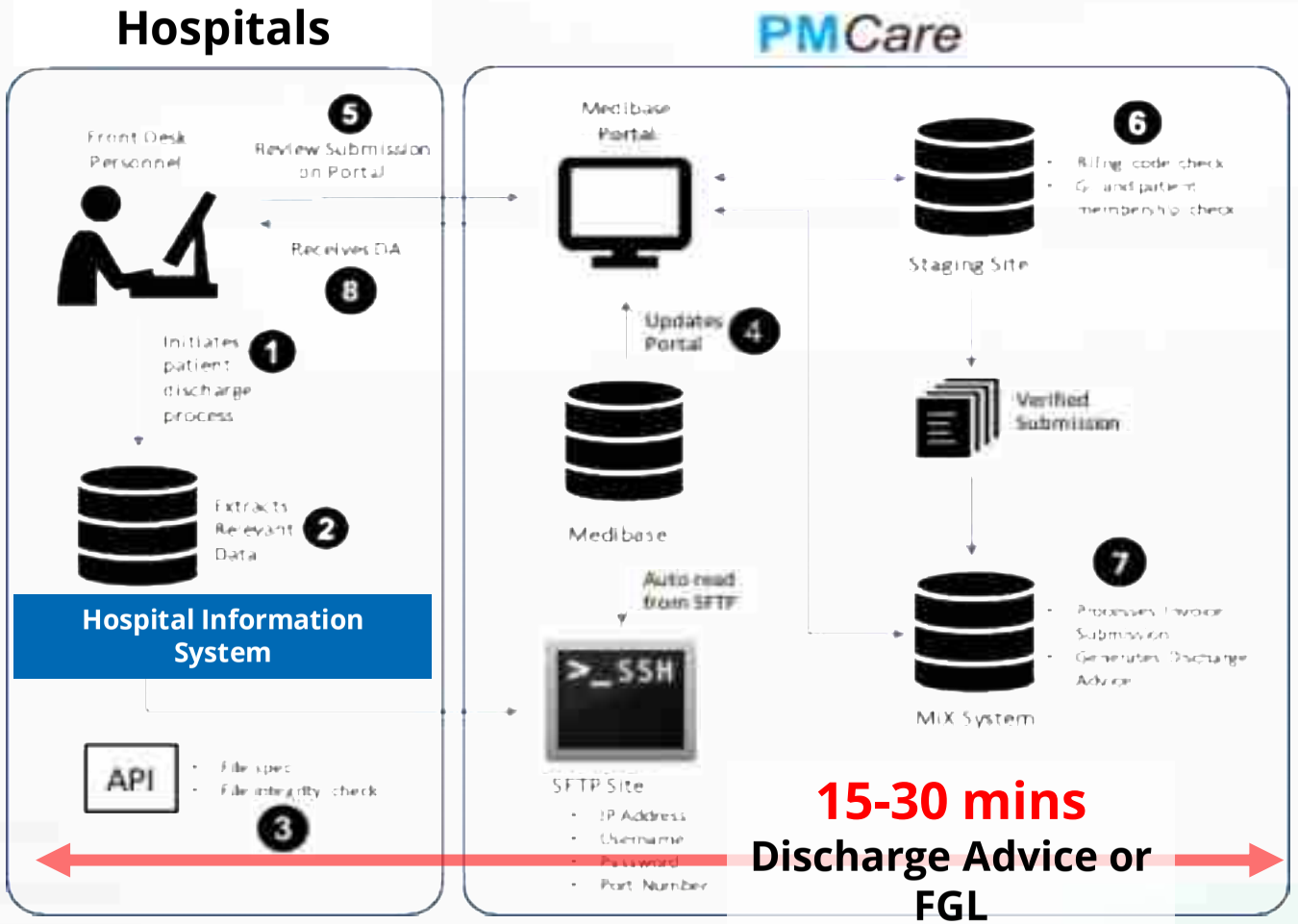
API-based e-billing with hospitals accelerates claims adjudication for FGL, ensuring a faster and more accurate discharge process

What is E-Billing

- **Conversion** from manual invoice data entry
- **Enhance** claims processing TAT
- Detailed data capture for **accurate processing**



API Process Flow



API Progress

Completed

COLUMBIA ASIA

KPJ

People caring for people

SUNWAY MEDICAL CENTRE

INSTITUT JANTUNG NEGARA
National Heart Institute

Work In Progress

AVISENA

Empowering Members

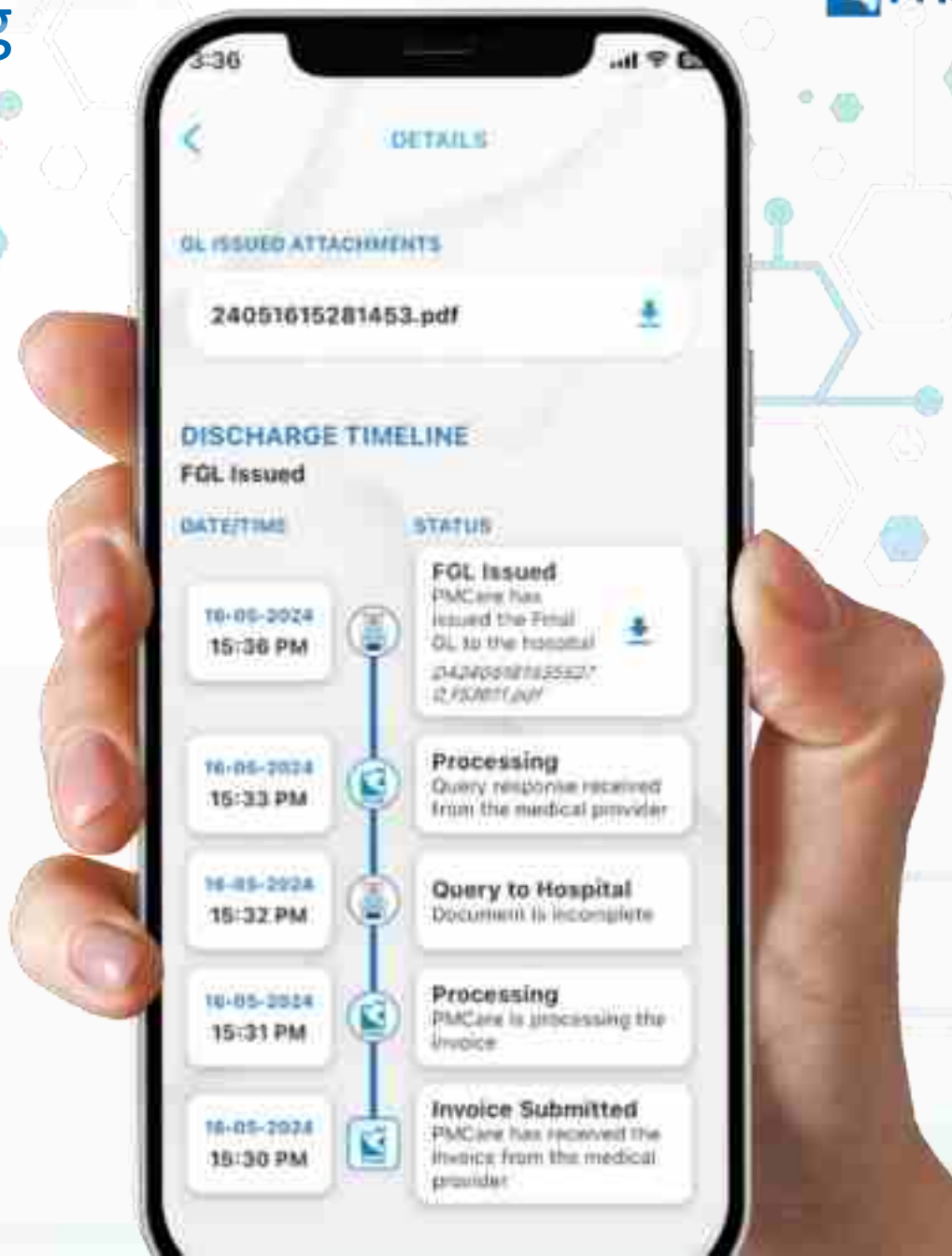
- Final Guarantee Letters (“FGL’) Tracking

Real-Time Updates
Patients receive live updates on their discharge status via our mobile app

Clear Visibility
Patients can easily track their discharge progress and coordinate plans with their families

Reduced Uncertainty
Real-time notifications help ease anxiety during waiting periods by keeping patients informed

Instant Notifications on Issues
If there are delays, rejections, or pending approvals, patients are promptly notified with clear reasons—no need to contact HR or PMCare



Comprehensive Medical Utilisation Analysis

Medical Cost Analytics Dashboard HR Portal (Medifile)

PMCare

HR Medical Portal | Medifile

Monitoring

1. Dash Board
2. Membership
3. Primary Care
4. GL & DA
5. Medical Utilization
6. Exceptional Claim

Report

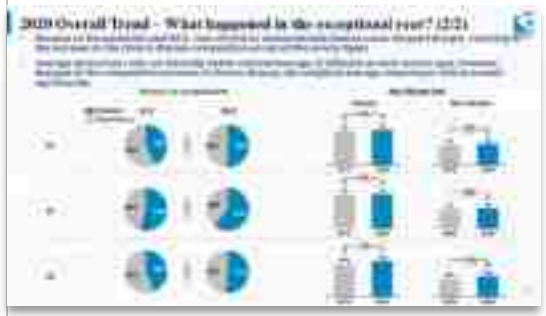
1. Summary of Utilization
2. Diagnosis Trend
3. Top20 Provider
4. Details of MC
5. GL issues

More.



Medical Utilization Analysis







Comprehensive Analysis

We give meaningful data and insight reports so that you can make better decisions

1. **Medical Cost Inflation**
2. **Utilization Trend overview**
3. **Benchmark Analysis**
4. **Saving Analysis**

Healthcare Solutions

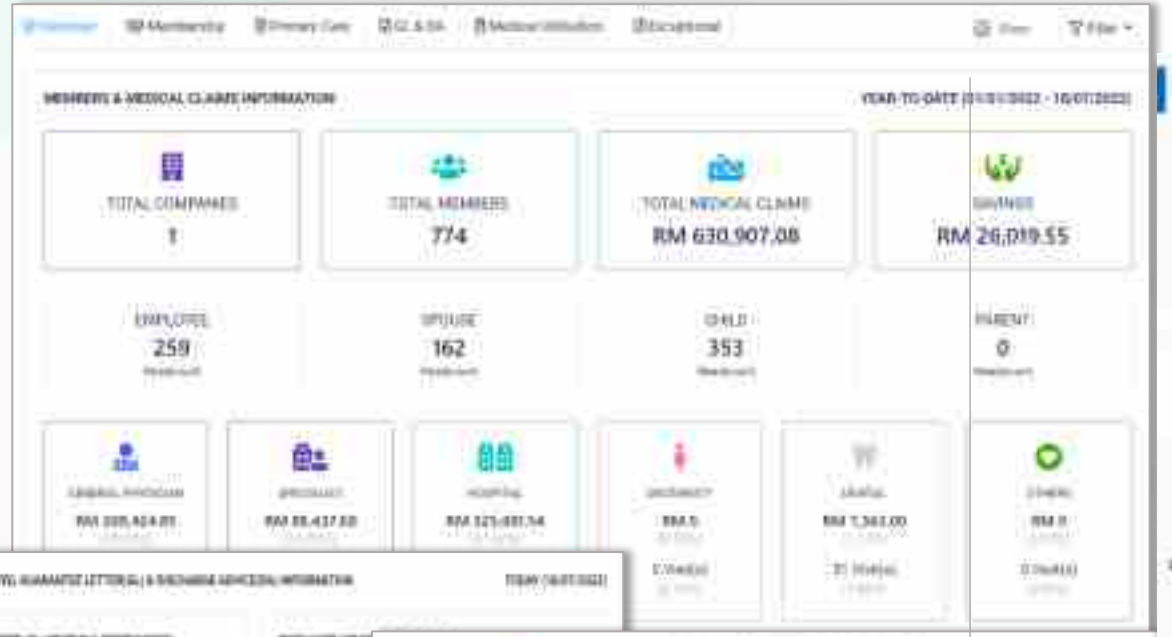
Based on the trend and analysis we propose unique healthcare solutions

1. **Overall cost containment Strategy**
2. **Fundamental Solutions**
3. **Value-added services**

More..

Digital Health: Data Analytics

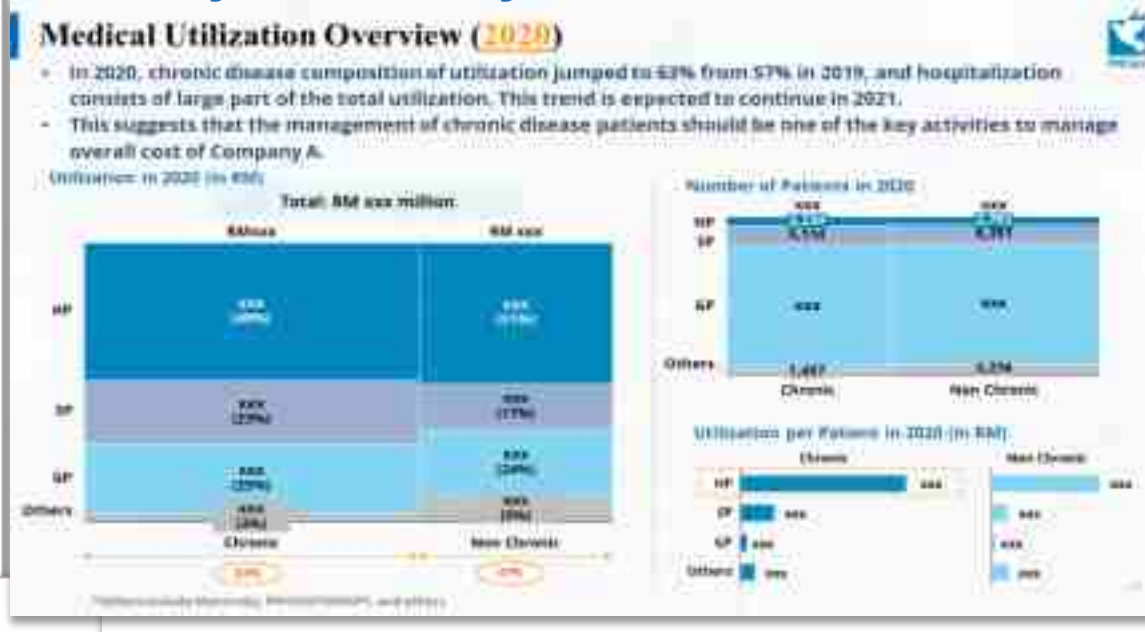
Medical Cost Analytics Dashboard (Medifile)







Customised Reports by Data Analytics Team



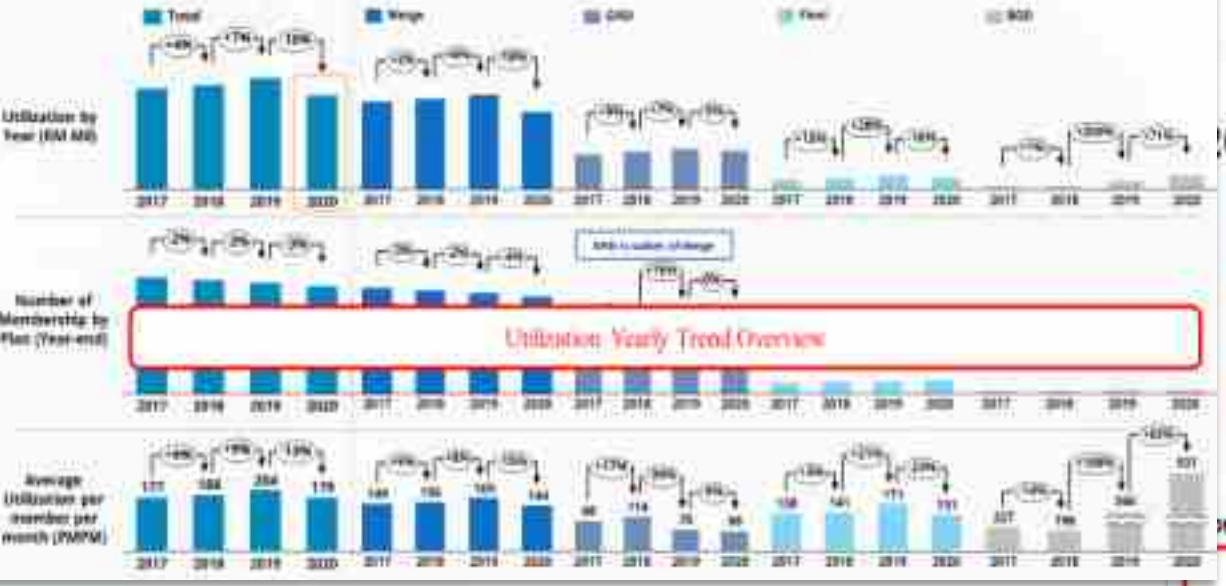


Comprehensive Analysis
- Data Analytics & Solution Proposal

PMCare

Utilization Trend Overview

- Utilization in 2020 dropped by 16% from 2019 mainly because of the pandemic and Movement Control Order, which resulted in the reduction of the visits to medical providers



2021 Medical Utilization Forecast

Precise forecast for 2021 utilization is not easy at this moment as there is still uncertainty of the prevalence of Covid-19 vaccination. Thus, PMCare used following assumptions and prepared two scenarios for the reference of CompanyA.

Scenario 1 : Utilization Forecast 2021 -> RM xxx million

- Assumptions: There would be similar level of movement restrictions nationwide until the end of the year, and utilization amount would continue to be the same as the average between June 2020 and Jan.2021 when the amount was stabilized.

Scenario 2 : Utilization Forecast 2021 -> RM xxx million

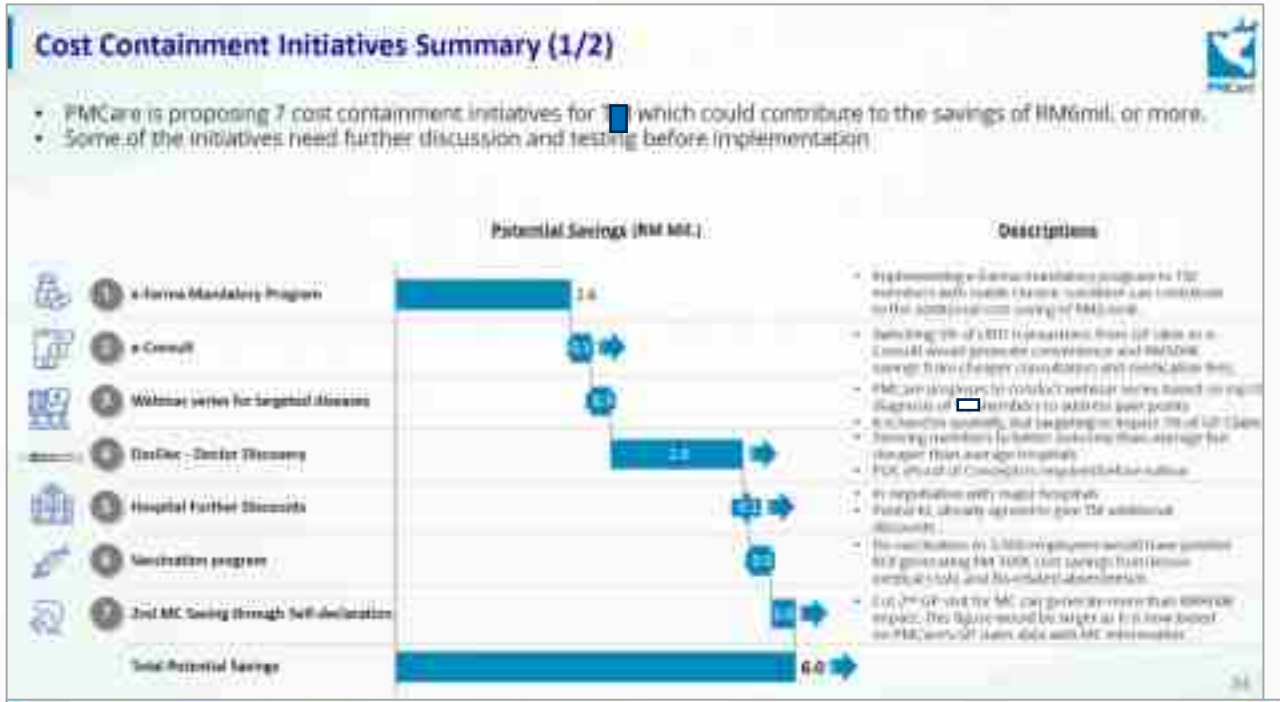
- Assumptions: From the later half of the year, the movement of the people would be close-to-normal and the utilization amount would be close to 2019 level toward the end of the year.

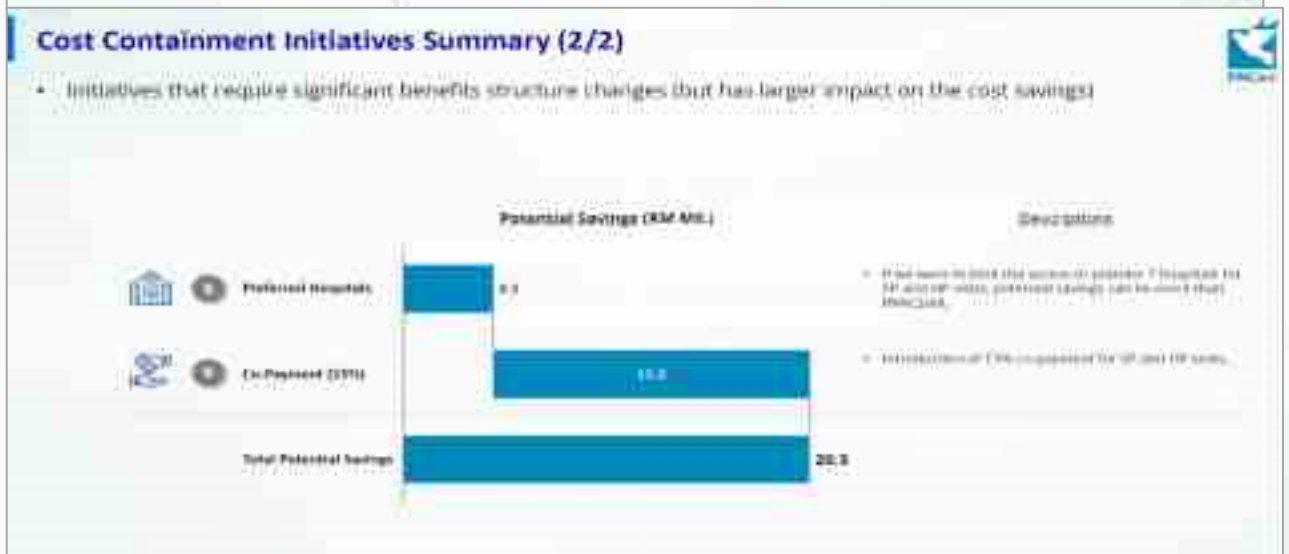
Monthly Utilization Trend (in RM)



Comprehensive Analysis
- Data Analytics & Solution Proposal







04

Medical Inflation & Cost Containment Measures



Medical Trend Rates

Medical costs are rising, and so is the workload

	2024			2025		
	Annual General Inflation Rate	Annual Medical Trend Rates		Annual General Inflation Rate	Annual Medical Trend Rates	
		Gross	Net		Gross	Net
Asia-Pacific	3.6	9.7	6.1	2.8	11.1	8.3
Australia	3.2	4.2	1.0	3.0	5.1	2.1
Bangladesh	6.5	10.0	3.5	6.1	10.0	3.9
China	2.2	7.9	5.7	2.0	8.0	6.0
Hong Kong	2.4	7.5	5.1	2.3	8.0	5.7
India	4.4	12.0	7.6	4.2	13.0	8.8
Indonesia	3.0	13.1	10.1	2.6	16.2	13.6
Japan	2.2	0.4	(1.8)	2.1	0.9	(1.2)
Kazakhstan	8.5	30.0	21.5	7.0	29.0	22.0
Malaysia	3.1	15.0	11.9	2.5	15.0	12.5
Mongolia	8.8	15.0	6.2	10.0	n/a	n/a
New Zealand	2.6	10.0	7.4	2.5	17.0	14.5
Pakistan	21.9	n/a	n/a	12.7	n/a	n/a
Papua New Guinea	4.9	4.9	0.0	4.8	12.0	7.2
Philippines	3.2	14.0	10.8	3.0	15.0	12.0
Singapore	3.5	13.0	9.5	2.5	14.0	11.5
South Korea	2.5	10.0	7.7	2.0	10.0	8.0
Taiwan	1.7	10.0	8.3	1.5	n/a	n/a
Thailand	2.0	9.1	7.1	1.2	14.3	13.1
Vietnam	4.3	6.7	2.4	3.4	12.9	9.5

Source: Aon

Medical cost inflation in Malaysia 2025

15%*

Malaysia is amongst the countries experiencing the highest medical cost inflation rate in the region due to patient demand

Employee Benefit TPA Outsource Ratio

37%**

In Malaysia, almost 40% of Insured population outsource their medical administration job to TPA

Health trends 2025: Adapting plans to optimize value

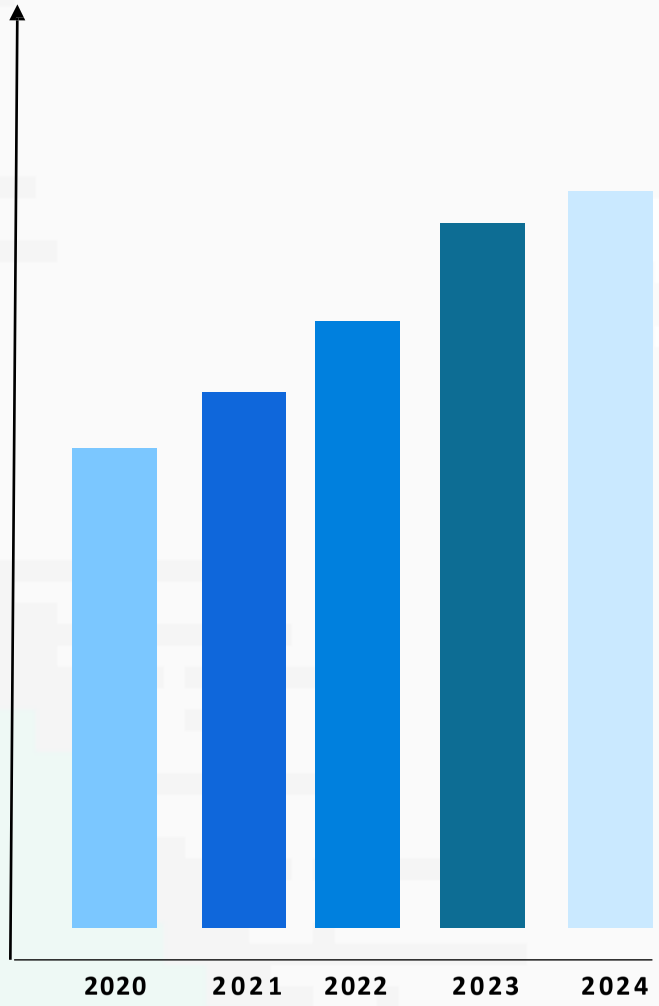
Country/Region	2023 actual medical trend rate*	2023 actual inflation rate*	2024 forecast medical trend rate*	2024 forecast inflation rate*	2025 forecast medical trend rate*	2025 forecast inflation rate*
Indonesia	14.6%	3.7%	17.9%	2.0%	19.0%	2.8%
Malaysia	13.0%	2.5%	14.0%	2.8%	15.0%	2.5%
Philippines	14.0%	6.0%	21.0%	3.6%	21.0%	3.0%
Singapore	13.0%	4.8%	12.0%	3.0%	11.0%	2.5%
South Korea	9.5%	3.6%	10.2%	2.5%	11.0%	2.0%
Taiwan	11.2%	2.5%	10.4%	1.9%	12.2%	1.6%
Thailand	12.5%	1.2%	11.1%	0.7%	11.4%	1.2%
Vietnam	9.5%	3.3%	10.0%	3.2%	11.0%	3.4%

*Sources: MercerMarsh Benefits – Health Trends 2025
2025 AON-Global-Medical-Trend-Report

** Source: Fitch solutions, Pharmaboard, Roland Berger

Control Measures

Medical Utilisation Cost Trend



Cost Inflation Factors

Internal Factors

- Prevalence of Chronic Disease
- Age-Related Conditions
- Inactive Lifestyle & Bad Habits
- Demand for More Employee Benefits
- Underuse of the Executive Screening & Wellness programme

External Factors

- Advancement in Medical Technology & Treatment Innovation and pharmaceuticals
- Frequent Increase in Drug Prices
- Availability of medical providers – easier access to private practice
- Lack of Transparency in Cost & Quality by the Providers
- Changing Regulatory Framework
- Doctors charging Multiple Procedures
- Unnecessary Admission
- Medical Malpractice & Fraud
- Weaker Ringgit
- Over Servicing (Excessive Investigations)

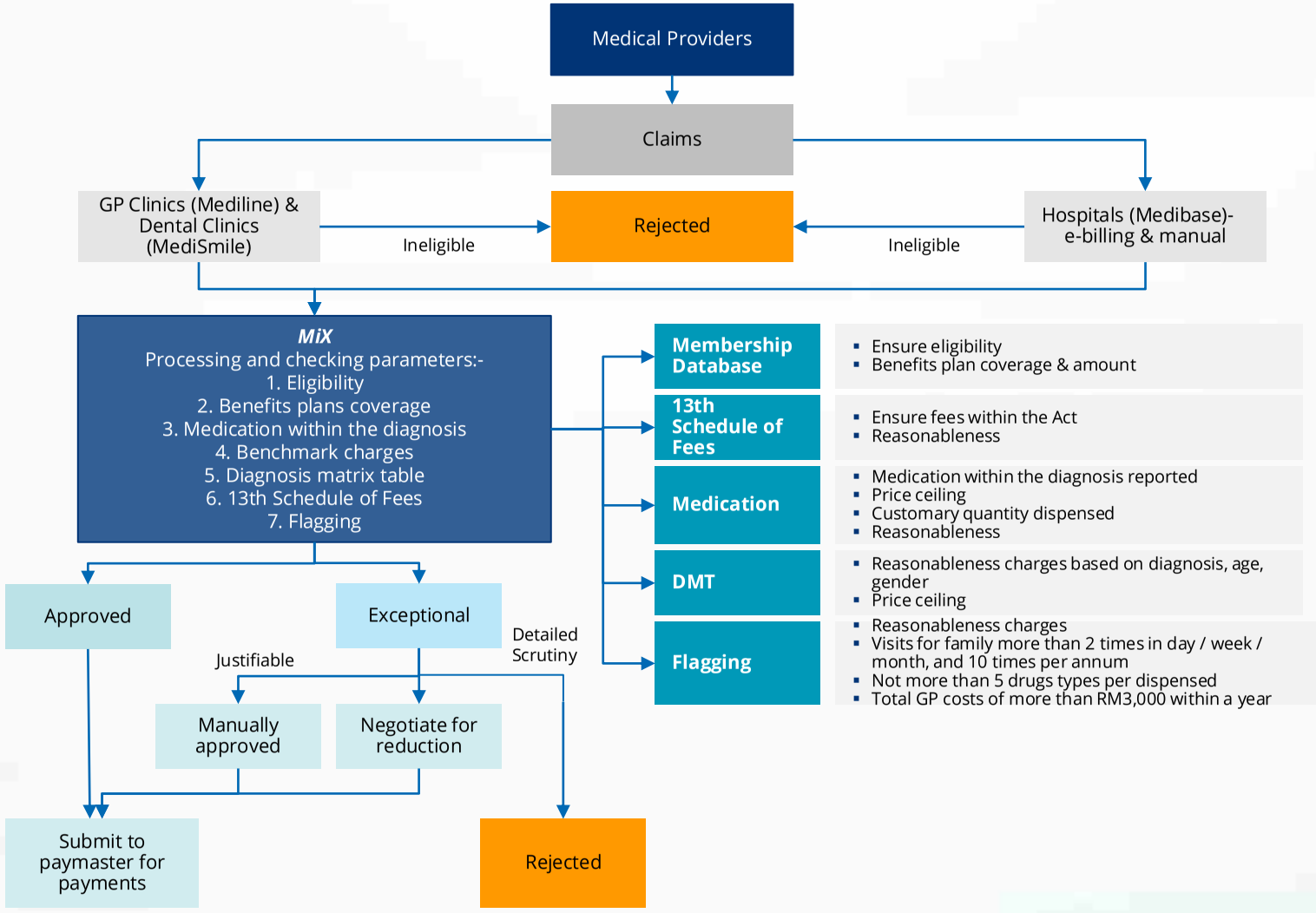
Cost Containment Initiatives



- Self-care & wellbeing
- Promotion of healthy lifestyle & Wellness programmes
- Pre-authorization focused on assessing reasonableness of procedure/cost
- Better Corporate Rates & Discounts by Medical Providers
- Negotiated Package and Bundles Pricing for Specific Procedures
- Managing Compliance
- Benchmark Charges & Flagging by Exceptional
- Fraud & Abuse Detection
- Audit on Providers
- Membership Database-Eligibility & Benefits Plan Checking
- Checking against 13th Schedule of Fees
- Customary Quantity Dispensed
- Price Ceilings
- Digital health – symptoms checker , tele-consultation and e-Farma

Claims Adjudication System To Detect Claims & Cost Irregularities

A system is in place to automatically detect irregularities and contain the medical costs to avoid Error, Fraud, Abuse, and Wastage ("EFWA")



PMCare Medical Trend

3 Main Service Types from the year 2017 to 2024
- Average cost per visit/admission (RM)

Code	2017			2018			Inflation	2019			Inflation	2020			Inflation
	Trx	RM	Avg	Trx	RM	Avg	%	Trx	RM	Avg	%	Trx	RM	Avg	%
General Physician	2,859,157	279,578,989	97.78	2,595,253	241,112,552	92.91	-4.98%	2,449,473	243,971,764	99.60	7.20%	1,893,818	207,141,941	109	9.82%
Specialist	505,168	251,810,930	498.47	414,475	198,060,766	477.86	-4.13%	400,539	194,138,389	484.69	1.43%	378,729	195,404,299	516	6.45%
Hospitalisation	67,665	493,080,160	7,287.08	58,041	395,608,138	6,816.01	-6.46%	57,007	412,684,252	7,239.19	6.21%	48,521	391,215,086	8,063	11.38%

Code	2021			Inflation	2022			Inflation	2023			Inflation	2024			Inflation
	Trx	RM	Avg	%	Trx	RM	Avg	%	Trx	RM	Avg	%	Trx	RM	Avg	%
General Physician	1,763,838	206,857,434	117	7.22%	2,486,074	267,288,755	108	-8.32%	2,780,050	331,118,419	119	10.78%	3,234,025	424,378,954	131	10.17%
Specialist	417,671	215,962,533	517	0.22%	464,368	242,600,627	522	1.04%	513,691	276,136,460	538	2.89%	685,451	360,748,797	526	-2.09%
Hospitalisation	41,831	378,280,930	9,043	12.16%	52,975	453,429,228	8,559	-5.35%	64,027	590,440,380	9,222	7.74%	87,789	815,491,913	9,289	0.73%

PMCare Medical Trend

Medical Inflation for 3 Main Service Types from the year 2021 - 2024

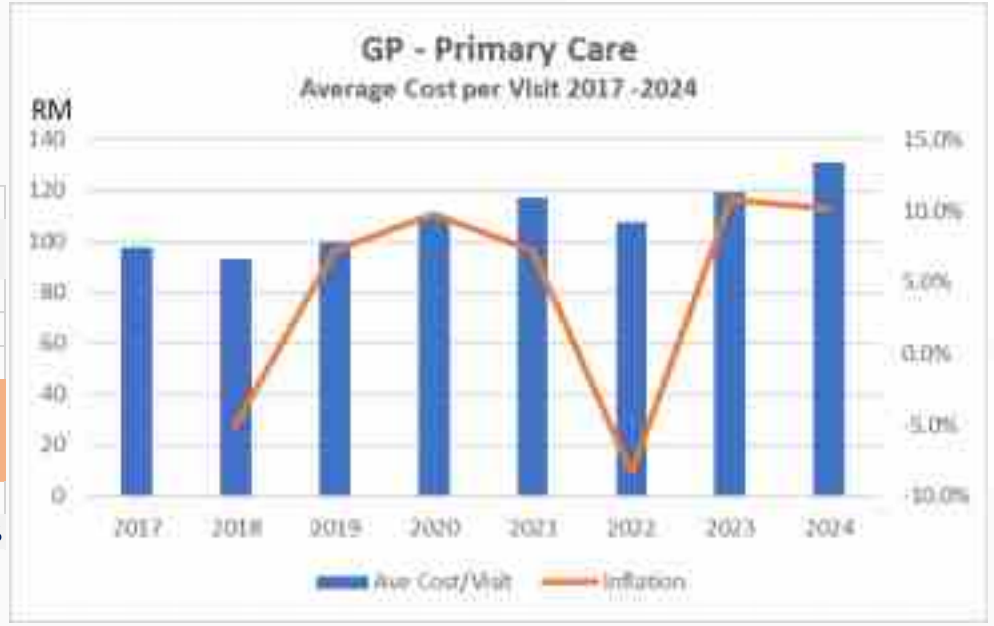
Malaysian medical inflation rate ranges between 12% and 14% in the year 2022 to 2024. While inflation for General Practitioner (GP) services is comparatively higher than for other categories, hospital-based medical utilisation—which represents the bulk of healthcare consumption—has been effectively maintained at approximately 0.7%

	Average Cost Per Visit (RM)				Inflation Rate			Transactions				Utilisation (RM)			
	2021	2022	2023	2024	2022	2023	2024	2021	2022	2023	2024	2021	2022	2023	2024
Malaysian Medical Inflation					12%	13%	14%								
General Physician	117	108	119	131	-8.3%	10.8%	10.2%	1,763,838	2,486,074	2,780,050	3,234,025	206,857,434	267,288,755	331,118,419	424,378,954
Specialist	517	522	538	526	1.0%	2.9%	-2.1%	417,671	464,368	513,691	685,451	215,962,533	242,600,627	276,136,460	360,748,797
Hospitalisation (Inpatient)	9,043	8,559	9,222	9,289	-5.4%	7.7%	0.7%	41,831	52,975	64,027	87,789	378,280,930	453,429,228	590,440,380	815,491,913

Outpatient- Primary Care & Specialist Care

Average cost per visit in the year 2017 - 2024

	Ave Cost/Visit	Inflation	
Year	RM	%	7 Year-CAGR
2017	97.78		
2018	92.91	-5.0%	
2019	99.60	7.2%	
2020	109.38	9.8%	
2021	117.28	7.2%	Covid-19
2022	107.51	-8.3%	
2023	119.11	10.8%	
2024	131.22	10.2%	4.3%



The average GP care per visit medical inflation was below 10% until 2022.

Post the COVID-19 period, the yearly inflation rate exceeded 10% per annum.

7-Year CAGR for the GP – Primary care is 4.3%.

	Ave Cost/Visit	Inflation	
Year	RM	%	7 Year-CAGR
2017	498.5		
2018	477.9	-4.1%	
2019	484.7	1.4%	
2020	516.0	6.4%	
2021	517.1	0.2%	Covid-19
2022	522.4	1.0%	
2023	537.6	2.9%	
2024	526.3	-2.1%	0.8%

The highest yearly medical inflation cost per visit at the Specialist clinics was 6.4% in the year 2020 during the Covid-19 period.

Post the COVID-19 period, the yearly inflation rate in 2023 was 2.9%.
In the year 2024, there was deflation by 2.1%.

7-Year CAGR for the GP – Primary care is 0.8%.



Hospitalisation

Average cost per Admission in the year 2017 - 2024

Ave Cost/Admission		Inflation	
Year	RM	%	7 Year-CAGR
2017	7,287		
2018	6,816	-6.5%	
2019	7,239	6.2%	
2020	8,063	11.4%	
2021	9,043	12.2%	Covid-19
2022	8,559	-5.3%	
2023	9,222	7.7%	
2024	9,287	0.7%	3.5%



The highest yearly medical inflation cost per Admission was registered during the Covid-19 period; 12.2% in the year 2021.

Post the COVID-19 period, the yearly inflation rate in 2023 was 7.7% and 0.7% in the year 2024.

7-Year CAGR for the Hospitalisation is 3.5% only.

Hospitalisation
- Billing & Cost Structure of Private Hospitals

Line Items Appearing in Patient's Bill

- Consumable Drugs
- Medical Supplies
- Rehab charges
- Operating Theatre
- Rehab charges
- Medical Officer fees

Line Items Appearing in Patient's Bill at Subsidised Rate

- Ward charges
- ICU Charges
- Nursing Care
- Emergency equipment

Items NOT listed in Patient's Bill

- Non-nursing staff cost
- Allied Health Staff Cost
- Building cost / rental
- General Plant & Equipment
- Land cost
- Maintenance of general plant and equipment
- IT Costs / Cybersecurity
- Utilities

Ambulances

- 24/7, 3 shifts staff cost
- Equipment & maintenance

Emergency Department

- Emergency Equipment
- Emergency OT
- 24/7, 3 shifts staff cost
- On Call Team

05

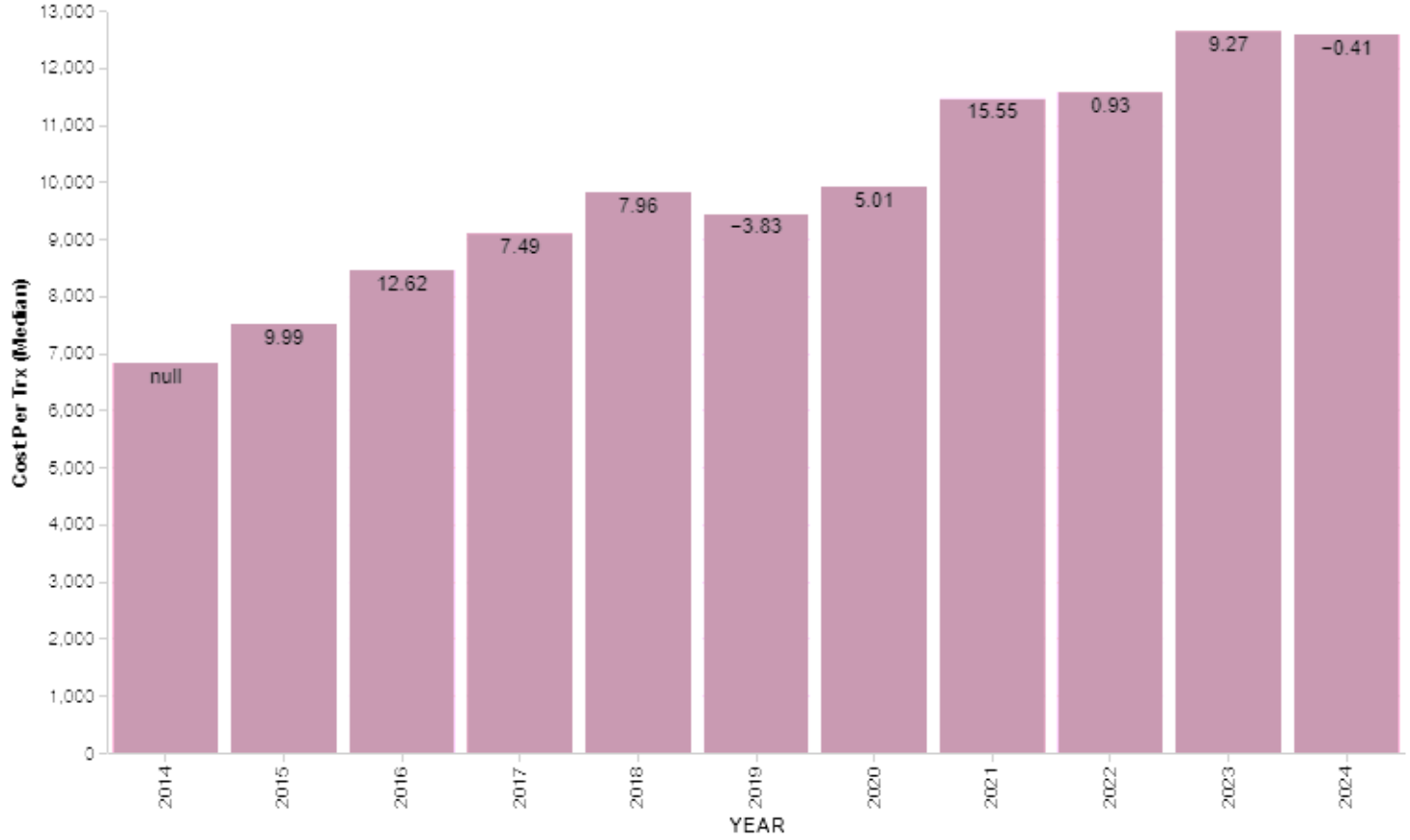
Medical Inflation Study



Surgical (SG)

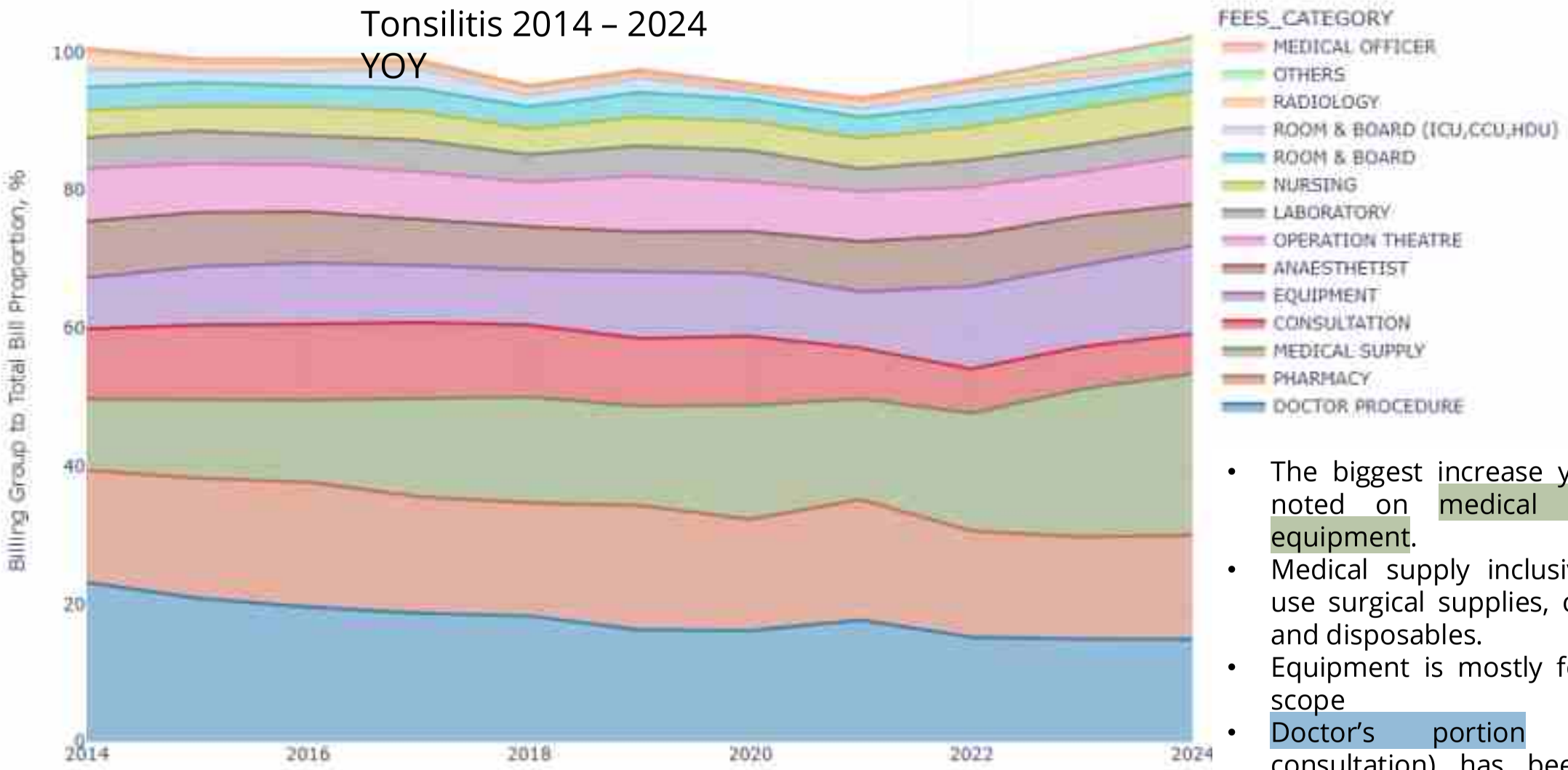


1. Tonsilitis/Tonsillectomy (ICD-10 :J03) - SG



- Chart represents median cost for management of acute/chronic tonsillitis WITH tonsillectomy procedure, with median length of stay is aggregated to 3 days (elective admission).
- Data shows a steady increase in median total cost in the range of 5-15%, year on year with highest increase is between year 2020-2021.
- In terms of RM, total median cost for management of acute tonsilitis with tonsillectomy increases from RM7,000 – RM12,800; a total of RM4,800.

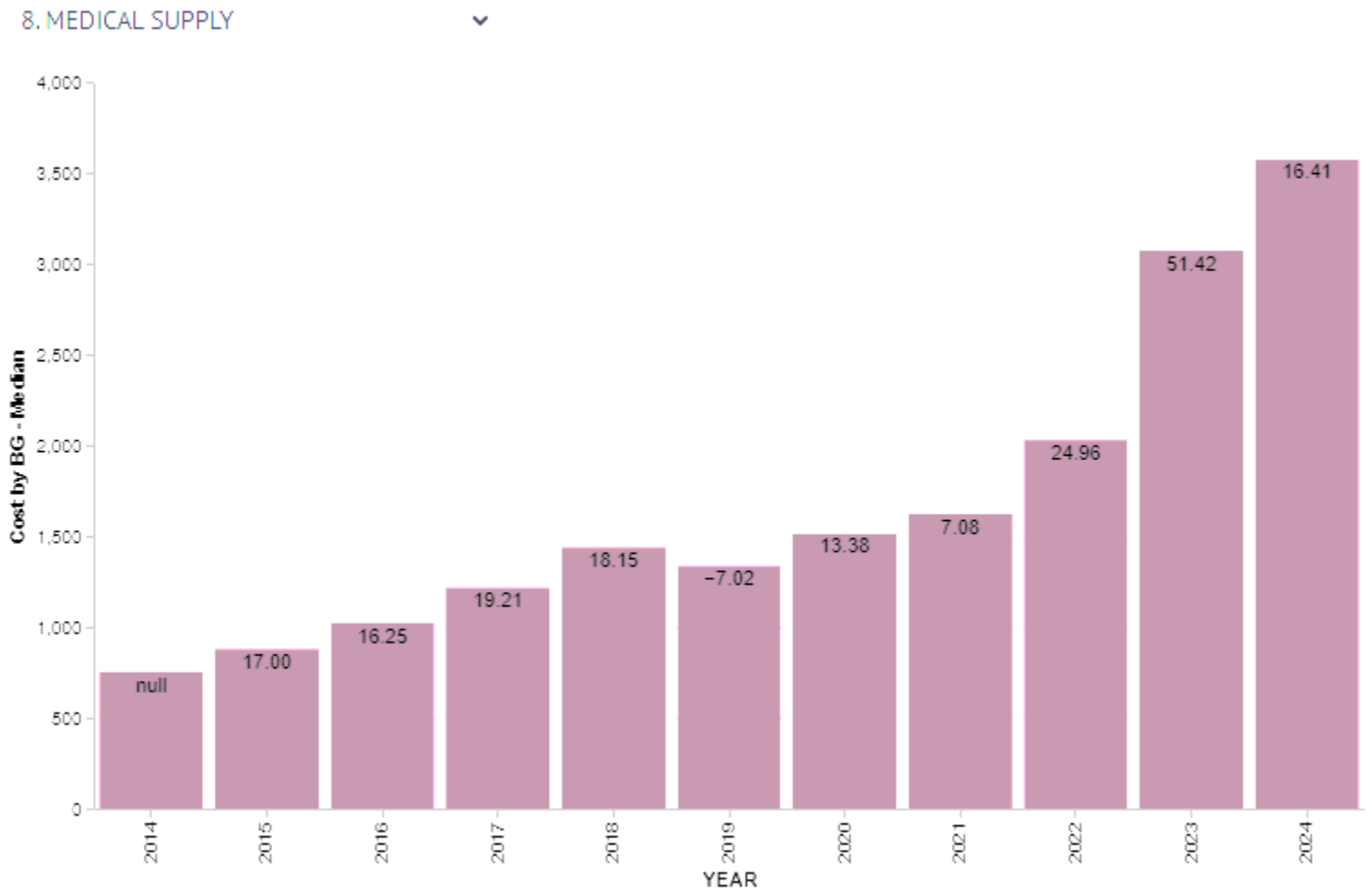
Tonsilitis 2014 – 2024 YOY



- The biggest increase year on year noted on medical supply and equipment.
- Medical supply inclusive of single use surgical supplies, consumables and disposables.
- Equipment is mostly for fibreoptic scope
- Doctor's portion (procedure, consultation) has been relatively unchanged since 2014 and reflects close to 0% as the cost driver for total median cost.

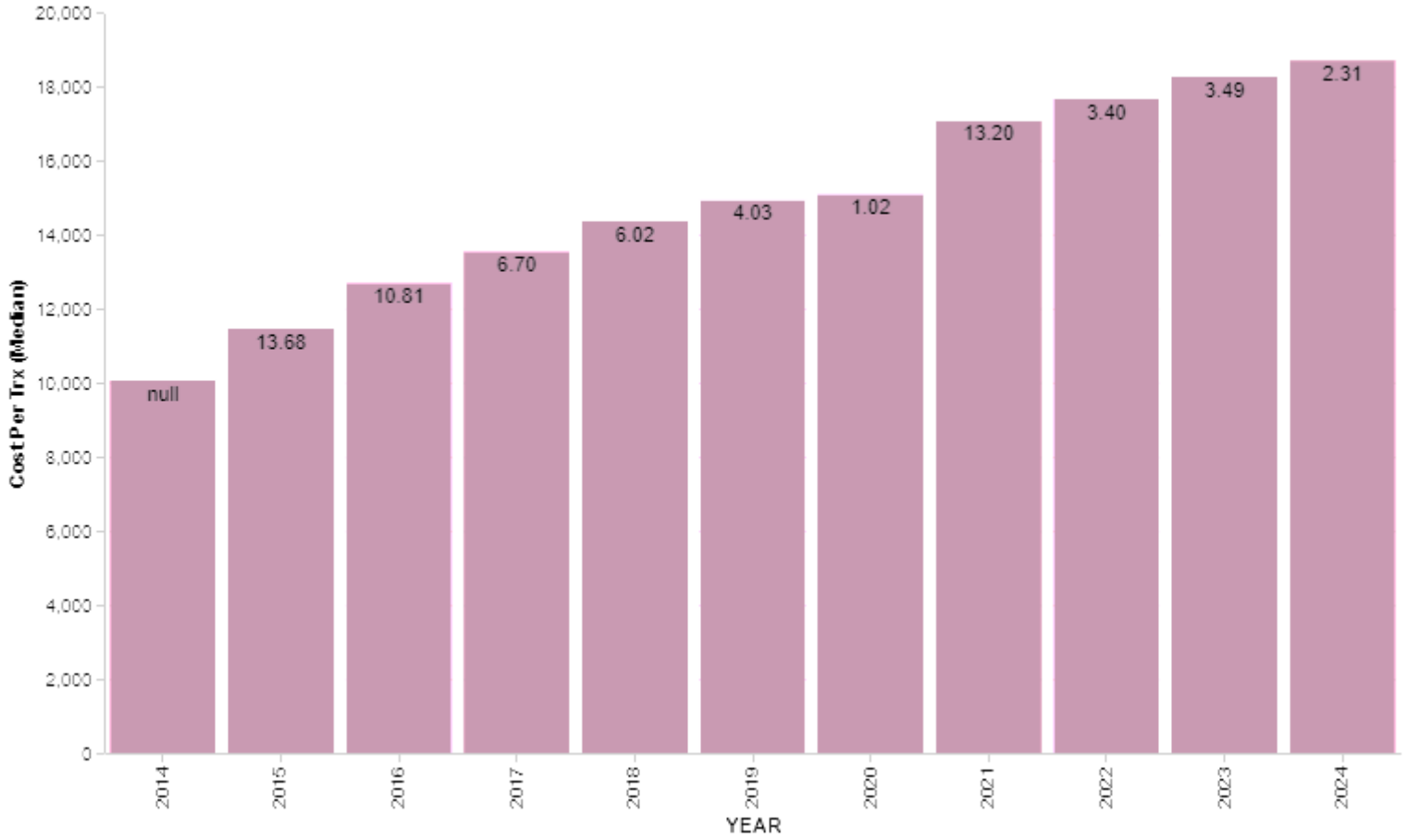
Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Tonsilitis 2014 – 2024 YOY – Medical Supplies Billing Group



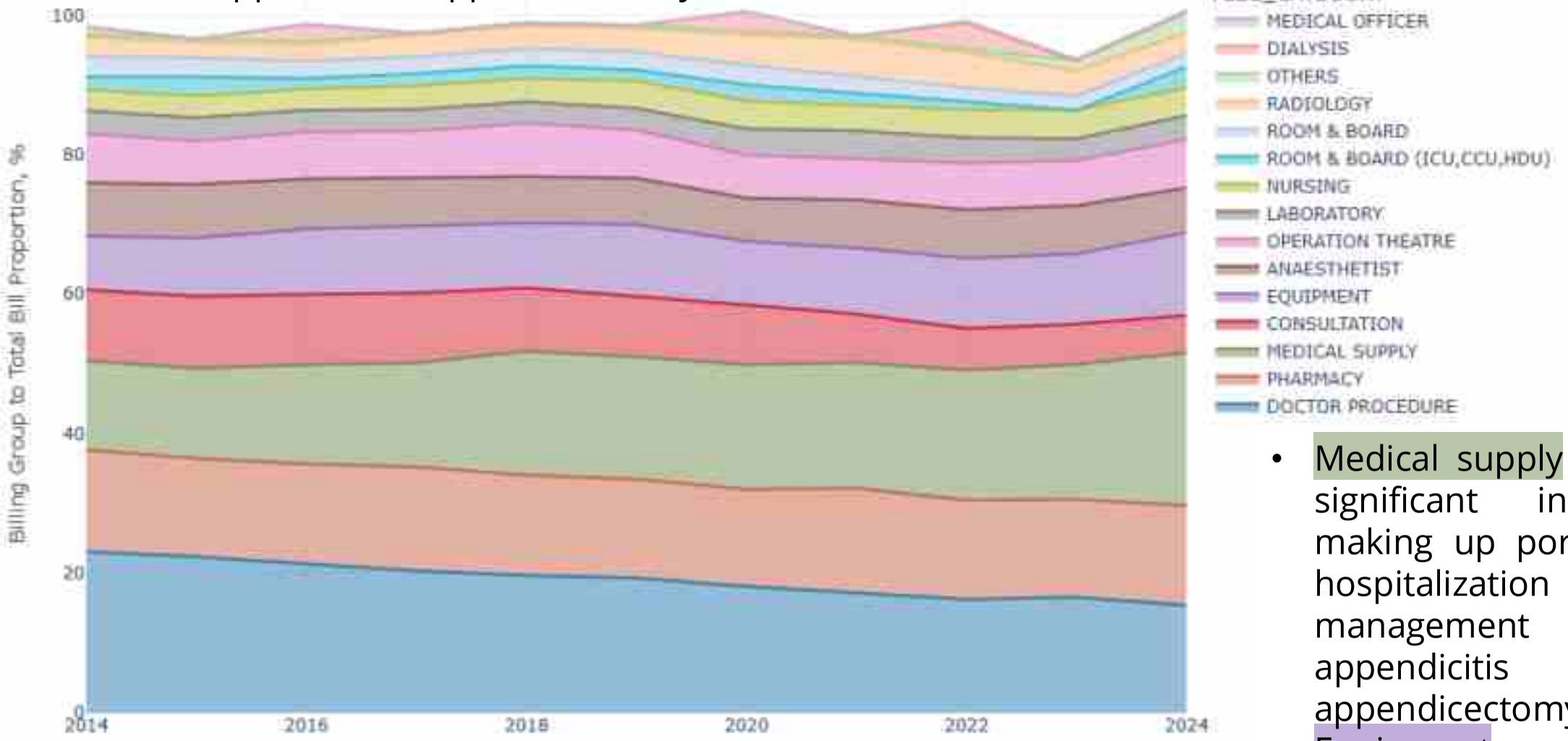
- Charges of medical supplies has been on steady increase from 2014 to 2024, with highest increase recorded between the year 2022 and 2023 (51.42%).
- Medical supplies has been identified as the main cost driver for acute tonsilitis/tonsillectomy in Malaysia (PMCare's data).

2. Appendicitis/Appendicectomy (ICD-10 : J18) - SG



- Chart showing total median cost for management of acute appendicitis WITH appendicectomy procedure, with length of stay aggregated to 3 days (emergency admission).
- Total median cost for management of acute appendicitis with appendicectomy has almost doubled from RM10,000 in 2014 to RM18,000 in 2024.

Appendicitis+appendicectomy 2014 – 2024 YOY



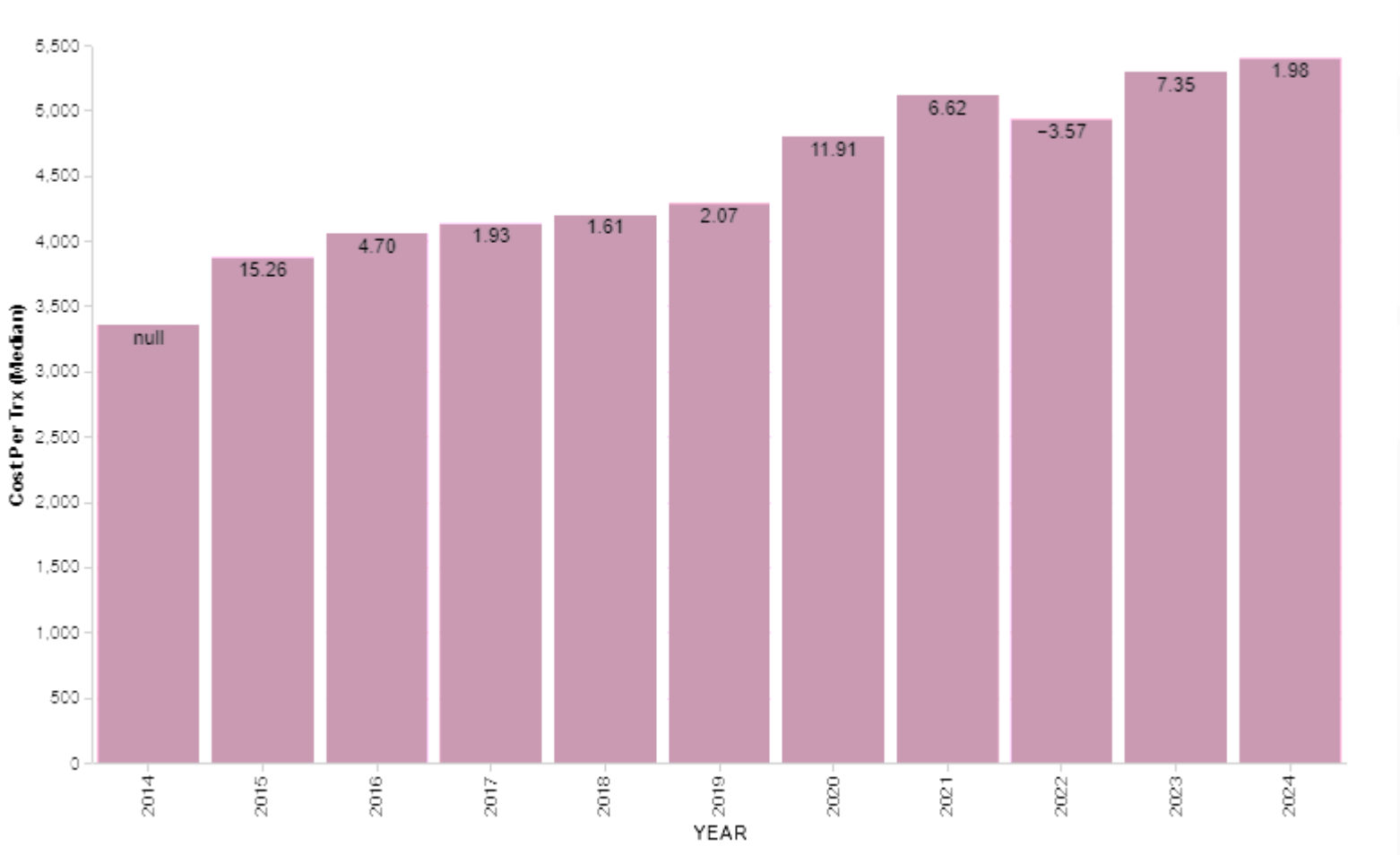
- Medical supply has shown significant increase in making up portion of the hospitalization charges for management of acute appendicitis with appendicectomy.
- Equipment (surgical equipment) has also shown increasing in trend in term of contributor to total bill for appendicectomy.

Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Non-Surgical (SN)

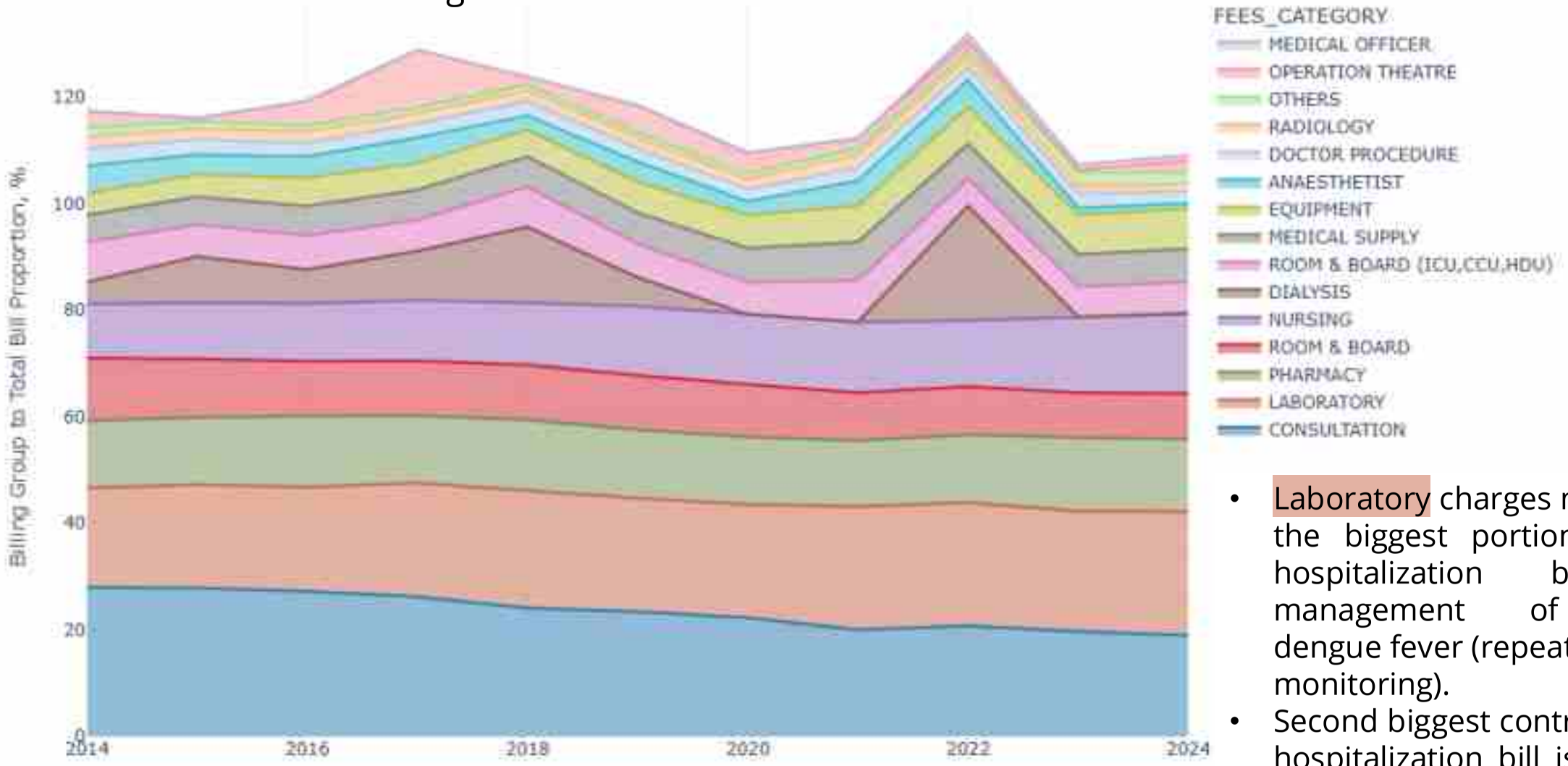


3. Dengue Fever (ICD-10 : A90) - SN



- A total of 20,386 cases involving dengue fever managed by PMCare from the year 2014 to 2024.
- Total median cost for management of acute dengue fever, with length of stay aggregated at 3 days shown increased from RM3500 to RM5400.
- Highest increase seen between year 2019 and year 2020 with 11.91% increases seen.

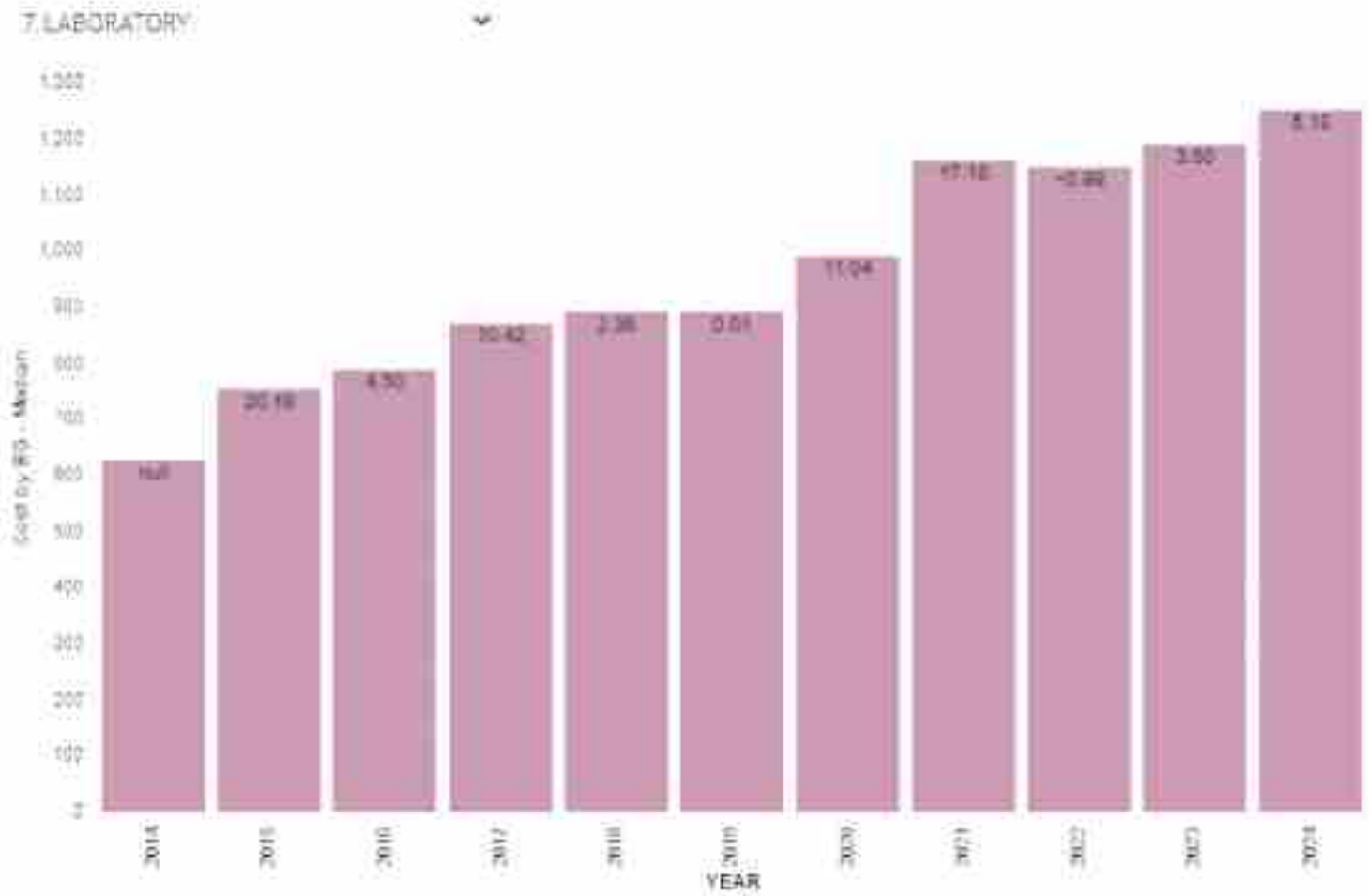
Dengue fever 2014 – 2024 YOY



- Laboratory charges makes up the biggest portion of the hospitalization bill for management of acute dengue fever (repeated blood monitoring).
- Second biggest contributor to hospitalization bill is nursing fee.

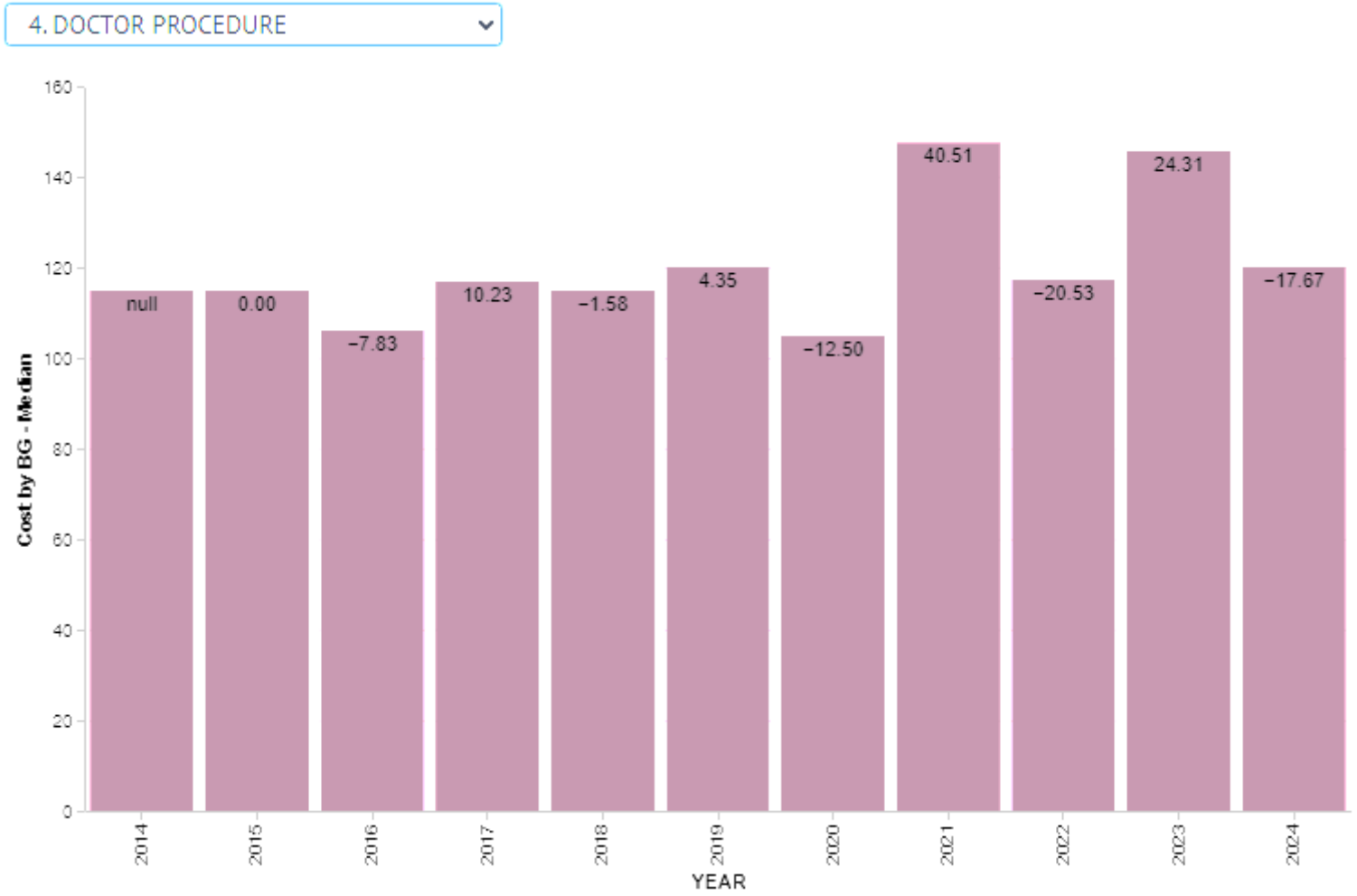
Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Dengue fever 2014 – 2024 YOY
Laboratory Billing Group



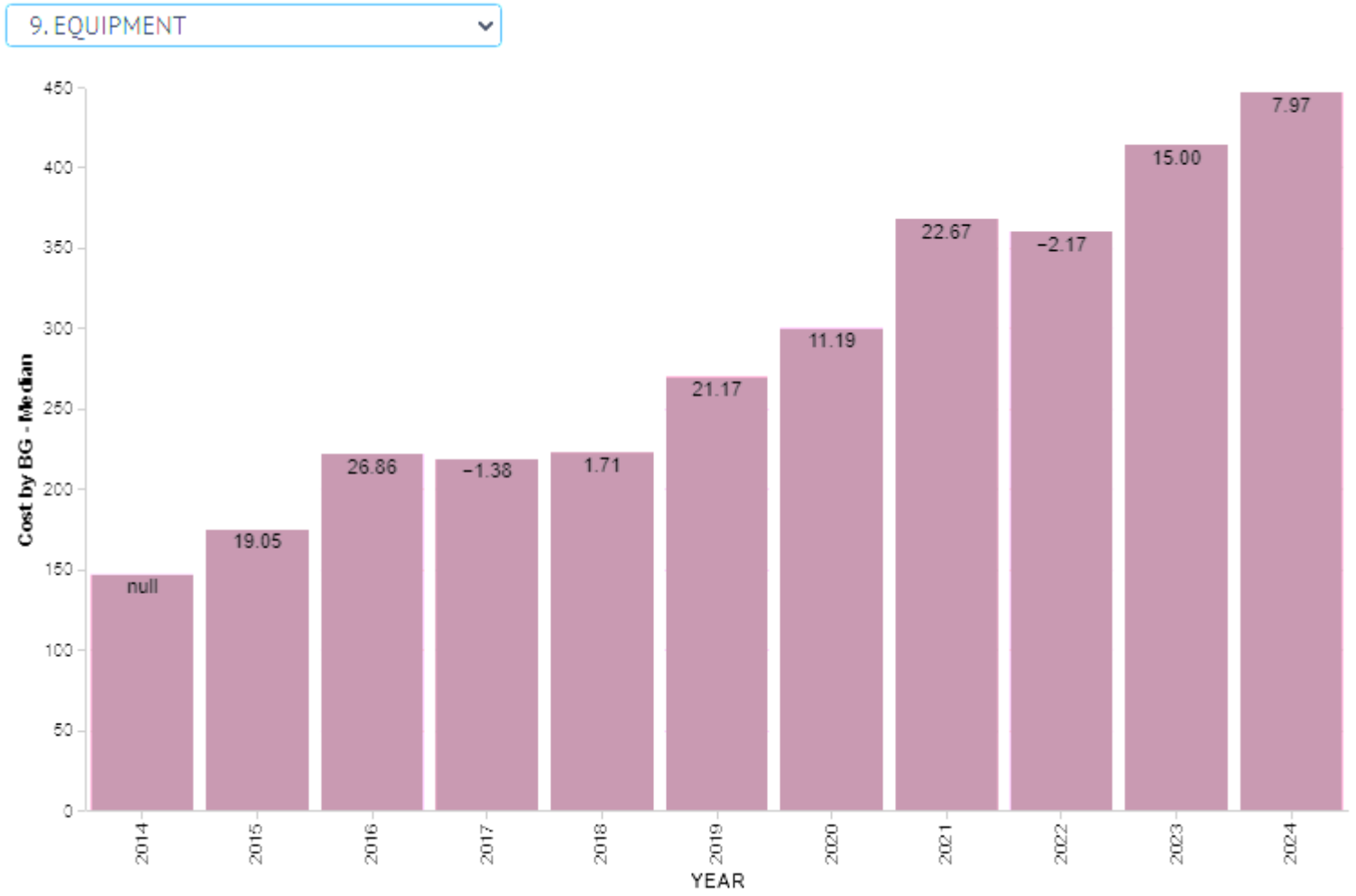
- Laboratory charges has steadily increased from 2014 to 2024, with the total median charges increased from RM 629 in 2014 to RM1250 in 2024

Dengue fever 2014 – 2024 YOY
Doctor Procedure Fees Billing Group



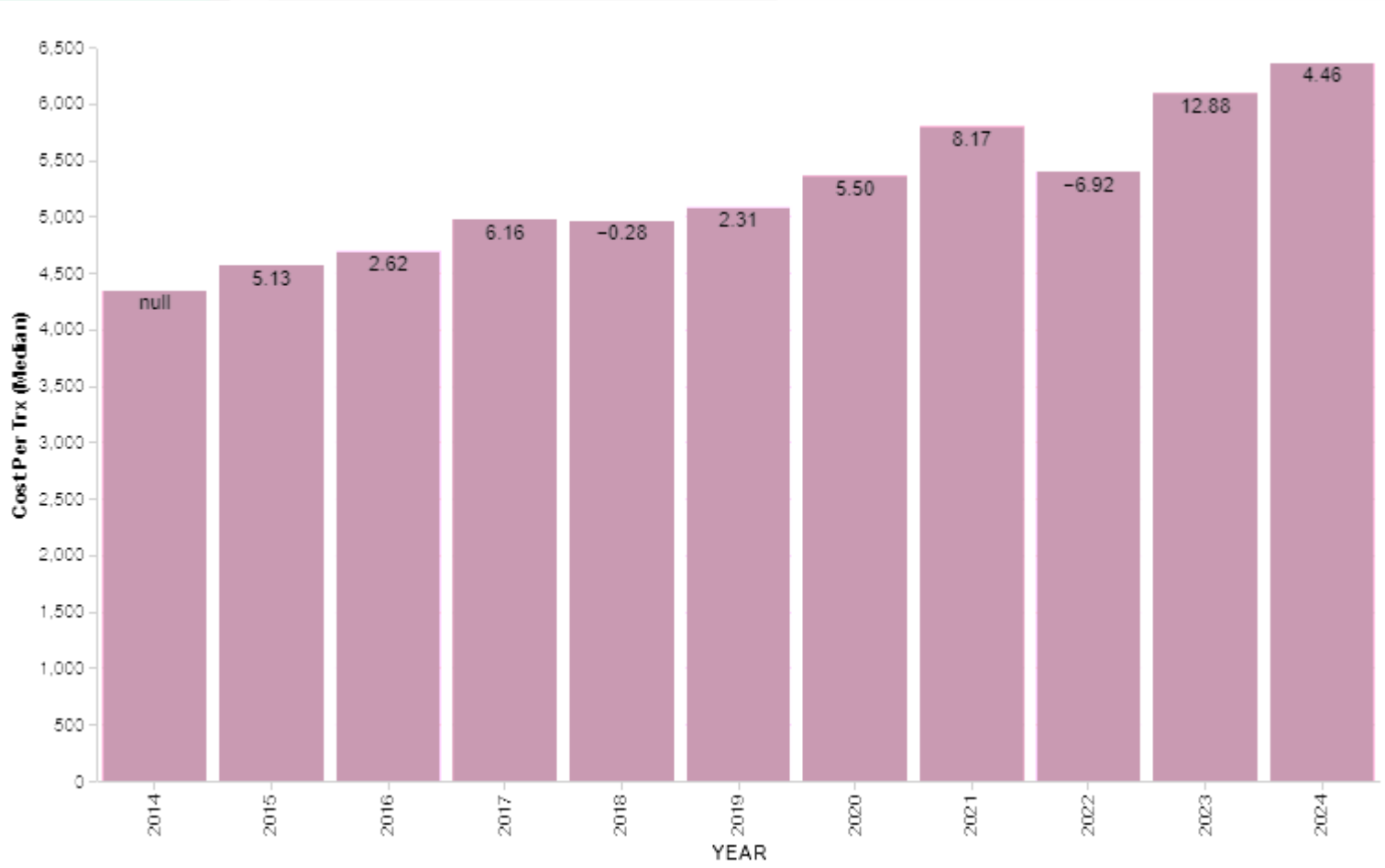
- Doctor's charges (consultation, procedure) in overall management of acute dengue fever has been relatively unchanged from 2014 to 2024, with total median charges for doctor's fee ranging from RM118 to RM144 since the past 10 years.

Dengue fever 2014 – 2024 YOY
Equipment Billing Group



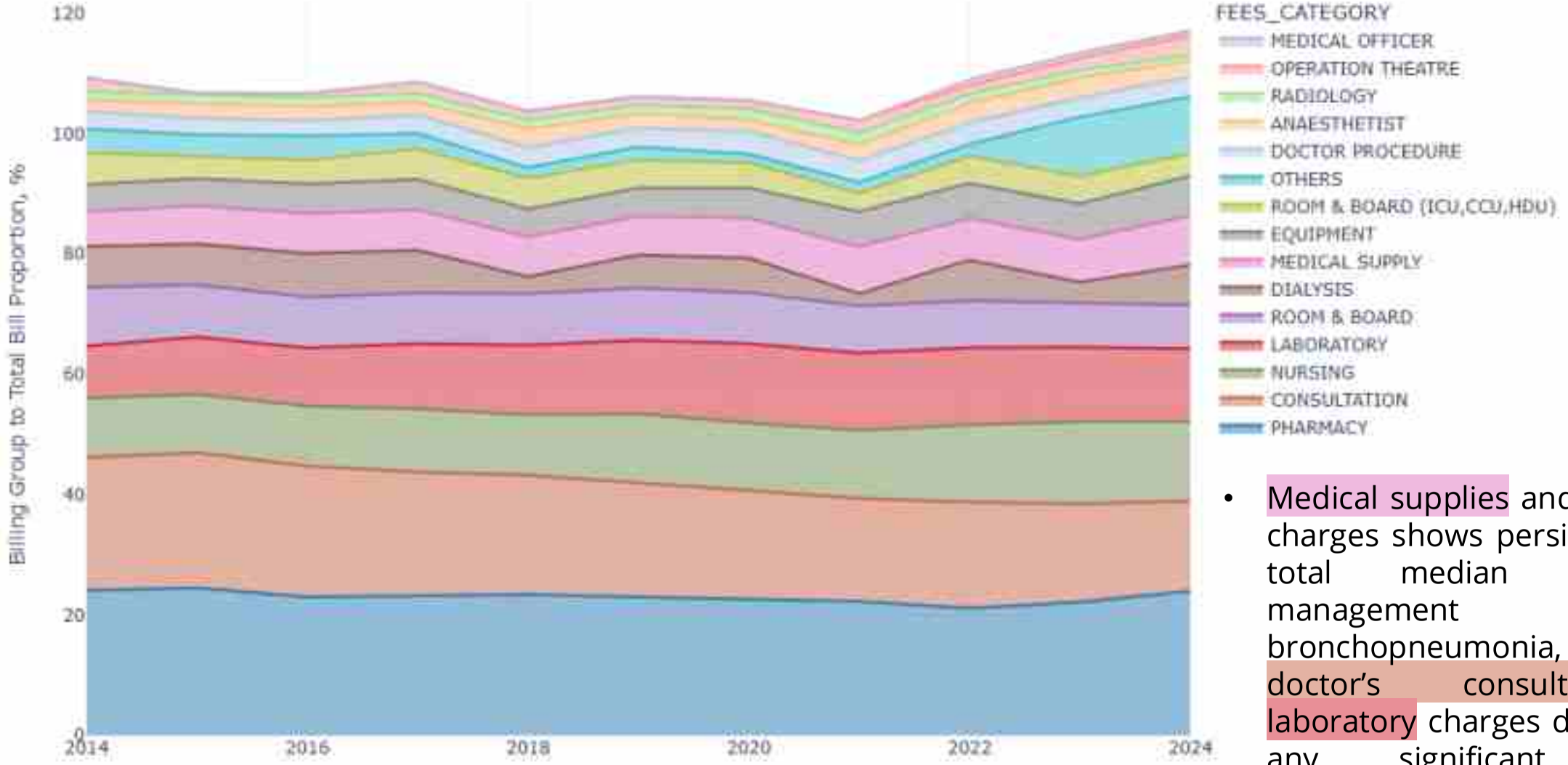
- Despite taking a relatively small portion of the total hospitalization charges, equipment (vital signs monitor, infusion sets, tube connector) has seen steep increases in overall cost for the past 10 years, with total median of RM150 in 2014 to RM450 in 2024.
- Highest increase recorded between year 2020 to 2021 with 22.67% increase.

4. Pneumonia (ICD-10 : J18) - SN



- A total of 20,953 transaction of adult bronchopneumonia cases managed by PMCare from 2014 to 2024.
- The total median cost for managing bronchopneumonia with a 3-day hospital stay has shown a gradual increase, rising from RM4,400 in 2014 to RM6,400 in 2024.

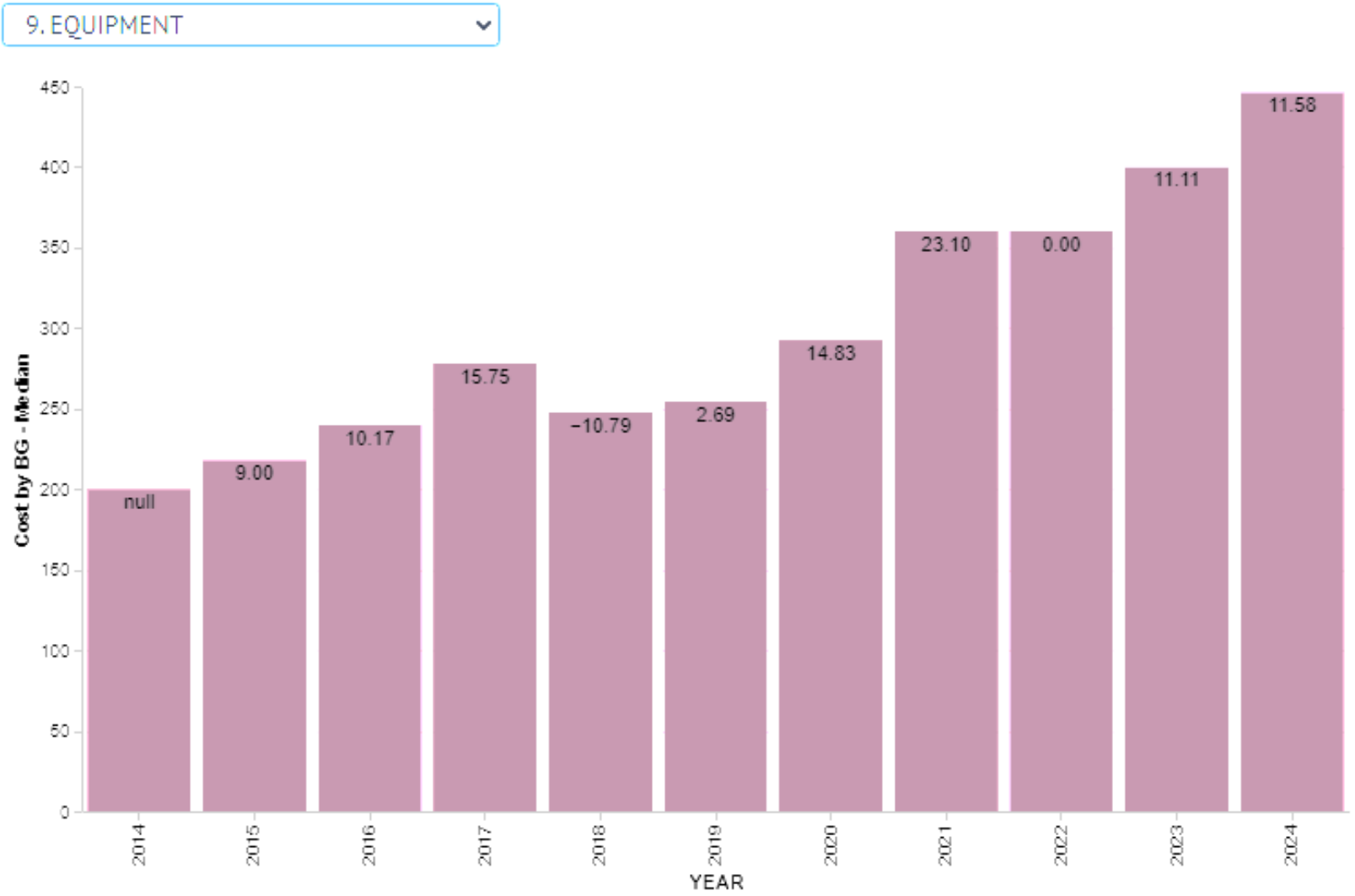
Pneumonia 2014 – 2024 YOY



- Medical supplies and equipment charges shows persistent rise in total median cost for management of bronchopneumonia, while doctor's consultation & laboratory charges did not show any significant changes throughout the decade.

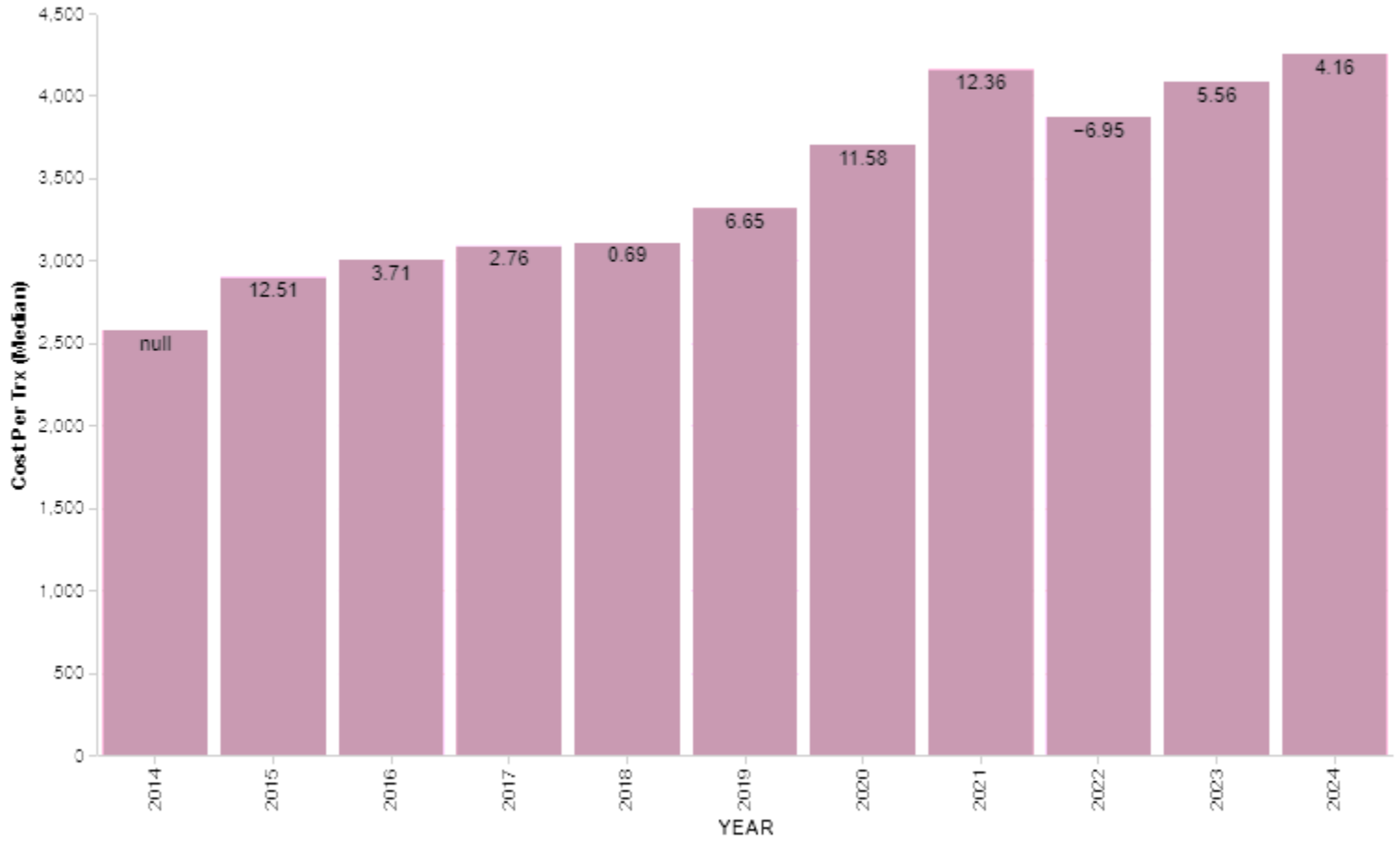
Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Pneumonia 2014 – 2024 YOY
Equipment Billing Group



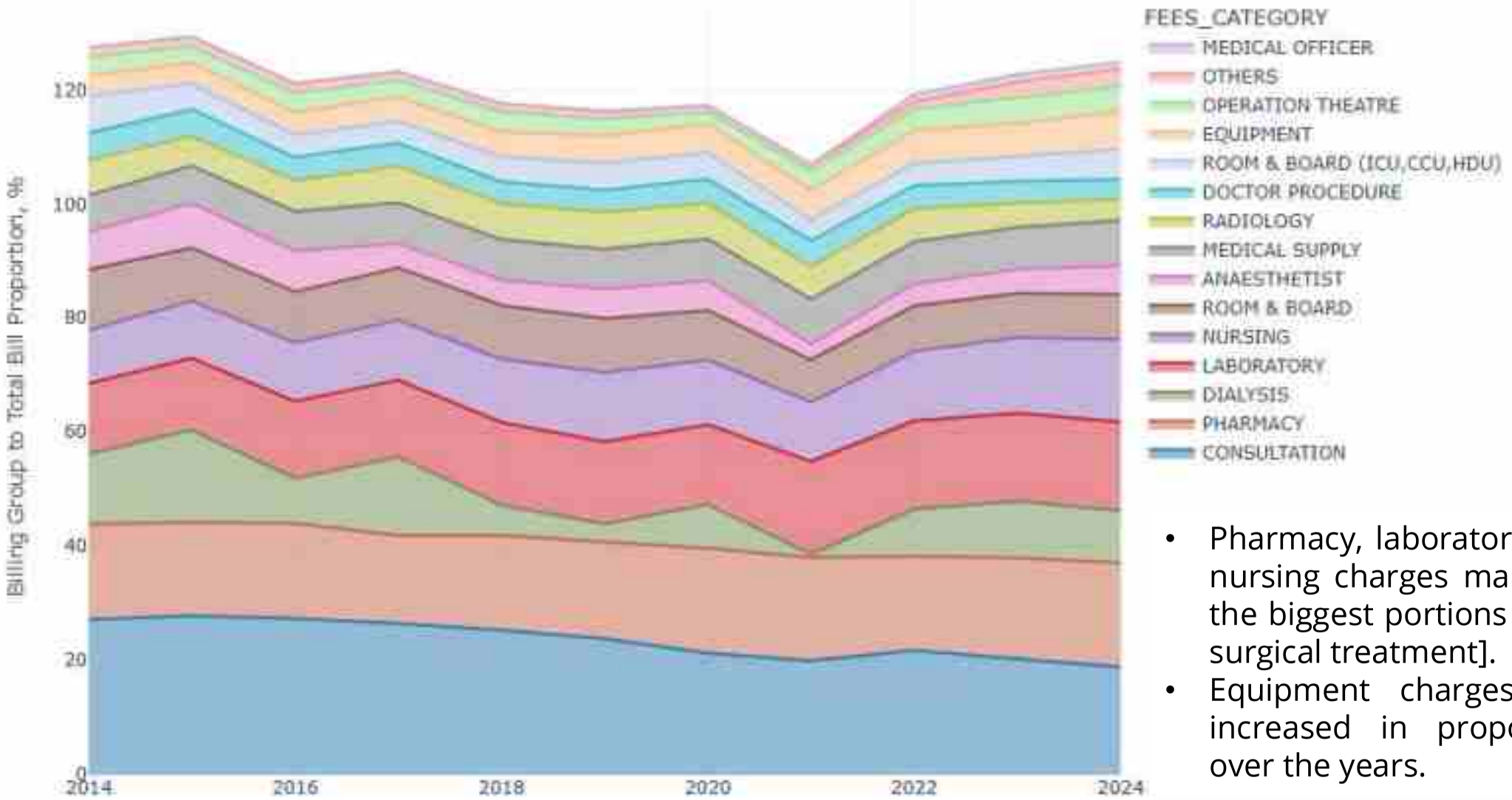
- Total median cost for Equipment shows consistent increment year on year, from RM200 in 2014 to RM450 in 2024.
- Highest increase seen between year 2020 and 2021, with 23.1% rise seen.

5. Acute Gastroenteritis (ICD-10 : A09) - SN



- A total of 28,838 cases of Acute gastroenteritis (AGE) managed by PMCare from 2014 to 2024.
- Total median cost of managing AGE, length of stay aggregated to 2 days increased from RM2,500 in 2014 to RM4,200 in 2024.
- The sharpest increase occurred between year 2020 and year 2021, with a rise of 12.36% seen.

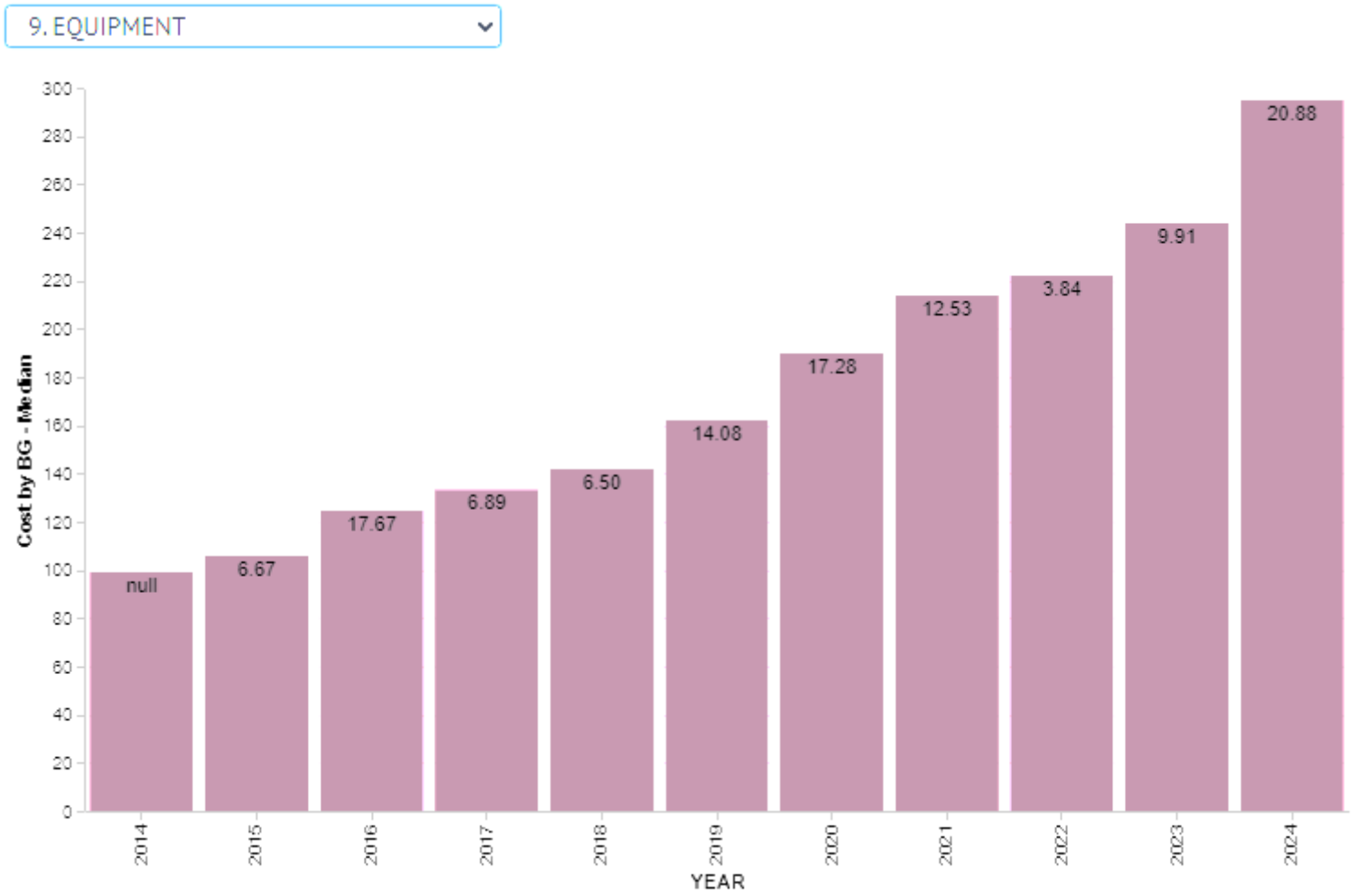
Acute Gastroenteritis 2014 – 2024 YOY



- Pharmacy, laboratory and nursing charges make up the biggest portions [non-surgical treatment].
- Equipment charges has increased in proportion over the years.

Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Acute Gastroenteritis 2014 – 2024 YOY
Equipment Billing Group



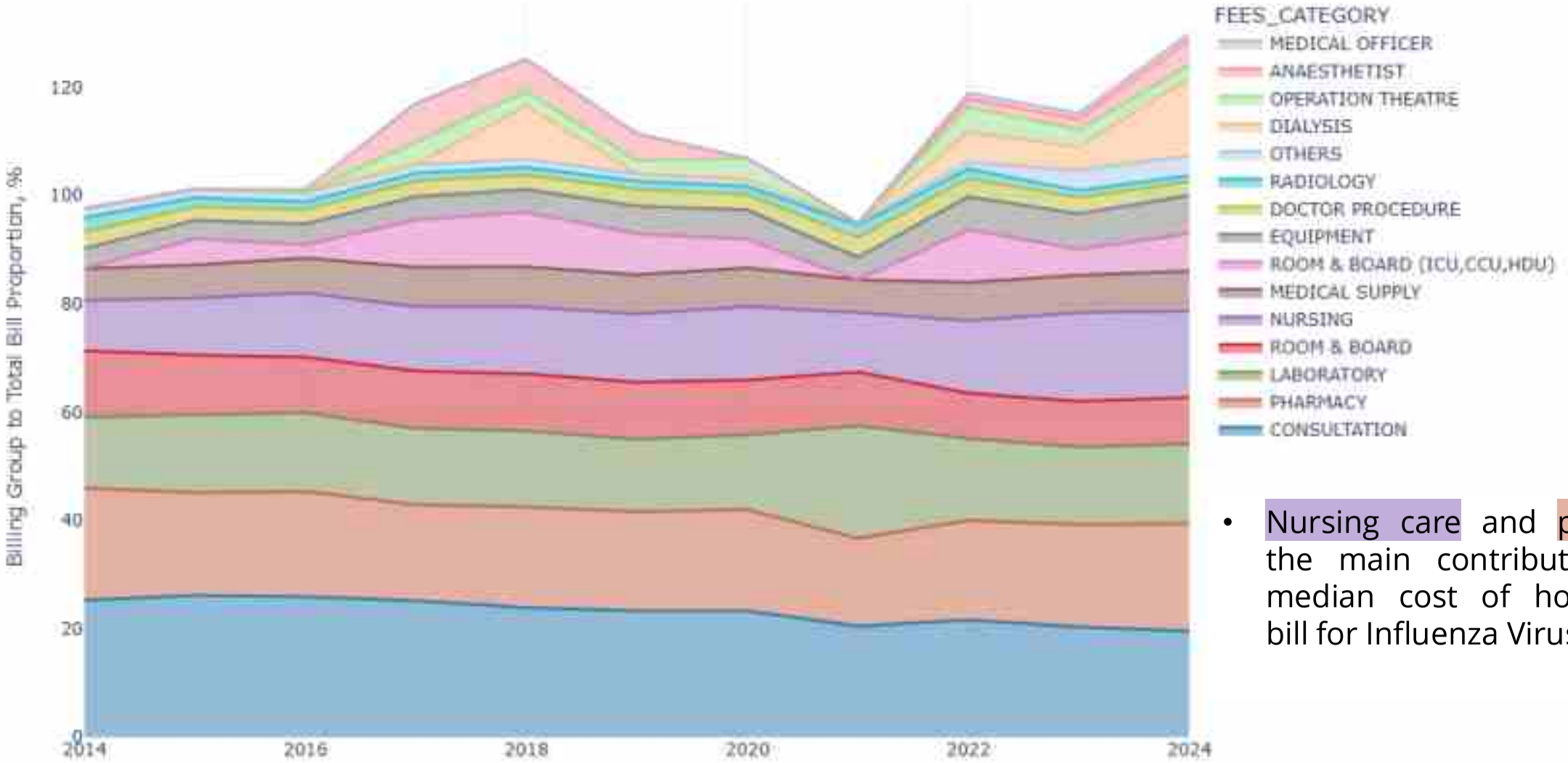
- Total median cost of equipment shows steep increase from year 2014 to year 2024, with total median cost of RM100 in 2014 to RM300 in 2024.
- Highest increase seen between year 2023 and 2024, with 20.88% increase seen.

6. Influenza Infection (ICD-10 : J09, J11.8)- SN



- A total of 7,774 Influenza Virus Infection (Influenza A, Influenza B, Parainfluenza) transaction recorded by PMCare from 2014 to 2024.
- Total median cost for management of Influenza Virus Infection, length of stay aggregated to 3 days ranging from RM3,000 in 2014 to RM4,500 in 2024.

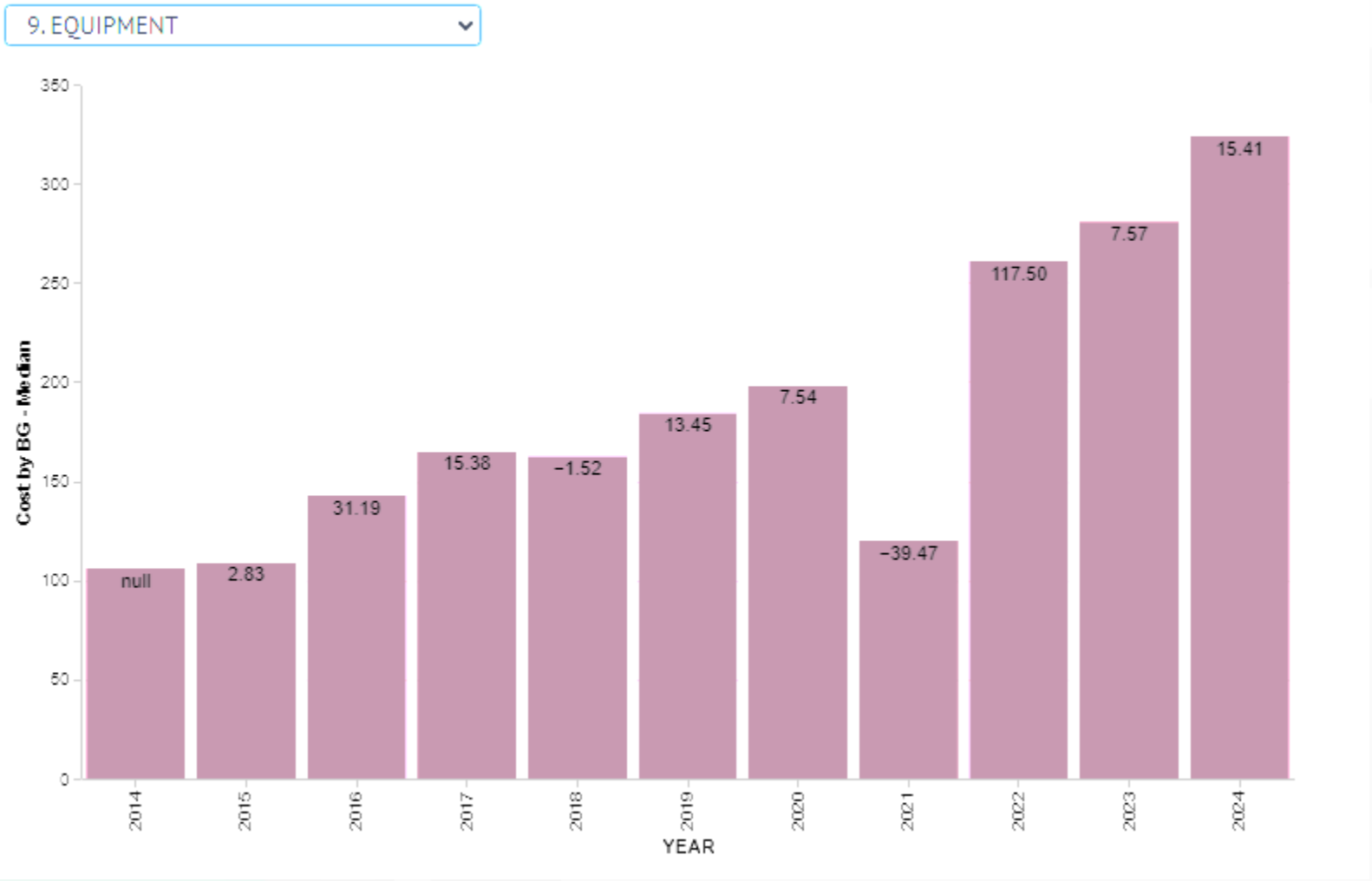
Influenza Infection 2014 – 2024



- Nursing care and pharmacy is the main contributor of total median cost of hospitalization bill for Influenza Virus Infection.

Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Influenza Infection 2014 – 2024 YOY
Equipment Billing Group

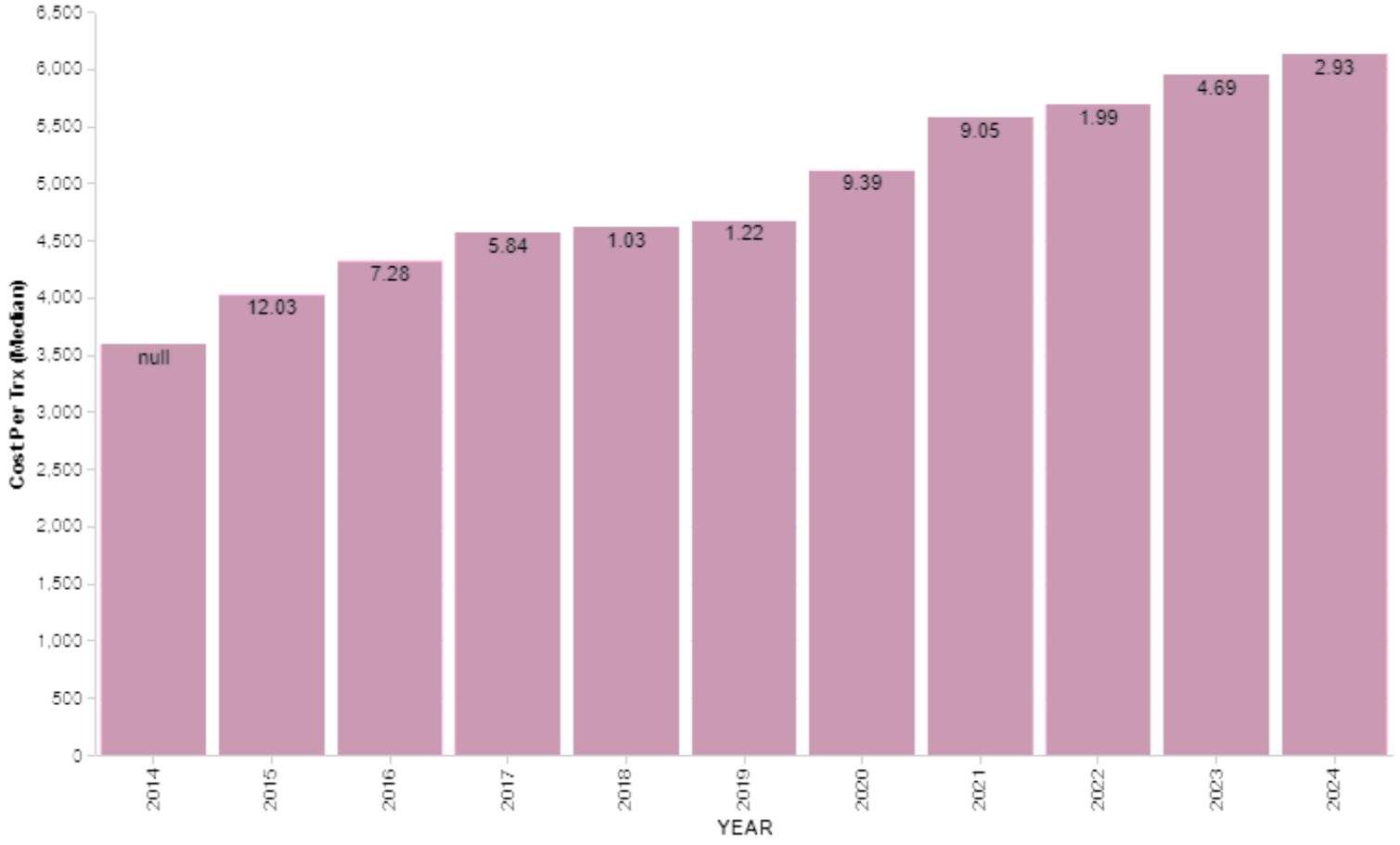


- Total median cost of Equipment in managing Influenza Virus Infections has tripled from RM100 in 2014 to RM330 in 2024.
- Highest increase recorded between year 2021 to year 2022 with 117.5% increase seen.



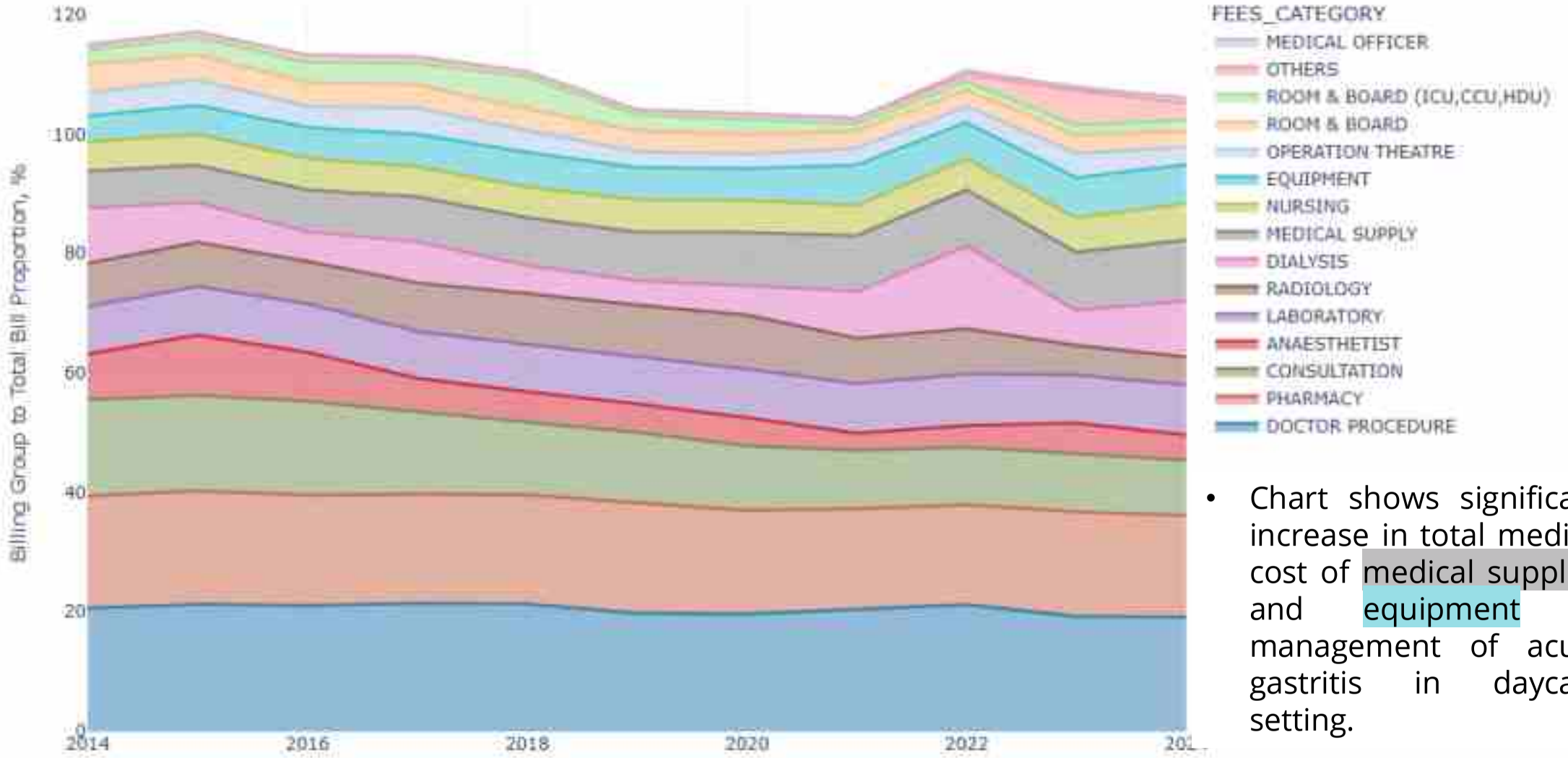
Non-Surgical (SN) + Surgical (SG)

7. Gastritis (ICD-10 : K29) – SN + SG



- A total of 15,238 transactions involving acute gastritis has been managed by PMCare from 2014 to 2024.
- Total median cost for acute gastritis, length of stay aggregated to 0 (daycare cases) ranging from RM3,500 in 2014 to RM6,100 in 2024.

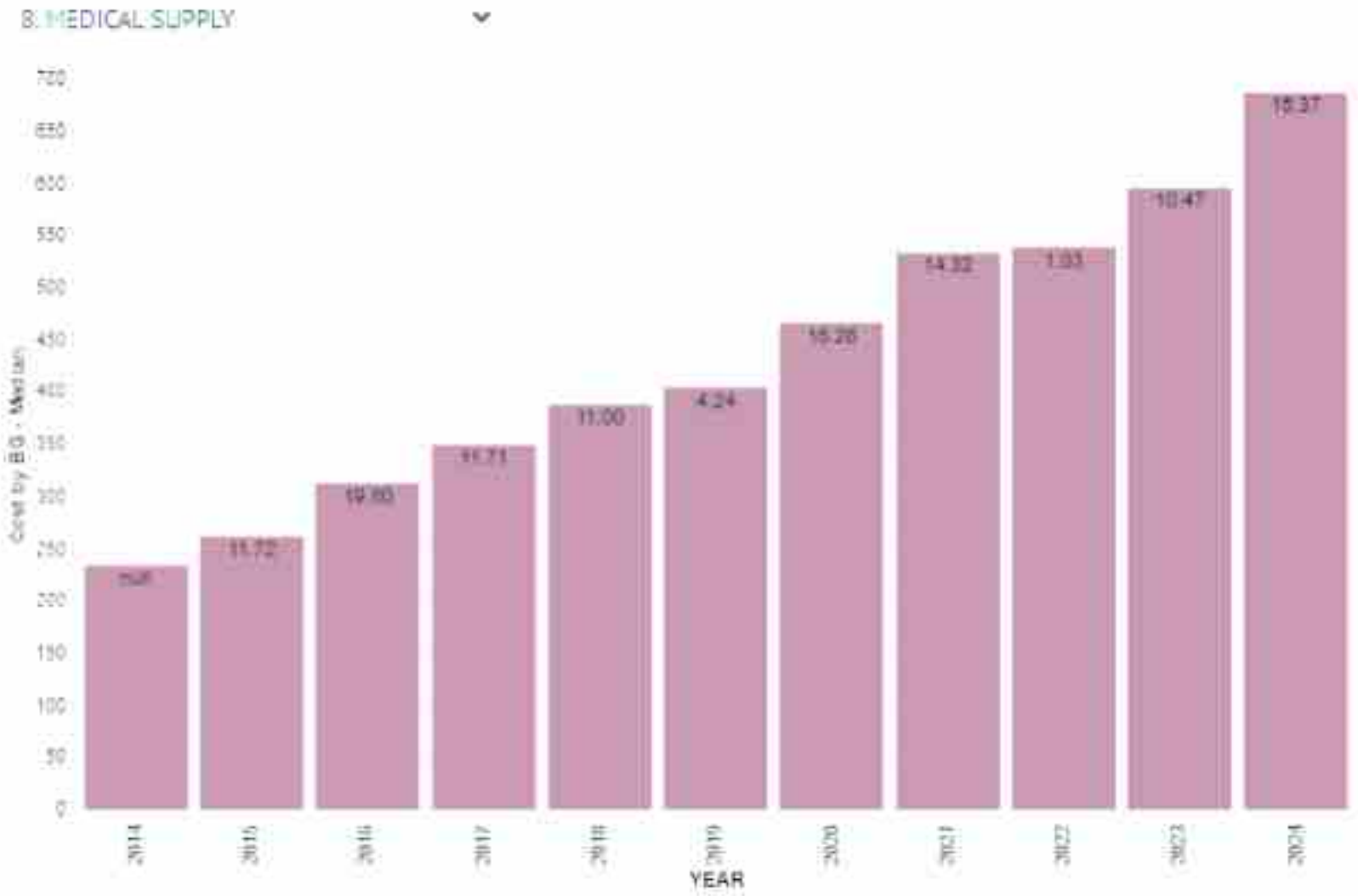
Gastritis 2014 – 2024 YOY



- Chart shows significant increase in total median cost of medical supplies and equipment in management of acute gastritis in daycare setting.

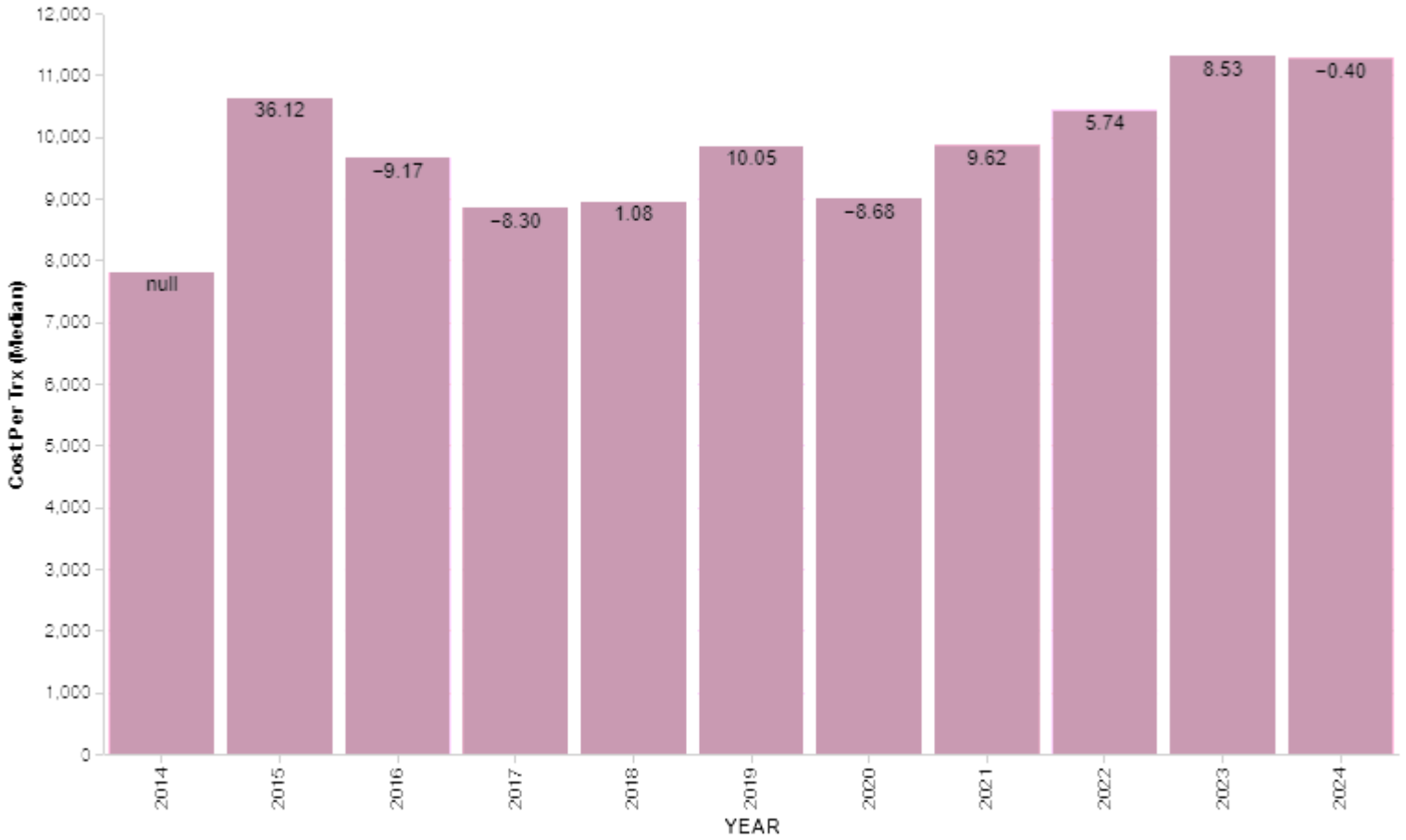
Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Gastritis 2014 – 2024 YOY
Medical Supplies Billing Group



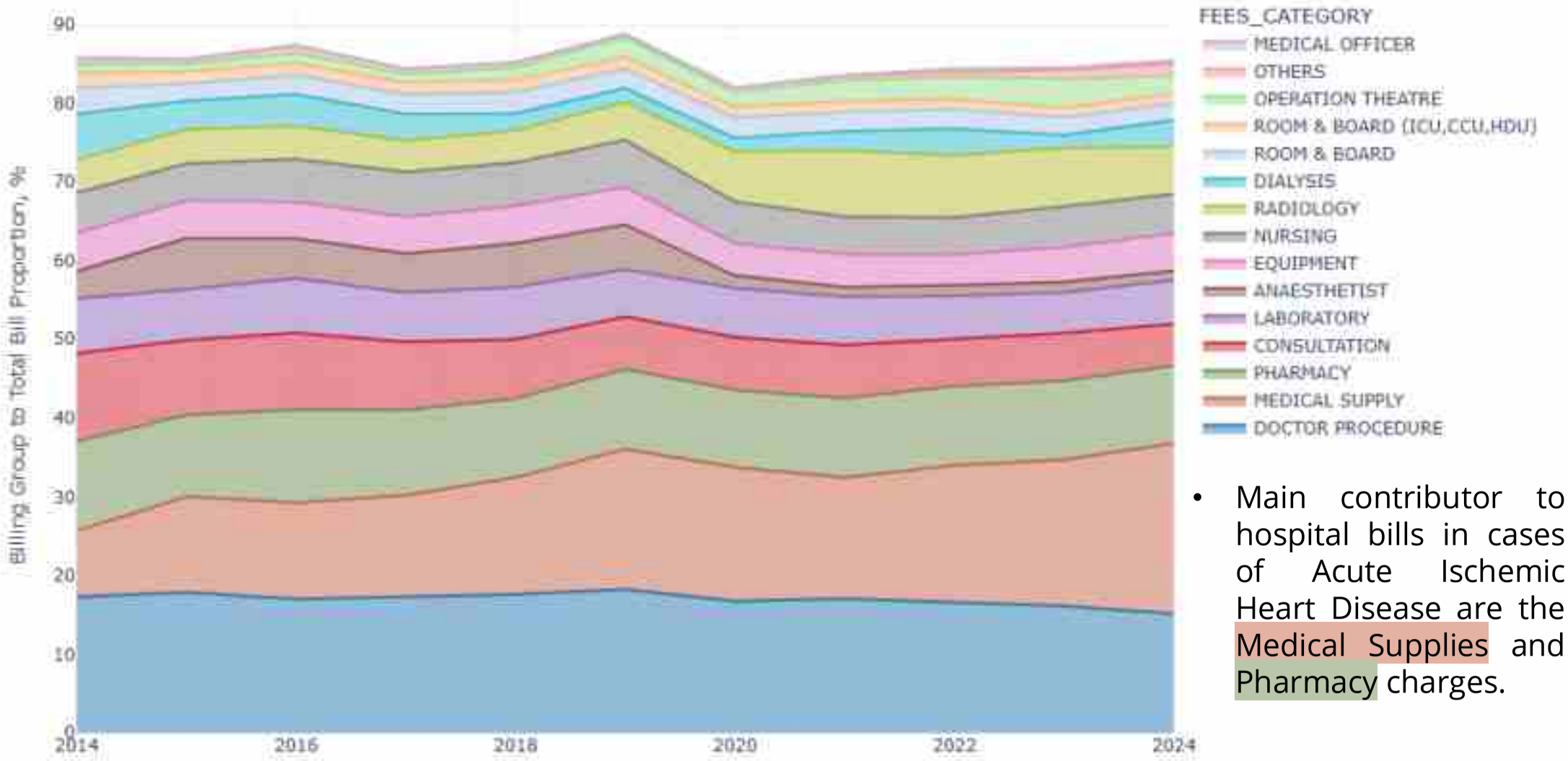
- Total median cost of medical supplies has more than doubled for management of acute gastritis in daycare setting from RM240 in 2014 to RM700 in 2024.
- Biggest increase seen between year 2015 and year 2016 with 19.6% increase seen.

8. Ischemic Heart Disease (ICD-10 : I24, I25) – SN + SG



- There are a total of 14,672 cases of IHD registered in PMCare's system for the past 10 years (2014-2024).
- Total median cost for management of Ischemic Heart Disease for the past 10 years has been well controlled between 1% to 10%.
- Total median cost for management of ischemic heart disease, aggregated to 4 days of stay is in between RM8,000 in year 2014 to RM11,000 in year 2024.

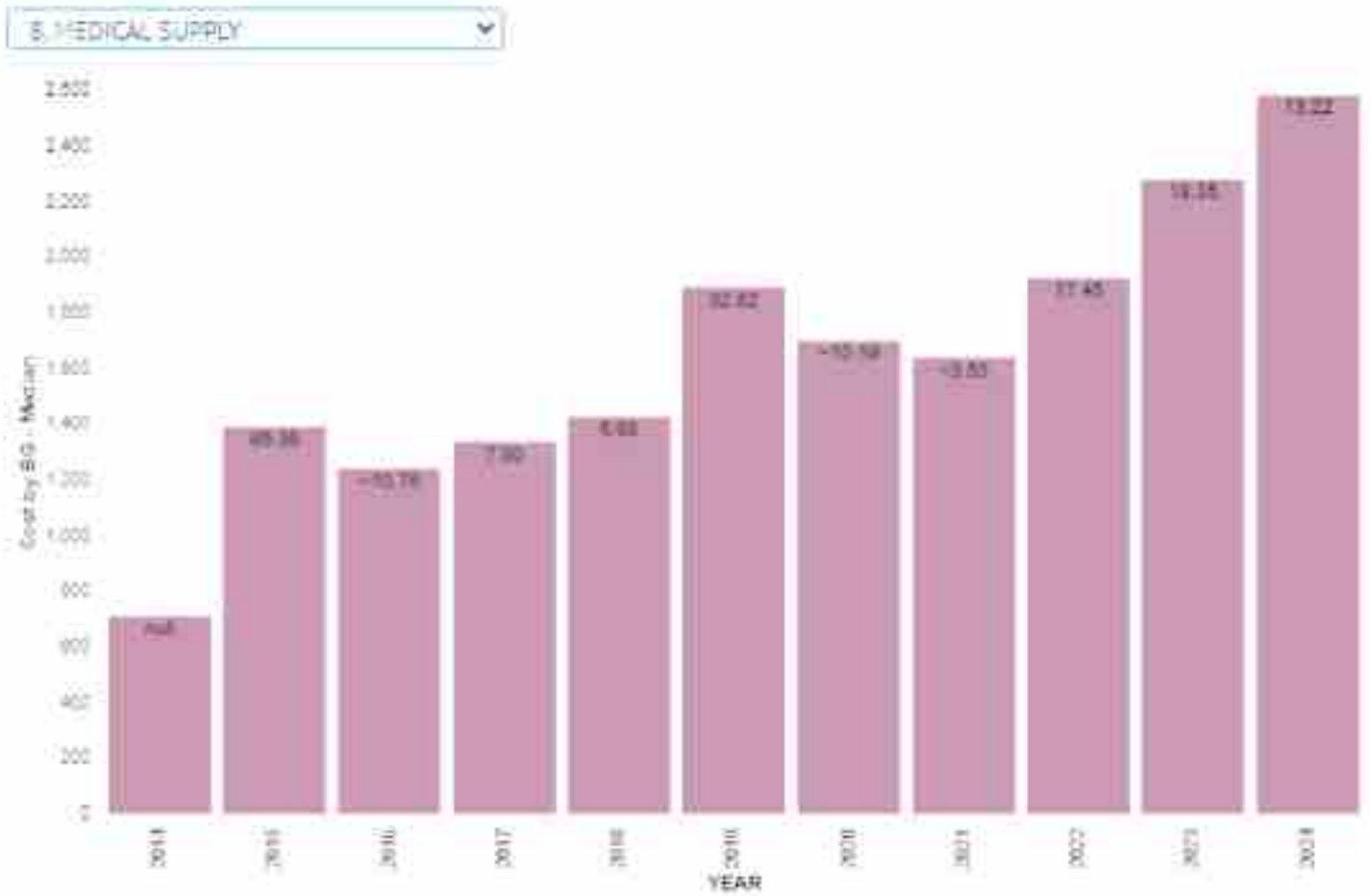
Ischaemic Heart Disease 2014 – 2024 YOY



- Main contributor to hospital bills in cases of Acute Ischemic Heart Disease are the Medical Supplies and Pharmacy charges.

Note: While each individual claim sums to 100%, the median proportions across claims may not, as medians are calculated independently for each billing group and do not preserve totals.

Ischaemic Heart Disease 2014 – 2024 YOY
Medical Supplies Billing Group



- Total median cost of management of Ischemic Heart Disease had increase from RM750 in 2014 to RM2,600 in 2024.
- Sharpest increase recorded between year 2018 and year 2019 with 32.62% increase seen.
- Medical supplies include coronary stents, cath-lab supplies

Challenges as TPAs

- Increasing in prevalence of chronic disease
  - Chronic diseases requires frequent inpatient and outpatient care, long standing medications use which is cost consuming.
  - Repetitive utilization patterns, especially among high-risk group inflating the average medical cost.
- Medication price variability
  - Medications with the same generic content priced differently across manufacturer/license holder.
  - Standard and transparent medication pricing seen as the leading solution for the problem.
- Overutilization of Medical Services
  - Employees with guaranteed medical benefits seek repeated treatment within their allocations.
  - TPAs faces with challenge to control despite stringent utilization reviews and claim audits.
- Poor health literacy and prevention
  - Preventive screenings and health awareness among Malaysian remains low, leading to late-stage diagnosis.
  - Delayed detection leading to higher claims incurred due to higher severity and cost at point of treatment.
  - Behavior of ‘health-care’ should take precedent as opposed to ‘sick-care’.

Conclusion

- The rise in total cost of medical supplies and equipment seen as the main cost driver for rise in total median cost of management of sick care in Malaysia.
- Doctor's fee has been unchanged since 2014 and has been well controlled due to strict adherence to Schedule 13th of Private Healthcare Facilities and Services Act 1998 (Amendment 2012).
- Multiple factors can be identified as the leading cause for the rise in total cost of medical supplies and equipment, including (but not limited to);
    1. Relatively weak currency – Up to 80% of medical supplies and equipment used in public and private healthcare facilities are imported from overseas.
    2. Advancement in medical technology – Introduction of new and advanced medical device, including diagnostic and treatment tools improve care but come with high development, research and implementation cost.
    3. Increased use if healthcare services – Growing awareness and access lead to more people seeking medical care, causing overuse of medical tests and procedures.
- Increasing Cost-to-treat e.g. price of medications, critical medical supplies (stents), new equipment and technology
- Other factors such as ageing population, rise in chronic diseases and better access to healthcare services in private providers cannot be excluded as the identified cost driver in health and sick care.
- Adapting regulations to benefit all the stakeholders especially the patients is needed to manage issues.



Thank you

Malaysian Medical Council
"Safeguarding patients and guiding doctors"

FUNCTION OF THE MALAYSIAN MEDICAL COUNCIL (MMC)





CORPORATE INFO

In the course of providing safe and competent health care services for the country, the Malaysian Medical Council was established by an Act of Parliament approved on 27 September 1971 and gazetted on 30 September 1971.

The Malaysian Medical Council (MMC) became a statutory body through amendments to the Medical Act 1971, specifically in 2012, which led to the gazetting of the MMC as a statutory body on July 1, 2017. This involved replacing the Medical Regulations 1974 with the Medical Regulations 2017.

MALAYSIAN MEDICAL COUNCIL

MOTTO

Safeguarding patients and guiding doctors

MISSION

The principal aim of the MMC is to ensure the highest standards of medical ethics, education and practice, in the interest of patients, public and the profession through fair and effective administration of the Medical Act.

FUNCTIONS OF THE COUNCIL (Section 4, Med. Act)

- To **register** medical practitioners.
- To **regulate** the practice of medicine.

POWERS OF THE COUNCIL (Section 4A, Med. Act)

- Registration or certification of medical practitioners.
- Regulation of the standards of practice of registered medical practitioners; and
- Regulation of the professional conduct and ethics of registered medical practitioners.

CORE FUNCTION

REGISTRATION FOR THE PURPOSE OF PRACTICING MEDICINE IN MALAYSIA:

- To register all **specialists.**
- To maintain a **Register** of medical practitioners & specialists.
- To evaluate and register foreign medical practitioners.
- To evaluate/monitor housemen training & performance under the **Medical Qualifying Committee.**
- To consider cases of mental illness, physical disabilities or competency to ascertain their **Fitness to Practice.**

TO ACCREDIT/RECOGNIZE MEDICAL QUALIFICATIONS, BOTH LOCALLY AND ABROAD IN COOPERATION WITH THE MALAYSIAN QUALIFICATIONS AGENCY (MQA).

TO REGULATE THE CONDUCT AND ETHICS OF REGISTERED MEDICAL PRACTITIONERS.

TO PUBLISH AND UPDATE RELEVANT GUIDELINES ON THE PRACTICE OF MEDICINE IN THE COUNTRY.

TO CARRY OUT SUCH OTHER ACTIONS SO AS TO GIVE EFFECT TO THE MEDICAL ACT 1971.

EXERCISE POWERS & DUTIES BASED ON MA & MR, CPC, GMP, GUIDELINES ETC.



COMPOSITION OF THE COUNCIL (SECTION 3A(1))

PRESIDENT

- DG - ex officio

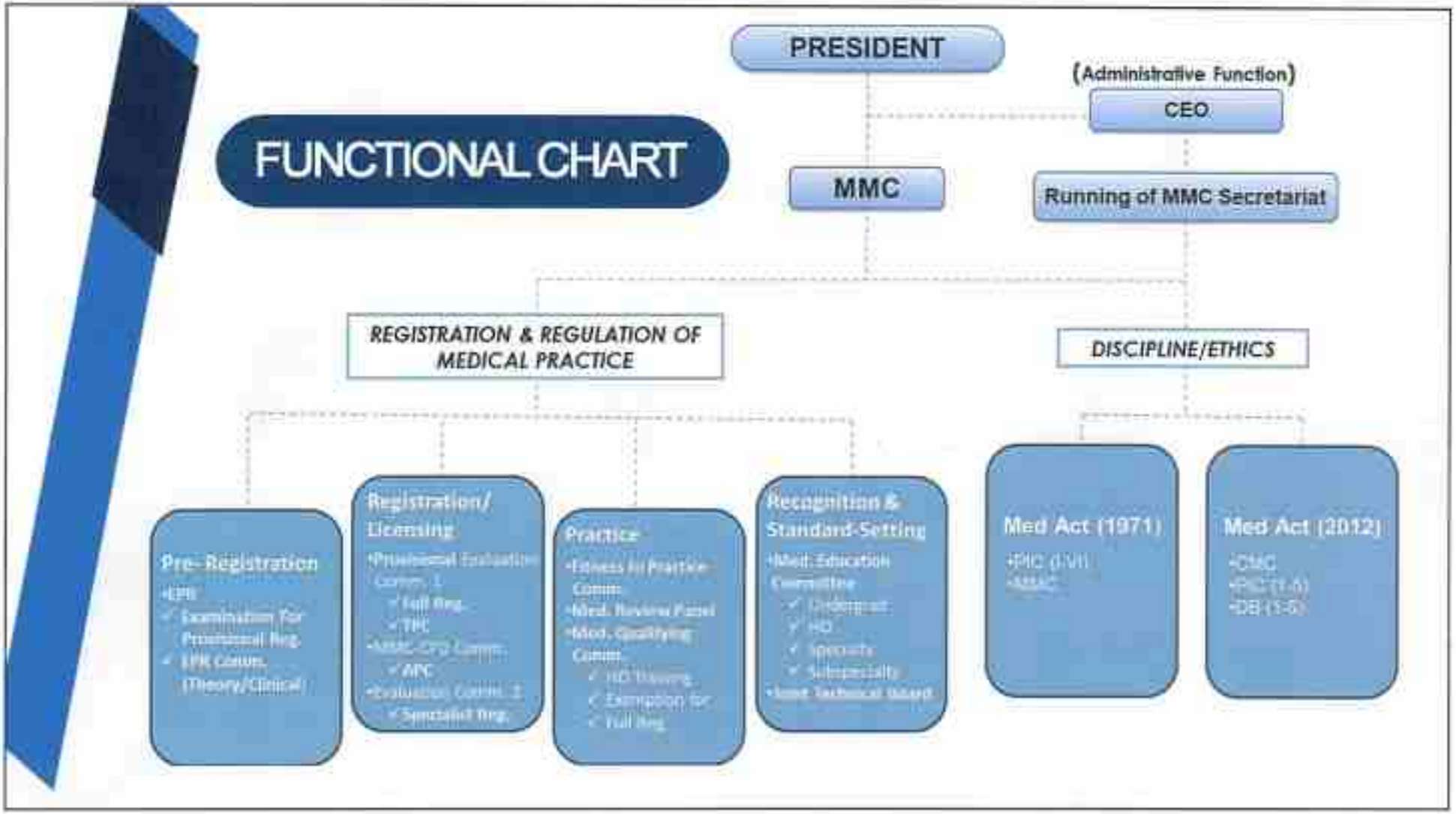
APPOINTED MEMBERS (Appointed by the Minister of Health)

- 9 RMPs from recognized local universities & university colleges - Nominated by the governing bodies of the respective institution
- 3 private RMPs - Nominated by the Council
- 3 public RMPs - Nominated by the Director General

ELECTED MEMBERS

- 15 RMPs from Peninsular Malaysia (9 + 6)
- 1 RMP from Sabah
- 1 RMP from Sarawak

TOTAL = 33 MEMBERS


FUNCTIONAL CHART
PRESIDENT
(Administrative Function)
CEO
MMC
Running of MMC Secretariat
REGISTRATION & REGULATION OF MEDICAL PRACTICE
DISCIPLINE/ETHICS
Pre-Registration
Registration/ Licensing
Practice
Recognition & Standard-Setting
Med Act (1971)
Med Act (2012)



COMPOSITION OF THE MMC

- THE COUNCIL
- THE COMMITTEES
- THE CEO AND THE SECRETARIAT
- THE CHAIRMAN OF COMMITTEES

COMMITTEES UNDER THE MMC

PRE-REGISTRATION

Examination for Provisional Registration Committee
- Main, Theory, Clinical

MEDICAL QUALIFYING

- Jawatankuasa Penilaian 1 (S 14,16)
- Jawatankuasa Penilaian 2 (Specialist and Subspecialty Committee -N5R) (43)

COMMITTEES UNDER SECT POLICY & INT'L DIV

- Jawatankuasa Pemilihan Ahli (JKPA)
- Jawatankuasa Semakan Pencalonan Ahli MPM – IPTA/IPTS
- Jawatankuasa Pembangunan Profesionalisme Pegawai Perubatan (JKPPP) MPM

REGISTRATION/ CERTIFICATION

- Evaluation Committee 1 (Undergraduate)
- Evaluation Committee 2 (Postgraduate/ Specialist)
- MMC-CPD Committee

RECOGNITION/ STANDARD SETTING

- Medical Education Committee (MEC)
- SSC-Edu (29) & Sub SSC-Edu (61)
- Joint Technical Board of MQA (MMC, MOH, JPA, MQA, MOE)

COMMITTEES UNDER SECT ADMIN DIV

- Jawatankuasa Lembaga Perolehan MPM
- Jawatankuasa ICT

FITNESS TO PRACTICE

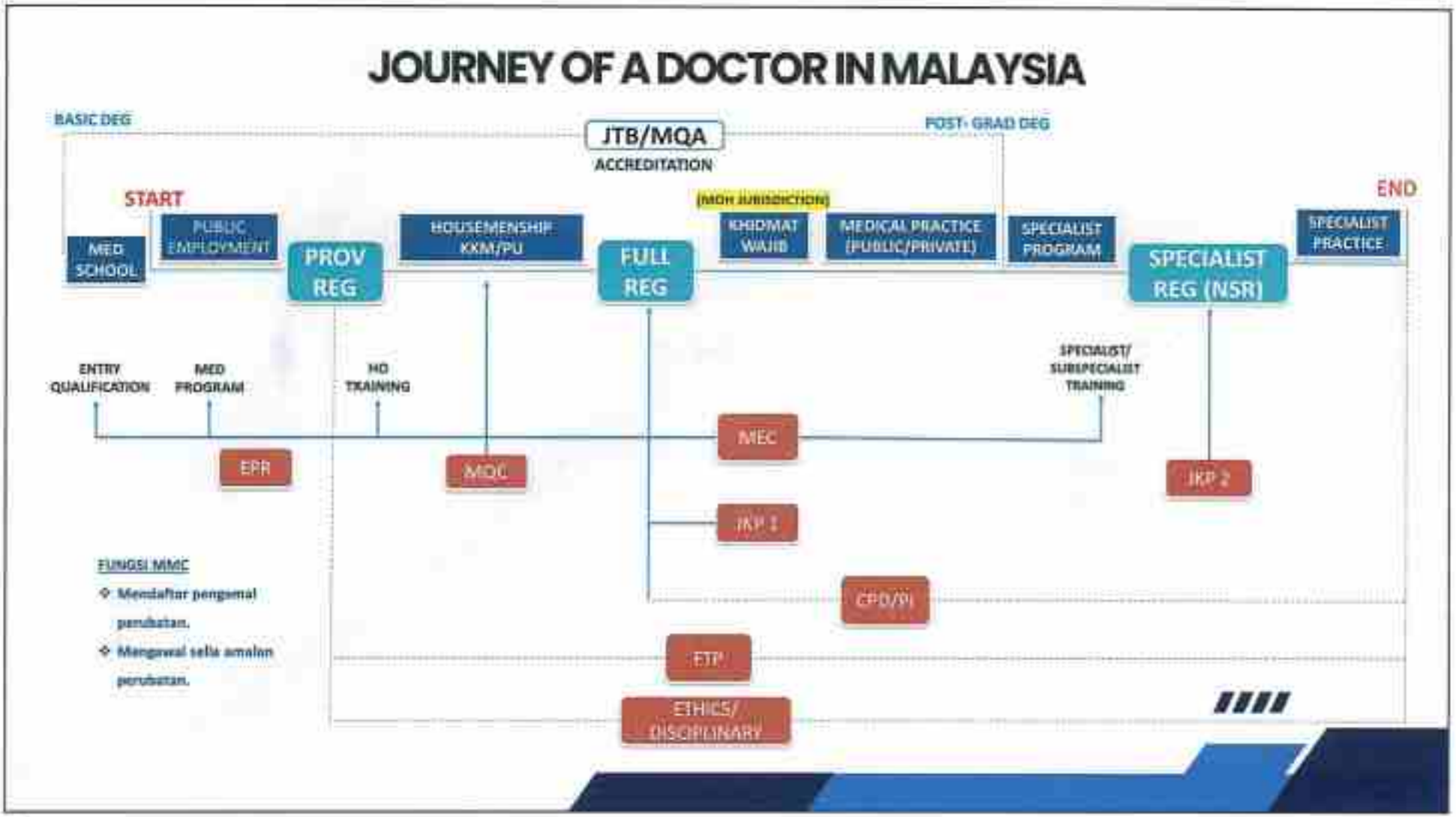
- Fitness to Practice Committee
- Medical Review Panel
- Medical Qualifying Committee

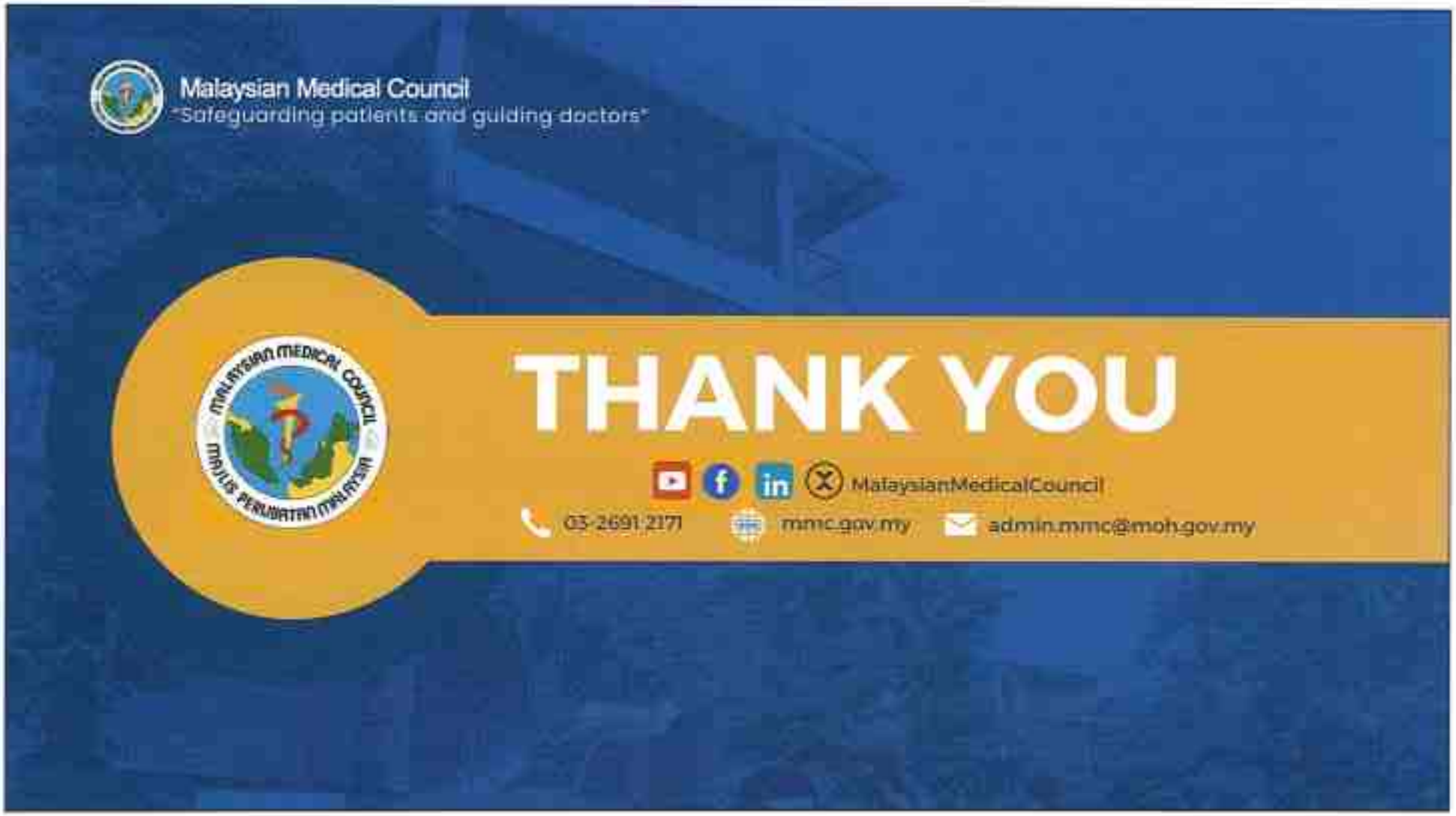
DISCIPLINE/ETHICS

- Ethics Committee & various Committees for MMC Ethical Guidelines
- Draft Charge Committee.
- Under Medical Act 1971: Preliminary Investigation Committees (I-VI)
- Under Medical Act (Amendment) 2012:- Complaints Management Committee
  - Preliminary Investigation Committees (1-5)
  - Disciplinary Board (1-5)

QUALITY MANAGEMENT & AUDIT UNIT

- Jawatankuasa Audit MPM (JAMPM)


JOURNEY OF A DOCTOR IN MALAYSIA
BASIC DEG
JTB/MQA
ACCREDITATION
POST- GRAD DEG
START
END
(MOH JURISDICTION)
MED SCHOOL
PUBLIC EMPLOYMENT
PROV REG
HOUSEMENSHIP KKM/PU
FULL REG
KHIDMAT WAJIB
MEDICAL PRACTICE (PUBLIC/PRIVATE)
SPECIALIST PROGRAM
SPECIALIST REG (NSR)
SPECIALIST PRACTICE
ENTRY QUALIFICATION
MED PROGRAM
HO TRAINING
SPECIALIST/ SUBSPECIALIST TRAINING
MEC
EPR
MOO
IKP 2
IKP 1
CPD/PI
ETP
ETHICS/ DISCIPLINARY
FUNGSI MMC
Mendaftar pengamal perubatan.
Mengawal selia amalan perubatan.


Malaysian Medical Council
"Safeguarding patients and guiding doctors"
THANK YOU
MalaysianMedicalCouncil
03-2691 2171
mmc.gov.my
admin.mmc@moh.gov.my

PEMBENTANGAN KEPADA JAWATANKUASA KIRA-KIRA WANG NEGARA (PAC):

PENINGKATAN BAYARAN INSURANS DAN CAJ HOSPITAL SWASTA SERTA IMPAK KEPADA KESIHATAN AWAM DI BAWAH MOF, MOH & BNM

CADANGAN PROGRAM PERINTIS PERLINDUNGAN BAGI PERUBATAN TEPAT KANSER RAKYAT MALAYSIA

Disediakan Oleh: Malaysian Reinsurance Berhad
Tarikh : 13 Ogos 2025

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Agenda

1 | Profil Syarikat Malaysian Reinsurance Berhad

2 | Cadangan dari Malaysian Reinsurance Berhad

3 | Perubatan Tepat untuk Penyakit Kanser

4 | Kesimpulan

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1. Profil Syarikat Malaysian Reinsurance Berhad

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Tentang Malaysian Re

- Kumpulan MNRB – Struktur Korporat
- Sejarah
- Profil Syarikat
- Perkhidmatan Pasaran
- Program Kesiapsiagaan Negara

Informasi Pasaran

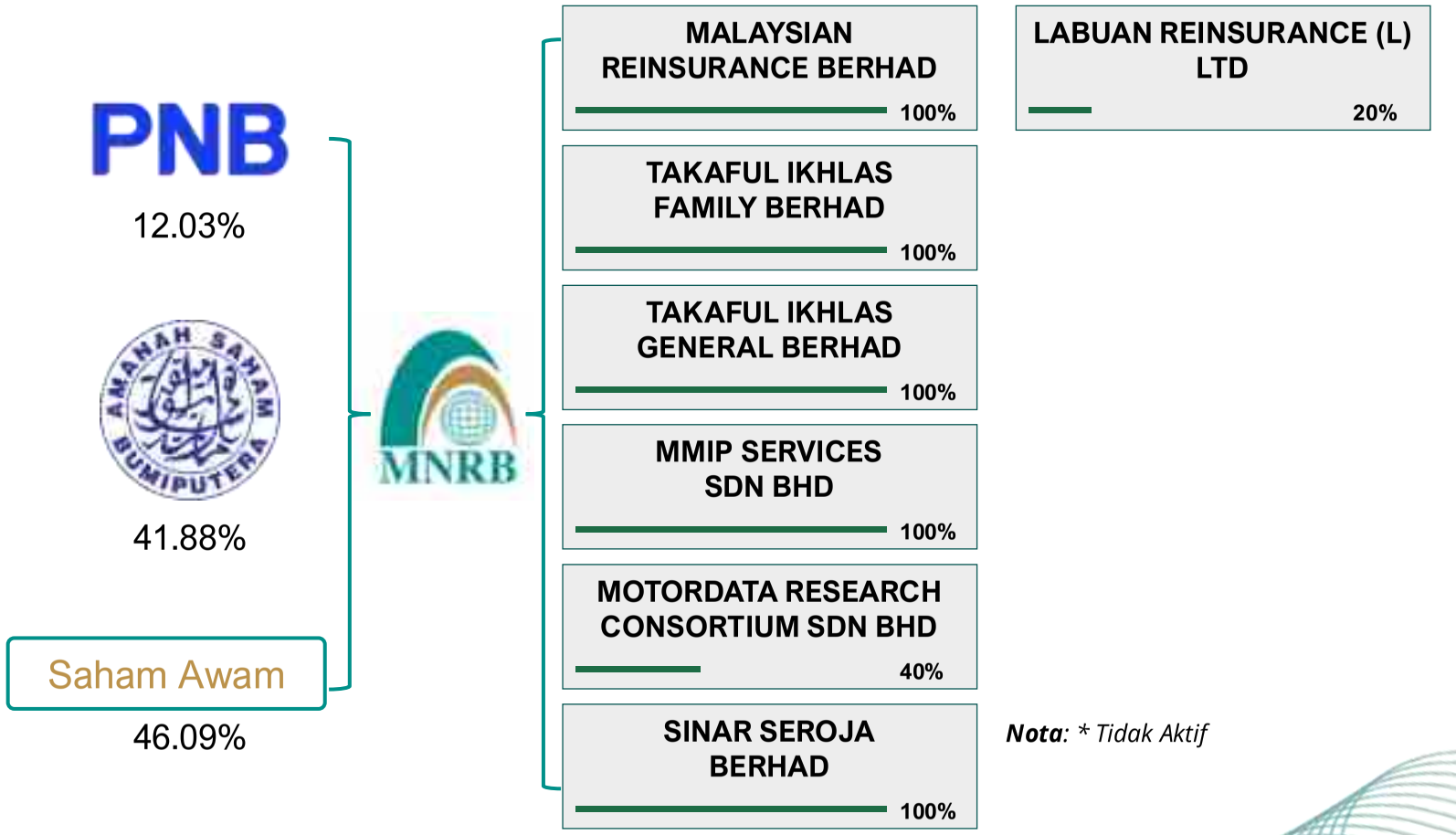
- Pasaran Reinsurans Dunia
- Pasaran Insurans dan Takaful Am
- Pasaran Insurans Hayat & Takaful Keluarga

Tentang Reinsurans

- Reinsurans
- Reinsurans & Insurans
- Kepentingan Reinsurans

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Kumpulan MNRB – Struktur Korporat



***Nota**: * Tidak Aktif*

Setakat 12 Ogos 2025.

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Malaysian Re – Sejarah

August 1973

Malaysian National Reinsurance Berhad (MNRB) telah ditubuhkan oleh kerajaan untuk mengurangkan kebergantungan kepada reinsurans asing.

August 2004

Malaysian Re telah diperbadankan sebagai anak syarikat milik penuh **MNRB Holdings Berhad**

April 2005

Sebagai sebahagian daripada usaha penstrukturan semula Kumpulan MNRB, lesen reinsurans dan aset telah dipindahkan daripada MNRB.

2015

Malaysian Re telah diberikan kelulusan oleh Bank Negara Malaysia untuk menjalankan perniagaan Retakaful Am dan Keluarga di bawah Seksyen 10 Akta Perkhidmatan Kewangan Islam 2013 (IFSA 2013) melalui penubuhan Bahagian Retakaful.

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Malaysian Re – Profil

Perniagaan

- Malaysian Re (MRe) menerima tanggungan insurans bagi **semua kelas perniagaan Re-insurans am** serta **perniagaan Retakaful am dan keluarga** melalui bahagian Retakafulnya.

Kehadiran Pasaran

- MRe telah berkembang sebagai syarikat antarabangsa dengan membina kehadiran pasaran yang kukuh di Asia dan Timur Tengah.
- MRe **adalah syarikat insurans semula nasional terbesar di rantau Asia Tenggara.**

Khidmat Negara

- Menyokong kestabilan pasaran insurans Malaysia dengan menyediakan kapasiti dan kepakaran reinsurans.
- Mengekalkan premium dalam negara, mengurangkan pergantungan kepada peniaga insurans semula asing.
- Menggalakkan pembangunan industri & produk, pertumbuhan takaful, dan analisis data daripada pengalaman antarabangsa.

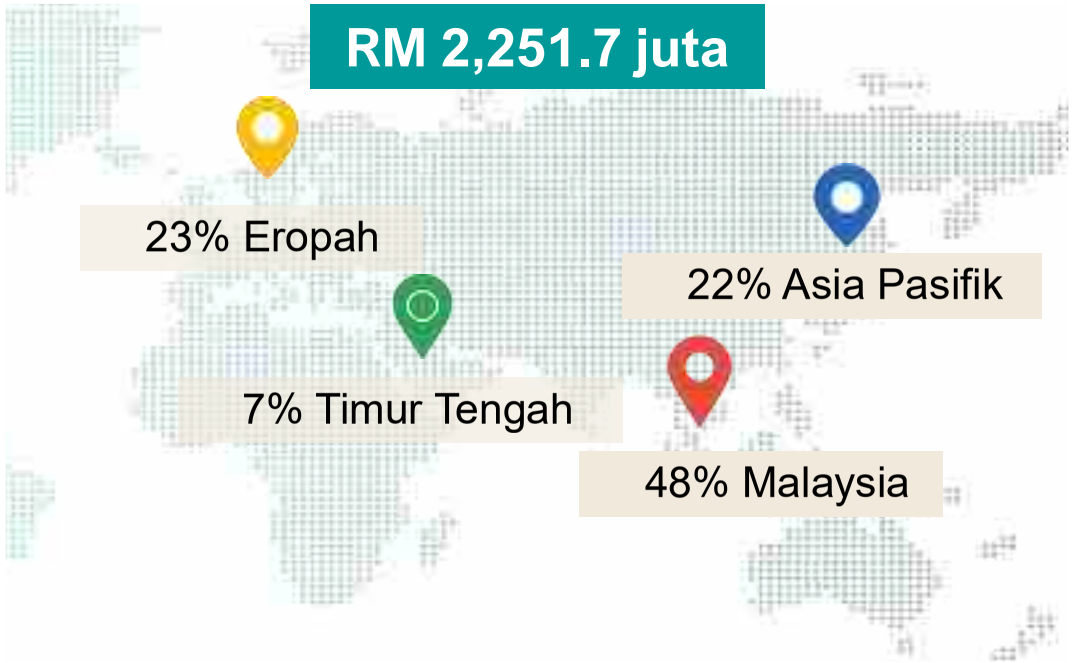
Penarafan & Pengiktirafan

- Kekuatan Kewangan “A” (Kukuh) – Pandangan stabil (Fitch Ratings)
- Kekuatan Kewangan “A-” (Cemerlang) – Pandangan stabil (AM Best)
- Menduduki tempat ke-43 global dan ke-18 di Asia bagi jenama peniagaan reinsurans (NMG Consulting)

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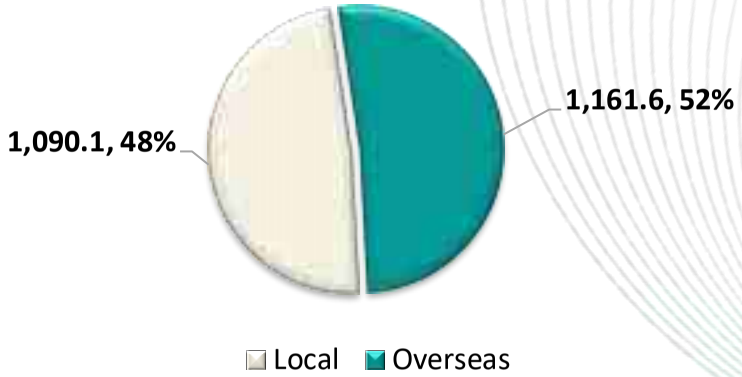
Malaysian Re – Profil

Premium Kasar Malaysian Re mengikut Pasaran bagi Tahun Kewangan Berakhir 31 Mac 2025 (RM juta)

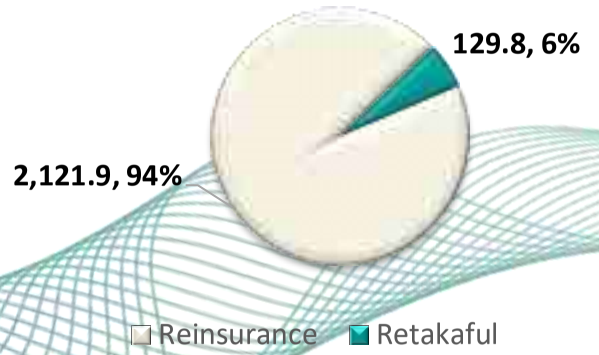


- Malaysian Re telah menerima lebih banyak perniagaan antarabangsa dalam portfolionya sambil mengekalkan kedudukan peneraju domestik.

Premium Kasar mengikut Pasaran FYE 2024/25 (RM juta)



Reinsurance vs Retakaful FYE 2024/25



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Perkhidmatan Pasaran – Projek Khas Nasional

PERLINDUNGAN TENANG VOUCHER (PTV)

- Pengurusan dana dan data PTV
- Sejumlah 1,080,753 baucar telah digunakan, bernilai RM53,903,091.07.

FLOOD RELIEF FUND

- Ditubuhkan oleh PIAM pada Januari 2022 untuk membantu pemegang polisi yang layak dan terjejas akibat banjir Disember 2021 di Malaysia.
- Dilantik oleh PIAM sebagai Pentadbir Dana dan Pejabat Pengurusan Projek (PMO).

COVID TEST FUND (CTF)

- Ditubuhkan oleh PIAM, LIAM & MTA pada April 2020.
- Dilantik sebagai Pentadbir Dana untuk mentadbir dan mengurus CTF.









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Program Kesiapsiagaan Negara
(National Resilience Programs)



SIBER



PERTANIAN



ASET (CECR)



KENDERAAN ELEKTRIK



ASEAN RENEWABLE ENERGY POOL (AREP)



PERNIAGAAN PERALIHAN



PERLINDUNGAN DAN PERMODELAN RISIKO BANJIR



RISIKO JANGKA HAYAT



KESIHATAN

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Tentang Malaysian Re

- Kumpulan MNRB – Struktur Korporat
- Sejarah
- Profil Syarikat
- Perkhidmatan Pasaran
- Program Kesiapsiagaan Negara

Informasi Pasaran

- Pasaran Reinsurans Dunia
- Pasaran Insurans dan Takaful Am
- Pasaran Insurans Hayat & Takaful Keluarga

Tentang Reinsurans

- Reinsurans
- Reinsurans & Insurans
- Kepentingan Reinsurans

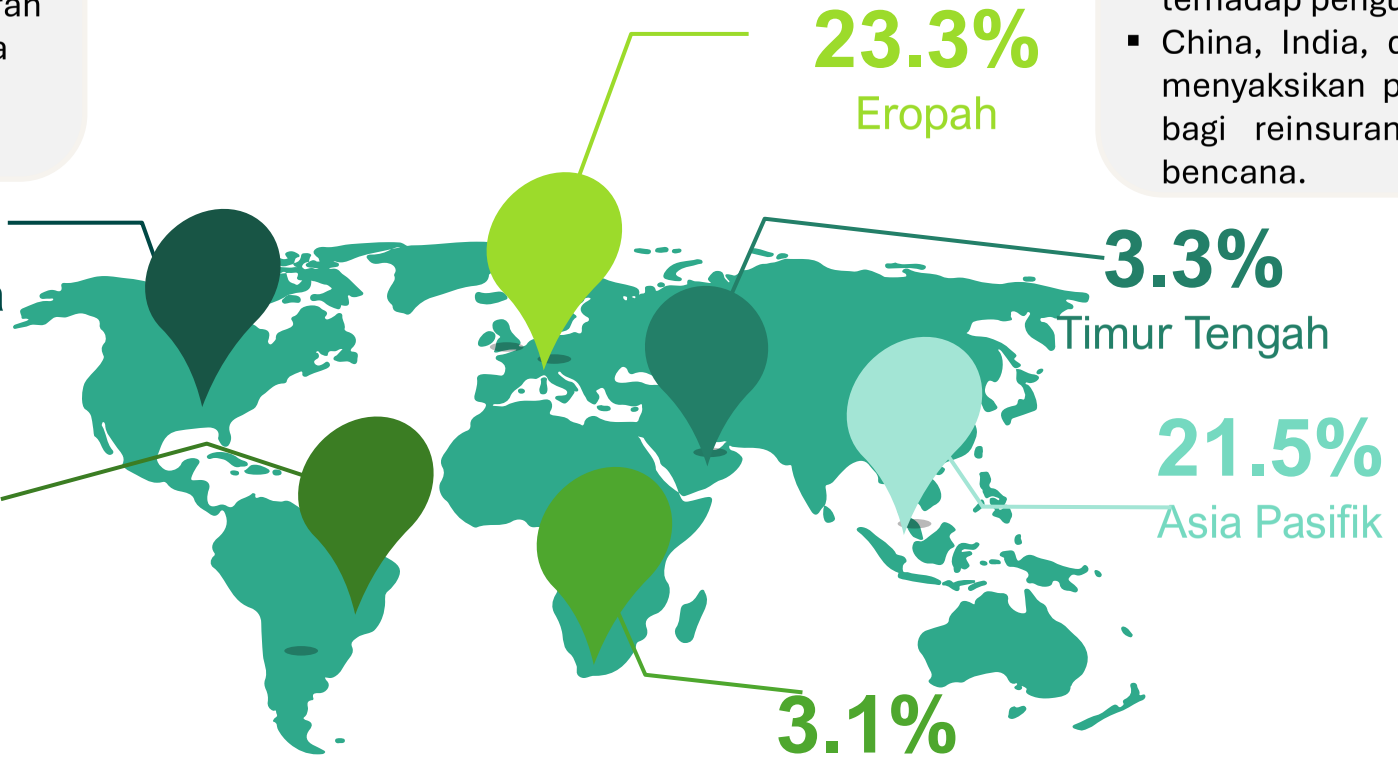
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Pasaran Reinsurans Dunia

Premium Reinsurans Dunia setakat 2024

- Amerika Utara merupakan pasaran reinsurans terbesar pada tahun 2024.
- Dominasi rantau tersebut disumbangkan oleh ekosistem insurans yang sangat maju, kehadiran pengendali reinsurans utama, serta pendedahan tinggi terhadap risiko bencana.

USD 712.5 Billion



- APAC kini merupakan pasaran reinsurans yang berkembang paling pesat disebabkan oleh peningkatan penembusan insurans dan kesedaran terhadap pengurusan risiko.
- China, India, dan negara-negara ASEAN menyaksikan permintaan yang signifikan bagi reinsurans harta, kesihatan, dan bencana.

Rujukan: Credence Research Reinsurance Report

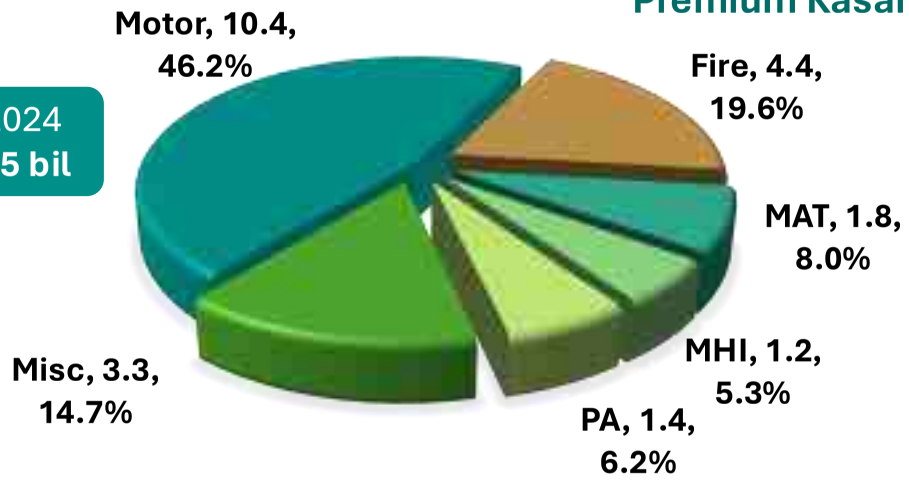
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Pasaran Insurans dan Takaful Am – Malaysia

Insurans Am

Premium Kasar

Total 2024
RM 22.5 bil

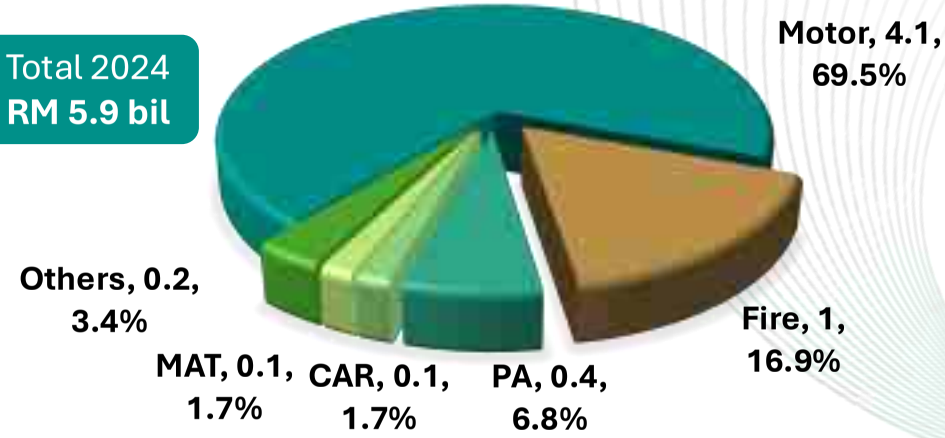


Type	2024 (RM bil)	Growth vs 2023
Motor	10.4	6.1%
Fire	4.4	7.3%
MAT	1.8	20.0%
MHI	1.2	9.1%
PA	1.4	16.7%
Misc	3.3	0.0%
Jumlah	**22.5**	**7.1%**

Takaful Am

Caruman Kasar

Total 2024
RM 5.9 bil



Type	2024 (RM bil)	Growth vs 2023
Motor	4.1	12.5%
Fire	1.0	8.0%
MAT	0.1	1.6%
PA	0.4	-33.9%
CAR	0.1	19.2%
Lain-Lain	0.2	18.6%
Jumlah	**5.9**	**9.3%**

Rujukan: ISM Insurance & Takaful Data 2024

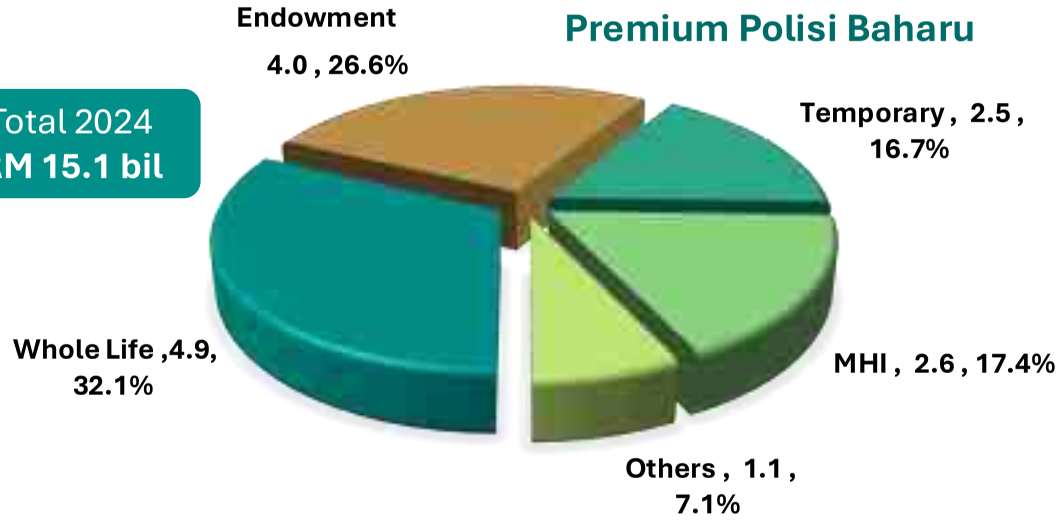
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Pasaran Insurans Hayat & Takaful Keluarga – Malaysia

Insurans Hayat

Premium Polisi Baharu

Total 2024
RM 15.1 bil

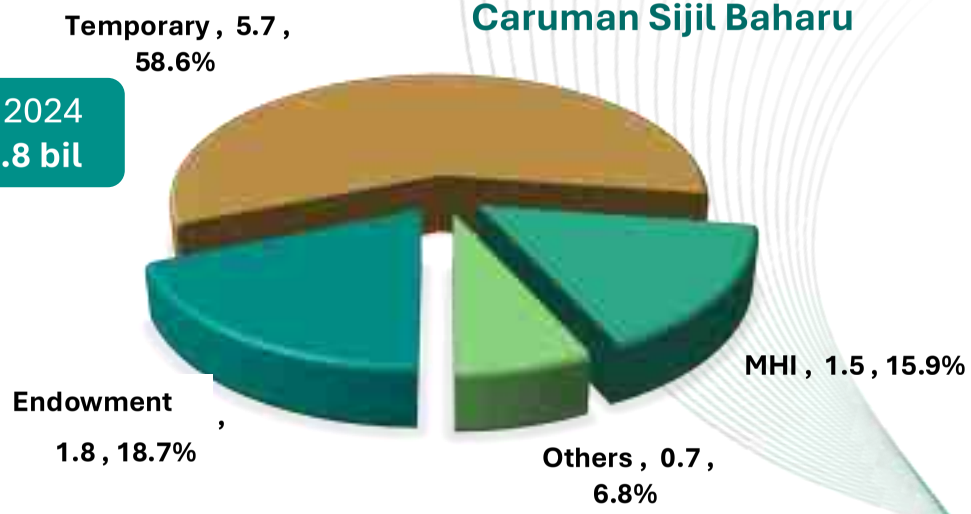


Type	2024 (RM bil)	Growth vs 2023
Whole Life	4.9	26.4%
Endowment	4.0	5.0%
Medical & Health (MHI)	2.6	16.2%
Temporary	2.5	4.8%
Others	1.1	10.7%
Total	**15.1**	**13.4%**

Takaful Keluarga

Caruman Sijil Baharu

Total 2024
RM 9.8 bil



Type	2024 (RM bil)	Growth vs 2023
Temporary	5.7	4.6%
Endowment	1.8	17.6%
Medical & Health (MHI)	1.5	-25.9%
Others	0.7	-0.1%
Total	**9.8**	**1.5%**

Source: ISM Insurance & Takaful Data 2024

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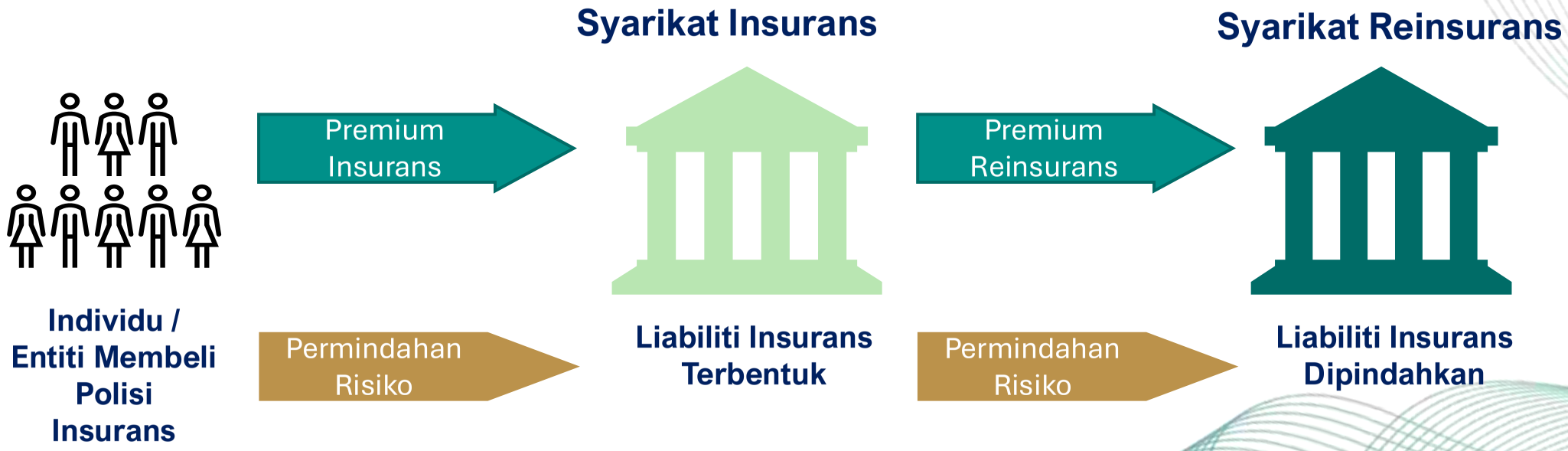
Tentang Reinsurans

- Reinsurans
- Reinsurans & Insurans
- Kepentingan Reinsurans

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Apakah itu Insurans Semula (Reinsurans)?

Reinsurans ialah insurans untuk syarikat insurans, di mana syarikat insurans memindahkan sebahagian risikonya kepada pengendali reinsurans dengan pemberian premium, dan pengendali reinsurans turut berkongsi dalam pembayaran tuntutan bagi kerugian yang dilindungi.



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Reinsurance & Insurance

Aspek	Insurans	Reinsurans
Siapa yang dilindungi	Individu, Keluarga, Perniagaan	Syarikat Insurans (dan Reinsurans lain)
Tujuan	Melindungi orang dan perniagaan daripada kerugian kewangan.	Melindungi syarikat insurans daripada kerugian besar atau tidak dijangka.
Pengagihan Risiko	Mengagihkan risiko dari individu kepada syarikat insurans.	Mengagihkan risiko dari syarikat insurans kepada syarikat reinsurans di seluruh dunia.
Bayaran Premium Oleh	Tertanggung (pemegang polisi).	Syarikat insurans (syarikat yang menyerahkan risiko).
Bayaran Tuntutan Kepada	Individu atau perniagaan yang mengalami kerugian.	Syarikat insurans, untuk membantu mereka membayar tuntutan pemegang polisi.
Skop Geografi	Biasanya dalam satu negara sahaja	Selalunya melibatkan pelbagai negara dan pasaran di seluruh dunia
Model Perniagaan	**B2C** – Perniagaan kepada Pengguna	**B2B** – Perniagaan kepada Perniagaan

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Kepentingan Reinsurans kepada Pasaran dan Negara

Pengurusan Modal

- **Pelepasan Modal:** Dengan berkongsi risiko bersama reinsurans, syarikat insurans melepaskan dana, membolehkan perkembangan perniagaan
- **Solvensi**: Syarikat insurans dikehendaki memegang modal yang mencukupi untuk tuntutan; reinsurans mengurangkan beban ini.

Pengurusan Risiko

- **Pengagihan Risiko:** Mengurangkan kesan bencana besar dan mengelakkan keruntuhan kewangan.
- **Mengurangkan ketidaktentuan:** Kewangan syarikat insurans lebih stabil dan mengelakkan pembayaran besar secara tiba-tiba.

Perkhidmatan Nasihat

- Berdasarkan pengalaman global dan ketersediaan data, reinsurans dapat membantu syarikat insurans dalam bidang seperti :
  - **Pembangunan Produk**
  - **Analisis Data**
  - **Penyertaan Pasaran Baharu**
  - ***Pricing / Underwriting tools***
  - **Meningkatkan Jualan**

Contoh Kerugian Bencana

Great Malaysian Flood 2021

- **Kerugian Ekonomi:** ~ RM 5.3-6.5 Billion
- **Kerugian Insurans:** ~ RM 1.5-2 Billion
- **Kerugian Reinsurans oleh Malaysian Re:** ~ RM 500 Million



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2. Cadangan dari Malaysian Reinsurance Berhad

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Faktor Utama Inflasi Perubatan

Pemacu yang menyumbang kepada peningkatan tahunan dalam **kos perubatan** swasta dan **tuntutan** :

- Kemajuan dalam rawatan perubatan
- Peralatan, bekalan dan ubat-ubatan import
- **Kadar tinggi penyakit tidak berjangkit (NCD)**
- Penuaan populasi
- Manfaat yang semakin meningkat dan reka bentuk polisi mempengaruhi tingkah laku
- Kekurangan maklumat
- Pembaziran, penipuan dan salah guna

Sumber : Kajian firma perunding aktuari Actuarial Partners

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Kanser menyumbang 23.67% daripada kos ubat-ubatan bagi 3 penyakit tidak berjangkit (NCD) terpilih (2017)

NCD category	Percentage of total by disease (%)							
	PUBLIC SECTOR		PRIVATE SECTOR			ALL SECTORS		
	Hospital	Clinic	Hospital	Clinic	Pharmacy	Public	Private	TOTAL
Cardiovascular disease	14.29	15.20	13.30	18.91	38.30	29.49	70.51	46.00
Diabetes	14.68	32.74	11.20	17.43	23.96	47.42	52.58	30.33
Cancer	44.93	0.64	37.56	6.50	10.37	45.57	54.43	23.67
Percentage of total medication costs provided by each facility and sector	**21.66**	**17.07**	**18.41**	**15.52**	**27.34**	**38.73**	**61.27**	**100.00**

Source: The Direct Health-Care Cost of Noncommunicable Diseases in Malaysia (MOH, WHO)

MRe mencadangkan tumpuan awal diberikan kepada usaha menangani kos rawatan kanser

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3. Perubatan Tepat untuk Penyakit Kanser *(Cancer Precision Medicine)*

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Penjagaan kesihatan yang mampu milik, berterusan dan dapat diakses oleh setiap keluarga di Malaysia

Cabaran Utama yang Dihadapi Rakyat Malaysia

- Premium insurans yang semakin meningkat menjadikan perlindungan tidak mampu dibayar, khususnya bagi golongan warga emas
- Masa menunggu yang panjang di fasiliti kesihatan awam kerajaan
- Akses terhad kepada rawatan berkesan tinggi seperti imunoterapi, yang mampu menyelamatkan nyawa
- Kekurangan alat sokongan kesihatan dan penyelesaian pengesanan awal yang boleh diperluas penggunaanya secara berskala

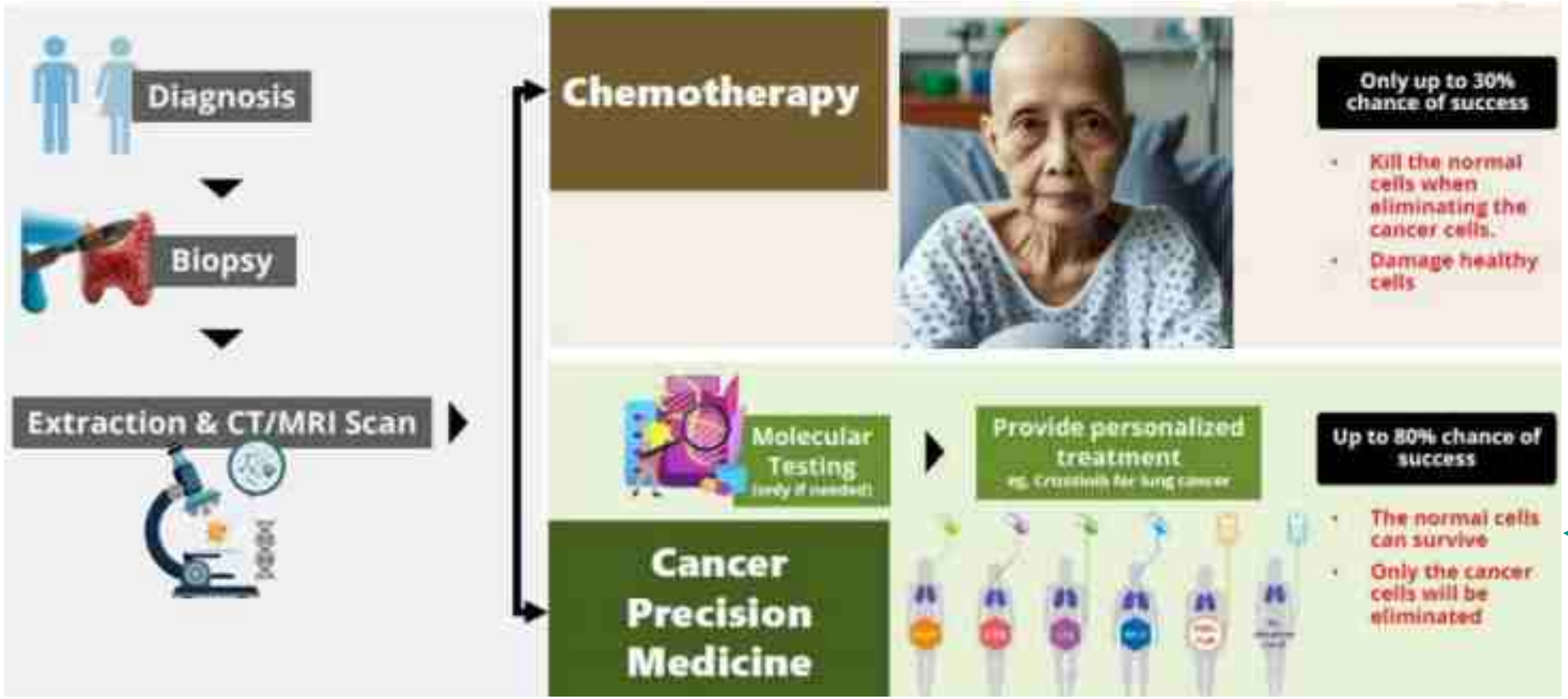
Menyebabkan rakyat berasa tidak pasti, bimbang dan kecewa...

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Rawatan kanser konvensional sering memberi hasil yang kurang memuaskan dan kesan sampingan yang tidak menyenangkan...

...jika dibandingkan dengan

Perubatan Tepat Kanser (Cancer Precision Medicine)



Sumber:

1) https://www.samitivejhospitals.com/article/detail/stopping-cancer-targeted-therapy
2) Tsimberidou, Apostolia-Maria, Funda Meric-Bernstam, Razelle Kurzrock, and others. "Review of Precision Cancer Medicine: Evolution of the Treatment Paradigm." *Cancer Metastasis Reviews* 39, no. 3 (2020): 619–39.

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Bagaimana CPM boleh mengawal kos perubatan nasional?

- **Kurang rawatan yang tidak relevan** – elak penggunaan ubat mahal yang tidak berkesan
- **Kurang kemasukan semula ke hospital** – rawatan tetap mengurangkan risiko kanser berulang dalam tempoh rawatan awal
- **Kurang kos kesan sampingan** – rawatan tersasar mengurangkan komplikasi, sekaligus mengurangkan rawatan sokongan
- **Penurunan kos ubat melalui "strategic purchasing"** → **Dengan pelaksanaan peringkat nasional, kerajaan boleh melaksanakan pembelian ubat secara pukal dan menurunkan harga ubat secara signifikan**
- **Mengawal kos premium MHIT –** dengan mengawal kos tuntutan (claims ratio)

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Pengalaman Perlaksanaan Negara China

- Insurans Kesihatan Nasional China (NHIS) menyediakan perlindungan insurans untuk mengurangkan beban ekonomi rawatan kanser
- Beberapa lapisan sokongan di bawah program NHIS : insurans perubatan asas, insurans penyakit serius, skim luar bandar dan bandar
- Contoh kesan rundingan harga NHIS melalui program Cancer Precision Medicine :
  - Sejak 2017, China memulakan rundingan harga berpusat bagi ubat anti-kanser
  - Rundingan tersebut menghasilkan penurunan harga antara 34% hingga 65%; sebagai contoh, harga ubat *trastuzumab (breast & stomach cancer)* menurun sebanyak **65.45**%
  - NHIS mengurangkan perbelanjaan sendiri pesakit di sesetengah wilayah mencecah 70% hingga 90% lebih rendah

Reference: Fang, Wenqing, Xinglu Xu, Yulei Zhu, Huizhen Dai, Linlin Shang, and Xin Li. "Impact of the national health insurance coverage policy on the utilisation and accessibility of innovative anti-cancer medicines in China: an interrupted time-series study." *Frontiers in public health* 9 (2021): 714127

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Cadangan Penubuhan "Dana Perubatan Kanser Rakyat"

Dana khusus yang menyediakan pembiayaan bagi rawatan Perubatan Tepat Kanser untuk rakyat Malaysia

Mengurangkan beban kos rawatan kanser yang tinggi dan meningkatkan akses kepada rawatan moden

Model kerjasama awam - swasta dengan pengurusan profesional untuk keberlanjutan dan ketelusan

Membantu memastikan rawatan kanser yang berkualiti dapat diakses tanpa halangan kewangan

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Contoh Projek Perintis Skim Kesihatan: Pelan Insurans Mampu Milik dan Mampan dengan Akses kepada Rawatan Bertaraf Terbaik

Perlindungan asas untuk semua.
Percuma – Ditanggung untuk 200,000 pegawai dan kakitangan polis

Tahap 2: Subsidi/Bayaran Sendiri – Produk khusus untuk tanggungan, koperasi atau kumpulan terpilih
Tahap 3: Bayaran sendiri – Perlindungan menyeluruh dan rawatan di luar negara (jika tidak tersedia di Malaysia)

Tahap 1 – Percuma

Semua Pegawai Polis Polis/Penjawat Awam

Tahap 2 or 3 – Subsidi atau Bayar Sendiri

Tanggungan / Koperasi / Kumpulan Terpilih

T20 / Mana-mana Rakyat Malaysia

CONTOH

OneHealth Malaysia

Pelan Asas
(Termasuk Penyakit Sedia Ada/PEC)
RM300* setahun.
(RM25 sebulan)

RM60mil

Pelan Dipertingkat (Subsidi/Bayar Sendiri)
(perlindungan lebih luas dan baik)
RM800* setahun

Pelan Utama (Bayar Sendiri) (Rawatan Luar Negara/ Saringan Kesihatan Lanjutan)
RM1500* setahun

* Untuk tujuan ilustrasi sahaja. Harga akhir akan disahkan dan bergantung kepada perlindungan, jumlah pemegang polisi serta reka bentuk produk.

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Perubatan Tepat Kanser – Contoh Manfaat Produk: Boleh Disesuaikan Mengikut Bajet dan Keperluan

BENEFITS	BENEFIT BASIS	Lite	Enhanced	Comprehensive
Targeted Therapies	 Cashless	10 drugs	15 drugs	20 drugs + Chemotherapy
Molecular Profiling Test		RM5,000	RM5,000	RM5,000
Patient Assistance and Rehabilitation Care**		No	Yes (Bronze)	Yes (Gold)
• Claimable Period		N/A	1 Month	3 Months
• Nutritionist			In total of RM5,000 *Physiotherapy- up to 2 times	In total of RM10,000 *Physiotherapy- up to 5 times
• Physiotherapy*				
• Dispatch of Medicine				
• Emergency Ambulance	Pay & Claim			
• Escort from Home to Hospital			N/A	
• Nurse Home Visit				
• Emergency Telemedicine Consultation				3 times
• Wheelchair Subsidy				RM500
• Emergency Evacuation and Repatriation				RM30,000
Annual Limit (RM)		100k, 125k, 150k, 175k, or 200k		

CONTOH

* Untuk tujuan ilustrasi sahaja. Harga akhir akan disahkan dan bergantung kepada perlindungan, jumlah pemegang polisi serta reka bentuk produk.

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Penjagaan kesihatan yang mampu milik, berterusan dan dapat diakses oleh setiap keluarga di Malaysia

Cabaran Utama yang Dihadapi Rakyat Malaysia

- Premium insurans yang semakin meningkat menjadikan perlindungan tidak mampu dibayar, khususnya bagi golongan warga emas
- Masa menunggu yang panjang di fasiliti kesihatan awam kerajaan
- Akses terhad kepada rawatan berkesan tinggi seperti imunoterapi, yang mampu menyelamatkan nyawa
- Kekurangan alat sokongan kesihatan dan penyelesaian pengesanan awal yang boleh diperluas penggunaanya secara berskala

= **Menyebabkan rakyat berasa tidak pasti, bimbang dan kecewa**

Perlindungan Kesihatan Menyeluruh untuk Semua Rakyat Malaysia – Perlindungan Inovatif yang Lebih Berkesan dan Kurang Membebankan

ONE HEALTH AI + SMART INSURANCE

Komponen	Ciri-Ciri	Manfaat
OneHealth AI App	Cegah, Rujuk, Urus, Tuntut, Berinteraksi, Nasihat	Mengurangkan lawatan ke hospital, menggalakkan pengesanan awal
Pelan Penyakit Critical Bayaran Terhad (Limited Pay Critical Illness Plan)	Bayar selama 10/20 tahun, dilindungi seumur hidup, bayaran berulang kali!	Perlindungan jangka panjang tanpa bayaran berpanjanganBayar ketika bekerja, bebas risau apabila bersara, alternatif kepada H&S (bayaran tunai sekaligus)
Pelan Perubatan Tepat Kanser (Cancer Precision Medicine Plan)	Melindungi rawatan moden yang mahal dengan premium rendah. Menyediakan bayaran tunai dan penjagaan.	Memberi akses kepada rawatan menyelamatkan nyawa untuk rakyat. Mengurangkan risiko malapetaka kewangan kepada keluarga
Pelan Hospitalisasi dan Pembedahan (H&S)	Menanggung kos rawatan di hospital dan pembedahan untuk pesakit dalam	Mengurangkan beban kos rawatan di hospital dan pembedahan

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Manfaat Program Perintis Perubatan Tepat Kanser

Menjamin akses rawatan kanser berteknologi tinggi kepada semua lapisan Masyarakat

Mengurangkan risiko beban kewangan yang boleh menjejaskan keluarga pesakit

Memperkukuh sistem pembiayaan kesihatan negara secara mampan

Menunjukkan komitmen kerajaan dalam memperbaiki kualiti hidup rakyat melalui penjagaan kesihatan terbaik

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4. Kesimpulan

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Daripada Cabaran kepada Penyelesaian

Bagaimana kita boleh membiayai kos rawatan yang semakin meningkat secara mampan untuk semua rakyat Malaysia?

- Di Malaysian Re, kami percaya bahawa insurans dan reinsurans adalah sebahagian daripada penyelesaian yang holistik dan berdaya tahan
- Langkah pertama adalah dengan melaksanakan **Program Perintis Perubatan Tepat Kanser** – menangani salah satu cabaran kesihatan paling kritikal di negara kita.
- Kami mencadangkan **penubuhan Dana Perubatan Kanser Rakyat** sebagai instrumen pembiayaan khusus untuk memastikan rawatan inovatif ini dapat diakses oleh kumpulan sasaran.
- Kita **boleh memperluaskan perlindungan kepada penyakit lain** melalui produk insurans inovatif yang direka khusus mengikut keperluan rakyat Malaysia.
- Dengan perlaksanaan di peringkat nasional, kita dapat merundingkan harga ubat kanser yang lebih rendah dan seterusnya **mengawal bayaran insurans dan caj hospital.**

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The MNRB Group adopts zero tolerance against all forms of bribery and corruption. We abide by the MNRB Holdings Berhad Code of Conduct and Business Ethics (CoBE) & Anti-Bribery and Corruption (ABC) Manual, guided by our Shared Values and Statement of Purpose.

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