HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's-eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Malaysia's healthcare system operates as a two-tier system, comprising a comprehensive public sector managed by the government and a dynamic private sector. The public sector, led by the Ministry of Health (MOH), is the primary provider of healthcare services to the general population. The MOH's structure is organised into three levels – federal, state, and district – to enhance efficiency, accountability, and supervision across the country. These hierarchical levels aim to ensure equitable access, greater utilisation of healthcare resources and an expansive network of physical facilities. In addition, national referral centres have been established to provide specialised care, complementing the basic services offered at health clinics.

The Malaysian Government allocated MYR7.6bn under Budget 2023 to strengthen health and wellness programme, improve and repair healthcare facilities, increase the effectiveness of health treatments, replace critical and old medical assets, and digitalise healthcare services.

The public healthcare system is primarily funded through general taxation, with minimal fees charged for services. The MOH is the cornerstone of Malaysia's public healthcare system which provides a wide range of health services through hospitals, health clinics, and community health centres across the country, ensuring accessibility for all citizens. The MOH oversees the public healthcare sector, working to provide high-quality, equitable and affordable healthcare to the population.

On the other hand, private healthcare sector in Malaysia plays a vital role in offering additional options for those who prefer private services. Private healthcare providers, including hospitals, clinics and medical centres, are driving innovation, particularly in health technology, and increasingly collaborate with international healthcare providers to attract medical travellers. Services at private healthcare facilities are either entirely self-funded out-of-pocket or covered by private health insurance.

Other financing sources, such as corporations and managed care organisations (MCOs), contribute to the healthcare economy, though to a lesser extent. MCOs, which are often partnerships between private health insurance companies and selected healthcare facilities, offer defined healthcare packages to policyholders for a predetermined monthly premium. These organisations manage prepaid funds within a capped budget and aim to control costs while delivering quality care. Some foreign companies have also set up MCOs or partnered with local entities to provide managed care services.

Healthcare in Malaysia is primarily financed through taxation, social and private health insurance, and out-of-pocket payments. Public healthcare is funded via the Consolidated Revenue Fund under the Ministry of Finance (MOF), while the private sector's funding mainly comes from consumers, either through direct payments or insurance premiums.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

The legal framework for healthcare financing and reimbursement in Malaysia is shaped by both public and private sector mechanisms, governed by specific regulations and oversight bodies.

Public healthcare financing is primarily overseen by the MOH. Funding for public healthcare services comes from general taxes (both direct and indirect) and non-tax revenues collected by the federal government. Public healthcare services are heavily subsidised, ensuring affordability for the population. MOH allocates budgets to public healthcare facilities using global budgets based on historical spending patterns.

In the private sector, healthcare financing is sourced mainly from household out-of-pocket payments, private insurance, and corporate health coverage provided by employers. Private health insurance, while voluntary, is often utilised to cover private hospital costs. Many private sector employers offer health insurance as part of employee benefits.

Over and above, the Social Security Organisation (SOCSO) administers the Employment Injury Insurance Scheme which is a social security scheme that provides financial protection to an employee against accident or an occupational disease arising out of and in the course of their employment.

The insurance industry is regulated by Bank Negara Malaysia (BNM) under the Insurance Act 1996, which governs all aspects of insurance operations, including private health insurance.

Public healthcare facilities are funded through MOH allocations, while private sector funders generally rely on fee-for-service models to reimburse healthcare providers. The establishment and operation of private healthcare facilities are governed by the Private Healthcare Facilities and Services Act 1998 and its accompanying 2006 Regulations. Professional fees in the private

sector are further guided by the fee schedule issued by the Malaysian Medical Association, ensuring a degree of standardisation and transparency.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

Healthcare financing and reimbursement in Malaysia is regulated by several key bodies and frameworks. The MOH plays a central role in planning and regulating public sector health services, which are heavily subsidised by the government. Public healthcare services are financed primarily through government funding, with nominal fees charged for services, such as MYR1 for outpatient visits, as outlined under the Fees Act 1951 and Fees (Medical) Order 1982. These regulations also allow higher charges for non-citizens.

The private healthcare sector, including clinics, hospitals, and other services, is governed by the Private Healthcare Facilities and Services Act 1998. The MOH oversees compliance to ensure cost control and service quality, although enforcement has historically faced challenges. Proposals to strengthen the legislation aim to better protect patients' interests.

Private health insurance, a significant source of private healthcare financing, is regulated by BNM under the Insurance Act 1996. This act covers the operations of all insurance providers, ensuring adherence to standards for fair practices and premium adjustments. Private health insurance plans offer varying levels of coverage and premiums, enabling individuals to access private healthcare services.

Additionally, the Fees Act 1951 provides a legal framework for healthcare-related payments, such as outpatient fee, ward fee and treatment fee. This ensures a structured approach to fee collection in public healthcare facilities, supporting financing mechanisms for subsidised services.

The efficiency of public health services is monitored by the MOH with performance indicators, while private health services are regulated by the Private Healthcare Facilities and Services Act 1998. The public health services, which are almost fully subsidised by the government, place competitive pressure on private health providers to set a reasonable price and to be efficient. Overall, public and private healthcare financing are closely monitored to maintain affordability, quality, and accessibility, with the MOH and BNM serving as the key regulators.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The pandemic did not fundamentally alter the general system of healthcare financing and reimbursement in Malaysia. However, it significantly influenced healthcare expenditure and the health insurance market.

In 2021, the total financing at MOH hospitals from both public and private sector sources amounted to MYR20,527m. MOH itself provided the majority of the financing, contributing MYR19,861m (96.8 per cent). The remaining MYR666m (3.2 per cent) was financed by various other sources. These included private household out-of-pocket payments (MYR311m), corporations excluding health insurance (MYR90m), other state agencies such as statutory bodies (MYR85m), nonprofit institutions serving households (MYR84m), private insurance enterprises excluding social insurance (MYR43m), SOCSO (MYR38m), and other non-MOH expenditures (MYR16m).

Total health expenditure in 2021 was estimated at MYR78,220m, of which MYR7,567m (9.7 per cent) was allocated to Covid-19-related spending. This included all cash and in-kind health expenditures related to the pandemic. The MOH was the primary source of financing for Covid-19 expenses, contributing 76.5 per cent, followed by public non-MOH agencies (17.6 per cent) and private sources (4 per cent). Notably, 61.1 per cent (MYR4,622m) of Covid-19 spending went to ambulatory healthcare providers, while 65.9 per cent (MYR4,986m) was allocated to vaccination efforts, reflecting the government's emphasis on immunisation and accessible healthcare during the pandemic.

The pandemic also spurred a surge in demand for private health insurance due to heightened awareness and the rising costs of medical services. Health insurance companies introduced tailored packages to cover Covid-19 treatment costs, contributing to significant growth in the private health insurance sector during this period. However, post-pandemic challenges, including increased claims and medical inflation, have placed pressure on insurers and takaful operators to adjust premiums between 2021 and 2023. While many industries struggled during the pandemic, the private health insurance industry experienced notable growth, driven by the need for comprehensive medical coverage.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

Public health services in Malaysia are available and accessible to all legal residents of Malaysia which include Malaysian citizens, permanent residents and expatriates with valid work permits. The public healthcare system offers a wide range of services, including outpatient care, hospital treatment, and emergency services. While the system provides subsidised care for all users, non-citizens typically pay higher fees. For example: in outpatient treatment, MYR1 for citizens and MYR15 for non-citizens, in specialist clinics, MYR5 for citizens and MYR60 for non-citizens, hospital admission fees for third class ward are MYR3 per day for citizens. Accessibility to these services can vary depending on location and service type. Emergency care is generally available to everyone, regardless of residency status, though public hospitals may experience long wait times. The MOH is implementing initiatives to reduce waiting times and enhance service delivery.

The utilisation of public health services is almost free: only nominal charges are levied upon certain services whereby the patients must pay out-of-pocket. Conversely, utilising private health services requires out-of-pocket payments or co-payments through private health insurance coverage. There is no mandatory national social health insurance scheme; instead, individuals can voluntarily purchase private insurance with premiums based on the type and level of coverage.

To access the healthcare system as a medical service provider or supplier of medical goods, medical service providers must obtain licences and accreditation from the MOH or relevant professional bodies, adhering to strict quality standards. They are also required to comply with the Private Healthcare Facilities and Services Act 1998 and other regulatory frameworks to maintain operations. Healthcare professionals, including doctors and nurses, must be registered with their respective professional councils, such as the Malaysian Medical Council (MMC). Similarly, suppliers of medical goods, such as pharmaceuticals and medical devices, must adhere to regulatory requirements and obtain product approval from the National Pharmaceutical Regulatory Agency (NPRA) to ensure safety and efficacy before entering the market.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

In Malaysia, health insurance carriers are financed through two primary mechanisms: private insurance and employee-based schemes such as SOCSO.

Private health insurance carriers are funded by the regular payment of premiums from policyholders, which keeps their policies active. These premiums cover a range of medical treatment costs, including hospitalisation, as well as pre- and post-hospitalisation expenses.

Private health insurance in Malaysia operates on a risk-rated system, meaning premium charges vary according to the risks borne by the insurer. Factors influencing premiums include age of the policyholder, type of coverage being purchased by the policyholder, claim history of the policyholder, and expected costs for the upcoming year. Premiums are reviewed periodically to address rising healthcare costs and an increase in hospital visits and claims. All premium adjustments require approval from BNM to ensure fairness and transparency.

BNM plays a critical role in regulating premium pricing. If premiums rise significantly, BNM can require insurers to review and justify their repricing strategies. The BNM may direct insurers to increase or reduce premiums as necessary. To further protect consumers, BNM issued the Guidelines on Medical and Health Insurance Business (2005), mandating that premium increases for high-risk individuals be moderated based on overall portfolio experience.

The MOH and BNM collaborate to implement mechanisms to control premium hikes, ensuring they remain reasonable and do not overly burden policyholders. They also regulate the profit margins of private hospitals, pharmacies and insurance companies to maintain affordability.

To improve healthcare outcomes while reducing financial burdens, the MOH has proposed the Value-Based Healthcare (VBHC) model and the Diagnostic-Related Group (DRG) system. Additionally, insurers are required to offer co-payment options, which allow policyholders to share costs and reduce their monthly premiums.

To address unfair market practices, BNM established a Market Conduct Examination Unit in 2000. This unit ensures compliance with regulatory frameworks, promotes fair practices, and safeguards the rights of policyholders.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

Health insurance carriers regulate coverage for medical services, including both in-person and telemedicine appointments, through specific policies and guidelines. A Medical and Health Insurance (MHI) policy is designed to cover the cost of private medical treatments, such as hospitalisation and healthcare services, in exchange for premium payments made to a licensed insurance company.

According to the Guidelines on Medical and Health Insurance/Takaful Business, insurers may adopt varying approaches to coverage depending on the type of product offered. Benefits under health insurance policies are typically subject to specific limits for each service and often include an annual maximum. Common offerings include hospitalisation benefits, surgical coverage, and reimbursement for medical expenses. These benefits are frequently provided as part of group hospitalisation and surgical (GHS) plans for employees of large companies, with coverage limits varying based on job level and company structure. Coverage is generally limited to medical treatments within Malaysia, although insurers may offer add-on benefits for an additional premium to cater to employers' needs.

MHI policies typically cover hospitalisation and medical expenses, including hospital room and board, nursing care, surgical and professional fees, and in-patient diagnostic tests. However, exclusions often apply, such as maternity care, congenital conditions, injuries from hazardous activities, cosmetic or plastic surgery, dental treatments and oral surgery.

While telemedicine is not yet widely integrated into Malaysia's public healthcare system, many private insurance providers are beginning to include telehealth services in their coverage. The extent of telehealth coverage varies significantly between insurers, depending on their specific policies.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Healthcare services in both stationary (inpatient) and ambulatory (outpatient) settings are financed and reimbursed through a combination of public funding, private payments and insurance mechanisms.

Public healthcare services are heavily subsidised by the government, ensuring affordability and accessibility for the majority of the population. The primary sources of funding for public healthcare include tax revenue, with MYR45.3bn allocated to the MOH for 2025. Public healthcare services are provided at minimal or no cost to patients, with nominal fees for certain services, such as MYR1 for outpatient visits and MYR5 for specialist care in public hospitals. Under the General Orders Chapter F (Medical) 1974, Federal Public Services personnel and pensioners receiving pension and their family members are eligible for free medical facilities at the government hospitals/clinics. This model ensures that healthcare remains accessible to all Malaysians, particularly low-income groups.

On the other hand, private hospitals operate on a fee-for-service model, where patients pay for the services they receive. Approximately 30 per cent of private hospital patients pay out of pocket, while around 70 per cent rely on private health insurance to cover their medical expenses. There are two types of health insurance, namely private and employee-based health insurance (also known as social security funds). SOCSO is the main social security funds providing health coverage for private sector employees. Private health insurance is voluntary for many people as it is useful mainly to cover private hospital costs. However, the rising cost of private healthcare has led to concerns about affordability, especially given Malaysia's high medical inflation rate of 11.9 per cent in 2024, which exceeds both the global and Asia Pacific averages.

9. How are the prices of such services determined? How is economic efficiency controlled?

The pricing of healthcare services is determined through a combination of government regulation and market-driven mechanisms, depending on whether the services are provided in public or private healthcare facilities.

In public hospitals, the government sets ceiling prices for treatments and medications to ensure affordability and accessibility. Primary care services, such as outpatient visits, are charged at a nominal fee of MYR1 per visit, while specialist care costs MYR5 per visit, as stipulated under the Fees (Medical) Order 1982. This Order also prescribes fixed fees for inpatient care, including ward charges, treatment, investigations, operations, and dental services. However, critics argue that these low fees are unsustainable, as revenue from them accounts for only 1

per cent of public healthcare expenditure. To address this, the government introduced the Rakan KKM initiative in 2025, a public-private partnership programme that allows non-emergency patients in public hospitals to opt for 'premium economy' value-added services, such as personalised care, choice of specialists and enhanced privacy. These services are priced above cost but below most private healthcare rates. Additionally, the 2025 Government Budget introduced higher fees for the top 15 per cent of income earners (T15) for public health services, though the exact amounts have not been specified.

In contrast, private hospitals operate on a fee-for-service model, where prices are influenced by market competition and the cost of delivering services. Consultation fees and procedure charges by doctors in private hospitals are regulated under the 13th Schedule of the Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006, which sets maximum professional fees. However, other components, such as hospital stay, laboratory investigations, nursing care, equipment use, and medications, remain unregulated. Private hospitals are required to provide itemised bills to ensure transparency. To improve economic efficiency and streamline billing, Malaysia plans to implement the Diagnosis-Related Groups (DRG) pricing system by the second quarter of 2025. The DRG system will charge patients based on the severity and category of their diagnosis rather than itemising each procedure or medication, simplifying billing processes and potentially reducing costs.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

Healthcare services provided by private practitioners are financed and reimbursed in the same way as for hospitals in the ambulatory/outpatient setting (see Q8 and Q9).

11. How are the prices of such services determined? How is economic efficiency controlled?

Prices of such services are set and their economic efficiency are being controlled in the same way as for hospitals in the ambulatory/outpatient setting (see Q8 and Q9).

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

In Malaysia, the financing and reimbursement of pharmaceuticals and medical devices are structured within a dual-tiered healthcare system comprising public and private sectors. The public healthcare system offers universal access to medical services, with the government funding the procurement and distribution of medicines through public facilities. Patients typically receive medications free of charge at the point of service delivery, incurring only minimal fees for treatment. The MOH procures medicines through three primary mechanisms:

a national concession agreement with a designated supplier, national tenders, and direct purchases by health facilities. All medicines listed in the MOH's formulary, commonly referred to as the 'Blue Book,' are provided free of charge at MOH facilities. Notably, when patients contributed MYR1 to their medications, studies indicated that an average of 9.4 per cent of the total pharmaceutical spending could be recovered.

In the private sector, healthcare services are predominantly funded through out-of-pocket payments or private health insurance. Private healthcare providers, including community pharmacies, serve as the primary sources of pharmaceuticals for patients who opt for private treatment. The private healthcare industry in Malaysia operates independently of government funding, allowing for the provision of the latest medicines and medical equipment, often with competitive service pricing. Unlike the public sector, there are no policies or regulations controlling drug pricing in the private sector, enabling manufacturers, distributors, and retailers to set prices within the free market.

Regarding medical devices, the Medical Device Authority (MDA) is responsible for the supervision and governance of the marketing and distribution of medical devices in Malaysia, as defined under the Medical Device Act 2012. The Health Ministry has announced plans to adopt a leasing approach for medical devices, medical assets and ambulances, starting next year, to enhance public-private partnerships. Under this approach, the ministry will no longer purchase medical assets outright, except for certain items of low or marginal value.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

In Malaysia, pharmaceutical and medical device prices are primarily influenced by market dynamics, as there is no legal price regulation. In the public sector, medicine prices are indirectly contained through bulk procurement and national tendering policies enforced by the MOF. These mechanisms enable cost savings and ensure affordability within government-funded healthcare facilities. However, in the private sector, manufacturers, distributors, and retailers are free to set prices based on market forces, leading to significant price variations and mark-ups.

Studies have shown that medicine prices in Malaysia, particularly in the private sector, often exceed international reference prices (IRPs) and are higher than in many other countries. Additionally, price discrimination among private healthcare providers results in disparities that restrict consumer access to affordable medicines. A survey conducted by the Pharmaceutical Services Programme found that the median wholesale price in the private sector was twice as high as in the public sector. This price gap contributes to the growing preference for public healthcare services, where medications are provided at minimal cost, thereby increasing the strain on the public health budget.

To address pricing inefficiencies and enhance transparency, the MOH has implemented the Medicine Prices Monitoring initiative, which systematically collects data on the cost, availability, and affordability of medicines across the public and private sectors. By providing reliable insights into pricing trends, the MOH aims to promote fair pricing practices and improve accessibility to essential medicines while maintaining economic efficiency in the healthcare system.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

In *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal [2017] MLJU 1448*, the Federal Court considered whether a plaintiff who has suffered personal injuries by reason of a defendant's act or omission may be awarded, as part of damages, medical expenses in respect of his personal injuries, but which medical expenses were borne and paid by an insurer. The Court ruled that medical expenses paid by an insurer are recoverable as damages by the plaintiff. This landmark case clarifies the position of law that the plaintiff's contract with the insurer is a collateral and extraneous matter and does not impinge on the plaintiff's claim against the defendant for damages suffered as a direct consequence of the tort.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

An unresolved issue is the persistent gap between public and private healthcare sectors, particularly regarding pricing and reimbursement structures. While fees charged in public healthcare facilities remain minimal due to substantial government subsidies, private sector prices are significantly higher, creating a notable disparity in healthcare access and equity across the system. This price differential often results in overcrowding in public facilities while private facilities may be underutilised, leading to inefficient resource distribution within the healthcare system.

The proposed implementation of a national health insurance scheme represents a major shift from the current tax-based financing system. The proposed framework suggests that patient healthcare funds could be collected through a hybrid model, with partial government contribution complemented by mandatory public contributions, similar to existing systems like the Employees Provident Fund and SOCSO. This development could fundamentally alter how healthcare services are financed and reimbursed across both public and private sectors,

potentially creating a more unified pricing structure and improving access to private healthcare facilities for a broader segment of the population.

The growing emphasis on digital health technologies and telemedicine represents another important trend reshaping healthcare delivery and reimbursement models. The Covid-19 pandemic has accelerated the adoption of these technologies, necessitating new frameworks for reimbursement of virtual consultations and digital health services. This transformation requires significant adjustments to existing payment mechanisms and regulatory frameworks, including establishing standardised fees for virtual consultations, developing guidelines for remote monitoring reimbursement, and creating payment models that appropriately value digital health interventions. The integration of these new service delivery models into the proposed national health insurance scheme will be crucial for ensuring comprehensive coverage and sustainable financing of digital healthcare services.