Kajian Malaysia, Vol. 29, Supp. 1, 2011, 239–264

THE 'FRANKENSTEIN'[1] OF INDUSTRIAL DEVELOPMENT: DIFFERENTIATION AND INTEREST GROUPS WITHIN THE HEALTHCARE INDUSTRY

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As studied elsewhere, other than providing in-service education for its members and functioning as a medium of professional control by establishing general standards of conduct, professional associations also work to uphold and protect the interests of their members. Professional bodies are thus both the product of and the driving force for professionalisation and the consolidation of professional interest. Bred within the historical context of the cultural and social collision between local, traditional authority and western colonial power in the last two centuries, the development of the (western-based) medical profession in Malaya (known as Malaysia from 1963 onwards and thus shall be used for entire article) shares many similarities with its western counterparts in terms of professionalisation. The establishment of the Straits Medical Association (SMA) in 1890 by a group of medical officers, all foreign, was one effort to advance the development of the profession and cater to the need for in-service education in the medical community. The association, renamed as the Malayan Medical Association (MMA) in 1959, was the sole official representative for the medical profession in Malaysia from the post-war years until the 1980s, when the launching of privatisation under the Mahathir administration led to differentiation within the healthcare industry. The emergence of managerialism and the growth of bureaucratisation within the modern hospital setting in the past three decades have added further to the tension between different medical groups in the healthcare industry. By investigating the development of different medical and paramedical groups, this paper aims to capture the main contention between these groups and explain the meaning of interest pluralisation in the Malaysian healthcare industry. This paper argues that differentiation and interest pluralisation are inevitable outcomes of industrial development and require democratisation as a resolution to the conflict between different interest groups.

Keywords: healthcare privatisation, differentiation, professional group, interest group, conflict

INTRODUCTION

Like their counterparts in western countries, biomedicine-oriented healthcare professions as a preferred career is a new phenomenon in Malaysia. Just a century ago, western biomedical services, as introduced by the British Malaya

government, were but one option among many competing traditional practitioners (Manderson, 1996). Today, its acceptance by the wider society is evident. Increasing numbers of biomedicine-based clinics and hospitals have been established, and medical courses are becoming one of the preferred choices of young Malaysians since the privatisation of both the healthcare industry and higher education were launched two decades ago under Mahathir's administration. This can be seen in the rapid rise of the total number of private hospitals—from 50 in 1980 to 233 in 2006[2]—and medical schools—from only 1 in 1962 to 10 in 2000 and 25 in 2010[3]. The physician-to-population ratio, which is projected to be 1:600 by 2020[4], is even taken by the Malaysian government as an indicator of development, in accordance with achieving Vision 2020 or becoming fully developed. Although the editor of *Berita MMA*, Dr Kuljit Singh, addressed the deep concern over the surplus of doctors and the congestion in the supply chain of new doctors in the February 2010 issue, he denied that it is a reflection of preference by Malaysian parents and the younger generation for the medical profession as a remunerative career (2010: 2).

Forming a new social stratum in post-independent Malaysian society, physicians and other healthcare professionals are often termed a *new middle class*, a social construct used by social scientists to indicate a change in social stratification. Based on common characteristics and interests, each of the newly emergent occupations or professions within the healthcare industry tends to organise itself along a different professional line, and it sometimes becomes political when it comes to securing each of its occupation/profession-based, sectoral interests in the face of intense competition in the contemporary healthcare market. The activities of occupational or professional groups and the diversification of interest within the healthcare industry, however, rarely become the objects of attention of social scientists. This new stratum, rather, is often taken as a monolithic occupational subcategory under the umbrella of the *new middle class*, which is supposed to put aside self-interest and is expected to selflessly provide healthcare services in order to maintain or uplift the health status of the larger population on the nation's journey to Vision 2020. Such simplistic construction of the professions reflects a functional view of the emergence of new occupations, regarding them as merely an instrument of national development in the post-independence era, and ignores the dynamics of differentiation within the healthcare sector and the impact that pluralisation has on healthcare policy.

Although competition and conflict between different groups within the Malaysian healthcare industry have become intense and frequent in the last two decades, as observable in several episodes of inter-group contentions and widely covered by the media, these events seldom reach the attention of social scientists. Only a handful of researchers and observers (Barraclough, 2000; Barraclough and Phua, 2007; Por, 2006) are concerned with differentiation within the healthcare sector

and the role of certain professional groups in the healthcare policy-making process. By investigating the pluralisation and differentiation that come with structural changes in the economy and development since the implementation of privatisation by the Malaysian government in the late 1980s, Barraclough (2000) and Barraclough and Chee (2009) highlight the importance of the role of the broad-based mobilisation of civil groups, like the Citizen's Health Initiative (CHI), Malaysia Trade Union Congress (MTUC), Federation of Malaysian Consumers Associations (FOMCA) and Malaysia Medical Association (MMA), in pushing policy change. Their focus, nevertheless, is on the coalescence of the professional group with other civil groups as an organised bloc *vis-à-vis* the state, leaving the divergent concerns of different professional groups and conflicting interests of healthcare providers and communities unexplored. Barraclough and Phua (2007: 25) are also aware that different groups have different interests and are unequally represented or consulted in the federal policy-making process, but their focus is on the state as the prime player that takes the initiative to invite different groups for consultation. Por (2006) is concerned with interest diversification and competing groups within healthcare industry; her probe, however, was not a systematic inspection of group-based divergence and inter-group conflicts within the healthcare industry. In a nutshell, group politics within the Malaysian healthcare sector is an area that has not been investigated systematically, leaving the structural divergence of groups and their conflicts a missing piece of the jigsaw puzzle that is a more comprehensive picture of the healthcare industry.

Given the rapid diversification of interests since the launch of privatisation as a strategy and engine to achieve Vision 2020, the significance of fragmentation within the Malaysian healthcare industry and inter-group relations on healthcare-policy decision-making is certainly worth further and deeper exploration. The main objective of this article is thus threefold: firstly, to investigate and theorise the differentiation, as manifested in the development of a variety of occupational-turned-political groups and their advocacy activities within the healthcare industry; secondly, to identify different loci of power in order to capture the dynamics and interaction among various sectors within the industry, an arena in which competition for limited resources takes place; and finally, to inspect the impact of group politics on the healthcare system. This article argues that differentiation and interest pluralisation are inevitable outcomes of industrial development and require further democratisation as a resolution to mediate the conflict between different interests.

THEORISING POLITICS OF SOCIAL DIFFERENTIATION AND PROFESSIONAL GROUPS

Broadly speaking, there are two ways to investigate and theorise occupational or professional group activities: focus on the nature of the subsystem or group and factors that affect it, "among these factors the larger system in which it operates;" or focus "on the larger system, raising questions about the significance within it of any pattern of pressure group activity which it comprehends" (Eckstein, 1960: 151). Because there are only a few studies on Malaysian group politics within the healthcare industry, much of the analysis in this article borrows concepts and experiences from studies elsewhere. In this section, we will move from the micro view of subsystems to the broad view of group politics by focusing on two major themes: "industrial development and differentiation" and "group politics and political economic environment."

Industrial Development and Differentiation

As suggested by Dahrendorf (1959), technical innovations in production and new philosophies of industrial organisation have given rise to new divisions of labour and thus to further differentiation within industrial society. Increasingly complex machines and technology require more skilled workers, and the more skilful one is the higher one's prestige and authority is in the hierarchy of labour. Parallel with technology development is the separation of ownership and administration. "The roles of owner and manager, originally combined in the position of the capitalist, have been separated and distributed over two positions, those of stockholder and executive" (Dahrendorf, 1959: 49) in industrial society. With these developments, authority and power is distributed unequally along different levels of skill, with the more skilful possesses more authority and thus more powerful; the manager exercises authority, as delegated by the owner, to command and expect obedience from his/her subordinate.

Generally, these two lines of development are true not only in the general industrial society but also, particularly, in the healthcare industry (Krause, 1971: 124–134). Firstly, the emergence of paramedical services is a response to advancements in healthcare technology. Although their work, just like the work of physicians, is also organised around the work of healing, they are ultimately controlled by the latter, because physicians were able to secure "the exclusive right to practice in face of the fact that many kinds of healers were [also] practicing", with the support of the state, through the licensure system (Freidson, 1973: 47–48). It is in this sense that professional dominance by physicians within the healthcare industry is political in its character and distinctive in modern, industrial society. The distinction between paramedical occupations and the more established profession of medicine could thus be understood as "the relative

lack of autonomy, responsibility, authority and prestige" and it is distinguished "sociologically than technologically" (Freidson, 1973: 49). Although pre-industrial societies also saw a certain degree of division of labour among herbalists, midwives, shamans and other traditional healers, "the distinctive division of labour labelled *paramedical*" is, however, "relatively new and is complex only in the highly industrialised societies" (Freidson, 1973: 50). Relations between physicians and paramedics are thus one of the potential sources of conflict within modern healthcare industry.

With the advancement of management science, two management techniques—the separation of ownership and management (Mills, 1967: 113–121) and third party administration (Krause, 1971: 133)—have been introduced into the administration of the healthcare sector. These two new management philosophies have generated more potential sources of conflict within the modern healthcare sector. Firstly, with the separation of ownership and administration, an intermediate level of rank, which includes the manager and the administrator, who work between the owner and the healthcare provider, has been created within the modern hospital setting. It is very common to observe disgruntlement among corporate bond physicians towards the manager and administration officer, who tends to act in the interest of the owner.

Secondly, Managed Care Organisations (MCO) or third party administrators (TPA) arose out of concern over the rising cost of healthcare services in the second half of the last century (Krause, 1971: 133). Working in addition to the once simple patient-doctor relationship, MCOs and TPAs are granted the authority to control costs by representing their clients or patients by collectively bargaining with healthcare providers. An example of an MCO or TPA is a health insurance company. Although MCOs and TPAs do not own hospitals, health insurance companies are influential because they might propose rules that affect the terms of payment for healthcare services, which could have a great impact on the interests of both physicians and paramedics. Figure 1 illustrates the multiple layers of relationships between owners, managers, healthcare providers and TPAs within healthcare organisations. The vertical dotted rectangle illustrates the separation of ownership and management and division of labour among healthcare providers, while the horizontal dotted rectangle shows the triangular relationship between healthcare provider, MCO/TPA and patients.

Although the pathway of industrial development differs from one society to another, newly formed differentiation and pluralisation are inevitable outcomes of development. The degree and aspect of differentiation, and whether divergent interests will organise themselves and engage in advocacy activities and collective bargaining, is subject to empirical study. The latter depends on a series of factors, ranging from internal conditions within the community, such as the

availability of leadership and resources, to the external economic and political environment, which could be either conducive to group politics or constraining of them. This article will focus only on the inter-group and the state-group relationships. The following subsection focuses on the discussion of the larger political-economic environment and its relation with interest groups.

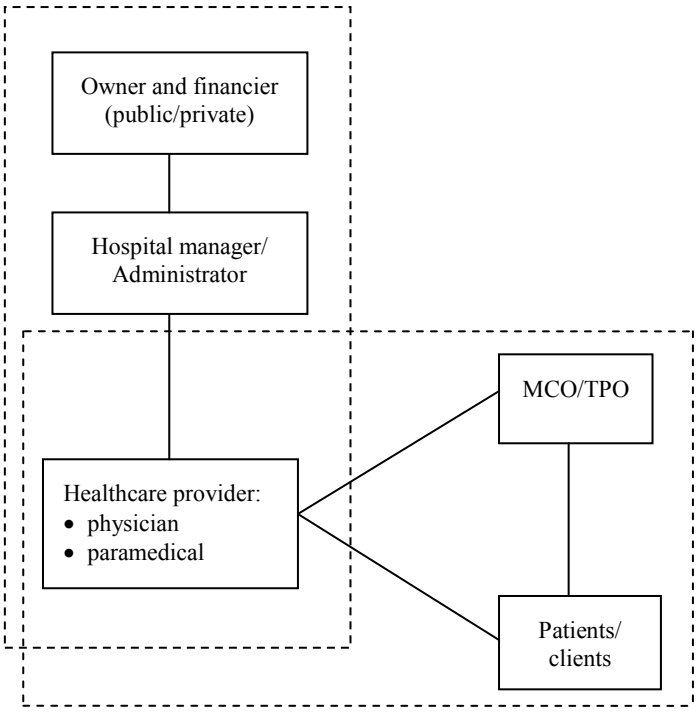

Figure 1: Relationship among different groups within healthcare sector

Group Politics and the Political-Economic Environment

The larger system that occupational associations or interest groups originate from and operate within consists of multiple sets of institution and multiple layers of authority. Based on the trichotomy of civil society theory and the particularity of the healthcare industry, Figure 2 illustrates the triangular relationship between the state, market and civil society and the direction and possible content of interaction between different spheres, institutions and groups. In theory, civil society refers to an arena of uncoerced action where different interests are articulated through voluntary self-organisation or institutions, interposed between the family and the state, that form the basis of a functioning society as opposed to the coercive structures of a state, regardless of that state's political system (Robertson, 2002: 75; Scott and Marshall, 2005: 72). The state is a set of

institutions, which sets the rules and parameters for the mediation of social or political conflicts among various interests over the use of resources and the direction of public policy, including such institutions as the armed forces, civil service or state bureaucracy, judiciary, and local and national councils of elected representatives, such as a parliament (Scott and Marshall, 2005: 631–633). Conceptually, the institutions of civil society, the state and markets are distinctively different from each other, but in practice, there is no clear boundary between the three institutions as none could exist without the other two (Robertson, 2002: 75).

It should be noted that the tripartite division is taken as an analytical tool, not a normative framework, to make sense of the activities of different players, both state and non-state. Certain researchers, such as Barraclough and Chee (2009), are concerned with the role of professional associations as civil organisations that oppose the state. This study views civil society as an arena occupied by voluntary groups with different degrees of politicisation and unequal resources over which they tend to compete. Different forms of voluntary social organisations, such as charity groups, religious groups, occupational/professional associations, non-governmental groups, guilds and advocacy groups, may seek to influence the government's legislation or encourage or prevent changes in existing policy, but they are not equally powerful or resourceful. As aggregated interests, pressure groups can exercise influence over governments and policy through many channels. They can educate citizens about the issues they are concerned with through their publications, publicity campaigns and advocacy efforts (Eckstein, 1960; Berry, 1989). By shaping public opinion, they are able to set their agenda, turn problems into issues and bring issues to light. They may also closely monitor programs or follow policy recommendations that affect their constituents and "try to draw attention to shortcomings through such strategies as issuing evaluative reports and contacting people in the media" (Berry, 1989: 7). When they attempt to influence policymakers, they are engaging in lobbying. The nature of the state may in turn affect the activities of the groups; sometimes, consultations are sought and different interests are equally or unequally represented in the policy-making process, depending on the political-economic environment.

Under a cabinet system, interest groups tend to channel their influence through the executive branch, while in an assembly-dominated context, collective bargaining tends to surround the legislature (Ball and Millard, 1986: 42–44). In political systems that practice corporatism, interest groups' opinions are usually institutionalised through consultations (Eckstein, 1960: 25). There are also differences between federal and centralised systems. The point of exerting influence, however, depends on issues, as not all issues fall within the discretion of the provincial government in a federal system. In a centralised environment, interest groups tend to influence central departments (Ball and Millard, 1986: 43).

Another important factor that influences group politics is fragmentation between governmental institutions. Differences not only take place between larger institutions, such as the legislative and executive branches, but power is also dispersed across different departments within the same institution. Fragmented decision-making authority thus affects the strategies of interest groups. Taking Malaysia as an example, tension between the Prime Minister Department's Economic Planning Unit (EPU) and the Ministry of Health (MOH) over healthcare-policy decisions is one of the fragmentations within the Malaysian Government. This tension was exposed in late 2005 when the EPU disclosed terms of reference on the National Health Financing Scheme (NHFS), which the MOH was unable to provide when pressed by a civil coalition called the Coalition Against Healthcare Privatisation (CAHP). The event uncovered the MOH's relatively minor role—with respect to the EPU—in healthcare financing policy.

Pressure groups also structure their influence differently according to the nature of the party system. One-party-systems and two-party-systems, compared with multi-party systems, offer fewer targets for pressure groups to channel influence. The degree of strictness of intra-party discipline also affects the ease of infiltration by external groups. Ideology is another factor that might limit the attractiveness of a party only to certain groups. For example, business groups mainly support parties on the right in both Britain and the US (Ball and Millard, 1986: 44–46). Major differences in party ideology in Malaysia are, however, are not based on economics, but on the difference between communal based and non-communal based. Although some political economists (Subramaniam, 2000; Chan, 2000a) criticise the Malaysian government for instituting liberal economic policies, as can be seen in a series of deregulation and privatisation policies since the 1980s, such critiques overlook the contradicting approaches of the Malaysian government itself. It is true that the Malaysian government has been reducing its role in welfare, providing healthcare through a series of deregulation and privatisation policies, but this cannot be equated to liberalisation if liberalisation means minimal intervention by the state in the market. It should be noted that although the past three decades saw a range of deregulation and privatisation policies emerge, increasing investment and intervention by the Malaysian government in profitable markets and rhetoric against liberalisation pressure imposed by supranational groups were also observed during the same period of time. The state's role has changed from being solely a regulator of markets to a mixture of regulator and investor in the past few decades. The right-left distinction is thus not a powerful analytical tool to understand the ideology of the Malaysian government.

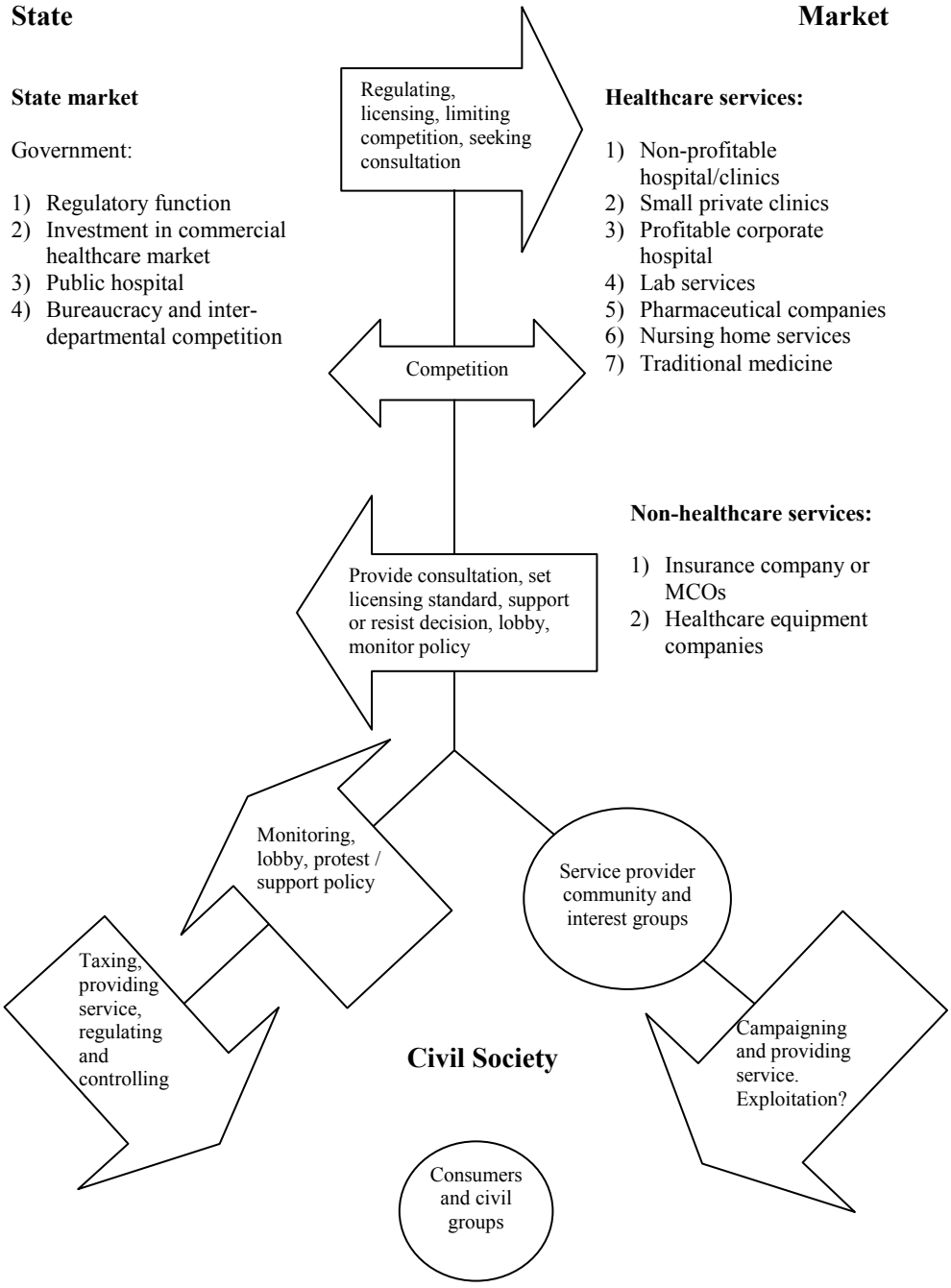

Figure 2: Triangular relationship and interaction between state, market and civil society

Last but not least is the extent to which the activities of pressure groups are tolerated or suppressed by the state. Democratised regimes tend to be more tolerant of, responsive to and consultative divergent demands in a pluralised society. Active group politics is thus a common political scene in liberal democracies. In the case of Malaysia, Crouch (1996: 236–247) calls Malaysian government as a 'repressive-responsive regime', democratic in terms of constitutional structure but tending to use an authoritarian approach to control social divisions and political tensions. Factionalism and social differentiation, created by industrial development, provide incentives for the leadership to protect interests and maintain stability by resorting to repressive measures, but at the same time, diversification also "act[s] as a brake on authoritarianism" (Crouch, 1994: 32). As an authoritarian capitalist state, which plays both regulator and investor roles in the profitable market, the Malaysian government does not seek consultation by nature, but its power is likely to be limited as it is faced with countervailing forces in an increasingly divided and pluralised industrial society.

DIVERGENCE AND DIFFERENTIATION WITHIN THE HEALTHCARE SECTOR IN MALAYSIA

Social Divergence in the Pre-independence Period

During the colonisation of Malaya by the British, traditional healers played an important role in delivering healthcare and ritual services to the natives and immigrant labourers, while western healthcare services were originally meant primarily for the purpose of serving the needs of British administrators, troops and other colonists in Colonial Malaya (Manderson, 1996: 15). When western biomedical services were newly introduced by the British Colonial government to the natives and immigrant labourers in Malaya around a century ago, in order to control the health status and thus the productivity of the colonised community, it was then but one option among many competing traditional practices (Manderson, 1996: 18–25). A shortage of human and physical resources was another obstacle to the British population-based approach of maintaining a healthy and strong labour supply for the expansion of colonial state capitalism. Traditional healers, especially midwives, were thus later co-opted into the colonial healthcare system to legitimise the state's control over the domestic affairs and maternal health of the natives and immigrant communities (Manderson, 1996: 201–229). Schools were established to educate the girls and women of the colonised communities on domestic science and hygiene, and local women were recruited to be trained as western, biomedical midwives beginning in the early 20th century. Compulsory registration, for both biomedically and locally trained midwives, was also instituted in 1917 to control the practice of midwifery. The allocation of roles within the biomedical healthcare system and hospitals, however, was based on

race, not on training. Europeans were always regarded by the Colonial government as superior (Manderson, 1996: 212) and were given superior positions (Manderson, 1996: 208). The differential treatment of locally recruited and foreign-recruited personnel was not only reflected by positions held, but also by salaries, opportunities for promotion and status (Cohen, 1971: 124; Danaraj, 1988: 23).

By distinguishing between white European and non-white-European labour[14] and associating the demarcation with biomedicine vs. traditional healing, modern vs. backward and superior vs. inferior, the British Colonial government instituted new social stratification in the colonial society. The new social stratification was then the main divergence in the society, where people were accorded treatment and granted authority based on racial differences. Such demarcation continued among the locals even after independence, as can be seen in the negative attitudes of western-trained, local physicians to traditional healers. Sometimes, such differences have become a source of tension between western-trained, local healthcare providers and traditional healers (Laderman, 1983: 103–123) and have persisted even after decades of independence (see the following section and Table 1).

Though bred within a historical context of the cultural and social collision between local, traditional authority and western colonial power, the development of the biomedical professions in Malaysia shared many similarities with their western counterparts in terms of professionalisation: it took them quite some decades to gain acceptance for biomedical science in the larger society before it was able to consolidate and become dominant among all healers; its consolidation and professionalisation were backed by the state through a registration and licensure system; and, its professional interest was protected, and its dominance maintained, through the active political engagement of occupational associations. The establishment of the Straits Medical Association and the *Journal of Straits Medical Association* (*JSMA*) in 1890 by a group of medical officers, all British, was one such effort to advance the development of the profession and cater to the need for in-service education by the medical community (Cohen, 1971). The association, however, faced difficulty in recruiting new members until it was registered as the Malaya Branch of the British Medical Association (MBBMA) in 1894 (Cohen, 1971), and the *JSMA* was also renamed correspondingly as the *Journal of Malaya Branch of British Medical Association* (*JMBBMA*) in 1904 (Chen, 1982). The change in name of the association and its journal is illustrative of the aforementioned social stratification and contention. Nevertheless, disgruntlement started to grow in the local professional community after World War II, as it was exposed to the full experience of running hospitals without governance by British officers during war time and thus gained confidence. The Alumni Association of the King

Edward VII College of Medicine, the oldest organisation of local medical professionals, was seen taking political character in 1948 to represent the views and interests of the local men to the British administrator (Cohen, 1971). Turning political a few years before independence, the Alumni Association was mainly concerned with breaking the discriminatory dichotomy between the British and the local and gaining independence from colonial authority. Two years after independence, the Malayan Medical Association (MMA) was formed out of merging the MBBMA and the Alumni Association, reflecting the political developments that were taking place during the post-war era.

As a body that sought to cultivate professionalism and uphold the interests of its members, the MBBMA basically was "advising government in medical matters" (Strahan, 1948) and providing in-service education, through seminars and publication, since the British colonial era (Cohen, 1971). It was undeniable that the MBBMA, and later its successor, the MMA, had enjoyed status as the sole official representative for the medical profession in Malaysia from the post-war years until 1980. Other than the physician's group, the post-war years also saw the formation of the Trained Nurses League Penang in 1950, the Malayan Trained Nurses Association (MTNA) in 1952 and many other paramedical groups. However, the relationship between different occupational groups within the healthcare industry in the pre-independence and early post-independence years has yet to be explored. The social divergence that made the physician's group turn political in the pre-independence years was to break the discriminatory binary barrier, not differentiation among physicians nor between physicians and other healthcare providers.

Social Change and Differentiation in the Post-independence Years

The early period of post-independence saw the continued persistence of local elites to decolonise local society. One such effort was to establish a local higher education system in order to produce enough skilful workers for social development. Local medical education was seen as needed and urgent in order to gain autonomy and cease reliance on foreign doctors to provide for the healthcare needs of the local community (Danaraj, 1988: 22). The ability to train local medical professionals in local universities was an integral part of the newly independent nation's self-strengthening, industrialisation and modernisation.

On the way to becoming a modern, industrialised and developed nation, the Malaysian government introduced a new dichotomy to replace the discriminatory binary between the British and locals after the race riot on 13 May 1969, which was claimed to be the result of economic inequity between the Chinese and Malays.[18] Bumiputra and non-Bumiputra became new markers under the New Economic Policy (NEP), introduced in 1971 by then Prime Minister Tun Abdul

Razak in order to narrow the disparity between the two communities. The stated objectives and goals of the NEP, which sought to restructure the economy so as to eliminate the identification of ethnicity with economic function, were good, but the implementation had been controversial. Two decades after the implementation of the NEP, the expansion of the middle class or the emergence of the new middle class across ethnic groups generally and in the Malay community particularly is seen as a direct result of the state's intervention in restructuring the economy (Abdul Rahman, 2001).

It is in this historical context, that non-race-based social differentiation caught the attention of some social scientists, who focused on the study of the middle class as a potential base for democratisation. They were particularly concerned with how much or to what extent the political and civic engagement of the newly emergent middle class could break the communal politics that had dominated the country since independence (Kahn, 1996; Saravamuttu, 2001; Abdul Rahman, 2001, 2002). Supportive to or sceptical about the state, embracing or opposing racial politics, these dichotomies actually do not exhaust the divergence of the new middle class. Other than diversification along racial, religious and political lines, new differentiations that involve competition for authority and resources within certain industrial sectors, such as the healthcare sector, also take place as a result of industrialisation and development. The new division of labour, the introduction of administrators, such as MCOs or TPAs, and the emergence of different healthcare providers, such as physiotherapists, pharmacists etc., within the healthcare industry, are also result of the state's development policies in the late 1980s. Old racial politics continue to persist, while new group politics have begun to emerge. The following discussion will focus on the differentiation as manifested in the formation of different groups within the Malaysian healthcare industry. These groups not only reflect the plurality within the modern healthcare sector, which is interposed between the individual and the state, but they also function to articulate, aggregate and organise divergent interests in modern industrial society.

Before independence, although it was engaged in the larger anti-colonisation political movement, the MMA mainly adopted a non-political stance in favour of upholding professional interest, such as holding seminars and publishing new scientific information. Nevertheless, the MMA became increasingly political after independence. Conflict between physicians and the newly independent state became common in the days after independence. Resources were scarce then, yet demands were growing among the population and physicians as well. Salary scale, opportunity for promotion, work load and the outflow of medical officers from government service to private practice were among the most debated issues. The MMA was vocal about the working conditions of medical officers in public hospitals and keen on protecting the image of physicians who left public service

for private practice. It was also active in contributing ideas for developing and upgrading the nation's healthcare system, such as medical education, the training of specialists and recruitment of foreign doctors to overcome shortages in public hospitals.

The political character of the MMA has grown even stronger, and the state-group relation has become more complicated, since the 1990s. The main reason for this change is the healthcare privatisation policy, a strategy of industrial development undertaken by the Malaysian government in the late 1980s. The MMA's activities are increasingly political in the sense that the physician community as an organised bloc is increasingly bargaining collectively with the state whenever there are indications of likely impingement on the economic setting or professional autonomy of physicians' work in the process of federal policy formulation or promulgation. This can be observed in its response, sometimes even protest, to many of the policy recommendations or implementations made by the federal government, such as the proposal of the National Health Financing Scheme, the mandatory medical screening of foreign labour by the authorised company FOMEMA, compulsory engagement with authorised clinical waste disposal companies, e-Kesihatan, the separation of prescribing and dispensing etc. Table 1 shows a series of contentions that have been taking place within the Malaysian healthcare industry since 1996.

Parallel with its growing political character, however, the MMA has gradually been losing its status as the sole voice of the medical community in the face of rapid differentiation and expanding plurality within the healthcare industry. The establishment of the Primary Care Doctors' Organisation Malaysia (PCDOM) in the mid-1990s is a sign of increasing divergence between primary care doctors and corporate hospital practitioners. The frequent appearance of the Federation of Private Medical Practitioners' Association of Malaysia (FPMPAM), which was founded in 1989, in the mainstream media in the past few years is another symptom of the growing disparity between physicians working in public hospitals and those in private settings. Both the MMA and FPMPAM are very aggressive in their publicity campaigns. Media exposure is not only a channel to voice their grievances on certain policies but also a way to uphold the community's image.

Table 1: Inter-group and state-group contentions within the Malaysian healthcare industry since 1996

Year	**Inter-group or state-group contention**	**Description**
1996	National Healthcare Financing Scheme proposal	The recommendation was first made during early 1980's. MMA expressed serious concern when the federal proposal reemerged during late 1990s. Such concern is documented in MMA (1999).
1997	Mandatory health screening for all legal foreign workers in Malaysia by authorised private agent, FOMEMA	FOMEMA stands for Foreign Workers' Medical Examination Monitoring Agency. It is also a government linked company, established in 1997 to manage and operate a mandatory foreign worker health screening system in Peninsular Malaysia. The federal government's decision was not so welcomed by MMA, the then President Dr. Milton Lum claimed that the doctors, like the foreign workers and the employers, were the victim of the new agreement. See *New Straits Times*, 22 September, 1997, National News, pg. 17.
1998	Promulgation of Private Healthcare Facilities and Services Act 1998	The act was not enforced until the promulgation of Private Healthcare Facilities and Services Regulation 2006 eight years later by the then Health Minister, Dr. Chua Soi Lek.
July 2002	Compulsory engagement with authorised clinical waste disposal companies	Introduced in the mid of 2002, the policy requires all clinics to engage with only three registered companies appointed by the Department of Environment for clinical waste disposal service, effective on 1 July 2002. MMA released a press statement "MMA Advises Private Clinics to Engage the Services of Authorised Clinical Waste Disposal Companies Only", on 23 August 2002. The private practitioners were particularly not happy with the fee and other terms of service.
May 2004	Private wing in government hospital	APHM expressed discontentment over the government's decision to set up private wing within government hospital, which was aimed to stop brain drain. It was perceived by the former as threat to the private hospital's business. APHM insisted that government should leave the market of the rich patient to private hospital. See APHM's position paper, "Private Wings in Public Sector Hospitals", on 10 May 2004.

(*continued*)

Table 1: (*continued*)

Year	Inter-group or state-group contention	Description
July 2005	Replacing Hospital Directors with Paramedics or Administrative Officers	No policies announced this time, it was just a precaution taken by the MMA to warn against the government from any move of appointing paramedics, other administrators or non-physicians as director of the government hospital. The event illustrates the tension between physicians and paramedics as well as administrators.
March 2006	Dispute over the Term of Reference of NHFS	On early 2006, EPU disclosed terms of reference on the National Health Financing Scheme (NHFS), which MOH was unable to provide when pressed upon by a civil coalition called Coalition Against Healthcare Privatization (CAHP). The event uncovered MOH's relatively minor position, in relation to EPU, over healthcare policy decision.
April 2006	Promulgation of Private Healthcare Facilities and Services Regulation 2006	Private practitioners and clinics are particularly unhappy with the requirement under this regulation that they had to re-register with MOH and the hefty fines and jail term if they fail to re-register. This is mainly tension between the private practitioners and the MOH. See the MMA's press statement on 21 April 2006 and 27 June 2006.
April 2006	Introduction of traditional medicine into public hospital systems by MOH	Traditional Medicine section was introduced in selected government hospital. MMA opposed the idea and clamed that traditional medicine is "premature", "non-evidence based", "unproven medical systems" run by "improperly trained and unlicensed persons". This episode is the continued tension between traditional healers and biomedical professionals since British colonial years. See their press statement, "Traditional medicine to be introduced selected government hospitals: MMA's views" on 27 April 2006.

(*continued*)

Table 1: (*continued*)

Year	Inter-group or state-group contention	Description
2007–2008	e-Kesihatan	E-Kesihatan is a federal policy proposed by the Road Transport Department. Under this proposal, the compulsory annual medical examination of commercial transport drivers is to be monitored by a third party, a private company between the drivers and the doctors, and only clinics registered with the company are allowed to carry out the screening. The intention was firstly expressed on early 2006 and re-raised in late 2007, but scraped in late 2008 in face of strong protest by both the physician community and the commercial drivers. MMA released at least seven press statements from 2006 to 2008 on e-Kesihatan.
2007–2008	MCO charging doctor "management fee" or "splitting fee" case	This episode involves conflict between Federation of Private Medical Practitioners Association (FPMPAM) and Managed Care Organization, ING. During September 2007, ING demanded discounts from the doctors and private hospitals in order for the latter to be on the insurance company's panel. The discount, claimed ING senior vice-president Mr. Phoon Yew Sang, would not affect the patients, and would be passed back to their customers and not go to ING. The proposal was considered as "fee-splitting"[a], an unethical practice, by private practitioners. Physicians from eight private hospitals in Klang Valley formed Joint Inter Hospital Committee (JIHC) to oppose the plan. Both camps claimed that their concern was patient centered and were aggressive in their advocacy. The controversy ended on April 2008, with the MCO required to register with MOH and only discount in administration fee is allowed.

(*continued*)

Table 1: (*continued*)

Year	Inter-group or state-group contention	Description
2008	Reviewing private hospital charges	This is a continuation of the above tension between MCO and private hospital that started on the third quarter of 2007. The focus is on hospital charges in this dispute. It shows that there is a certain degree of tension between hospital and physicians, as the latter do not own hospital and some are not satisfied that hospital charges are not regulated while medical fees are. Both MMA and FOMCA supported the Health Ministry's plan to review private hospital charges for room, equipment and medicine. See "Ministry to study hospital charges" in *The Star*, 17 April, 2008 and Milton Lum[b] (May 2008) "Hospital charges and fee splitting". *The Star*, 18 May 2008.
January 2009	Separation of prescribing and dispensing	The contention took place around early 2008, between pharmacist group and physicians. MMA protested against the proposal in its press statement, "MMA opposes the separation of the role of prescribing and dispensing by doctors", on 29 March 2008.
October 2009	One Malaysia Clinic and paramedical	Both MMA and FPMPAM opposed the setting up of One Malaysia Clinic which is to be run by paramedics. It is perceived as a threat to the physician's authority generally and to solo practitioners particularly. The urban solo practitioners especially take it as a blow on their business.
October 2009	Primary care feeder clinics by private corporate hospital	This episode is illustrative of the tensions between solo practitioner and corporate hospital. See MMA press statement, "Private Medical Centers break the law by opening feeder primary care clinics", on 21 October 2009.

a - A type of kick-back arrangement
b - It should be noted that Milton Lum is former President of MAA, for year 1997. He is very active, even after relieved from the MAA's Presidentship, in protecting professional interest through writing articles for the media and vocal in many episode of contentions in the past few years.

The emergence of managerialism and the growth of bureaucratisation can be observed in the formation of the Association of Private Hospitals Malaysia (APHM), which represents the commercial interests of the owners and administrators of corporate hospitals. Though private hospitals are not new in the

Malaysian healthcare industry, until recently they were basically run by doctors and charitable organisations, and the total number was small. By the 1990s, profit-oriented private hospitals began to be set up by large corporate entities, leading to a new phase in the development of private hospitals. This occurred as a result of the state's healthcare liberalisation, deregulation and privatisation project, which marked the beginning of healthcare pluralisation (Barraclough, 1997). The liberalisation of healthcare was not only a response to the external structural adjustment requirements or deregulation pressures that were imposed by supranational organisations such as International Monetary Fund and World Bank in the 1980s as a condition for the developing country to get development loans (Chan, 2000a, 2000b; Subramaniam, 2000); it has also been a measure undertaken by the Malaysian government to relieve the public healthcare system from becoming overburdened (Barraclough, 1999). Another internal factor conducive to the expansion of private healthcare came from the growing middle class and newly emerging urban areas (Barraclough, 1997), which were a result of state-led industrialisation. Both increasing buying power and growing discontent over public healthcare services among the middle class provide incentives for the expansion of the profitable private healthcare market. As of 2006, the total number of private hospital had reached 233, up from 50 in 1980. Table 2 shows different combinations of ownership and financing of Malaysian healthcare services. The mushrooming of private corporate hospitals led to the emergence of hospital administrators and growing tensions between managers and the physicians within the private hospital setting. Business competition between sub-sectors C and D is also a source of conflict, as can be seen in the APHM's opposition to the establishment of a private wing within a public hospital in the middle of 2004 and the MMA's opposition to One Malaysia Clinics in late 2009 (refer Table 1). Other than contention across sub-sectors, there is also divergence within the same sub-sector. The MMA's disgruntlement over primary-care feeder clinics run by corporate hospitals takes place within sub-sector D; this is symptomatic of the tension between solo practitioners and corporate hospitals.

Other than the division of labour among physicians and conflict between administrators and physicians, the emergence of paramedical professionals has further added to the tension between different groups in the medical industry. The entry of Managed Care Organisations (MCO) into the medical industry after 1994 is another source of complexity in healthcare politics, as observed in frequent friction and collective bargaining between private corporate practitioners and the MCOs over terms of purchase and payment for healthcare service. There are a few episodes particularly symptomatic of this divergence. One took place in 2005, when the MMA opposed the suggestion of replacing Hospital Directors with Paramedics or Administrative Officers (refer Table 1). Another occurred in the first quarter of 2008, when the MMA stood by the FOMCA to welcome the

proposed move by the MOH to review private hospital charges for room equipment and medicine, while the APHM was not so happy with it (refer Table 1). Conflict between pharmacists and physicians also emerged around the first quarter of 2009, when the former attempted to promote the separation of prescribing and dispensing (refer Table 1). One additional episode of inter-group conflict, which has great impact on the public, is worth noting. It took place between physicians and MCOs over the terms of purchase and payment. Portraying themselves as 'patient/consumer advocate[s]', both professional groups and MCOs tend to use rhetoric such as 'for the patient's benefit' or 'for consumers' rights' in defence of their proposals or counter proposals whenever disputes emerge. Although affected, consumers are often regarded as objects of exploitation by different groups, and yet they are not organised as a collective-bargaining bloc like professional groups and MCOs. The MOH, squeezed between contending groups and expected to be an impartial arbitrator acting for the benefit of the public, is always perceived as benefiting certain sectoral interests by resolving disputes.

Table 2: Malaysian health system: Ownership of providers and financing of health services

		Ownership of providers	
		Public	*Private*
Financing of health services	***Publicly funded:*** entitlements (citizens, government employees), donations and (co)payments	**A.** Formal public sector: rationed, free or highly-subsidised services	**B.** Non-profit providers: voluntary services, donations, paying patients, internal cross subsidies
	Privately funded: self-paid private employers, co-payments	**C.** Publicly-owned commercial providers, private wards/patients	**D.** Privately-owned commercial providers

Source: Chan (2010)

Group formation and activities, inter-group conflicts and the state-group friction are all illustrative of the new differentiation that has been taking place since the implementation of privatisation in the late 1980s. As can be seen in the active political engagement of different groups in the past two decades, the aggregation of interest and collective bargaining put forward by these professional associations and guilds are highly tolerated by the Malaysian government, compared with what other democratisation or social movement groups, such as BERSIH, HINDRAF and *Gabungan Mansuhkan ISA* (GMI), have experienced. No professional associations or guilds have ever resorted to public assembly as a

way to express their interests, probably because they are resourceful and have many channels through which to exert their influence. The Medical Council is one of such channel in which physicians' views are consulted. Their collective bargaining activities are tolerated as long as they pose little or no threat to the ruling coalition's political interests.

CONCLUSION

Although there was competition between traditional healers and biomedical professionals in the pre-independence period, the discriminatory dichotomy created by the British colonial government was the main social divergence. The Alumni Association of the King Edward VII College of Medicine adopted a political character in the early years after World War II to break the binary system imposed by the British. In the early post-independence period, although there were different intensities of tension between the MMA and the state on many occasions, an economic imbalance between bumiputra and non-bumiputra was the main social contention. Four decades after gaining independence, new social differentiations arose and became new sources of conflict in the newly industrialised Malaysia. Among the new divergences within the healthcare industry were those among physicians, the division of labour among different occupations and competition between sub-sectors. The formation of new professional groups and guilds and inter-group/inter-occupational conflicts are illustrative of the new differentiation and stratification.

Control of medical work and control of economic arrangements are two loci of competition for power. Analytically, these are two different concepts. In practice, they are always overlapped, as control of work usually, although not always, guarantees control of remuneration. Rivalry between physicians and paramedics is a competition over control of medical work or professional autonomy, whereas the contest among doctors and the contention between the former and administrators, MCOs, commercial players (e.g., the APHM) and the state are usually over control of remuneration or economic arrangements. In terms of capability and politicisation, physicians' groups are clearly more powerful than paramedical groups and MCOs, as can be observed in their aggressive PR campaigning, lobbying activities, frequent publicity and regular publication. Among physicians, primary care doctors' positions are more vulnerable than the positions of their specialist and corporate-bond counterparts. It is obvious that consumer groups are rarely present in these contests, reflecting an imbalance in interest representation during each contention. Finally, the state is not a neutral player; it is also an investor in the profitable, private healthcare market.

Given this plurality, any change in healthcare policy in the near future is likely to add more diversities, contentions and uncertainties to the healthcare system. Although there are many different lines of diversification in modern, industrialised Malaysia, this study shares the concern of some other social scientists regarding the role of the new middle class as the prime force of democratisation. After five decades of independence, social change has made democratisation an urgent matter in order to institutionalise a fair and transparent mediation framework of new social diversifications in contemporary Malaysia. Though different healthcare professions and commercial players are mainly concerned with their own sectoral interests, competition could be a process that allows each player to learn and recognise the plurality of modern industrial society and the importance of having a fair and transparent mechanism that represents different interests. Group politics research is thus very important and worth further exploration, as it captures the intermediate level between the middle class and the state, how different interests are aggregated and how mediation takes place in modern industrial Malaysia.

ACKNOWLEDGEMENT

The author would like to express gratitude to the editors of Kajian Malaysia for the comments they have given and committees of PSSM (Persatuan Sains Sosial Malaysia) for the platform they have built for young Malaysian scholars.

NOTES

1. The term 'Frankenstein' in the title of this article is a metaphor. 'Frankenstein's monster' (or referred to as 'Frankenstein' here) is created by a scientist to control life and death, but later the creature gains life and a will of its own. Pluralisation created out of industrial development is very much like the man-made 'Frankenstein'. This article aims to capture how the 'Frankenstein' of the healthcare industry has been created and its impact on the healthcare sector within which it has been created.
2. See Nik Rosnah Wan Abdullah (2005: 54) and *Health Facts* (2006) by Ministry of Health (MOH). Both figures include private maternity and nursing homes, as the MOH does not sort them out from private hospitals.
3. The figures shown here include both public and private medical schools. There were no private medical schools before the 1990s. See speech delivered by Ismail Merican (2009) as Director General of Ministry of Health. See also Kuljit Singh (February 2010) and Danaraj (1988).
4. In 2008, the ratio was 1:1105. For details, see Ismail Merican (2009).
5. *Berita MMA* is a monthly bulletin published by the Malaysia Medical Association (MMA).

6. The consolidation of bio-medicine as a dominant healthcare profession in the West only took place around the early 20th century. Today, physicians are no longer considered new middle class in the West. They have been, rather, regarded as the *old professions* in the American and European contexts since the middle of the 20th century, which saw the rise of managers and administrators as the new professions. For a related discussion, see Mills (1967). In Malaysia, both managerial and professional occupations are commonly termed *new middle class* by different social scientists who define the term based on occupations. However, with the rise of managerialism, tensions grow between administrators and physicians within healthcare organisations. This point will be discussed further in the following section.
7. Such a view is common among the national leaders and ministerial officers, who tend to take professional contribution to national development for granted.
8. According to their observations, the Association of Private Hospital Malaysia (APHM), MMA and FOMCA are relatively more frequently consulted than the more critical Consumer Association of Penang (CAP).
9. The distinction Dahrendorf made between capitalistic and industrial societies is based on the separation of ownership and administration, but that discussion is beyond the scope of this study.
10. For detailed discussion of internal factors that affect the collective action of occupational-turned-political groups, refer Olson (1965), Eckstein (1960) and, Ball and Millard (1986).
11. This episode of tussle is documented in *The Star* (14 December 2005), Netto (2006) and Subramaniam (2005).
12. As can be seen in the tariff protection of the two national car manufacturers against foreign competitor.
13. Investment in private profitable chain hospital by Khazanah Nasional Berhad and Kumpulan Perubatan Johor (KPJ), both state owned enterprise, to generate revenue are examples of the state's role as investor in profitable healthcare market.
14. Including the natives and immigrant labour from China and India.
15. It was originally named as Straits Settlements and Federated Malay States Government Medical School in 1905 and renamed as King Edward VII Medical School in 1912. Since the term *school* was perceived as not conveying the academic status of university standard, it was later renamed as King Edward VII College of Medicine in 1920 and reinstituted as the Faculty of Medicine under Malaya University in 1948. See Cohen (1971).
16. Later renamed Malaysian Medical Association, but the year when it was renamed as such is unclear. Singapore Medical Association was formed in the same year, separated from the then Malayan Medical Association. See Chia (2006).
17. Renamed as Malaysian Nurses Association in 1980, see Malaysian Nurses Association (n.d.).
18. Not all social researchers agree that it was a racial riot, see Kua (2007).
19. The discussion on MMA-state conflict during early post-independent years is based on the news article in the *Straits Times* from year 1957 to 1972 and *Berita MMA* from 1970s throughout 1980s.

20. Such as primary care and tertiary care or specialists, corporate and government bond practitioners.
21. Such as nurse, radiologist, lab technician, anaesthesia technician, physiotherapist, pharmacist, etc.
22. See news article 'Managing healthcare,' *The Star*, 20 April 2008.
23. *The Star*, "Health Ministry to check on private hospital charges deemed excessive," 16 April 2008.
24. Read commentary made by former MMA President, Milton Lum, "Hospital charges and fee splitting," *The Star*, 18 May 2008.
25. Coalition of Abolishing ISA.

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