

# Growth and Geographic Concentration of Licensed Private Healthcare Facilities and Workforce in Sarawak, Malaysia

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DOI: <https://doi.org/10.47772/IJRISS.2026.100900174>

Received: 21 September 2026; Accepted: 26 September 2026; Published: 05 October 2026

## ABSTRACT

**Background:** Current state-level information on the licensed private healthcare sector is needed for regulatory planning, workforce monitoring, and assessment of geographic concentration. This study described the growth, licensed bed capacity, medical workforce, nursing workforce, and geographic distribution of licensed private healthcare facilities and services in Sarawak, Malaysia.

**Methods:** A secondary descriptive analysis was conducted using aggregated administrative data provided by the Licensing Unit of the Private Medical Practice Control Section (CKAPS) Sarawak. Facility records were validated by CKAPS Sarawak against official licence registers and renewal records. The dataset included annual regulatory stock counts of licensed private healthcare facilities and services from 2007 to 2025 and cross-sectional bed and workforce data updated to 3 April 2026. Frequencies, percentages, absolute changes, growth measures, and population-standardised rates were calculated. Individual facility histories, operational bed status, travel time, public-sector capacity, healthcare utilisation, and clinical outcomes were unavailable.

**Results:** The number of licensed private healthcare facilities and services increased from 1 in 2007 to 60 in 2025. The count remained at 29 from 2012 to 2014, increased to 38 in 2019, and reached 60 in 2025. Thirteen private hospitals accounted for 697 licensed beds, of which 363 (52.1%) were in Kuching, 152 (21.8%) in Miri, 97 (13.9%) in Sibu, and 85 (12.2%) in Bintulu. There were 258 specialists, 63 medical officers and 1,657 nurses amongst the specialists in licensed private facilities/services. Based on the Sarawak population estimates for 2025, these numbers amounted to an average of around 2.4 licensed facilities, 27.6 licensed private hospital beds, 10.2 specialists, 2.5 medical officers and 65.5 nurses per 100,000 persons. Nursing numbers increased by 75, or 4.7%, between 2024 and 2025. The data did not determine if beds were open, staffed or occupied, or if they were temporarily closed.

**Conclusions:** The private healthcare sector in Sarawak continued to increase and grew markedly since 2019. The medical personnel and licensed beds were seen to be geographically clustered in the towns of Kuching, Miri, Sibu, and Bintulu. However, the administrative data describes licensed private-sector capacity rather than operational capacity or equitable access. Integration with public-sector capacity, healthcare utilisation, facility-level operational data, and travel-time analysis is required for a more complete assessment of service availability and geographic equity.

**Keywords:** private healthcare; health workforce; regulation; geographic distribution; Sarawak; Malaysia

## INTRODUCTION

Malaysia has a mixed health system with a sizeable private health sector and a public health system that is financed by taxation. Besides the public hospitals, ambulatory care centres, haemodialysis centres, nursing care homes, hospices and related services all work toward increasing service capacity, and all need effective service licensing, monitoring, and planning. The Private Healthcare Facilities and Services Act 1998 and its regulations form the main legal framework related to private healthcare facilities and services in Malaysia (Laws of Malaysia, 1998).

The planning situation in Sarawak is unique. In 2025, it had an estimated population of 2.53 million people and is the state with the lowest population density in Malaysia with around 20 people per square kilometre (Department of Statistics Malaysia, 2025a, 2025b). Practical access is determined by travel distances, the distribution of settlements, and the clustering of specialist services in major cities, which can have a significant impact regardless of statewide increases in capacity. So counts of facilities and people should be read in conjunction with their geographic distribution.

The Health White Paper for Malaysia prioritizes equitable, sustainable, and quality service, a fit for purpose workforce, enhanced governance, and improved effective public-private collaboration (Ministry of Health Malaysia, 2023). International guidance also considers reliable information on private providers as an integral part of governance in mixed health systems (World Health Organization, 2024a, 2024b). Regulatory information may help to achieve this aim, as it demonstrates where capacity is and where it is licensed and also reveals the flow of the registered workforce over time.

The description of privately licensed health facilities in Sarawak is still limited, at the State level. Thus, the objectives of this study were to describe (1) the trend of licensed private health care facilities and services from 2007 to 2025; (2) the bed capacity in private hospitals on 3 April 2026; (3) the distribution of specialists and medical officers; (4) the change in the nursing workforce from 2024 to 2025; and (5) the overall distribution of type of private health care facilities across regulatory health care enforcement jurisdictions.

## METHODS

### Study design and data source

This study was a secondary descriptive analysis of aggregated administrative data provided by the Licensing Unit of the Private Medical Practice Control Branch (CKAPS), Sarawak. The records were maintained by CKAPS Sarawak for regulatory and licensing purposes. The dataset included annual counts of licensed private healthcare facilities and services from 2007 to 2025, together with cross-sectional information on licensed private hospital beds and the medical and nursing workforce, updated to 3 April 2026.

CKAPS Sarawak verified the records of the facility against the actual licence records and renewal records. Licensing status of facilities & services in the administrative data set was verified against this process. The aggregated results were then checked for arithmetic consistency, completeness of categories reported, agreement of total figures with the respective categories in the tables, and consistency in the figures in the four tables (hospital, bed, workforce and enforcement jurisdiction). Since the researcher examined the tabulations of the aggregated data, no further facility-level verification has been made.

Annual series values are the number of facilities and services that are reported as being licensed for that year. It should therefore be read as a series of annual counts of facilities under regulation and not necessarily as a sequence of measurements from the same cohort of facilities over time. - The number of facilities opened and licensed during the study period could result in an increase in the annual count while closure, cancellation, suspension, and non-renewal of facilities could produce a decrease in the annual count. Administrative updating or a change in licensing classification also may affect the recorded totals. However, separate changes in the number of facilities and changes in their classification were not included in the amalgamated data and the contributions that these two factors made to the trend could not be quantified.

### Measures

The longitudinal measure was the annual number of licensed private healthcare facilities and services, reported in the source as “*Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta*” (KPJKS). Cross-sectional measures included licensed beds by private hospital; intensive care unit, high-dependency unit, and coronary care unit capacity; specialists and medical officers by facility type; specialists and medical officers in private hospitals by division; nurses by facility type; nursing category; and facility counts within three enforcement jurisdictions and the CKAPS Sarawak headquarters area in Kuching.

The nursing categories were retained as reported: state registered nurse (SRN), jururawat masyarakat (JM), and assistant nurse (AN). Facility categories were translated into English as private hospital, private ambulatory care centre, private haemodialysis centre, private nursing care home, and private hospice.

All hospital bed figures represented licensed beds. The dataset did not indicate how many licensed beds were operational, currently staffed, temporarily unavailable, or routinely used for patient care. Licensed bed capacity was therefore treated as the maximum capacity authorised through the licensing process and not as a direct measure of available or functioning bed capacity.

## Analysis

The analysis used frequencies, percentages, absolute changes, and percentage changes. The change in licensed facilities was defined for the full series and for 2012-2025 as the single facility reported in 2007 makes a compound growth rate for the full period unstable and potentially misleading. Licensed private hospital beds and hospital medical personnel were aggregated by division. A contextual bed-to-population estimate used the 2025 Sarawak population estimate from the Department of Statistics Malaysia; this was not treated as a measure of service availability because the numerator and denominator came from different reporting dates and private hospitals may serve patients across district and state boundaries.

To provide population context, selected statewide indicators were expressed per 100,000 population using the 2025 Sarawak population estimate of 2.5298 million. These indicators included licensed facilities and services, licensed private hospital beds, specialists, medical officers, and nurses. The licensed facility count was available for 2025, whereas the bed and workforce figures were updated to 3 April 2026. Rates based on the latter were therefore interpreted as approximate contextual measures because the numerator and denominator referred to different reporting dates. Division-specific rates were not calculated because sufficiently comparable divisional population denominators and facility-level workforce data were not included in the administrative dataset.

## Ethical considerations

The analysis used aggregated administrative counts and contained no patient-level, staff-level, or personally identifiable information. No individuals were recruited and no intervention was performed. Formal ethics review was therefore not sought for this descriptive secondary analysis.

## RESULTS

### Growth in licensed private healthcare facilities and services

Licensed private healthcare facilities and services increased from 1 in 2007 to 60 in 2025. Rapid early growth was followed by a plateau at 29 facilities from 2012 to 2014. The count then rose gradually to 33 in 2018 and accelerated thereafter, reaching 38 in 2019, 47 in 2022, 55 in 2023, and 60 in 2025. From 2012 to 2025, the number increased by 31 facilities, equivalent to 106.9%, with an approximate compound annual growth rate of 5.7%.

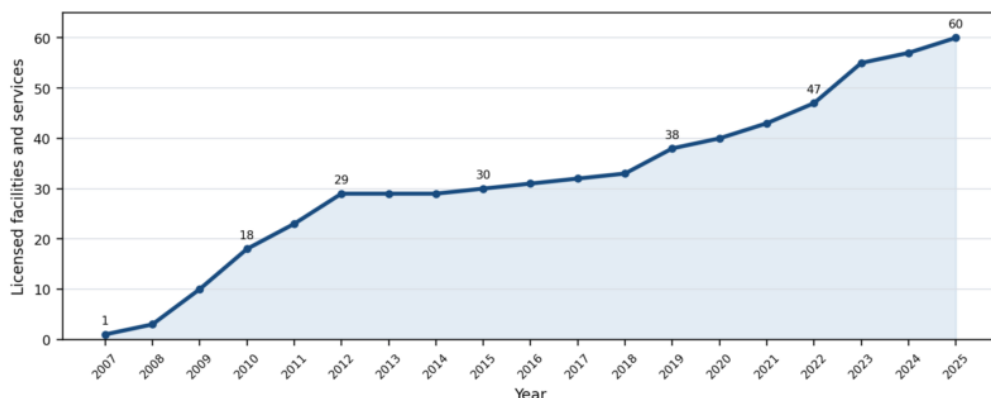


Figure 1 Number of licensed private healthcare facilities and services in Sarawak from 2007 to 2025

## Private hospital bed capacity

Thirteen private hospitals accounted for 697 licensed beds. These figures represent beds authorised through the licensing process; the dataset did not identify how many were operational, staffed, occupied, or temporarily unavailable on 3 April 2026. The findings should therefore be interpreted as licensed capacity rather than immediately available service capacity

The number of licensed private hospital beds in Kuching was 363 beds at five hospitals (52.1%). Four hospitals in Miri accounted for 152 beds (21.8%), two in Sibu for 97 beds (13.9%), and two in Bintulu for 85 beds (12.2%). Kuching Specialist Hospital was the hospital with the highest licensed bed complement (118 beds), followed by Borneo Medical Centre Kuching (86 beds) and Timberland Medical Centre (86 beds). 18 ICU beds were reported in this source as well as 23 HDU and 1 CCU beds. Around 42 beds were thus identified as being in ICU/HDU/CCU.

| Division | Hospitals | Licensed beds | Share of beds (%) |
|----------|-----------|---------------|-------------------|
| Kuching  | 5         | 363           | 52.1              |
| Miri     | 4         | 152           | 21.8              |
| Sibu     | 2         | 97            | 13.9              |
| Bintulu  | 2         | 85            | 12.2              |
| Total    | 13        | 697           | 100.0             |

Note: The counts from the hospital-level table in the provided information were aggregated.

With the population of the state in 2025 estimated at 2.5298 million, there were about 2.8 licensed private hospital beds per 10,000 population. This is an estimation and is not seen as a target or a threshold of adequacy as it does not include beds in the public sector.

## Medical workforce

Across the reported licensed private facilities and services, there were 258 specialists and 63 medical officers. Private hospitals accounted for 239 specialists (92.6% of all reported specialists) and 40 medical officers (63.5% of all reported medical officers). Private ambulatory care centres reported 13 specialists and no medical officers; private haemodialysis centres reported four specialists and 21 medical officers; and private hospices reported two specialists and two medical officers.

| Facility type                   | Specialists | Medical officers |
|---------------------------------|-------------|------------------|
| Private hospitals               | 239         | 40               |
| Private ambulatory care centres | 13          | 0                |
| Private haemodialysis centres   | 4           | 21               |
| Private hospices                | 2           | 2                |
| Total                           | 258         | 63               |

Among private hospitals, Kuching accounted for 139 specialists (58.2%) and 19 medical officers (47.5%). Miri had 49 specialists (20.5%) and 11 medical officers (27.5%), Sibu had 29 specialists (12.1%) and two medical

officers (5.0%) while Bintulu had 22 specialists (9.2%) and eight medical officers (20.0%). The divisional specialist displayed are 239 in total while there were 40 medical officers in all the divisions.

| Division               | Specialists | Share (%) | Medical officers | Share (%) |
|------------------------|-------------|-----------|------------------|-----------|
| Kuching                | 139         | 58.2      | 19               | 47.5      |
| Miri                   | 49          | 20.5      | 11               | 27.5      |
| Sibu                   | 29          | 12.1      | 2                | 5.0       |
| Bintulu                | 22          | 9.2       | 8                | 20.0      |
| Other listed divisions | 0           | 0.0       | 0                | 0.0       |
| Total                  | 239         | 100.0     | 40               | 100.0     |

### Nursing workforce

The number of licensed nurses grew from 1,582 in 2024 to 1,657 in 2025, or a 4.7% growth (75 more nurses). State registered nurses increased from 1,484 to 1,571, a rise of 87 (5.9%). There were no changes in number of JM Nurses (19) but a 15.2% reduction in number of Assistant nurses from 79 to 67 (12 nurses).

In terms of the type of facility, in 2025, private hospitals employed 1,320 nurses, accounting for 79.7%. There were 226 (13.6%) private haemodialysis centres, 39 (2.4%) private ambulatory care centres, 63 (3.8%) private nursing care homes and 9 (0.5%) private hospices. There was a small increase in all three service categories experiencing growth in the number of providers, and a decrease of one nurse in nursing care homes and two in hospices.

| Facility type                   | 2024  | 2025  | Absolute change | Change (%) |
|---------------------------------|-------|-------|-----------------|------------|
| Private hospitals               | 1,258 | 1,320 | +62             | +4.9       |
| Private haemodialysis centres   | 212   | 226   | +14             | +6.6       |
| Private ambulatory care centres | 37    | 39    | +2              | +5.4       |
| Private nursing care homes      | 64    | 63    | -1              | -1.6       |
| Private hospices                | 11    | 9     | -2              | -18.2      |
| Total                           | 1,582 | 1,657 | +75             | +4.7       |

### The distribution of jurisdictions in enforcement is used to show diversity.

Five private hospitals, 18 private haemodialysis centres, three private nursing homes, 10 private ambulatory care centres and two private hospices were reported under the jurisdiction of CKAPS Sarawak headquarters area in Kuching. Two private hospitals, four private haemodialysis centres, one private nursing care home and three private ambulatory care centres were reported in the central enforcement sector in Sibu. In the northern sector, there were four private hospitals, three private haemodialysis centres and a private hospice in Miri. Two private hospitals were reported in the Bintulu sector, with a report of one private haemodialysis centre.

So, when the four jurisdictions labelled in the map are all added together, it covered 13 private hospitals. This sum is in line with the table of the licensed private hospital beds.

## Population-adjusted table

Using the 2025 Sarawak population estimate of 2.5298 million, the 60 licensed private healthcare facilities and services recorded in 2025 corresponded to approximately 2.4 facilities per 100,000 population. The April 2026 administrative snapshot corresponded to approximately 27.6 licensed private hospital beds, 10.2 specialists, 2.5 medical officers, and 65.5 nurses per 100,000 population. These statewide rates describe private-sector regulatory capacity only. They exclude public-sector facilities, beds, and personnel and do not account for cross-boundary utilisation, differences in facility size, or whether licensed beds were operational and staffed.

| Measure                                             | Count | Approximate rate per 100,000 population |
|-----------------------------------------------------|-------|-----------------------------------------|
| Licensed private healthcare facilities and services | 60    | 2.4                                     |
| Licensed private hospital beds                      | 697   | 27.6                                    |
| Specialists                                         | 258   | 10.2                                    |
| Medical officers                                    | 63    | 2.5                                     |
| Nurses                                              | 1657  | 65.5                                    |

Notes: Population denominator: 2,529,800 residents in 2025. The facility count relates to 2025, whereas bed and workforce counts were updated to 3 April 2026. Rates are approximate and represent the licensed private sector only.

## DISCUSSION

### Principal findings

This analysis points towards a marked growth of licensed private health facilities and services in Sarawak. This sector grew more than double from 2012 to 2025 and there was a marked increase after 2019. Similarly, the 2026 snapshot reveals that the distribution of capacity and medical specialists in private hospitals was generally clustered in Kuching, followed by Miri, Sibu and Bintulu. The number of nurses has increased from 2024 to 2025 primarily with the increase in the number of state registered nurses working in private hospital and haemodialysis centres.

The results reflect regulatory inventory, not health care performance. The licensed facility count has no information on number of licensed private hospital beds that are full, how many are empty, how cases are divided between the facilities, the cost of space, the quality of the facilities, the outcome for patients, hours the facilities are open, or whether there are enough staff or facilities to match the licensed private hospital beds. Likewise, head counts are not an indicator of full-time equivalent employees, deployment of staff, turnover, or deployment by shift. The results are best used thus, to determine a baseline for regulatory intelligence and to answer planning questions.

### Workload of development and regulation

A 106.9% increase in facilities from 2012 to 2025 will result in a greater licensing and surveillance workload. Growth was not consistent, as the three-year period from 2012 to 2014 was characterized as a plateau period while growth rates in 2019 and later were higher. Future analysis is needed to determine if this growth is due to newly opened facilities, changes in classifications, better registration, policy changes or change in demand. These explanations are non-discriminatory in terms of the current data.

Administrative data is of higher value, as regulators need more complete, standardised and timely information from providers as the provider base grows. Strategic intelligence is a foundation for private sector regulation and engagement in mixed health systems, as per WHO guidelines on private-sector governance (World Health

Organization, 2024a; 2024b). The licensee and the state could report on a consistent set of definitions and dates on a routine state dashboard of individual licence information, such as active licences, bed capacity, staffing, services, inspections, enforcement actions, closure or suspension status.

### **Geographic concentration and access**

More than half of the licensed private hospital beds and private hospital specialists were located in Kuching. The remaining reported capacity was concentrated in Miri, Sibul, and Bintulu, while the divisional workforce table recorded no private-hospital specialists or medical officers in the other listed divisions. This pattern demonstrates geographic concentration within the licensed private sector, but it does not by itself establish inequitable access or an inadequate distribution of healthcare resources.

The geographic findings must be interpreted within the limitations of the administrative dataset. The analysis used licensed capacity rather than operational or staffed capacity and did not include public hospitals, public-sector personnel, facility utilisation, patient origin, referral flows, affordability, road and river travel times, or cross-divisional use of services. Furthermore, the geographic data were aggregated by administrative division and enforcement jurisdiction rather than by exact facility location or population catchment. A facility situated in one division may serve patients from several neighbouring divisions, while the absence of private-hospital personnel in a division does not imply the absence of public-sector services.

This concentration in Kuching, Miri, Sibul, and Bintulu is perhaps partly due to the concentration of specialist and capital-intensive services in larger urban centres. However, whether this distribution produces clinically meaningful access gaps cannot be determined from the present data. A more complete assessment would combine private- and public-sector capacity with divisional population characteristics, service utilisation, patient referral patterns, and geographic information system estimates of travel time. Until such information is available, the present findings should be interpreted as a description of the location of licensed private-sector resources rather than a comprehensive assessment of healthcare accessibility or equity.

### **Workforce composition**

State registered nurses accounted for the 4.7% annual growth number for nurses. These changes in assistant nurses and the same number of JM may be due to workforce restructuring, attrition, reclassification or recruitment patterns, but are not determinable from two consecutive annual observations. Workforce monitoring should also differentiate by facility, specialty, labor status and FTE provider contributions as there is a strong specialization of specialists within private hospitals.

### **Implications for Policy & Practice**

To start with, Sarawak should have a consistent regulatory data set, with stable identifiers, at facility level. This would enable over time openings and closures, changes in licences or ownership and changes in capacity to be followed. Second, if possible, workforce counts should be reported as both headcount and full-time equivalent, and specialty and employment status. Third, there should be a differentiation between the number of beds that are licensed, operating, staffed, ICU, HDU, CCU and temporarily unavailable beds in bed statistics. Fourth, regulatory data should be coupled with population and travel time data to inform service planning but should not necessarily make an assumption that improving access to services in the private sector will automatically lead to better access to services for all.

The set of data could effectively be used in a structured manner for public-private planning. In the context of this, Malaysia's Health White Paper also recommends enhanced workforce planning and effective inter-sectoral collaboration (Ministry of Health Malaysia, 2023). For Sarawak, it could be collectively understanding the availability of critical care, haemodialysis, specialists, emergency preparedness, and referral pathways, without sacrificing the different roles of regulators, purchasers, and providers.

## RECOMMENDATIONS

The study results indicate that the state of Sarawak should have a regulated database of licensed private healthcare facilities and services which can be standardised and updated on a regular basis. Every facility should have a permanent identifier to track changes in its licensing status, ownership, number of licensed private hospital beds, services offered, staffing, suspension, and closure, throughout the time period.

Workforce monitoring should be broader than just the number of workers. There is a need to implement reporting of professional category, clinical specialty, employment status, FTE contribution, dual practice status (if applicable) and staff turnover in future. These indicators would be a better reflection of the adequate workforce being in place to support licensed beds and services. Nursing care homes and hospices specifically should be of concern, as the data available indicated small decreases in the numbers of nurses employed between 2024 and 2025.

Also, regulatory data should be combined with population size, population demographic characteristics, disease burden, capacity of public sector, service utilisation, and geographic accessibility. Estimates of travel time to private hospital, haemodialysis centres, ambulatory care centres, nursing care home and hospice could be achieved by using geographic information system analysis. This would be useful to help identify areas where there is low coverage, as well as whether the high number of licensed private hospital beds and specialists in the divisions of Kuching, Miri, Sibul and Bintulu translates to significant access gaps for people in other divisions.

Lastly the expansion of the private sector (licensed health care providers) should be matched with regulatory capacity. Periodic reviews of staffing, inspection frequency, surveillance techniques and digital systems that are used for licensing and enforcement should be conducted by the responsible authorities. A state-level regulatory dashboard could provide evidence-based planning information by providing data on: Active licences, Operational and staffed beds, Critical-care capacity, Number of workers, Inspection report results, and Inspection enforcement actions. Provided there are no contraindications, these data may also facilitate coordinated action between the public and private sectors in specialist referrals, haemodialysis facilities, disaster preparedness, critical-care facilities, and other areas, without compromising regulatory accountability.

### Strength and Limitation

This study has the advantage of using a long annual series and a recent regulatory cross section, providing several facility and workforce categories. It also maintains the original administrative divisions.

A number of restrictions need to be highlighted. Underlying facility registers, definitions of inclusion/exclusion, methods of data collection and procedure of validation were not included from the data provided. The annual trend put together all facilities and services together, so it was not possible to analyse trends for each category of facilities and services. There was only a single reporting date for the cross-sectional measures, with nursing counts data from two years. Patient volumes, occupancy, utilisation, prices, quality indicators, outcomes, capacity in the public sector and FTE staffing were not included in the analysis. Geographic information was only available on a coarse level and was not amenable to spatial accessibility analysis based on enforcement jurisdictions. Lastly, the bed estimate was based on the denominator (2025) and numerator (2026 capacity) for the population.

Because the annual dataset contained aggregate stock counts rather than individual facility histories, the analysis could not distinguish growth arising from newly opened facilities from changes caused by closures, suspensions, reclassification, relocation, ownership changes, or administrative updating. The study also was unable to cross-check each observation with the underlying information from the facility licence record. The annual trend reflects thus the changes in the number of facilities or services notified in the margin of that year and not the development of facilities as such.

## CONCLUSION

The number of licensed private health care and services in Sarawak had experienced a marked increase from 2007 to 2025 with more annual growth rate after the year 2019. As of April 2026, licensed private hospital beds and medical personnel were concentrated in Kuching, Miri, Sibul, and Bintulu, and the nursing workforce had grown modestly over the preceding year. This administrative data provides a useful regulatory baseline but do not establish whether capacity is adequate, accessible, affordable, or equitably distributed. Standardised facility-level reporting, validation of totals, and linkage with population, utilisation, quality, and travel-time data would make the dataset more useful for health-system planning.

### Declarations

#### Ethics approval and consent to participate

Not applicable. This study is based on analysis of regulatory statistics and does not involve human participants, personal data or animals.

#### Consent for publication

Not applicable.

#### Availability of data and materials

This study based its analyses on regulatory statistics that was provided by the License Unit, CKAPS Sarawak. For this study, no individual-level data set was created.

#### Competing interests

The author declares no competing interests.

#### Funding

The author received no external funding for this study.

#### Author contributions

The author conceptualized the study, conducted the regulatory statistics analysis and prepared the manuscript.

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