6. CORPORATISATION OF PUBLIC HOSPITALS

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1. Background of Malaysian Health Services:

1.1 Malaysia's epidemiologic transition is changing to one that resembles a developed environment. It is expected that in the future the main concerns will be predominantly the lifestyle disease such as AIDS, trauma, mental health and psychiatric conditions and diseases related to environmental and industrial hazards and drug addiction and dependence.

1.2 Demographically, increasing population size, the changing population structure with a larger proportion of the elderly, a shelf of population distribution from rural locales to towns and cities will increase the demand for health care and consequent need to enhance both service capability and capacity. As a result of the affluence brought about by progress in socioeconomic development, the wide exposure through IT information on hitech medicine will continue to motivate Malaysians thus generating ever higher expectations and demands for better and more sophisticated health care in the future.

1.3 Health care technology which includes medical interventions and procedures, scientific processes and methods, medical equipment and devices are progressively and very rapidly changing as the result of research and development in the field of medicine which is becoming more complex with new discoveries almost everyday. New areas such as genetic therapy, reimplantation of severed appendages, transplantation of organs using artificial tissues, computer and surgical procedures, tele-radiology and tele-medicine are some of the examples of how much more complex and sophisticated medicine will be in the future.

1.4 In Malaysia too, the health care system is changing from the government dominated model tone with greater private sector involvement. This is in line with the Government's commitment to encourage privatisazation of government activities and functions following the relevant policies being implemented now. However, being often profit driven, the private sector tends to concentrate in the up-market urban areas, providing more curative and less promotive and preventive care and with a preference to cater to the well-to-do among the population. To the customer the cost of private care is much higher than the Government services. In this way, private growth tends to contribute to the increasing health care cost in the country. This is an issue of grave concern to the Government in the planning for health in the future.

2. Definition of Corporatisation

2.1 Corporatisation refers to an organisational restructuring which shifts operational control of an entity from a bureaucratic government model to a more entrepreneurial maket driven form. Corporatisation can be thought of as a more general form of privatisation.

It will involve transfer to an entity outside the traditional public sector but should remain wholly owned by the government.

2.2 With corporatisation the patients should be entitled to an EQUITABLE, ACCESSIBLE, APPRORIATE, QUALITY CONTROLLED, CARING AND COMPREHENSIVE HEALTH CARE SYSTEM

3. Rationale and Benefits of Corporatisation

3.1 Better quality services

This is a general term, which will describe the assessment of service at the health care service provide-client level.

3.2 Corporatisation will enhance the role of the private sector in the economy while at the same time creating new opportunities for the public. It allows transfer of dominant responsibility for either the financing of health care and services in terms of production and for distribution from the government to agencies or firms in the private sector.

3.3 Responsiveness of service provider- leading to more managerial autonomy at grass roots level and financial accountability - budgetary controls and adherence to micro-accounting principles as in the corporate sector. This will generally introduce the concept of cost centers in service providers and prompt more efficient ways of doing things. At the same, SCHOMOS is aware that some training will have to be started to enable our clinicians to undertake more managerial duties inline with the concept of decentralization.

3.4 Retention of public service skilled personnel

The main objectives of restructuring of the public hospitals are (1) to introduce accounting responsibility and commercial discipline to achieve a more efficient and cost-controlled system of delivery of health services. This is to ensure that hospital services remain affordable to the population, and hospital subsidies do not grow beyond what the economy can reasonably sustain in the long term; and (2) to improve upon the standard of hospital services and responsiveness to patients' needs. Restructuring was to give hospital more autonomy and flexibility in exercising initiative and creativity to improve service levels and respond to the changing needs of patients.

4. Benefits of corporatisation to doctors and patients

4.1 To the government:

- greater predictability in health services budgeting
- improved equity in health care financing
- increased focus of public resources on health manpower development. medical research and health policy definition, implementation and monitoring, implementation and monitoring
- improved public satisfaction with available health services and
- greater involvement and coordination with the private sector in addressing the health needs of the people.

4.2 To the Public:

- continued access to high quality health services regardless of ability to pay
- improved consumer responsiveness in the delivery of health care services, consistent with consumer expectations and
- increase access to objective measures of clinical service quality through development and
- application of accreditation programs,licensing, data reporting and quality assurance activities to public, private and corporatized hospitals
- good distribution of competent staff to all levels of health service by providing better packages for those willing to go to rural areas.

4.3 To the Employees:

- opportunity to participate in an open labour market for their specialised skills regardless of employment in corporatised or private sectors
- improved personal and professional satisfactions associated with practice in more consumer responsive organisation
- potential for greater empowerment and involvement in quality improvement and decision-making, as managerial authority is decentralized.

4.4 To the Privatized or Corporatized Entity:

- enhanced ability to attract and retain well-qualified health manpower
- streamlined decision making authority coupled with increased managerial responsibility
- greater flexibility in the use of available resources
- application of market discipline to enhance clarity of purpose, cohesiveness of action and ability to reward effective performance
- potential to develop formal or informal relationships with other providers or sources of services to enhance the delivery of care.

5. Objectives of Corporatisation

5.1 The objectives of corporatisation are as follows:

Create a more efficient and effective health delivery system.
Improve professional and technical standards thereby being more responsive to a clients needs.
Improve accounting responsibility and discipline for effective control over the running cost of the organisation.
Attract, retain and reward productive staff.
Finally and most importantly to relieve the financial and administrative burden of the government.

5.2 Corporatisation and privatisation is synonymous but yet in corporatisation it avoids being a profiteering venture. It is a non-profit organisation. The quality of health care services and delivery will not be compromised or become inferior to the existing health care.

5.3 The low-income group and the poor will not be denied health care. There will be continued SUBSIDISED HEALTH CARE.

6. Principles of Corporatisation

6.1 In implementing corporatisation of the health system, the following criteria should be incorporated.

EQUITABLE
ACCESSIBLE
QUALITY AND APPROPRIATENESS
COMPREHENSIVE
CARING

6.2 The following principles should be included (Reforming Health Care)

- Driven by values of human dignity, equity, solidarity and professional ethics.
- Targeted on protecting and promoting health.
- Centred on people, allowing citizens & community services to influence health services and take responsibility for their own health to ensure no one is affected badly by the reforms or some aspect of health care forgotten
- Focused on quality of health care, including cost effectiveness.
- Based on sustainable finances, to allow universal coverage and equitable access.
- Orientated towards primary health care.

6.3 The principle of **non-profit organisation** should be maintained and should not be a 'halfway' direction towards privatisation. The corporated shoul always remain a **wholly government owned** entity.

7. National Health Care Financing

7.1 It is realised that the contribution of health care financing will ultimately need to be borne by the individual specifically and the public collectively.

7.2 It should be the system whereby every able person will contribute to the financing while every individual is assured of health.

7.3 The regulatory role of the government, with the shared responsibilities of the providers and the consumers, cannot be overemphasized.

7.4 The broad objectives of establishing a National Health Care Financing scheme are to provide a health care that is accessible, affordable, to achieve budgeting and control of the total health care expenditure.

7.5 The following are primary considerations

- to encourage the people to contribute for health care and to use it economically
- to encourage the providers to minimise costs, inefficiently and overservicing; while assuring them clinical freedom, in the best interest of the patients
- to ensure an equitable distribution of health care, so that no person is denied health care because of inability to pay for it
- to ensure that healthcare for aged, chronic illness and for critical care illness which maybe beyond the means of the average individual, will be covered with this system.

7.6 The fundamental principle in equity in health care financing is based on national solidarity and social responsibility. This can be achieved when people realise that issues of health care are a shared responsibility of all citizens, which means that healthy people and high income earners out to subsidize the cost of health care of the sick, the low income earners and the poor. The economic burden of the health care system should be collectively shared according to the ability of the citizens. All principles therefore that are drawn up for this system should ensure that the guidelines above are adhered too.

* A set of principles or suggestions that might be considered and suggested by a member of SCHOMOS Exco is listed in Appendix 1. This is not the view of SCHOMOS in general.

7.7 In the corporatisation plan for the public hospitals, the restructuring of the facilities and services will have to be worked out in great detail. Some of the scenarios that should be addressed are :

- reducing the high cost of acute care beds and length of hospital stay
- greater reliance on continuing care, so that acute care cases are reduced
- greater emphasis on ambulatory care than in-patient care
- monitoring and controlling invasive procedures
- reducing diagnostic procedures to the most essential
- promoting day care surgery wherever possible
- rational and economical drug prescribing with uniform national guidelines
- reducing institutionalisation of the elderly and chronically ill, subtituting with home rehabilitation, palliative and continuing care.

7.8 Primary care services and public health services should also come under corporatisation but there is always the option that charges may not be raised but the managerial and financial autonomy be given if there is consumer outcry.

7.9 General practitioners in private practice in the country should be an integral part of the national primary care network. In other words, the primary care infrastructure should be unified entity.

7.10 Corporatisation should assure that the quality of health care services and delivery will not be compromised or become inferior to existing health care. It is important that corporatisation will result in improved efficiency and retain qualified and experienced manpower. It must ensure that there is no increase in workload to the level of causing low morale by adding too much administrative and clinical work when there are staff shortages and the same staff have to be involved for instance in audit committee, management committees, supervisory committees and additional workload perhaps from the IT teleconsulting etc. Non revenue generating activities or revenue generating activities such as these should be reimbursed separately under the corporitised system. This is one major problem that will lead to staff still leaving when they realise that they are working much harder and very much like their counterparts in private companies except for much less remuneration.

7.11 There is no doubt that the final system of contribution will probably be a tier system based on a percentage of basic salary but it would be better for this percentage to come from ones taxable income (see Appendix 8).

8. Doctors Perspective on Key Issues

Corporatisation and Human Resources:

Health personnel issues are key issues in the implementation of corporatisation. Following issues have to be addressed during the corporatisation process and thereafter.

8.1 **Reorientation and Motivation** - Dealing with staff anxieties, fear of the unknown, good communication programmes, and supplemental newsletter to explain changes can be instituted. Changing the mindset - getting all to understand and accept changes in concepts. Staff will need to question-

Are we doing what is appropriate?
Can we do it more simply, more efficiently and effectively and yet with a personal touch?

Reorientation of staff attitudes towards customer relations and service-

Aim to focusing the staff on the needs and expectations of customers. "To provide a level of patient care and services good enough for our own mothers without the need of special arrangements".

Customer relations will have to improve. Programmes on development have to be set up to look into this. Making use of external consultants and packages on training.

8.2 Work Environment and IT

8.2.1 Redesigning work processes with training and information technology as key enablers. In order to have the best, you have to provide the best! Staff should be working in proper environments suitable to their jobs. No compromises on this aspect so as to get the best from them. Environment being something easily controlled and easily modifiable.

8.2.2 Access to IT and the knowledge of IT is looked into.Personnel should be well versed in this, in order to be on top all the time. Updated with the latest and to deliver the most modern. This increases productivity and efficiency. All staff should have internet and computer access. Introduction of mechanisation, automation and computerisation. Streamlining management and work systems and undertaking rigorous technology assessments and cost benefit analysis in the working of the system. Information technology will also be needed for delivering a system which shown in high degree of uniformity under decisions made by the National Health Policy Board.

8.2.3 Telemedicine, national network for information technology and IT should involve all levels of clinicians. These clinicians should be reimbursed a consultants fee for their involvement in the pilot projects and safeguards ensured that the IT companies do not influence their decisions to take up substandard systems that become obsolete.

8.2.4 One important aspect is that the concept toward buying the IT and then hoping the government system will maintain it is not workable. One only has to look at the present system and realise how long it takes to replace a faulty piece of hardware or to get a competent IT person to fix a problem. It would make more sense to sign an operational maintenance deal with 24 hour online helpdesk and 24 hour repair or replacement till repair and backup storage of data in a data centre to prevent data loss. The IT company must ensure continous education for new and existing staff and make them comfortable using the new equipment especially in rural areas.

8.2.5 Integration is also extremely important. Several pilot projects each addressing different aspects will lead to the situation that the different software will not talk to each other and doctors will need to log out of one system to enter another system and this is time consuming. It would be better to use a tried and tested integrated solution than to come up with a home made solution because home made solutions often do not work or integrate and in the end cost a lot more. Sometime the Made in Malaysia attitude may need to be sacrificed in order to save many man years and prevent delay in establishment of a good IT system.

8.3 Rewards and CME

8.3.1 A transparent system of rewards should be present. More regular adjustments in promotions. Renumerations should be based on revenue and non-revenue generating work such as teaching, administration and research. Rewards should be given for innovative ideas that bring costs savings.

8.3.2 Performance appraisal is an art taught and supervisors will need to be trained on performing unbiased appraisals. Rewards of proper denominations should be there. Staff should work with this in mind and therefore the best from them will be tapped.

8.3.3 CME should be made a part of the system. Being a medical service, CME activities should be encouraged and in fact made compulsory. A certain allocation of time should be given for such activities. Equal opportunities for staff of various categories must be present. In house CME activities should be planned and ongoing. Ministry of Health should include management courses, improving interpersonal communication skills. Positive attitudes and thinking etc.

8.3.4 CME activities is disseminated from a central CME office. All specialist can submit towards the National Health Policy Board. CME activities should be available on the internet.

8.4 Doctors Expectations

8.4.1 A fair deal is of essence! Doctors should never be made to feel second to doctors in private sector in terms of earnings. This will avoid brain drain and the best will remain with the services. This will also avoid unnecessary employment of foreigners to serve in these hospitals, since they will always remain foreign in all aspects and the Malaysian touch of a doctor will be lost.

8.4.2 A higher clinical allowance based on their grade and years of experience and overall performance. It is anticipated that certain services will get higher remuneration. All out of hours must be given proper amounts in remuneration. Benefits in terms of time based increments should exist.

8.4.3 Better call allowances are recommended by SCHOMOS must be seriously looked into.

8.4.4 A more attractive loan scheme befitting the status of each staff should be made available. This includes car and housing loans. Education loans for their children, study loans for staff that want to further themselves and perhaps even reimplementing the world tour incentive for staff above a certain category. Special cover for treatment in case of family members is falling sick.

8.4.5 ALL EXISTING BENEFITS FOR GOVERNMENT SERVANTS SHOULD BE RETAINED AND INCREASED. The sistem saraan baru for University Malaya could be used as a model. At least 3 half-day private practice sessions should be allowed. Medical defence union subscriptions should be paid by the employer, i.e. the corporatised hospital.

8.5 Auditing the Performance of an Institution

8.5.1 Continuous quality improvement by means of auditing is important as a driving force to sustain the momentum in ensuring quality and effficient services in any organisation.

8.5.2 Availability of outcome measures facilities patient awareness, enabling patients to assess the care they receive.

8.5.3 Continuous quality improvement should emphasize these aspects;

Technical
Interpersonal
Customer satisfaction driven
Customer satisfaction relates to accessibility, quality of amenities and interpersonal process experienced

8.5.4 Continuous quality improvement initiatives should not be seen as additional workloads or projects. It requires multidisciplinary team approach and participatory management hence the involvement of the management and her staff, doctors included

8.6 Allowances

8.6.1 All existing benefits for government servants should be retained and if possibly increased.

8.6.2 The sistem saraan baru for University Malaya could be used as the model for the new government orders under corporatisation.

8.6.3 At least 3 half-day private practice sessions should be allowed.

8.6.4 Parents' health should be covered if they are no longer earning and or are not getting pension.

8.6.5 Medical Defence Union subscriptions should be paid by the corporatised hospitals or bodies that employs the doctors.

9. Role of Ministry of Health Post Corporatisation

9.1 "The government will gradually reduce its role in the prevention of health services and increase its regulatory and enforcement functions."
7th Malaysia Plan (Chapter 17 Health: III Prospects 1996-2000).

9.2 With corporatisation, the role of MOH in protecting citizens' interests and ensuring the systems remain equitable, efficient, accessible, affordable and responsible, becomes paramount.

9.3 This function should be through the establishment of a National Health Council with representation from the government, professional medical bodies, consumer organisations and the corporate sector. The responsibilities of this Council will be to ensure the government policies prevail in the implementation of its corporatisation plans. This role under no circumstances should be delegated to another agency.

9.4 The responsibility of licensing and accredition of health care providers and services will be borne by the government.

9.5 The government will have to ensure corporatisation holistically covers all aspects of health care including primary care, preventive and promotive care, human resource training and development and Continuing Medical Education. In the situation where the corporatised entities are unable to shoulder this responsibility, the government will have to find means to ensure these services continue or even continue being the provider.

10. Conclusion:

10.1 Corporatisation most definitely brings about a great and welcome change to the entire health system of the Malaysia. It changes the face of medicine by incorporating a more efficient and less taxing system of health care.

10.2 MMA being the representative of the medical profession has a social and professional responsibility to ensure that health reforms are accomplished for the benefit of the public and government but yet not jeopardising the legitimate interests and autonomy of the medical profession.

10.3 Challenging times await us in the future. MMA looks forward to working together with the government and consumers to ensure that Malaysians will always have a health care system that befits the nation.

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Appendix 1:

The following principles could probably exist in the system:

- it is desirable that each individual pays a percentage of their income towards this fund except for the very poor who should be subsidized by the National Health Financing scheme.

Patients who demand an alternative or higher level of accommodation and allied facilities will have to be prepared to pay more if the actual premium collected from their set contribution from their income does not achieve the premium set for a particular level of service.

The level of service should be premium based as is present in time honored insurance system that presently exists as we know it works. Based on the level of premium contributed in real terms one would receive a certain tier of service but it is imperative that the lowest level of service i.e. access to 3rd class government wards and primary care visits and drugs and repeat prescriptions covered by the blue book be covered

under the compulsory monthly contribution even if it does meet the level of premium for the lowest service. In other words the government will have to make up the shortfall for all those whose premiums do not meet the stipulated minimum premium.

The calculation of the minimum premium should be based on actuarial studies. The system should cover patients in both the private and public (or corporatised hospitals). In other words if the level of contribution matches premiums currently quoted for health insurance schemes for private hospitals the National Health Financing Body can buy this level of cover from the existing or tendered private hospital coverage for hospitalization from insurance companies and cover the primary care visits separately. Since the premiums will cover primary care visits, repeat medications and not just hospitalization as in present private schemes the level of premiums that will need to be charged will naturally be higher.

There is a suggestion that role of SOCSO which already exists be expanded to become the National Health Financing Board and cover all strata of society. Of course the mechanisms for quick settlement of payments to providers must exist with a very efficient information technology system for patient identification and verification as a contributor or status as being in the category for subsidy and for billing.

The proposal is that all wage-earning people will have to fill in a J form to obtain a Health Benefit number. The incentive to join the national health insurance scheme will be that health care after contribution for a certain number of years based on actuarial calculations will enable one to get clinical care up to their demise unlike present health insurance schemes that stop insuring you or have extremely high premiums after the age the healthcare will result in a tremendous increase in collection of taxes from he previously 'hidden subset of population' as they will be identified at the point of contact when presenting with illness at a hospital or primary care centre without a Health Benefit number. Stiffer penalties for those who falsify their J form will need to be enforced and deadlines for getting their Health Benefit number, including ones dependants.

The Health Benefit number will only be issued on return of a J form regardless of whether the patient is eligible to pay tax or not.

It is proposed that the quantum of fees from the percentage contribution be linked to certain premiums of standard nature as for private health insurance providers now.

The premiums paid can all be to a central collecting agency and a private and public hospital mix may lead to delays in treatment as who pays which aspect of the bill need to be addressed.