

Clinical Governance

What has Malaysia done?

Private Healthcare Facilities and Services Act 1998/Regulations 2006

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INTERNATIONAL MEDICAL UNIVERSITY
MALAYSIA

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Clinical Governance

What has Malaysia done?

Private Healthcare Facilities and Services

Act 1998/Regulations 2006



Clinical Governance

- Accountability
- Reconciling Public Accountability and Health Care Quality Improvement

Private Healthcare Facilities and Services Act 1998/Regulation 2006

- License holder, Person in Charge
- Policy

Government Roles in Hospital Accountability

- Regulator
- Shaping, facilitating quality improvement
- Promote, regulate disclosure
- Promote public – private partnership to promote quality improvement



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What has Malaysia done?
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Act 1998/Regulations 2006



Clinical Governance

- A system of governing clinical affairs
- Requires an explicit means of
 - Setting clinical policy
 - Monitoring compliance with clinical policy in institution or network
- Involvement of all hospital doctors in clinical audit activities
- Emphasis on culture of life long learning, to meet needs of patients and deliver improved health outcomes



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Accountability

Based on foundation of public disclosure, willingness of providers to share information about their performance with their stakeholders

- Are providers ready?
- What information should be shared?
- How to determine accuracy, validity of information?
- How to ensure that information is useful and understandable to stakeholders?



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Accountability

What information is most meaningful?

- Measuring
 - Health promotion efforts
 - Clinical outcomes
 - Patient satisfaction
 - Individual functional status
 - Standards compliance

Combination of above??



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Accountability

Public disclosure initiative

- Depends on strength of its underpinnings
 - Quality of data obtained through performance measurement process
- Need to design measures that truly measure what is intended to measure
- Need to evaluate to ensure measures meet objectives



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Accountability

- Major gap between performance data and understandable and useful information
- Basic obligation in public accountability is not merely disclosure
 - It is the responsibility to translate data into information through objective, well informed interpretation, and present this in ways that is understood by the stakeholders



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Accountability

- Hospital accountability – difficulties
- Data on quality of care
 - Not enough available
 - What is available – poorly specified, may be misleading, potentially dangerous if misinterpreted



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Accountability

Accountability in healthcare should accomplish

- Documentation of the use of health care services
- The rationale for important actions taken
- Assess differences in outcomes
- Provide an information base that supports health care decision making



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Accountability

- Vision for Healthcare Quality Improvement
- Vision for Public Accountability

Both very important, however reality falls short of the vision, due to enormous complexities

Differences in paradigm for quality improvement and public accountability



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Differences in the Paradigms for Quality Improvement and Public Accountability (R.J. Panzer, 1995)

<i>Quality Improvement</i>	<i>Public Accountability</i>
<i>Doctor-patient relationship - special</i>	<i>Healthcare as a business</i>
<i>Systems/process thinking</i>	<i>Focus on performance</i>
<i>Teamwork</i>	<i>Measure individual and organisational performance</i>
<i>Confidentiality</i>	<i>Public's right to know</i>
<i>Drive out fear</i>	<i>Good providers have nothing to fear</i>
<i>Ranking is bad</i>	<i>Publish report cards, reward best providers, avoid worst</i>
<i>Finding problems - praised</i>	<i>Problems – "bad" and should be prevented</i>



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Reconciling Quality Improvement and Public Accountability

- Vision, paradigm, decision making approaches driving Quality Improvement and Public Accountability are different, and both sets are valid
- Effective public accountability efforts – can guide collection and publication of useful quality information
- Effective quality improvement oriented healthcare providers can meet public's concern for accountability



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Reconciling Quality Improvement and Public Accountability

- Coordinate efforts for quality improvement and public accountability – negotiate between providers and purchasers. Discussion between providers and regulators. Avoid redundancy of data collection. Focus on public data to areas where processes and individual performance can be affected
- Systems Integration – work to make quality improvement and public accountability to be in the same system – **challenging!** Having public and providers on same platform, issues of distrust, confidentiality and honesty can be resolved over time
- Information Systems to support Quality Improvement and Public Accountability. Need to take a broader approach of “health of the community” report as a planning document for public and providers



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“Learning organisation” concept (Peter Senge)

In environment of rapid change, organisations that can learn and adapt will thrive. Concepts of systems thinking and learning organisations overlap with those of quality improvement



Born in 1947, Peter Senge graduated in engineering from Stanford and then went on to undertake a masters on social systems modeling at MIT (Massachusetts Institute of Technology) before completing his PhD on Management. Said to be a rather unassuming man, he is a senior lecturer at the Massachusetts Institute of Technology. He is also founding chair of the Society for Organizational Learning (SoL). His current areas of special interest focus on decentralizing the role of leadership in organizations so as to enhance the capacity of all people to work productively toward common goals.



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Key activities of effective learning organisation (David Garvin)

- Promoting scientific problem solving
- Promoting experimentation
- Learning from the organisations' own experiences
- Learning from the experiences of others
- Disseminating the knowledge



Relevance – if healthcare system of the community worked like a learning organisation, need for providers and consumers to work together



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Private Healthcare Facilities and Services Act 1998 Regulations 2006

- License holder – qualified
- Person in Charge – registered medical practitioner
- Medical Advisory Committee (MAC) - doctors, to represent doctors practising
- Board of Management (Directors) – two members from MAC



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Person in Charge

- Policy Statement
- Patient Grievance mechanism
- Incident reporting
- Emergency Treatment & Services
- Healthcare Professional
- Patient care & treatment
- Orders, investigation, treatment
- Department, organisation of services
- Volunteer programme
- Patient identification
- Registration policies



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Policy (written)

- Departmental
- General Policies
- Policy Statement on staff identification, billing procedures, etc
- Patients' rights
- Patient's medical record system
- Consent
- Infection control



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Policy (statement)

- Obligations to patients using facilities or services (Part IV, Section 21 of regulations)
- All department or units to have written policies, standards, procedures, guidelines relating to services and clinical practice
- Patient to be provided with information about proposed treatment, investigation, procedure and to be provided with medical report on request



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Policy (statement)

- Where there are two or more practitioners in a speciality, one will be appointed head of the service, unit or department
- Grievance mechanism
- Incident reporting
- Emergency treatment
- Welfare contributions
- Fee schedule



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Private Healthcare Facilities and Services Act 1998; regulations 2006

- Quality and appropriateness of healthcare services delivered
- Mortality Assessment
- Wide powers in law and regulations for Director General of Health to ensure quality and appropriateness of healthcare services delivered

Major emphasis on :-

- Ensuring quality of healthcare services
- Accountability by healthcare providers



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License holder

Sole proprietor	Registered medical practitioner
Partnership	At least one partner is a registered medical practitioner
Body Corporate	Board of Directors, at least one member is a registered medical practitioner
Person in Charge	Registered medical practitioner



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Licensee and Person In Charge

Responsible for compliance to the law and regulations

Person In Charge

- Heavy responsibility, responsible for infractions of law, regulations
- Need for authority in organisation
- Generally medical director of institution
- Need for undertaking that organisation will work towards achievement of compliance with laws and regulations



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Clinical Governance

- System, platform for managing clinical affairs
- Process for ensuring healthcare quality improvement and patient safety and to be applied under direct oversight of The Board of Directors
- Integrate it with organisation's other quality activities
- Direct oversight of the Board of Directors



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Clinical Governance

Government Roles in Hospital Accountability

- Shaping a "Quality Community"
- Developing methods and infrastructure
- Standardising information
- Facilitating Quality Improvement
- Enforcing Standards



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Government Roles in Hospital Accountability

- Promote the community of professionals, industry, purchaser, and consumer groups to work together to improve healthcare quality
- Promote and regulate disclosure – need to be carefully developed
- Create, convene public – private partnerships to ensure that decisions on healthcare quality improvements reflect community consensus (not views of government employees)
- Promote public – private partnership as the foundation for healthcare quality improvement (need to include patients on the platform)

Note: MSQH – public private partnership



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