ORIGINAL ARTICLE

Exploratory Study on the Compensation Practices in Private Hospitals for Clinical Specialists in Malaysia

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ABSTRACT

INTRODUCTION: Fee-for-service (FFS) has been the main payment method for clinical specialists around the world. However, until most recently, several payment methods for doctors, particularly clinical specialists, such as salary, pay for performance and blended remuneration of the above models have been researched. This mechanism is being used to increase the level of quality and value of healthcare services in the health sector. Despite increasing interest in these alternative payment methods, there is limited research about the payment method offered to clinical specialists in Malaysia. **MATERIALS AND METHODS**: Using qualitative interview with 15 private clinical specialists and 4 hospital administrators working in private hospitals in Malaysia, we explored the existing payment methods offered to private clinical specialists by private hospitals. **RESULTS:** Our study found that four payment methods were used which were FFS, salary-based, salary-based plus incentives and pool system. Majority of the clinical specialists interviewed were under the FFS payment method. New emerging payment methods which include salary-based and salary-based plus incentives were implemented in recent years, while the pool system was confined to certain specialities. **CONCLUSION:** The private hospitals in Malaysia provides different payment methods to the private clinical specialists which includes FFS, salary-based, salary-based plus incentives and pool system. These findings can help policymakers to explore the potential of various payment methods in the near future.

Keywords
Compensation package, hospitals, specialists, salary, fee-for-service

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INTRODUCTION

Malaysia practices a two-tier healthcare system, the public and private sectors.[1] The private healthcare system mostly serves the urban population and those with the financial resources to pay for their services. All Malaysians have access to the public healthcare system, but a token fee is imposed. According to the report by the Malaysia National Health Accounts (MNHA)– Health Expenditure Report 1997-2017,[2] the health expenditure in the public and private sectors had an almost equal share (51:49), although the public sector is the main healthcare provider for Malaysians. Clinical specialists have a unique position in the health care system. They not only provide health care services to patients, but they also provide patients to, and order services from other health care providers. Around 70% of healthcare expenditure is influenced by clinical decisions by doctors, independent of their compensation.[3] All matters that influences the attitude, practice or behaviour of clinical specialists can have a significant impact on the hospital's efficiency and quality of care delivered to patients, and therefore hospital cost and payment method for clinical specialists are one of them.[4,5]

As a strategy to maximize the level of quality and value of health services in the health sector, various payment methods for doctors, especially specialists have been studied and applied.[6] Appropriate payment methods for specialists will be able to optimize the level of efficiency as well as the quality of patient health care.[5] The specialists are compensated to convey their services by providing healthcare and ensuring that the highest standard of the health care system is delivered.[6] In the past, specialists in many developed health systems have been remunerated through a pure FFS payment method, and only very recently, the limited introduction of alternative payment methods such as episode-based and salary-based payments

have been adopted.[7] A review of the literature found that there is a shift in the preference among clinical specialists from FFS to the salary-based payment method, especially in high-income countries.[5] This salary-based payment is believed to offer better work-life balance, etc. This shift seemingly creates a win-win situation for both the clinical specialists (better work-life balance) and the patients (reduce healthcare cost) without jeopardizing the quality of healthcare. Studies have shown that there is no significant difference between the quality of care provided under both the payment methods (salary versus FFS).[5,8]

In the last decade, various studies have been done on the existing payment method offered to specialists. In Indonesia where the National Health Assurance has been implemented since 2014, the–payment method for their physicians in both private and public hospitals is diverse. It is reported that most hospitals use pure FFS for self-employed physicians (part-timer employees) while for full-time employees, they applied the FFS mixed with salary or remuneration.[9] Such findings are also seen in recent reports in the literature on specialist payment method adopted in Canada where specialists are paid using FFS, capitation and blended remuneration.[4,10–12] However, there are limited published results about existing payment methods offered to clinical specialists by private hospitals in Malaysia.

Exploring the payment method of clinical specialist is an important knowledge gap, as it has major implications for the implementation, adoption, and potential impacts on the reformation of the payment method for clinical specialists. This study aimed to investigate the perspective of clinical specialists in private hospitals in Malaysia on the existing payment methods offered.

MATERIALS AND METHODS

This study is an exploratory qualitative research design using an In-Depth Interview (IDI) for data collection. The sample size of 19 clinical specialists was selected as there is no new data found after the analysis of the interview transcripts, thus indicating saturation of data. Inclusion criteria were Malaysian clinical specialist with a minimum of two years working experience in private hospitals, and top management (Chief Executive Officer, Managing Director or equivalent) with a minimum of 15 years working experience were involved. The respondents were recruited through purposive sampling and the 'snowballing' technique with specific characteristics for the understanding of the various payment methods in Malaysia and comprehensive exploration of relevant compensation practices.

Ethical approval was obtained from the Universiti Kebangsaan Malaysia Research Ethics Committee. All informants were contacted via phone calls and the first meeting arrangement between the researcher and informants were scheduled. All informants were provided with invitation letters and information sheet on the participants and upon their agreement, an interview session was arranged. All informants provided informed consent before the interview with the option to withdraw at any time.

Interview sessions were conducted in the respective private room in the hospitals of the specialists and was audio recorded with their permission. Each interview lasted between one to two hours, and all interviews were conducted by the lead researcher. The informants were asked the following queries: (i) 'Tell me about your background as a clinical specialist, and how long have you joined private hospitals?', (ii) 'What are the current compensation scheme available in your hospital?' and (iii) 'Are you aware of other compensation scheme?' Several participants provided confidential documents such as Letters of Offer and Service Agreements, strictly for the main researcher viewing only. No copies were allowed to be made. The documents shown by the informants were triangulated with the hospital administrators, who agreed these documents were handled as private and confidential. The confidentiality of the informants was recorded and maintained in the recruitment log. Field notes were prepared immediately after the interview for reflection purposes.

Voice recordings of IDI were done during the interviews, which were later transcribed. The transcriptions were given to all participants for them to re-check the details and later were returned to the researchers. Then, the

interview transcripts were analysed for common themes using framework analysis. QSR NVivo software version 1.7 was used extensively to generate and grouped based on similar views. The relationship and similarities between the themes were then established. The data was then reviewed and the degree of consistency between the phenomena and the final themes finalized. The initial and final themes were developed with a peer de-briefing sessions with a third-party researcher. Subsequently, the trustworthiness which includes credibility, consistency and transferability of the findings were verified.[13] The data was analysed using a thematic analysis approach, in which the data was analysed into codes, then categories, followed by themes.[14] The Standards for Reporting Qualitative Research: A Synthesis of Recommendations (SRQR) was a guide in reporting this study.

RESULTS

Fifteen Malaysian clinical specialists from various specialities and four hospital administrators working in private hospitals in urban areas were interviewed. The background of the participants is shown in Table 1.

From the interviews held, we discovered that there are four modes of compensation practices offered to private clinical specialists by private hospitals in Malaysia: 1) FFS, 2) salary-based, 3) salary-based plus incentives and 4) pool system. Majority of the clinical specialists interviewed were under the FFS payment system.

Theme: Limited availability of alternative payment methods

This theme centred around the limited availability of alternative payment models for private clinical specialists. The majority of specialists in our study said that there are no other alternative payment methods available to them when they were hired other than the FFS. Some even never thought or heard about other payment methods being practised in other countries, such as salary-based and pay-for-performance. Below is how one hospital administrator explained:

Table 1: Background of participants

Participant	Institution	Speciality/Current Role	Experience as clinical specialist/ administrative role	Experience as clinical specialist/ administrative role (in private sector)
Informant 1	Hospital A	Anaesthesiology & Critical Care	7 years	3 years
Informant 2	Hospital B	Emergency Physician	7 years	4 years
Informant 3	Hospital C	Internal Medicine	10 years	8 years
Informant 4	Hospital D	Otorhinolaryngology	10 years	5 years
Informant 5	Hospital D	Anaesthesiology & Critical Care	28 years	27 years
Informant 6	Hospital D	Anaesthesiology	6 years	2 years
Informant 7	Hospital E	Paediatric	6 years	4 years
Informant 8	Hospital E	Obstetrics & Gynaecology	30 years	26 years
Informant 9	Hospital F	Radiology	2 years	2 years
Informant 10	Hospital G	Gastroenterology	11 years	4 years
Informant 11	Hospital H	Otorhinolaryngology, Head & Neck	14 years	3 years
Informant 12	Hospital I	Managing Director	23 years	23 years
Informant 13	Hospital J	Otorhinolaryngology	4 years	4 years
Informant 14	Hospital J	Chief Executive Officer	21 years	21 years
Informant 15	Hospital K	General Manager	22 years	22 years
Informant 16	Hospital J	Orthopaedic & Trauma	11 years	4 years
Informant 17	Hospital L	Plastic Surgery	8 years	3 years
Informant 18	Hospital M	Deputy Chief Executive Officer	28 years	28 years
Informant 19	Hospital N	Neurology	10 years	5 years

"If it's this type (salary-based), I don't know, I don't even think about it. When you mentioned this, I just realised/heard about it." **– Informant 12**

Fee-for-service (FFS)

There were clinical specialists who preferred the FFS payment system because it brings higher income to them as illustrated below:

"He'll be doing everything because every procedure that you do, you'll get some cut from there. So, you can charge. End up, you earn the most by doing this. Because this is the biggest catchment area in the hospital."– **Informant 2**

"If you are salary-based, you report how many, what procedures you've done, your salary is fixed. So, not *worth it for the salary package if you're doing the extra job from others right? So, I think maybe we can consider a fee-for-service."* – **Informant 9**

Salary-based

However, both the clinical specialists and hospital administrators interviewed supported the salary scheme to be implemented as an alternative payment model in private hospitals:

"If we're going for expansion and all, we can consider and test it, because this has never been tested so far here." – **Informant 12**

There were a few clinical specialists interviewed who were already on the salary-based payment scheme. The salary-based clinical specialists explained:

"For the next 14 years, we have a bond. So, they just give us the salary-based. Not fee-for-service." – **Informant 9**

"I mean the salary-based programme in private, it's new. I think there was, but it doesn't apply to most of the residents here. So, in this hospital, I'm the only person (clinical specialist) on salary-based." – **Informant 13**

Salary-based plus incentives

Some of the clinical specialists who were in the salary-based scheme also got additional incentives on top of their monthly salary:

"They pay me a monthly salary. They also give me payment for whatever procedures I perform." – **Informant 2**

"After I achieve more than my fixed salary, so that becomes my incentive. So, with this incentive, I will get that 40%. This is for the first two years. In the next two years, later it will be different. My salary goes up, my incentive percentage also goes up." – **Informant 13**

There were also some clinical specialists and hospital administrators interviewed who disagreed with the salary scheme to be implemented as an alternative payment model in private hospitals. Having a fixed income will cause a huge loss to the hospitals since it will not encourage the specialists to work hard every day. The purpose of clinical specialists joining private practice is to earn as much as they can and be independent. Being a salaried clinical specialist will oppose the purpose. The following quotes illustrate these views:

"We talk to the doctor; we pay you a salary of such an amount. You work. When we give salaries, doctors become lazy. They are lazy." – **Informant 15**

"Don't tie up yourself. Be free, do your own. That's what my principle is to be free. You don't tie up. You know, be salaried". – **Informant 16**

Pool system

Clinical specialists in our study also shared that there is a pool system practised in private hospitals but only limited to anaesthetists as they always work as a team:

"Anaesthetists are doing this pool system. But of course, it has to be that these five surgeons agree to that idea, and they have to be able to work with each other."– **Informant 10**

The pool system has helped the anaesthetists to have a work-life balance as they can easily take leave whenever they want to since they have their team members to cover each other. For example, a clinical specialist said:

"After six months, you can take a week off. You don't need to worry because you know the people in your group will cover for you. I would say this is a big benefit." – **Informant 6**

On the other hand, the clinical specialists shared their concerns about the pool system. They agreed that mutual understanding among clinical specialists in the pool system is crucial to ensure the implementation will be a success and to avoid problems in the future. They explained that it is difficult for other specialities to implement the pool system as anaesthetists do, as there are different charges for every procedure:

"There is a benefit but implementing it is going to be very difficult. The problem is in the other disciplines such as the surgical side. I'll be doing these certain kinds of surgeries, I'm a sub-speciality in this, I'm not a general surgeon. So, the income from these surgeries is way different." – **Informant 5**

Another clinical specialist said that the pool system will reduce the productivity of the specialist:

"*Like in private, the pool system is difficult to be implemented. It's hard. There must be someone who is lazy. Confirm there is. If I do it or not, I can just sleep. You know the money is there. It's difficult."* – **Informant 16**

DISCUSSION

To our knowledge and based on literature search, this is the first study to explore the existing payment methods for clinical specialists working in private hospitals in Malaysia. We found that there are four modes of payment methods offered to private clinical specialists by private hospitals in Malaysia, namely FFS, salary-based, salary-based with incentives and pool system. However, most of the clinical specialists interviewed were under the FFS payment system.

The result of this study suggests that despite the preference of the clinical specialists for a particular payment method, they did not have the option to select the type of payment model they preferred. Presently, the number of alternative payment models for clinical specialists continues to be limited. This finding is similar with a study conducted in Alberta, Canada that found that the FFS is the main payment system for clinical specialists.[3] However, the FFS system is still the preferred system for some clinical specialists as it brings higher income compared to other payment models. Payment methods for clinical specialists may affect the decision-making by the healthcare provider, including patient admission policies and treatment decisions.[15] FFS motivates clinical specialists to provide more services and services that are not obligatory to maximize their income.[9] Due to the dependence on out-of-pocket payments (OOP) as the primary source of payment, this would not only have a negative impact on the demand for services but will also raise the financial burden on patients and their households, which will cause them to become impoverished.[16] This is a very alarming situation since Malaysians do not practice a healthy lifestyle which will increase the likelihood of them needing treatment from specialists.[17]

We found that three hospitals in Kuala Lumpur and Selangor have started offering salary-based payment scheme for clinical specialists. This practice is still in the trial phase as it was only recently introduced by the hospitals in 2019 and 2021. These two hospitals have taken the bold step in offering fixed income to their specialists. There are hospitals that have started to offer salary-based to clinical specialists, especially in high-income countries such as Canada.[5] Although FFS and salary-based payment models both offer some flexibility, the salary-based model typically had specific requirements about the minimum full-time equivalent needed. The type of flexibility also varies, while the specialists enjoy the peace of mind of having a fixed income at the end of the month. As such they are able to be involved in other non-clinical work activities such as involvement in medical associations and teaching. Salary-based models allow for non-traditional work hours, which may be especially appealing to specialists who combine other, non-clinical activities including teaching and research.[18] In contrast, FFS allows part-time work arrangements but offers limited flexibility regarding work hours especially for outpatient and follow-up clinical services. This situation resonates with the statement from healthcare practitioners who agreed that more emphasis is given to physical health, leading to an imbalance between physical and emotional care in the healthcare system.19 The differences suggest that there might be a need to explore clear communication with specialists pertaining to potential benefits, incentives, or opportunities for flexibility under the salary-based remuneration. However, the implementation of this new payment method must be regulated and enforced by the government.

Salary-based plus incentives is also currently practised in several private hospitals. The informants revealed that they are comfortable with this payment scheme as it motivates them to work harder. This finding is consistent with a study which found that financial incentive is the key to strengthening health worker motivation in doing their jobs.[20] This is because they also feel secure because they have a minimum income each month. The incentives provided, encourage them to work harder because they feel that they are being compensated for the extra work they do. Incentives given that reward a specific behaviour

or task will increase the likelihood that the person receiving the reward will carry out the behaviour or task.[21] This brings a win-win situation for both the clinical specialists and the hospitals. Hospital administrators are also willing to offer this payment method to younger specialists who will be joining them.

Pool system was successfully implemented in a private hospital because the specialists within that department possess strong work cohesiveness amongst themselves. They could take leave from work and there are colleagues who will cover their work the following day. They are able to take a week leave because they have their colleagues to continue giving the services needed during their absence. They can also take emergency leaves to attend to their personal issues without much hassle because their colleagues will cover their work. This pool system which is a "partnership-based" practised by anaesthetists offers internal flexibility and work-life balance to clinical specialists working in private hospitals as they have other team members to cover them during their off days.[22] The pool system has been in practice for several years and was successful because they have a good understanding among the anaesthesiologists. Implementation of the pool system needs strong practice management resources and mutual understanding between the members of the system to ensure it can run smoothly.[18] However, the pool system may be difficult to be implemented in other departments such as surgery or internal medicine because there are many different sub-specialities. The different sub-speciality costs and charges are different. Therefore, the pool system may not be suitable for departments with various subspecialties such as internal medicine, orthopaedics, and surgery. The pool system as an alternative payment model for specialists is difficult to be implemented in other specialities since every procedure is charged differently.[23]

Despite the private hospital's goal to achieve a high profit, the hospital management needs to improve employees' satisfaction and performance. In order to maximise the value of the payment models, the hospital should create the tailoring programme by incorporating the clinical specialist in the design of the system for hospital compensation.[7] The right blend of financial and non-financial incentives, including specialist wellness, is needed to incentivize physicians.

The findings of our study must be seen in light of the primary limitation in which respondents involved, were purely from private clinical specialists in the state of Selangor, Kuala Lumpur and Negeri Sembilan. Their perspectives may be influenced by their environment, working, and living in an urban metropolitan area.

CONCLUSION

There are four identified existing compensation practices offered to private clinical specialists by private hospitals in Malaysia which are FFS, salary-based, salary-based plus incentives and pool system with the majority of the interviewed clinical specialists under the FFS payment method. FFS is the preferred payment method since it brings higher income to specialists compared to other methods. However, salary-based payment method has started to be implemented in a few hospitals with some getting added incentives on top of their monthly salary. The pool system is implemented among anaesthetists in a small way which can be an alternative payment method for specialists who provide ancillary services such as emergency physicians and radiologist. Our findings may assist health officials to explore the potential of various payment methods in the near future.

CONFLICT OF INTERESTS

The authors declare there is no conflict of interest.

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