PRIVATE HEALTHCARE POLICY AND SYSTEM IN MALAYSIA AND JAPAN: SUSTAINING HARMONIOUS WORKPLACE RELATIONS THROUGH GOOD GOVERNANCE AND BEST PRACTICES

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INTRODUCTION

The article discusses on healthcare policies in Japan and Malaysia, especially on the private healthcare sector of the two nations, who now view healthcare industry as important economic contributors. While Malaysia aims to excel in medical tourism, Japan hopes to expand globally. As a general rule, Japan does not substantiate the role of private healthcare as very different from the public healthcare, as the case is for Malaysia. Japan has long been a role model for Malaysia, especially on work ethics, work culture, management and technology. The healthcare industry in Japan is bigger, as compared to Malaysia, which now is given the task to steer the Malaysian economy from the middle-income trap to a high income society. In this article, private healthcare providers refer to hospital and clinical setting scenarios and not the healthcare industry per se, where Japan is the second largest drug and medical device market in the world. The discussion highlights the good governance and best practices that become the foundation for workplace relations that keep together people working at the healthcare industry.

No matter how different we perceive it, or how different the experience was, without good workplace relations, organizations would be in crisis, as history of both countries attests to, and the development progress may be affected. The debate is that a good policy may make a difference to an economy of a country; at operational level, good working conditions, enabled by many factors, motivate workers and encourage them to stay at the workplace, either unionized or not. There are differences in terms of employment practices for both countries, which may trigger different consequences. Japan, before the 1990s, still honored lifelong employment, seniority-based wages and enterprise unions. However, this type of labor management has changed since the bubble economy burst in early 1990s (Tatara, 2009). In Malaysia, it was also the same scenario, but the change is quite drastic now when young graduates do not mind

job-hopping, prefer performance-based salary and adopts human resource practices, instead of unionising.

The study investigates at macro level, the practices and challenges private healthcare scenario of Malaysia and Japan, and in brief, the human resource practices through good governance and best practices.

JAPAN AND MALAYSIA'S ECONOMY

Japan economy has been reported to have experienced what is termed 'Lost Two Decades', from 1990 to until about 2010. Even now, Japan is seen as still struggling to recover from the burst of the Bubble Economy, and it has never again enjoyed the robustness of the economy pre-1997. Faced with three recessions, in 1997, 2000, and 2008, it was a very long way back for Japan. Financial shrinkage resulted in cutting back of production and employment, which saw the unemployment rate arisen to 5.5% in 2002 (Labor Situation, 2012). Japan was proud to claim its distinguished identities in lifetime employment, seniority-based wages, and enterprise-based union, which was heavily emulated by Malaysia under the leadership of Tun Mahathir Mohamad, the Fourth Prime Minister (Jomo, 1994). Japanese work ethics, management style and technology were promoted under the Malaysian Look East Policy, starting from 1983, until the end of his administration. However, Japan, like the rest of the world who faced the economic challenge in the later part of 1990s has to resort to adaptable changes.

Today Japan is facing two distinct problems: ageing population and declining birth rate, both of which will have a profound impact on society and industry (Labor Situation, 2012; Health System Review, 2009). Japan population is almost 128 million, approximately 2.1% of world's population as compared to Malaysia's current 28 million. People in Japan enjoy the longest life expectancy at birth in the world. Life expectancy at birth was 83 years in 2009 (for males it is 79.6, and for females, 86.4 years respectively). This may have been contributed to affordable and better health care enjoyed by Japanese, coupled with healthy lifestyles. However, the forecast is not good for Japan, as in 2050 the population will shrink to 100.6million, while the proportion of the population aged 0-14 years will decrease to 10.8 million, against an increase of population aged 65 years to 35.7%.

Nevertheless, even though the Japan economy has been reported to be 'moribund, stagnant, shrinking…' (The Economist, 10 Sept 2011; Labor Situation, 2012; Health System Review, 2009) to name a few, it is in fact, by comparison still better than most countries in the world. Currently, Japan is the third largest economy in the world behind the US and China (www.economywatch.com). Japan may have lost its prized position but still highly strong and advanced in sectors such as manufacturing, especially in electronics and auto mobiles. Industry becomes 23% of Japan GDP in 2010, with major industries include motor vehicles, electronic equipment, machine tools, steel and non-ferrous metals, ships, chemicals, textiles and processed foods.

In fact, after the 2008 global financial crisis, its economy showed strong period of recovery, with real GDP growth of 3.38%, the fastest among the G-7nations for the year. It was the March 2011 earthquake and tsunami that brought back the derailment of the economic growth. Japan was forced to downgrade its assessment of the economy, for the first time in six months.

Meanwhile, Malaysia, a democratic monarchy like Japan, comprises 13 states, has two different geographical regions; the Peninsular Malaysia, and Sabah and Sarawak on the Borneo Island, divided by the South China Sea. Though a small economy, Malaysia at times is referred to as the Asian Dragon. In healthcare, Malaysia is now known as offering high end hospitals, especially private run hospitals.

Malaysian economy has also been affected by the Bubble Economy burst, but it recovered quite fast as compared to most Asian countries. In 2013, its economy is projected to grow by 5.4%, which is the same pace as 2012. The Malaysian government, which, at the time of this writing is on the verge of dissolving its Parliament for the 13th General Election, has embarked on a very brave national government transformation plan (GTP), which includes the Economic Transformation Plan (ETP). Malaysia is well under way of its 10th Malaysia Plan, a five-year plans that has started since right before Independence from the British in 1957. It is under the ETP within the GTP that private healthcare has been identified as one of the twelve National Key Economic Areas (NKEA) to play key roles in the economy (Durrishah, 2012; The Edge 12 Feb 2013). Malaysia has to transform its economy, which has been caught in the middle income trap, and under the risk of being overtaken by other faster growing nations such as Vietnam (Durrishah, 2012).

Table 1: Malaysia at a Glance

		2009	2010	2011	2012
Population (million) – Total		28.1	28.6	29.0[p]	
	Male	14.5	14.7	14.9[p]	
	Female	13.6	13.9	14.1[p]	
Average Annual Population Growth Rate (%)		1.8	1.8	1.3[p]	
Birth and Death (per 1,000 population)					
	Crude Birth Rate	18.5	17.5[p]		
	Crude Death Rate	4.8	4.8[p]		
Total Fertility Rate		2.3	2.2[p]		
Life Expectancy (years)					
	Male	71.6	71.7[p]	72.0[e]	72.3[e]
	Female	76.5	76.8[p]	77.1[e]	77.2[e]
Gross Domestic Product (GDP)		-1.5	7.2	5.1	5.6
Employment					
	Labour Force ('000)	11,315.3	12,303.9	12,675.8	13,119.6
	Employed ('000)	10,897.3	11,899.5	12,284.4	12,723.2
	Unemployment ('000)	418.0	404.4	391.4	396.3
	Labour Force Participation Rates, LFPR (%)	62.9	63.7	64.4	65.5
	Unemployment Rate (%)	3.7	3.3	3.1	3.0

Source: Adopted from Department of Statistic, Malaysia, 2012.

According to Department of Statistic Malaysia, the country is in a better position. As seen in Table 1, Malaysians now live longer, GDP growth rate is higher and the unemployment rate is lower. These are important index for Malaysia to move ahead, especially in meeting the objectives of healthcare as an economic endeavor.

Both Malaysia and Japan stresses on the important position of healthcare industry in their economy. For Japan, it spends 8.3% of its GDP on healthcare, below the OECD average, and offers good quality care to patients. (See Table 2 on Japan health expenditure as compared to some other countries). Japan has excellent health indicators, but with increasing demands from doctors and patients. The Japanese pharmaceutical market was worth almost US$100 billion in 2010. Malaysia, as discussed above, has laid a foundation for private healthcare to assist the government in bringing up the status of the people to a high income society.

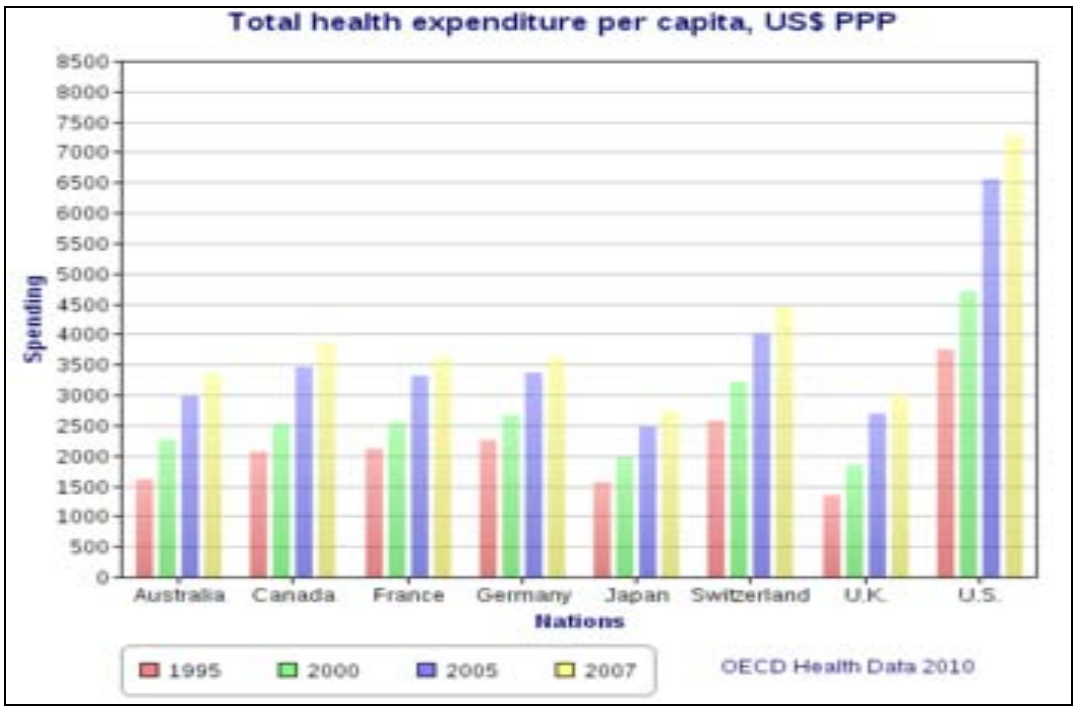


Table 2: Source: Wikipedia: healthcare system in Japan

HEALTHCARE POLICY AND SYSTEM IN BOTH COUNTRIES

JAPAN

By comparison, Japanese people have enjoyed and still are enjoying better and more affordable healthcare system than Malaysians. The Japanese government runs almost a welfare-like system, ensuring all citizens enjoy the coverage for healthcare, regardless of their economic standing, or either the entity is public or private. Since all hospitals and clinics are regarded as 'not for profit organizations', it does not matter where patients get their treatment, either at private or public hospitals, which is quite different in Malaysia. In Malaysia, people with insurance or coverage by employers seek treatment at 'better hospitals' which, almost automatically meant the various private hospitals in the country. (For detailed discussion on Japan Health System, refer to Health Systems in Transition, Vol 11, No 5, 2009).

In Japan, health insurance is mandatory, but no penalty for those who do not want to take them (only about 10% of the Japan's population does not enroll). The system is fundamentally a universal health insurance coverage whereby citizens can get insured under categories of national health insurance, workplace-based insurance, or government-managed health insurance system (Masako, 2009; Matsuda, 2012). The free-access system lets people to be examined and treated at the medical institutions of their choice, and this is quite a different case for Malaysians. It is interesting to note that patients' visits to doctors outstrip the average of OECD countries. This may have led to the problem of excessive demand by patients, even though it is documented that the visit is as short as three minutes.

Affordable cost is the key policy for Japanese healthcare system, and it has worked to the advantage of the Japanese people, and bears no consequences in times of robust economy. Public health insurance since 1961 covers most citizens/residents and the system pays 70% or more of medical and prescription drug costs with the remainder being covered by the patient themselves (they contribute 10%, 20% or 30% depending on family income and age of the insured). The monthly insurance premium is paid per household and scaled to annual income. Supplementary private health insurance is available only to cover the co-payments or non-covered costs, and usually makes a fixed payment per days in hospital or per surgery performed, rather than per actual expenditure.

It is interesting to note that by law, hospitals in Japan must be run as non-profit organizations, which is in stark contrast, if compared to opportunities and support given to Malaysian hospitals. As noted quite openly, this created some issues with physicians, who the responsible persons entrusted to run hospitals and clinics in Japan.

It is not surprising that in the latest OECD Report 2011 for Japan, the country is now embarking on reform on social security funding, which actually refer to heavily subsidized health care for the people of Japan. With the population ageing social security outlays by the central government are going to rise by almost 2% GDP, or maybe more given the consensus on the need to improve the quality of health and long-term care over the next decade. The four reforms undertaken by Japanese government now include:

- Promoting the shift of long term care away from hospitals toward more appropriate institutions using the fee schedule and closer monitoring of the classification of patients in hospitals.
- Improving the payment system by reforming the diagnostic procedure combination, which sets an overall fee based on the illness, so as to strengthen incentives for hospitals to increase efficiency.
- Expanding the use of generic medicine by making them the standard for reimbursement.
- Introducing gatekeepers to reduce the number of unnecessary consultations with specialists.

These four moves saw Japan making structural moves, to ensure healthcare does not become a burden to the government, but at the same time, increase efficiency for hospitals, thus making them more an attractive venture, if Japan is seriously considering healthcare as one of its important economic drivers. However, it is not yet still certain, what level of gatekeepers will be established, because all these while Japan has been proud of the freedom of patients to see their physicians for consultations, without making appointments (OECD 2011 Report on Japan).

In Malaysia, the private hospitals are profit-oriented, where they are obliged under the law to provide quality patient care, but at the same time financially independent from the government. In Japan, hospitals are managed by physicians, and clinics are owned and operated by them. For-profit corporations are not allowed to own or operate

hospitals, whereas corporations who are financially able are the ones allowed to run hospitals in Malaysia.

However, the bonus point for Japanese people is when they can enjoy affordable medical fee, with public or private hospitals/clinics, since it is strictly regulated by the government. Medical fees, exceeding the monthly threshold for household are waived or reimbursed by the Japanese government, something unheard of in Malaysian private healthcare, whose fee for patients are being covered by employers or private insurance. In Japan, uninsured patients have to pay on their own, but if they are under government subsidy, or homeless, their fees can be waived too. The Japanese government control over fee is very detail, and negotiations are made between health ministry officials with physicians every two years. This negotiations is for every medical procedure and medication, and on top of this, all fees are identical across the country. Physicians cannot order more procedures to generate income, as this may prompt the government to lower the fees for those procedures in the next round of negotiations. By this policy, Japan kept medical fees low and affordable. How this affects physicians, their readiness to work long hours or displaying highest quality of professionalism, when they know they are not getting extra income for their hard work, may need another investigation.

Nevertheless, there are exceptions. Approximately, 55 % of hospital beds in Japan are in private non-profit hospitals (Matsuda, 2012), whereas the rest are in public hospitals. Physicians who work at public hospitals can also practice privately with consent of the hospitals they are salaried. Financial incentives also exist, e.g. extra billing, where patients are charged more than their insurance coverage. Extra fees are charged for examples for follow-ups after discharge, or for referred patients (Matsuda, 2012).

It has to be noted here that in Malaysia, medical fees differ from organizations to organizations, with some prestigious hospitals charging exorbitant fee. The prestige of hospitals depends on the competence and caliber of the individual medical specialists residing at those hospitals.

The norm of Japanese healthcare practitioners is that physicians and nurses are licensed for life, and they are not required to renew their license. They are not subject to continuing medical or nursing education and there is no peer or utilization review. Japan does not differentiate between specialist and non-specialist. Traditionally

physicians were trained to became subspecialist, and once they completed their trainings, only a few continued to practice as a subspecialist, and the rest left the large hospitals to practice in small community hospitals or open their own clinics without any formal retraining as a general practitioner.

MALAYSIA

Today in Malaysia, the private healthcare sector is given the task to be one of the catalysts in the Government Transformation Plan (GTP), to assist the country to attain a 'high income society' status (www.moh.gov.my/images/gallery/ETP/NKEA).

The Malaysian healthcare system is divided into two distinctive types, i.e. the public and the private sector healthcare system. Workers from public or private sector are free to pay by themselves or insure themselves with any insurance agencies. However, government servants are privileged to use governments' hospitals, almost free for all treatments and inpatient treatments. Many employers in the private sector also provide medical treatment for their staff, usually at private hospitals and clinics, but also, at times to government hospitals.

Healthcare in Malaysia has undergone radical transformation, from traditional practices that reflect the three major ethnic groups of Malays, Chinese and Indians, plus other ethnic groups. This is a country that has been under British colonialism for more than a hundred years. With the western influence come the modern medicine, and birth of modern hospitals. Like Japan, Malaysia has a universal healthcare system, co-existing with the private healthcare. Mortality rate stood at 10 in 2005, and life expectancy has arisen to 77 in 2011. Today the Malaysian government has started to give bigger emphasis on the expansion and development of healthcare, by increasing the 5% budget into public healthcare, an increase of 47%, with overall increase of RM2 billion. Government of Malaysia, like Japan, has to improve healthcare refurbishment of hospitals, building and equipping of new hospitals, increasing the number of clinics, training of the current human resource in the healthcare, and explore further the usage of tele-health.

The Malaysian health care system requires doctors to perform a compulsory three years service with public hospitals to ensure that the manpower in these hospitals is maintained. Foreign doctors are welcome to apply for employment in Malaysia, especially if they are qualified specialists. There is still significant shortage in the

medical workforce, especially of highly trained specialists; thus, certain medical care and treatment are available only in large cities. The majority of private hospitals, like KPJ Healthcare Group of Hospitals are situated in urban areas, which is a key factor in numbers of patients and their affordability to pay. Most private hospitals are equipped with the latest diagnostic and imaging facilities.

A few years back, private hospitals have not generally been seen as an ideal investment, since usually it took up to ten years before making any profits. However, the situation has now changed and many companies are now exploring this area again, corresponding with the increased number of foreigners entering Malaysia for medical care and the recent government focus on developing the health tourism industry.

Today, the number of specialist hospitals, clinics, and dental surgeries has increased tremendously. By August 2011, Malaysia has 145 public hospitals, 2,880 health clinics, and 165 mobile health clinics across the country. Interestingly, there were 217 private hospitals, 34 maternity and nursing homes, 36 ambulatory care centers, and 6,442 medical clinics in the private healthcare sector. Malaysia is still behind Singapore and Thailand, but very optimistic that healthcare travel industry in the country will contribute 10% per annum growth for the period 2011-2015 (ETP: Roadmap for Malaysia). The majority of medical health visitors in Malaysia come from neighbouring countries such as Indonesia (69%), Singapore (12%), while other health travelers, interestingly, are from Japan.

In summary, the private healthcare in fully developed Japan has been huge, but administered differently from the Malaysian counterparts, and quite recently foreigners are enticed again to come to Japan to work, and for health care treatments. Japan's health care system is established, always perceived as technologically advanced, and has undergone changes and transformation. Malaysia has just experienced robust development in the sector, and until very recent, still looked up to Japan in terms of work culture and ethics, originated from the Look East Policy in the 1980s.

GLOBAL STANDARDS OF HARMONIOUS WORKPLACE RELATIONS

Both Malaysia and Japan embrace the global standards for harmonious workplace relations, though the level needs to be examined further.

Japan, under the Ministry of Health, Labour and Welfare (MHLW), with ILO/ASEAN has adopted five key elements of a stable industrial relations system as identified by the ASEAN:

• A sound legal framework must take into account national economic and social conditions specific to each country, while guaranteeing the basic rights of employers to manage their business and of workers to just and decent working conditions.

• Fundamental rights of employers and workers is an essential element of the legal framework that recognizes the basic rights of both parties — the right of employers to manage their business reasonably, and the right of workers to enjoy basic universal rights such as freedom of association and the right to collective bargaining.

• Genuine bipartite cooperation and collaboration lead to both higher enterprise productivity and better working conditions. Effective bipartite cooperation entails the following:

- building mutual trust and respect, which means frank and meaningful dialogue and consultation between the parties on mutually beneficial approaches to work relations;
- 'best practices' in work relations; and good faith in negotiations and collective bargaining.

• Tripartite partnership and social dialogue are essential in developing national competitiveness and harmonious industrial relations. A key guideline, in successful tripartite partnership, is a focus on mutuality of purpose and benefits based on a tripartite vision (on the part of Governments, employers, and workers) and formulation of a common understanding of shared IR concerns and responsibilities.

• Effective labour dispute settlement is integral in the development of any sound industrial relations system. This means the establishment of effective mechanisms for conciliation, mediation, arbitration, and adjudication that are fair, affordable, and acceptable to all the parties.

Good governance and best practices include applying consensus, participatory, following the rule of law, being effective and efficient, accountable, transparent, responsive or equitable and inclusive. Best practices sometimes termed as good

operating practice in strategic management term, a method consistently has shown results superior to those achieved with other means, and that is used as a benchmark.

Malaysia, being very pragmatic, always ensures smooth and close working relationships with its social partners. The success of its economic development plans is always the utmost priority, as discussed by scholars (Durrishah, 2001; Jomo, 1994; Todd and Peetz, 2000). Since Independence from the British, Malaysia has never shied away in ensuring its economic policies succeeded. The Barisan Nasional Government truly believes that economic prosperity will ensure people's stability and happiness.

In the Ministry of Human Resource Strategic Plan from 2008 to 2010, Decent Work agenda, which employ universal components as proposed by ILO, focusing on six priority areas as strategies, was adopted. Malaysia supported Decent Work for Decent Life agenda by holding a tripartite conference, inducing closer social partnership with trade unions, union federations and other employee associations (MOHR Malaysia, 2009). For the MOHR Malaysia, the six strategies in realizing Decent Work Agenda in Malaysia were:

- to create employment opportunities and ensuring workers' rights
- to maintain harmonious industrial relations
- to resolve industrial disputes fairly and equitably
- to develop competitive workforce
- to implement dynamic Occupational Safety and Health Programmes
- to provide Social Safety Network

Malaysia has been quite committed to developing its human capital, not just through education, but also training, and life-long learning. Globalization and the need for competent workforce, and the danger of over relying on foreign workers were acknowledged by the government. However, for Malaysia, some issues are harder to solve, and at times, are thought to be impossible. This is especially true in relations to foreign workers issue in Malaysia (Azizah Kassim, 2012; Durrishah 2012). A number of actions have been taken to lessen over-dependency towards foreign workers in Malaysia, especially the Indonesians, who made up the biggest number. They are now the dominant presence in the construction, and domestic sector, but not much progress has been achieved.

Both Malaysia and Japan have seen the deteriorating number of workers unionized. In Malaysia, unions role are already being replaced by good human resource management practices. The long process of this evolution has started more than thirty years ago, when there were a lot of constraints put forward by the Malaysian government, towards the establishment of national unions (Durrishah, 2001). In late 1980s, enterprise unions, very much like the ones in Japan, were tolerated in Malaysia. Slowly with the advance of human resource best practices, the new norm now enveloped most of Malaysian industrial workplaces, healthcare sector included.

CURRENT CHALLENGES OF HUMAN RESOURCE AT HEALTHCARE ORGANISATIONS

Healthcare organizations today have to address many challenging issues to stay competitive, just like any other businesses. A world class human resource management, better working processes and deliveries, and use of appropriate technologies/ICT to the best advantage may also assist in creating harmonious workplace relations. In terms of human resource, this may mean talent management, workforce planning and scheduling, self service applications, business intelligence, and other approaches deemed appropriate.

However, at best, a country has to reinvent some of its established policies, for it to be able to stay competitive and relevant, or at least to achieve its own national targets, in the midst of intense globalization. The challenge faced by Japan and Malaysia, in this context, are quite different, even though quite interconnected. Malaysia wishes to put healthcare sector upfront as one of the key economic catalyst for Malaysia. Japan sets to lure international community to Japan, as medical hub, and please its own citizens with quality healthcare, but at the same time, not burdening the country's financial pockets.

Both these targets can be achieved by applying universally accepted and proven changes, in terms of policy and right human resource management approaches.

KEY CHALLENGES OF HUMAN RESOURCE FACED BY HEALTHCARE PROVIDERS IN JAPAN AND MALAYSIA

At the moment, both Japan and Malaysia face several key challenges; some are the similar, others different. Both countries realize the need to overcome tangible challenges, such as shortage of human resources. Comparatively, the challenge for Japan is bigger. The Japan healthcare system has worked wonderfully in the past 50 years in ensuring Japanese people overall wellbeing. However, today Japan's healthcare system success also depends on the perception of Japanese people, not just by the data provided by the government ministries. Being an advanced developed country, it is a great challenge to have the real GDP growth in the negative since 2008, while the employment situation is severe, with placement rates of university graduates in 2009 stood at 60.8% (Nursing in Japan, 2011). In the healthcare perspectives, a number of structural changes need to be implemented to stay relevant or upfront in the competitive world.

OUTSIDE FORCES

At times, the challenges of promoting harmonious workplace relations lie outside the jurisdiction of healthcare providers. There are a number of incidences triggered by bad government policies, but affect the respective professions. As an example, the Malaysian government recently has given incentives to trained nurses to join back the public sector, and thus triggering alarm at private hospitals, including KPJ Healthcare Group of Hospitals. More than a hundred highly trained and experienced nurses left KPJ to work at government hospitals who promised the guaranteed pension schemes, and other perks (Interview, KPJ HR Personnel).

Currently, there is a perception among Malaysians that working for the public sector is much better, since it provides stability and job security. In times of economic hardship, the Malaysian government was always obliged to create more jobs for the market, and with the promotion of minimum wage in Malaysia, the inclination towards working at the public sector grows. The general perception is that public sector employment is less appealing to non-Malays.

Malaysia is seen as less safe and this may discourage patients getting treatment in the country. Apart from Singapore, emerging markets such as Korea and Taiwan also may be more appealing to foreigners or some locals.

SHORTAGE OF DOCTORS

Shortages of manpower, such as doctors, may inhibit private hospitals' ability to deliver the desired 'luxury' treatment expected from private healthcare providers.

The issue on the shortage of physicians/medical doctors is heatedly debated in Japan. Japan has fewer physicians per capita than most OECD countries Tatara, 2009). Even though there are increases of 3,500-4,500 physicians per year, in certain areas such as obstetricians, gynaecologists, and paediatricians, there are still shortages. (Health Service Delivery Profile: 2012). There are a relatively stable number of other health care professionals. The low number of health care workers per hospital bed, particularly physicians, is a considerable issue. The number of hospital beds has increased substantially with the aging population. The Medical Care Act sets staffing numbers for physicians and nurses for each type of hospital bed as a quality measure but there is not enough staff to meet the stated standards. The shortage of physician may mean doctors are burdened and overwhelmed with work and other duties.

The shortage of physicians are one of the three urgent problems identified which relate to problems with personnel management in Japanese hospitals, the other two being nurses, and the absence of integrated system (Various reports; Interview: Hayakawa, 23 March 2012). According to some, hospitals are still 'pyramid organisations', but with authoritative, strong management by doctors. The small number of midlevel practitioners dampened the spirit of healthcare workers. However, in Japan, medical doctors still enjoy unchallenged prestige, as compared to other healthcare players in a hospital setting, especially nurses.

In Malaysia, there are concerns over quality of healthcare in rural areas, due to concentrations of healthcare-either public or private in major cities or densely populated areas. At public hospitals, usually patients cannot choose physicians of their choice. Most doctors and nurses in public hospitals in major cities have heavy schedule. By comparison, doctors at public hospitals earn less than their counterparts at private hospitals. Patients getting treatment at private healthcare in Malaysia is regarded as capable of paying for the much higher fees.

The fact that hospitals are only headed by physicians, differ from situation in Malaysia private healthcare. At KPJ Healthcare Berhad Group of hospitals, medical directors head clinical governance, but corporate governance are headed by Chief Executive

Officers or General Managers, who could be from amongst senior and capable nurses. (Refer to KPJ Various Reports and Magazines; www.kpjhealth.com.my). Among the concerns at private hospitals are doctors are 'stand-alone', and the fact that private patients and families are more demanding, expect high-end, state-of-the-art medical technologies, fast service, and much better than public hospitals (Interview with KPJ HR Personnel).

Interestingly, in Malaysia there was already a moratorium over the offering of medical degree programmes. The mushrooming of medical schools in Malaysia (at present there are twenty), either by local players or international competitors has alarmed the Malaysian Medical Council, the professional body that ensures the quality of medical programmes in Malaysia. Even though KPJ Healthcare has been given the approval to run medical degree programmes, it was denied due to technical matters. The Ministry of Higher Education and the council was of the view that Malaysia should fulfill the shortage for specialists or post-graduate medical degrees.

Table 3: Trends in number and proportion of doctors, dentists, pharmacists and nurses in Japan, 1960-2006

	1960	1970	1980	1990	2000	2002	2004	2006
Number								
Doctors	103 131	118 990	156 235	211 797	255 792	262 687	270 371	277 927
Dentists	33 177	37 859	53 602	74 028	90 857	92 874	95 197	97 198
Pharmacists	60 257	79 393	116 056	150 627	217 477	229 744	241 369	252 533
Public Health nurses	13 010	14 007	17 957	25 303	36 781	38 366	39 195	40 191
Midwives	52 337	28 087	25 867	22 918	24 511	24 340	25 257	25 775
Nurses	185 592	273 572	487 169	745 301	1 042 468	1 097 325	1 146 181	1 194 121
Proportion (per 100 000 population)								
Doctors	110.4	114.7	133.5	171.3	201.5	206.1	211.7	217.5
Dentists	35.5	36.5	45.8	59.9	71.6	72.9	74.6	76.1
Pharmacists	64.5	76.5	99.1	121.9	171.3	180.3	189.0	197.6
Public Health Nurses	13.9	13.5	15.3	20.5	29.0	30.1	30.7	31.5
Midwives	56.0	27.1	22.1	18.5	19.3	19.1	19.8	20.2
Nurses	198.7	263.8	416.2	602.9	821.4	861.1	897.6	934.6

Source: Japan Ministry of Health, Labour and Welfare, 2006

Table 4: Japan Healthcare Facilities, 2009

Healthcare facilities		Number
Hospital	National	275
	Public	1,296
	Others	7,168
Clinic		99,635
Dental Clinic		68,097

Source: Japan Nursing Association, 2011.

Table 5: Japan Human Resources for Health, 2009

Health human resources	Full-time equivalent (people)
Physicians	191,125.3
Dentists	9,993.1
Pharmacists	43,113.6
Public health nurses	4,459.9
Midwives	18,881.5
Nurses	660,142.9
Assistant nurses	166,546.0
Physical Therapist	42,813.0
Radiology technicians	38,079.4
Clinical laboratory technicians	48,055.4

Source: Japan Nursing Association, 2011.

CAREER IN NURSING IN JAPAN AND MALAYSIA

Both nursing professions in Malaysia and Japan have gone through quite tremendous upgrade through training and tertiary education. Both governments try their level best to ensure nurses graduates are employed and possess the needed level of competence.

Today Japan has 193 nursing colleges/universities with 121 graduate school offering master programs and 61 offering doctoral programs. What does that make nursing professions in Japan? While it does contribute to higher social status, and upgrading of nursing personnel, as also happened in Malaysia, there were questions on disparity between schools and quality of faculties (JNA, 2011). The government has taken move to amend Act on Public Health Nurses, Midwives and Nurses and Act on Assurance of Work Forces of Nurses and Other Medical experts, making it obligatory to give postgraduate clinical training to newly-graduated nursing personnel. Starting from April 2010, this move is expected to improve Japan quality of nursing, secure medical safety, and prevented early turnover of fresh graduates, since they are also partially subsidized.

Meanwhile, recently Malaysia has been bogged down by the excess of nurses, due to uncontrolled number of graduates by private higher institutions in the country. The issue in Malaysia, may be more towards quality, highly trained and competent nurses,

as compared to Japan, where the issue of nursing shortage is still unsolved. This situation affects the quality of patient care in hospitals.

Table 6: Nurse turnover rate and working conditions in Japan

	Item	Survey in 2009	Previous Survey
Turnover rate	Full-time nursing personnel	11.9%	12.6% (2008)
	Newly-graduated personnel	8.9%	9.2% (2008)
Work conditions	Days of taken paid holidays	8.4 days	8.0 days (2005)
	Average utilization of paid holidays	46.0%	41.1% (2005)
	Night shifts of nursing personnel with preschoolers	59.5%	Unknown

It is debatable but nursing career in Japan is viewed by some researchers as not achieving its peak yet, when the perception is nurses have high turnover rate, given wide and ambiguous jobs, which lead to burnout, inefficiency, lack of integration and weak teams (Interviews, Nursing Personnel, March 2012). Malaysian nurses enjoy more perks and career advancement, especially in private healthcare sectors, like KPJ Berhad Group of Hospitals, the biggest private healthcare providers in Malaysia.

The recent issue faced by Malaysia is when the government is accused of giving permissions for private higher institutions to over-supply of nursing graduates in the country. The claims made by NGOs and parents are:

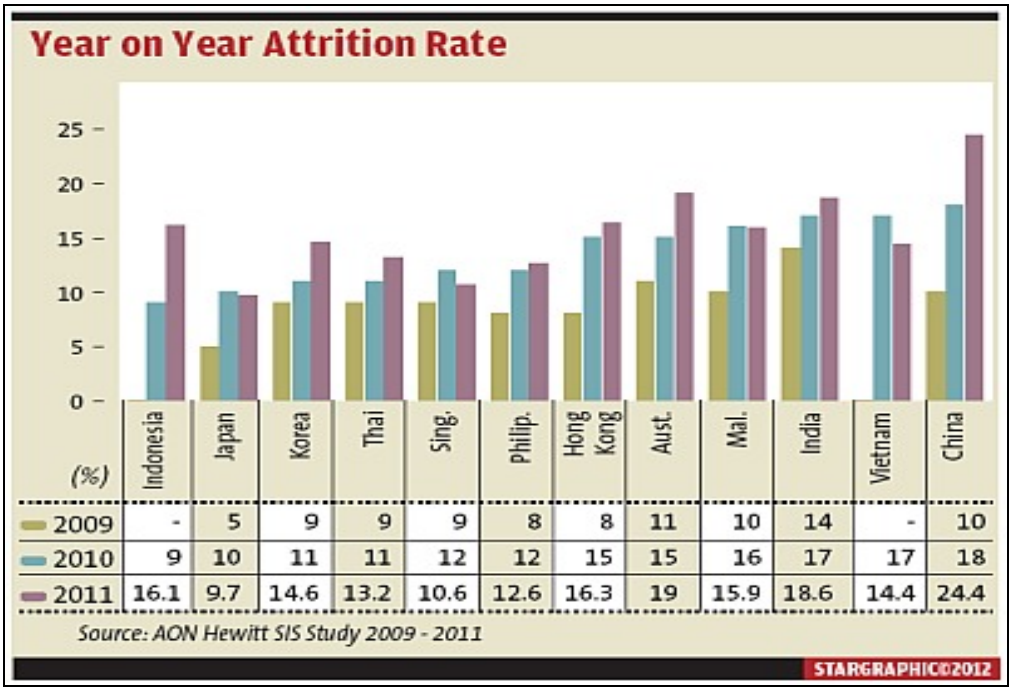
- There are 61 private institutions have been given the go-ahead by the Higher Education Ministry to conduct nursing courses;
- There are currently more than 37500 nursing undergraduates enrolled in these 61 private learning institutions. A large percentage of these undergraduates have acquired the PTPTN loan, normally around RM55000;

- The total amount of staff nurses employed throughout the country as of December 2010 was 61110. Of that total, 47992 were stationed in the government sector and the remainder 21118 in the private sector;
- In 2010, 7665 nursing graduates from private institutions sat for the Nursing Board examination. Only 70.1 per cent of them passed the examination compared to the passing rate of 98.4 per cent amongst graduates from Malaysian Health Ministry colleges.
- Only 42.7 per cent of nursing graduates from private higher education institutions in 2010 succeeded in acquiring jobs at hospitals and clinics

At present, the issue is being addressed by the Malaysian government, by engaging private hospitals to assist in placements for these graduates, which may not make some of the players, like KPJ Healthcare Berhad happy. For genuine player like KPJ Healthcare, who has 24 hospitals all over Malaysia and 2 in Jakarta Indonesia, their supply of nurses were met through their own University College, who never filled up the small quota given, that is only 450 per year. However, it is a public knowledge in Malaysia that many private colleges and university colleges are producing graduates with the hope that the graduates can find their own jobs after graduating. In other words, government policy at times is the course for concern, since private players will take the opportunity to make financial gains through parents and family hardship.

One of the new challenges faced by Malaysia is the younger generation who job-hob, which is triggered by many factors. In the past Malaysians believe more in lifetime employment, where one stayed at a job until they retire. Today, young people in Malaysia job-hob more frequently. It may be caused by money, career development opportunities, boredom (need challenges), colleagues /office politics (The Star 19 Feb 2012). The impact is on healthcare sector, where nurses and other health sciences practitioners have no qualm of changing jobs, when they have the opportunity to do so.

Table 7: Year to Year Attrition Rate



Source: Japan Healthcare System, Wikipedia

HUMAN RESOURCE BEST PRACTICES

In Japan the role of enterprise unions are still relevant. However, more educated workforce, the difficulty to unionise, especially with the rise of non-regular workers who do not have the privilege to unionise, the ageing workforce who are mostly managerial employee – all these contribute to the emergence of corporate communities and shareholders relations that promote union'worker 'incorporation' or 'participation' (Whittaker, 1998). In Malaysia, this scenario is more pronounced, where human resource management practices are becoming more rampant, and become a matter of choice for workers in bargaining their positions at the workplace.

Malaysia, private healthcare providers compete amongst them to win over patients to their respective hospitals, a fact that may be different in Japan. The hospitals staffs are not unionized. They rely totally in best human resource practices, and good governance on the hospital side. At KPJ Healthcare Berhad, a comprehensive human resource package has been in place, and still is undergoing a lot of review, to make it stay competitive. Among strengths of KPJ Healthcare Berhad are dynamic leadership, strong and competent management, reputable medical consultants, group synergy, and more

than thirty years of experience. (KPJ Annual Reports; KPJ Thirty Years Care for Life). The wholesomeness of KPJ as a healthcare business entity also help, as it owns a University College and two Colleges, regard the institution as learning organization, internally developed integrated information system, and emphasise on corporate culture. As a very strong recognizable brand, KPJ Healthcare is supported by a range of supporting healthcare related companies. In Malaysia, these are important factors, as more players are expanding their business in Malaysia, such as Sime Darby Berhad, and Pantai Group of Hospitals.

At KPJ Healthcare Berhad, there is no unions, human resource best practices are fundamental, where employees are assessed using performance-base HR Metrics, which is implemented group wide. Career growth of employees has always been given emphasis, and everyone, from the bottom-up are given equal opportunities to grow in the company. KPJ has invested hundreds of millions of ringgit in training and re-training, through a comprehensive training policy. It is under KPJ that private sector nurses had the opportunity to lead not just wards, but hospital top management. A few of the more competent ones have been appointed to hold group wide positions. Extra benefits, like day care centres are already established in hospitals to the benefit of hospital young employees. Career enhancement and development, staff performance appraisal (SPAR) are already established and reviewed yearly. To encourage strong bonding among KPJ Group 10000 strong employees, KPJ holds early of the year Public Address by the Managing Director of KPJ Healthcare Berhad, called PEDOMAN (In English- DIRECTION).

In Japan, the same opportunities now apply. At Tokyo General Hospital, which is a member of Tohoku Group, nurses were given opportunity to grow in their career, and they are already regarded as important player in the hospital setting. They can be appointed to the post of Director of Nursing at the hospital, where they ensure good management of staff, and achieve financial targets. The absence of unions, like at Kasuga Clinic, are replaced by consultations between management and representative of employees, and this is important when rules and regulations are to be changes. Performance based system is practiced, where performance review is made every six months. Apart from bonuses, employees enjoy many benefits such as paid holidays, summer vacations, year-end vacation, maternity leave and child care leave. For those who go for child care leave can use 60% from government insurance, and are permitted to come back to work. Kasuga Clinic can afford to employ highly trained nurses only,

and therefore has no need to provide a training scheme. The general perception at the management was ‘nurses are powerful than doctors’- acknowledging their dominant roles, and they have good career path, where one can be promoted to Manager in the Clinic.

In short, good human resource practices are already employed at various private hospitals in both Japan and Malaysia, ensuring stable and harmonious workplace relations.

CONCLUSIONS

Malaysia looks highly committed in transforming its private healthcare sector to assist the country towards a high income society. Japan shies away of declaring drastic change in ensuring Japan becomes a hub for medical tourism. There is a valid reason for this: Malaysia needs to get out of the middle income trap, and private healthcare sector is one of the twelve key drivers. Japan has strong diversifications in its economy and healthcare tourism was never really one of them. If Japan is ever to open doors to international market in a big way, it has to be more adaptable to global criteria. Malaysia has already adopted some of these. Out of colonialisation, Malaysia is an English speaking country, more welcoming towards foreigners, multi-cultured, multi-racial, and open its doors widely, sometimes too wide, to the world. Malaysia will achieve what it aims for; to make Malaysia a medical tourism hub, with all the consequences. However, both Japan and Malaysia ensure working conditions of all healthcare practitioners are conducive, to support the appeal of healthcare sector through harmonious workplace relations.

REFERENCES:

Anantaraman V. Malaysian Industrial Relations System: Its Congruence with the International Labor Code. http://www/mtuc/org.my,anantaraman%20paper.htm

12th Annual Nursing Bulletin: Closing the Gap: From Evidence to Action. KPJ Healthcare Berhad. Dec 2012. Vol 12/12/

Annual Report. 2011. KPJ Healthcare Berhad.

Asian Decent Work Decade 2006-2015. 2012. Building Better Industrial Relations in an Integrating ASEAN. ASEAN=ILO/Japan Industrial Relations Project Regional Office for Asia and the Pacific. International Labour Organisation.

Ayadurai, D. 2004. Industrial Relations in Malaysia: Law and Practice. Malayan Law Journal. Kuala Lumpur.

Azizah Kassim. 2012. Dasar Pekerja Asing di Malaysia: Perlunya anjakan Paradigma (Foreign Workers Policy in Malaysia: the Need for Paradigm Shift). Penerbit Universiti Kebangsaan Malaysia. Bangi.

Barnett, T, Namasivayam P and Narudin D.A.A. 2010. A Critical Review of Nursing Shortage in Malaysia. International Nursing Review.

Care For Life. Prepared For Emergency – Giving Proper Care to the Elderly. Vol 3 Issue3.

Celebrating 30 Years Caring for Life: Our Commitment to Excellence in Healthcare. KPJ Healthcare Berhad. Kuala Lumpur.

Dexter A. 2012. Expansion Mode for Malaysian Private Healthcare Players. http://www.theborneopost.com/2012/07/08

Durrishah Idrus. 2001. An examination of the Contending Factors Shaping The Role of The State in Malaysian Industrial Relations System. Unpublished PhD thesis, University of Stirling.

Durrishah Idrus (eds) . 2012. Human Capital Transformation: 55 Years of Malaysian Experience. Institute of Labour Market Information and Analysis, Ministry of Human Resources.

Economic Transformation Programme: Roadmap for Malaysia, Creating Wealth Through Excellence in Healthcare. www.moh.gov.my/images/gallery/ETP/NKEA

Fujimura, H. 2012. Japan's Labor Unions: Past, Present, Future in *Japan Labor Review*, The Japan Institute of Labour Policy and Training. Vol 9, No 1, Winter 2012.

Franscisco, J. ----Healthcare Sector in ASEAN: "Who will care for the caregivers?" Implication of Regional Economic Integration to Trade Union Organizing in the Health Care Sector'. Women and Gender Institute, Miriam College .Philippines.

Healthcare Malaysia. 2012. www.mhtc.org.my
International Business Review: of Global Leaders, Businesses & Innovations. In Pursuit of Wellbeing: Malaysia's Healthcare Tourism Excellence. www.internationalbusinessreiew.net

Health Service Delivery Profile: Japan. 2012.

Jomo K.S. (eds). 1994. Japan and Malaysian Development: in the Shadow of the Rising Sun. Routledge. London.

Jomo K.S. and Todd, P. 1994. Trade Unions and the State in Peninsular Malaysia. Kuala Lumpur. Oxford University Press.

KPJ Healthcare Quarterly. Issue 9/ Apr-Jun 2010.

Labor Situation in Japan and Its Analysis: General Overview 2011/2012. 2012. The Japan Institute for Labour Policy and Training.

Labour Situation in Malaysia: General Overview 2007/2008. 2008. Ministry of Human Resources.

Lee Cheng Poh. 2008. Nurses' Job Satisfaction In The Malaysian Private Hospitals

Malaysia Employment Act 1955.

Malaysian Institute of Economic Research (MIER). www.mier.org.my

Matsuda R. 2012. The Japanese Healthcare System 2012 in International Profiles of Health Care System 2012.

Ministry of Health Malaysia. Country Health Plan: 10th Malaysia Plan 2011-2015. Kementerian Kesihatan Malaysia. Putrajaya.

Ministry of Human Resources Malaysia. 2009. Realising Decent Work for Decent Life. National Institute of Human Resources. Putrajaya.

OECD. 2011. OECD Economic Surveys: Japan, 2011. OECD Publishing. http://dx.doi.org/10.178/eco_survey-jpn-2011-en

Rajah Rasiah, Nik Rosnah Wan Abdullah, and Makmor Tumin, 2011. Markets and Healthcare Services in Malaysia: Critical Issues. *International Journal of Institutions and Economies Markets and Healthcare Services in Malaysia.* Vol. 3, No. 3, October 2011, pp. 467-486.

Shibuya K, Hashimoto H, Ikegami N, Nishi A, Tanimoto T, Miyata H, Takemi K and Reich M.R. Lancet 2011. published online September 1. DOI:10.1016/S0140-6736(11)61098-2.

Tatara K, Okamoto E. 2009. Japan Health Systems Review in *Health Systems in Transition*. European Observatory on Health Systems and Policy. World Health Organization. 11 (5): 1-164.

The Economist. Healthcare in Japan, Not All Smiles. Sept 10th 2011. www.economist.com/node/21528660/print

Todd, P and Peetz, D. 2000. 'Malaysian Industrial Relations at the Century's Turn: Vision 2020 or a Spectre of the Past? Presented at AIRAANZ Conference, Newcastle, 2-4 Feb 2000.

The EDGE. 13 Feb 2013. www.theedgemalaysia.com

The Star Newspaper, 19 Feb 2012.

Whittaker, D. 1998. Labour Unions and Industrial Relations in Japan: Crumbling Pillar or Forging a Third Way? Industrial Relations Journal. 29: 4. Blackwell Publishers.

Interviews and Discussions:

- With key persons at several institutions in Tokyo, Japan (from 17 to 31 March 2012):
    - Doyukai Corporation (Mr Bouda- Head/ Secretary General- Kasuga Clinic)
    - Ministry of Labour, Health and Welfare (Mr Toki- Health Policy Division)
    - Japan Association of Nursing (Madam Suga Sakamoto-President, Mr Shinobu Ogawa-Executive Officer)
    - JTUC - RENGO, Trade Union (Mr Ito- Director, Welfare Policy Division, Department of Economic and Social Policy, Miss Kotoe Morihara-Assistant Director, Welfare Policy Division, Mr Endoh-Section Chief, Welfare Policy Division, Mr Satoshi Nakata,Section Chief ,Employment and Labour Legislation Division, Department of Working Conditions)
    - Miss Sachiko Hayakawa, Doctoral Candidate, Meiji University
    - Research and Statistical Information Analysis Department, JILPT (Mr Eiji Okuda)
    - Mr Sumio Sakai, Researcher, JILPT
    - Mr Akira
    - Southern Tohoku Healthcare Group (Mr Toshizo Abe- Head of Human Resource, Shinurigaoka General Hospital)
    - Dr Mitsuko Nakashima- Director of Nursing, Tokyo General Hospital
- Discussion with KPJ Healthcare Group Human Resource Personnel (May 2012)