CHAPTER V PUBLIC AND PRIVATE SHARES IN THE DISTRIBUTION OF BEDS, DOCTORS AND NURSES

5.1 Introduction

There has been increasing focus on human resource in the provision of health care services worldwide, as well as in Malaysia. The delivery of health services effectively depends on the supply of trained health manpower with doctors being a major component. According to the WHO (2000:75), manpower of health is one of the three principle health system inputs with the other two major inputs being physical capital and consumables.

There has been a rapid transformation in the healthcare system in Malaysia particularly in the balance between public and private sectors in healthcare provision. Fast growth in private healthcare providers has intensified the competition for doctors in the 1980s. A combination of lower salaries and bureaucratic managing conditions has driven the movement of trained doctors and nurses from public to private healthcare operators. Although the government has tried to solve this problem by approving several medical colleges in the country, commentators have raised concerns over falling quality standards as a consequence of a lack of sufficient professional trainers.

The gravity of the outflow of health personnel from the public sector to the private sector can be seen in the 7th Malaysian Plan (Malaysia, 1996). Between 55-60% of the country's doctors were in the private sector. Numerous highly experienced doctors and nurses had left for the greener pastures of private healthcare and even abroad. According to Rasiah, Nik Rosnah and Makmor (2011) hiring staff without a significant

criterion of merit, as well as, the slowing down of wage rise in public hospitals affected staff morale. Trained doctors began to leave public hospitals to enjoy higher salaries and better working conditions in the private hospitals. This phenomenon had aggravated the internal brain drain from public to private hospitals, growing scarcity of trained doctors to treat the poor.

This chapter seeks to examine the scenario stated above by looking at the changes in the composition of beds, doctors and nurses in public and private practices. The next section discusses the analyses of the provision of healthcare in Malaysia. Section 5.3 and Sections 5.4 discusses the breakdown of public and private doctors and public and private nurses respectively. Section 5.5 presents the summary.

5.2 Provision of Healthcare in Malaysia

Rapid economic growth since 1980s expanded the demand for healthcare providers. Recognising the expansion in demand, the government took steps to ensure that the healthcare delivery system is efficient, optimal and equitable through proper coordination between the public and private sectors (Malaysia 1993: 224). The government also started to assertively promote the private provision of healthcare since the 1980s (Malaysia, 1986).

The private healthcare sector in Malaysia received a further boost since the introduction of the Privatisation Master Plan in 1991 (Rosnah, 2005). Many medical services had been corporatized or privatised since 1991 with considerable expansion in hospital and specialised care. As a consequence, the number of private healthcare providers rose

from 50 hospitals in 1980 to 233 in 2006, which included hospitals, nursing and maternity homes (Por, 2011).

One of the indicators that can be used as an evidence of the rise in private hospital care is the ratio of public and private hospitals beds. Table 5.1 shows the total, annual increase and ratio public and private hospital beds in Malaysia. The public-private ratio fell in trend terms from 1:7.08 in 1990 to 1:3.30 in 2009.

Hospital care in Malaysia was heavily dominated by the public sector until the 1990s. Public hospitals still commandeered 76.7% of the beds in Malaysia in 2009 (see Table 5.1). The highest increase in public hospitals beds can be observed in the year 1996 followed by the year 1999. Even though the public sector had the most beds compared to the private sector, the increase of beds in private sector annually was greater compared to the public hospitals. The average growth of beds in public hospitals was only around one per cent compared to the private hospitals around 5 per cent.

Private hospital beds increased around three times from 4,675 in 1990 to 12,619 in 2009. Private beds only contracted in number in 2002 over the period 1990-2009. The number of private beds increased most at nearly 20% in 1997 following government initiatives to promote privatisation of healthcare and government efforts to privatise several services in public hospitals. As the financial crisis struck in 1997 the government launched the medical tourism initiative to substitute for fallen demand domestically. Alarmingly, if the government achieved its target, private hospitals will achieve parity in the number of beds by 2020.

In the private sector, the proportion of first and second class beds to third class was approximately 2 to 1, as compared 1 to 4 in the public sector. A high proportion of first and second class beds in the private sector indicate that the objective of these hospitals is to meet the demands of the comparatively affluent consumers in the community (Muhamad, 1996). This unequal skew in the supply of facilities by private hospitals threatens to unduly reduce services rendered to the poor.

Table 5.1 Number of Beds in Public and Private Hospitals and Ratio, Malaysia, 1990-2009.

Year	Public Hospital Beds	Private Hospital Beds	Annual Increase of Public Hospital Beds	Annual Increase of Private Hospital Beds	Ratio between Public and Private Hospital Beds
1990	33,124	4,675	-	-	1: 7.08
1991	33,476	4,898	0.23	4.77	1: 6.83
1992	33,261	5,401	-0.64	10.27	1: 6.16
1993	33,183	5,799	-0.23	7.37	1: 5.72
1994	33,246	6,492	0.19	11.95	1: 5.12
1995	33,588	7,192	1.03	10.78	1: 4.67
1996	35,881	7,471	6.83	3.88	1: 4.80
1997	35,981	8,963	0.28	19.97	1: 4.01
1998	33,338	9,060	-1.61	1.08	1: 3.91
1999	37,255	9,498	5.24	4.83	1: 3.92
2000	37,519	9,547	0.71	0.52	1: 3.93
2001	34,552	9,949	-0.23	4.21	1: 3.76
2002	37,436	9,849	0.01	-1.01	1: 3.80
2003	37,001	10,405	-1.16	5.65	1: 3.56
2004	37,280	10,542	0.75	1.32	1: 3.54
2005	37,677	10,794	1.06	2.39	1: 3.49
2006	38,625	11,637	2.52	7.81	1: 3.32
2007	40,057	11,722	3.71	0.73	1: 3.42
2008	41,249	12,165	2.98	3.78	1: 3.39
2009	41,580	12,619	0.80	3.73	1: 3.30

(Source: Ministry of Health, various years)

Higher growth of private hospital beds reflects that the number of private hospitals had increased greatly. The increase of private hospitals and the number of beds leads to the increase of demand for trained doctors. This situation gave opportunity to the public hospital trained doctors to shift to better perk private hospitals.

5.3 Public and Private Doctors

The movement of public hospital doctors to private hospitals is a worldwide phenomenon. Although it may be more visible in less-developed countries, fast developing countries such as Malaysia are not an exception. It is well known that doctors are the most important element of the health system's input. The concentration of doctors in private practice will clearly deny public hospitals adequate supply of doctors to treat the majority of patients in most countries. The exodus of especially trained doctors to the private sector can raise waiting time and widen of poor quality treatment.

The improvement in income levels, especially over the period of 1987-1997 when Malaysia's GDP grew at over 8% per annum raised demand for more quality and faster services, which, helped support an expansion in the number of private hospitals. A combination of government initiatives and increased domestic demand offered the impetus for a number of doctors to move from public to private hospitals. Civil servant themselves did not necessarily support the privatisation policy. For example, in a speech addressed to the National Healthcare Conference in 1993, the Director General of Health of Malaysia expressed his reservations about commercialised medicine:

> "*The issue of health care as a business is a complex one, and the perception held by the business community, doctors and the community may differ greatly. In corporate terms, health care may be viewed as products to be marketed that will result in good returns on investment that will please the stakeholders. Patients and members of the public may hold completely different perspectives and consider health as service to be made available to as many as possible, and may view the profit motive in a negative manner. Doctors will have to decide and choose between being Samaritans and businessmen. In my own naïve view, healthcare is a social service and it would be preferable for doctors who consider medicine as a business to become businessmen rather than to practice medicine."*
>
> *Tan Sri Dr. Abu Bakar Suleiman*

Since the 1980s, qualified private practitioners and private profitable hospitals have been allowed to freely enter and exit the healthcare sector without contractual relationships with the government. The public hospital doctors are free to exit from public hospitals after finishing their housemenship.

5.3.1 Share of Doctors in Public and Private Hospitals

The delivery of efficient and effective healthcare services depends on the supply of trained health personnel. The mushrooming of private hospitals created a big demand for trained doctors. Shortage of trained doctors in public hospitals will affect the delivery and scope of health services. With income five to ten times higher in the private hospital, it encourages for internal brain drain from public to private hospitals.

Table 5.2 provides the data of doctors in public and private practice and the population - doctor ratio. The number of doctors in both public and private hospitals combined increased from 5,794 in 1987 to 15,619 in 2000 and 32,979 in 2010. The number of doctors in the private health practice tripled over the period 1987 to 2010. The population-doctor ratio improved from 1:2,852 to 1:905 in 2010, though, it is still below the standard ratio set by the World Health Organisation of 1:600. The share of doctors in the private sector is projected to rise further as doctors desert the low paying public sector to pursue more lucrative private opportunities.

The rise in doctors hired by the public sector began to grow strongly from 1992 following government policy during the Sixth Malaysian Plan to expand the number. In order to overcome the shortage of doctors, the government recruited foreign doctors on contract basis. The government also increased the intake of medical students in local universities and utilised the services of retired health personnel.

Between 1990 to 2001, nearly 4,000 doctors resigned from the public sector and most of them went to work in private practices (Malaysian Medical Association, 2006). However, in the year 2006 onwards the share of public doctors started to increase following an expansion of doctors gradually supplied from new medical colleges established in the country.

Table 5.2: Number of Doctors in Public and Private Hospitals, Malaysia, 1987-2010.

Year	Public	Private	Total	Ratio Medical Doctors: Population
1987	2,463	3,331	5,794	1:2852
1988	2,666	3,608	6,274	1:2700
1989	2,781	3,796	6,577	1:2638
1990	3,021	3,991	7,012	1:2,533
1991	3,069	4,129	7,198	1:2,441
1992	3,516	4,203	7,719	1:2411
1993	3,810	4,469	8,279	1:2301
1994	4,023	4,808	8,831	1:2207
1995	4,412	5,196	9,608	1:2,077
1996	4,614	5,582	8,831	1:2076
1997	8,235	6,013	14,248	1:1521
1998	7,637	6,461	14,098	1:1477
1999	8,723	6780	15,503	1:1465
2000	8,410	7,209	15,619	1:1490
2001	8,615	7,531	16,146	1:1474
2002	9,424	8,018	17,442	1:1406
2003	8,946	9,245	18,191	1:1377
2004	9,410	8,836	18,246	1:1,402
2005	10,943	9,162	20,105	1:1,300
2006	13,335	8,602	21,937	1:1,214
2007	14,298	9,440	23,738	1:1,214
2008	15,096	10,006	25,102	1:1,105
2009	20,192	10,344	30,536	1:940
2010	22,429	10,550	32,979	1:905

(Source: Ministry of Health, various years)

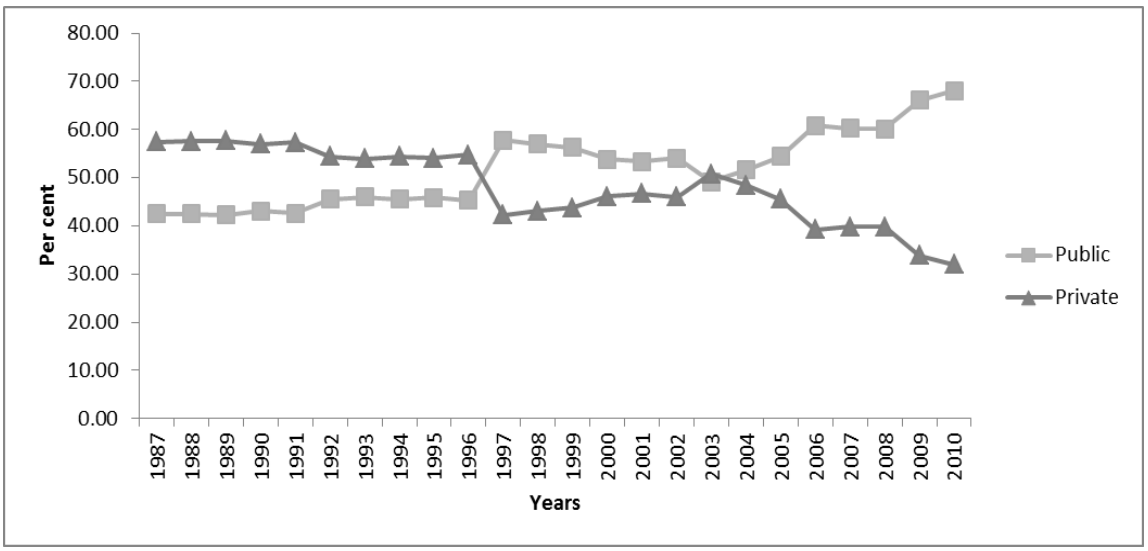

Figure 5.1: Share of Doctors in Public and Private Practices.
(Source: Ministry of Health, various years)

Furthermore, the government had created some improvements in the terms and conditions of doctors' services in the public sector. The government undertook to improve and increase in-service training of doctors who were deployed in the various hospitals in the country. Other incentives were also provided, such as free institutional quarters for doctors performing under on call-duty, higher specialist allowances and greater post-graduate training opportunities for doctors in the various professional fields (Malaysia, 1996:350).

The massive growth in the number of doctors in 1997 and also the event of the Asian Financial Crisis undermined the demand for private healthcare (see figure 5.1). The crisis also caused many local patients of private hospitals to switch to public hospitals. Many of the businesses effected by the crises either closed, downsized or cutback on the range of benefits for employees, which also saw a return of a number of doctors to the public hospitals (Chee & Barraclough, 2007).

The lag effect of the financial market trauma of 1997 drove deceleration in hiring in the private sector, which hit its trough with a negative growth rate in 2000. However, the hirings in the private healthcare sector began to grow strongly again since 2004.

The number of doctors started to decrease in 2007-2008 before increasing again in the 2009-2010. The MOH revealed in 2008 that Malaysia faced a shortage of 9,000 doctors, which accounted for 40% of the vacancies in government hospitals and private healthcare centres (Ministry of Health, 2008). Among the government announcement to solve this problems was to woo Malaysian doctors and graduating medical students to come back to serve the country.

Further evidence can be observed through the bed to doctor ratio in Table 5.3. In 1990, beds-to-doctor ratio in public hospitals was 1:11 and the ratio increased tremendously over the years until it reached 1: 2 in the year 2009. However, in private hospitals the bed to doctor ratio was 1:1 from 1990 to 2009. The bed to doctor ratio in private hospitals were relatively stable over the years.

The decrease in beds-to-doctor ratio in public hospitals was due to the government policy where the Government introduced a new promotion system at the public hospitals. The government also approved a number of new medical colleges in the country to raise the number of doctors in public hospitals. The number of medical colleges in Malaysia rose from 1 in 1980 to 36 in 2012 (MOH, 2012). The rising number of medical colleges helped reverse the number of doctors in public hospitals, which started rising since 2009.

Table 5.3: Beds to Doctor Ratio in Public and Private Hospitals

Year	Public Hospital	Private Hospital
1990	1: 10.79	1: 1.13
1991	1: 9.52	1: 1.17
1992	1: 8.73	1: 1.21
1993	1: 8.25	1: 1.21
1994	1: 7.54	1: 1.25
1995	1: 7.28	1: 1.29
1996	1: 4.36	1: 1.24
1997	1: 4.71	1: 1.39
1998	1: 3.82	1: 1.34
1999	1: 4.43	1: 1.32
2000	1: 4.36	1: 1.27
2001	1: 3.67	1: 1.24
2002	1: 4.18	1: 1.07
2003	1: 3.93	1: 1.18
2004	1: 3.41	1: 1.15
2005	1: 2.83	1: 1.25
2006	1: 2.70	1: 1.23
2007	1: 2.65	1: 1.17
2008	1: 2.04	1: 1.18
2009	1: 1.85	1: 1.20

The doctors in public hospitals were generally housemen doctors and there was a lack of trained and specialist doctors. A shortage in trained and specialists doctors had undermined the training of housemen in national hospitals. The ideal ratio of trainers to housemen is 1:4 but in a number of cases the ratio had increased to exceed 1:20 (Pagavalan, 2011). This situation reflected that the internal brain drain from public to private hospitals had reduce the quality treatment in public hospitals when most of the trained doctors were in private hospitals and left the housemen in public hospitals.

While a number of works have addressed problems with the supply of doctors, what has not received much attention is the lack of trained doctors and specialists, especially in public hospitals. The discussion on specialists in private healthcare cannot be examined systematically because the country has yet to have a mandatory specialist registration body. It is, however, implicit in the rise of private hospitals, because each private

hospital has a panel of specialists doctors. Approximately 60% of the medical specialists were practising in the private sector in 1995 (Malaysia, 1996).

Table 5.4: Number of Specialists in Public Hospitals, Malaysia, 1980-2005

Year	Number of Posts (A)	Number of Posts Filled (B)	Percentage (B/A x 100)%
1980	264	121	45.83
1981	304	129	42.43
1982	321	138	42.99
1983	324	144	44.44
1984	324	140	43.21
1985	321	229	71.34
1986	321	229	71.34
1987	325	208	64.00
1988	326	160	49.08
1989	327	151	46.18
1990	419	190	45.35
1991	434	193	44.47
1992	480	179	37.29
1993	498	-	-
1994	541	377	69.69
1995	680	339	49.85
1996	649	432	66.56
1997	724	522	72.10
1998	763	646	84.67
1999	924	587	63.53
2000	1,240	638	51.45
2001	1,710	864	50.53
2002	1,708	909	53.22
2003	2,164	1,256	58.04
2004	2,386	1,346	56.41
2005	3,310	1,321	39.91

(Source: Ministry of Health, various years)

The share of specialists in the total posts advertised at public hospitals was low over the period 1980-1984, less than 50%. During these years, profit oriented private hospitals began to mushroom. In this period, 162 specialists resigned or retired (see Table 5.4). However, between 1985 and 1987 there was an improvement in share of actual specialists in specialist demanded by public hospitals.

The formalisation of privatisation and corporatisation quickened the proliferation of profit-based hospitals from the 1990s (Rasiah, et al., 2009), which, opened opportunities for the public specialists to join private practices. However there was an abnormal growth in the number of specialists in public hospitals in 1997-1998 due to the economic crisis that undermined the private healthcare businesses with many closing down. Specialists in the private hospitals joined back the public hospitals during these years.

Between 2000 and 2005, specialist posts in public hospitals increased 3 fold while the share of the filling remained at 50%. The shortage in specialists in public hospitals hit a record of 60% of the posts announced. Inter alia, shortage in number of specialists has driven the government to approve more medical colleges in Malaysia.

Experienced specialists were disproportionately concentrated in the private sector where their skills may be under-utilised because of a limited patient pool who were occasionally presented with minor conditions, not requiring the attention of specialist expertise (Chan, 1996). This problem arose because of a laissez faire system where patients can directly access specialist services in the private sector, unlike the system of referral practiced in the public healthcare system. Specialists in the private sector made up 55 % of the total national specialist pool but only served 25% of major cases (Hamid, 1997).

A recent study by the MOH done in collaboration with the Academy of Medicine of Malaysia demonstrated this problem (Abu, et al., 1993:247). In the study it was stated that:

About 70 per cent of the patients managed by public sector specialists and about 25 per cent of those managed by private sector specialists were complex cases that required the expertise of specialist. This difference in the utilisation of specialist expertise is not unexpected. This is because in the present system, private specialists manage mainly unscreened, walk in-patients whereas the public specialists manage mainly referred patients.

In order to overcome the shortage of trained doctors and specialist in public hospitals, the government has hired more foreign doctors and asked Malaysian doctors who migrated overseas to return. The on-going shortage of public hospitals trained doctors and specialists could lead to erosion of patients' safety. Those in the category of well-to-do will seek the treatment in private hospitals and those who are under the category of poor have no choice but to seek treatment in public hospitals. The shortages of specialist in public hospitals and the long waiting time will give a negative impact to the poor. This situation might force the poor to seek treatment in private hospitals and they have to bear with higher debt.

5.4 Public and Private Nurses

Nurses are in high demand not only in developed countries; such as United States and United Kingdom, but also in developing countries like Malaysia. According to healthcare authorities, more than 70% of Malaysian hospitals currently do not have adequate nursing staff. With increasing population, the demand for nursing jobs entrance increase in parallel. Interestingly, it is identified that the nursing programmes are currently offered at 85 private universities and higher education institute colleges

and 10 public universities nationwide, including one operated by the Defence Ministry, and 38 nursing schools administered by the Health Ministry (Bernama, 2011).

Table 5.5 displays the number of nurses in public and private hospitals. There was an increase in the number of nurses in public and private hospitals over the years. Nurses in public hospitals increased from 11, 545 in 1990 to 47, 992 in 2010 with a subsequent improvement in the nurse to beds ratio from 1: 2.89 to 1: 0.87.

Nurses in private hospitals appeared to follow the same trend as public hospitals. The increase in the number of nurses in private hospitals is really remarkable. From 1990 to 2010, nurses in private hospitals increased on average by 10.3% per annum. The ratio of nurses to beds in private hospitals improved from 1: 1.59 in 1990 to 1:0.75 in 2010. Basically, both public and private hospitals showed improvements in the ratio of nurses to beds.

However, the ratio of nurses to population rose from 1:168 in 1990 to 1:419 in 2010 (see Table 5.5). Nevertheless, the ratio actually hit its point in the period 1990-2010 when it reached 1:937 in 1998. It has since improved significantly to reach 1:419 in 2010. The improvement had been a significant achievement though the country is still facing a critical shortage. As with the doctors, the increase had been achieved primarily by expanding the domestic supply of new graduates.

The Heath Minister said that about 9,000 nurses will graduate from nursing colleges nationwide to enter the healthcare workforce each year, but unfortunately this number needs to increase by another 30% according to experts (Bernama, 2011). It has been

estimated that a total of 174,000 nurses will be required by the year 2020 to reach a targeted 1:200 nurse population ratio (Chua, 2004).

Table 5.5: Total Number of Nurses in Public and Private Hospitals and Ratio between Nurses and Beds, Malaysia, 1990-2010.

Years	Public Hospital Nurses	Private Hospital Nurses	Ratio nurses to beds in public hospitals	Ratio nurses to beds in private hospitals	Ratio of Total Nurses to Population
1990	11,545	2,948	1: 2.89	1: 1.59	1:168
1991	11,763	2,869	1: 2.85	1: 1.71	1:120
1992	10,874	3,191	1: 3.06	1: 1.69	1:132
1993	11,961	3,861	1: 2.77	1: 1.50	1:120
1994	12,547	3,860	1: 2.65	1: 1.68	1:120
1995	14,614	5,442	1: 2.30	1: 1.32	1:103
1996	14,614	5,442	1: 2.46	1: 1.37	1:106
1997	16,068	8,477	1: 2.24	1: 1.06	1:883
1998	18,134	5,538	1: 1.95	1: 1.64	1:937
1999	20,914	6,322	1: 1.78	1: 1.50	1:834
2000	23,255	7,874	1: 1.61	1: 1.21	1:747
2001	24,543	8,752	1: 1.53	1: 1.14	1:715
2002	26,029	9,251	1: 1.44	1: 1.06	1:695
2003	27,089	9,695	1: 1.37	1: 1.07	1:681
2004	30,002	10,218	1: 1.24	1: 1.03	1:636
2005	32,580	11,540	1: 1.16	1: 0.94	1:529
2006	34,598	13,044	1: 1.12	1: 0.89	1:559
2007	36,150	12,766	1: 1.11	1: 0.92	1:555
2008	38,575	15,633	1: 1.07	1: 0.78	1:501
2009	45,060	14,315	1: 0.92	1: 0.88	1:477
2010	47,992	21,118	1: 0.87	1: 0.75	1:419

(Ministry of Health, various years)

The demand of nurses has increased, inter alia, due to ageing populations which in turn has driven increased consumer activism and rapid evolution of medical technologies, as well as, the susceptibly of the population to dangerous diseases. This demand has been exacerbated by the aging of the workforce resulting in more nurses retiring or seeking part-time work while increasing the propensity for nurses seeking alternative careers.

5.4.1 Share of Nurses in Public and Private Hospitals

The public hospitals could not keep pace with the demand since there is was a severe shortage in number of nurses, especially trained nurses (Utusan, 2004), which has been made worse by the outflow of trained nurses from public to private hospitals. Nurses in private hospitals earn up to 3-4 times the wages of nurses in public hospitals (Susila and Osman-Rani, 2010). Also, nursing is no longer an attractive profession among girls as the noble values of Malaysian society have changed with priority given to materialism (Rasiah, et al., 2011).

Table 5.6 display the ratio of nurses in private hospitals to public hospitals. The ratio shows, a trend but undulating fall from 1:392 in 1990 to 1:227 in 2010. This is due to the government policy and the expansion of private hospitals since the 1990s. During this period of time, the government was more concerned with the potential of the fiscal burden of medical care, and hence promoted aggressively private healthcare to take some of burden off the public system. However, it has led to the emergence of the healthcare sector, which has increasingly leaned towards the private hospitals.

There were 400 vacancies in public hospitals in 1990 (Malaysia, 1991). A greater number of experienced nurses left the Government service to join the private sector leaving behind inexperienced young nurses in public hospitals. Experts deemed this continual loss had caused problems in the public hospitals. A new generation of graduates will have different attitudes toward patients and those in authority than their predecessors (Barnett, et.al. 2010).

Table 5.6: Ratio of Private Hospital Nurses to Public Hospitals, Malaysia, 1990 2010

Year	Ratio of Private hospital Nurses to Public Hospitals
1990	1: 392
1991	1: 410
1992	1: 341
1993	1: 310
1994	1: 325
1995	1: 269
1996	1: 269
1997	1: 190
1998	1: 327
1999	1: 331
2000	1: 295
2001	1: 280
2002	1: 281
2003	1: 279
2004	1: 294
2005	1: 282
2006	1: 265
2007	1: 283
2008	1: 247
2009	1: 315
2010	1:227

(Ministry of Health, various years)

According to Rosnah (2005), the majority of private hospitals relied heavily on back-up services provided by public hospitals, ranging from blood banking to transfer of complex or terminal cases, as commonly reflected in the dispatching of patients to public hospitals when conditions deteriorate. The situation becomes bad when many new public hospitals were not able to open wards, intensive care units and operating theatres due to services shortages in nurses and doctors. As a consequence the government has resorted to recruit contract foreign nurses from Pakistan, Myanmar, India and Indonesia to meet the shortages (MOH, 2006).

The movement of trained nurses to private practice continues to affect the public healthcare system. Higher wages and better work conditions continue to pull the trained nurses from public to private hospitals. One major negative consequence of this is the overload of work for the remaining nurses still serving in public hospitals. Staff shortages can seriously aggravate the patient waiting times in public hospitals.

Private hospitals in Malaysia also recruited nurses from private nursing school/ colleges. Some of the private nursing schools are associated with foreign universities or colleges. Though some of the private hospitals train their own nurses, the graduates came without any experience and hence did not resolve the issue of experience involving nurses going to private practice.

5.5 Summary

This chapter focused on the distribution of beds, doctors (including trained/specialists) and nurses between the public and private hospitals to address concerns raised by experts over the increasing rate of privatisation in the healthcare sector. It can be seen that the spiralling healthcare expenditure noted in chapter three drove the government to promote the privatisation of the healthcare sector.

The consequences of privatisation initially aggravated the shortfalls in beds, doctors (including trained/specialists) and nurses in public hospitals at an alarming rate until the financial crisis of 1997-1998 reduced demand for private doctors. The subsequent resumption of the movement of doctors including specialists and nurses until the early year in the millennium was overcome by government policy to expand the number of hospitals through the approval of several new hospitals and medical and nursing colleges.

While the expansion in the number of hospitals and medical and nursing colleges has helped lower the population-bed, population-doctor and population-nurse ratios especially since 2009, it will take a long time for the quality of services rendered by

public hospitals to reach acceptable standards as the experience doctors that have moved to the private sector requires time to replace.

In light of the negative consequences that privatised healthcare presented, it is important that the government take measures to handle the transition carefully taking into account the need to maintain quality care in public hospitals at all times.