Research Article

The Influencing Factors On Clinical Governance Climate In Private Hospitals Of Malaysia

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ARTICLE INFO	ABSTRACT
	This paper aims to examine the factors that influence clinical governance climate in Malaysian private hospital. This study seeks to examine the connection among the dependent variable clinical governance climate and the independent variables goal conflict, risk aversion, information asymmetry and readiness for change using SPSS version 23. The correlation between the variables is investigated using SEM. It can be utilized to determine the magnitude and direction of the correlation between the variables. A total of 275 respondents were included in the survey. The result of study demonstrates that there is absolutely significant relationship among dependent variables and clinical governance in private hospital of Malaysia. *Keywords: Clinical Governance Climate, Private Hospitals, Malaysia, Influencing Factors*

1. Introduction

Private healthcare management in Malaysia must be committed to guaranteeing the delivery of safe patient care. Determining the optimal method for sustaining high-quality healthcare services remains a challenge. Although the topic of patient safety & quality of care has conventional substantial notice in nursing & clinical management literature, it has rarely been examined in the context of clinical governance. Effective clinical governance demands the dedication of both management & supporting employees. The relationship among these parties is essential for ensuring quality clinical treatment &practice. This study seeks to identify & address the issues that may contribute to an atmosphere of excellent clinical governance.

The concept of clinical governance should not be considered as a single action. It is a combination & range of activities & structures combined with significant effort. Its principles need its integration across systems at every level and by every employee. Most significantly throughout the healthcare organisation (Lugon, 2005). Since its inception by the World Health Organization (WHO) in 1983, the notion has continually evolved and remained a challenge for healthcare organisations, particularly in terms of system integration (Delaney, 2015). Clinical governance attempts to provide ongoing quality improvement in healthcare as well as a comprehensive framework that may encompass performance, risk management, resource allocation, & patient happiness (Som, 2004; Penny, 2000; Scaly and Donaldson, 1998). Later, the National Health System (NHS) advocated establishing a framework through UK healthcare organisations to strengthen the UK's healthcare system. The purpose of these frameworks is to establish accountability for patient safety & high-quality services (Department of Health, 1998). They also seek to guarantee that managers sustain & enhance the quality of clinical treatment & patient care.

1.1 Background

The purpose of integrating clinical governance into a healthcare organisation is to preserve & enhance the quality of patient treatment. This condition includes pertinent procedures for monitoring & evaluating the required quality objectives (Halligan and Donaldson, 2001). Contrary to popular opinion, governance believes that clinical practise& management are mutually exclusive. Therefore, they tend to occur separately in which management controls activities connected to everyday operations, comprising financial, revenue, & performance. This approach appears natural & expected of all organisations, yet it might result in the

neglecting of a company's clinical features. Therefore, improvement programmes, clinical practises, quality assessments, & clinical audits are frequently not discussed at business meetings (Delaney 2015).

1.2 Terms Definitions

➢ Clinical governance climate
It is theoretically described as the patterns and behaviours exhibited by clinical staff in order to strengthen the support of clinical governance in a healthcare setting (Sutton, J. et al. 2016; Schneider, B., 2000; Patterson, M. G. et al., 2005).

➢ Goal Conflict
It is described as "the extent to which people perceive that their goals are irreconcilable" (Locke et al., 1994).

➢ Information asymmetry
It is described as "one party having more information than the other, or the other party becoming unaware of information" (Tsang, E. W., & Blevins, D. P., 2015).

➢ Risk aversion
It is the preference for an assured result over a probabilistic one with equal predicted values (Mandrik, C. A., &Bao, Y. 2005).

2.   Literature Review

2.1 Past studies on clinical governance climate
Clinical governance has been characterised as a system of transformation requiring a suitable culture (Karassavidou, Glaveli, &Zafiropoulos, 2011). Healthcare environments are architecturally & culturally complex. Hierarchy and bureaucracy contribute to a complex structure. Culture is complicated by multifunctions&multidepartments, which result in variations in habits and procedures (Brooks, 1996; Nichols et al. 2000; Schein, 1992; Simpson, 1994). Changes in day-to-day policies and events that have an consequence on the norms & principles that influences an employee's activities to foster a conducive atmosphere or culture that promotes clinical governance. These surroundings & situations can facilitate the implementation of an efficient clinical governance framework (Karassavidou, Glaveli, &Zafiropoulos, 2011). Therefore, it is necessary to investigate the basics that result in high-quality patient care.

Rousseau (1988) stated that general organisational climate is a model of an organization's behaviour, which is the perception of a workplace. It describes how employees perceive the working environment, regulations, & procedures of an organisation. A company's culture is a predictor of performance (Kangis, Gordon, & Williams, 2000 & Eustace, & Martins, 2014). In a hospital setting with a favourableorganisational climate, increases in staff health outcomes, needle prick injuries, care quality, & patient satisfaction have been seen (Gershon et al. 2007; MacDavitt et al. 2007; Aiken et al., 2002 &Ancarani et al., 2009). In addition, nurses' job satisfaction has grown, which is connected with a favourableorganisational climate; satisfied nurses are thus less likely to leave their positions (Liou, & Cheng, 2010). These occurrences show that any healthcare organisation can enhance its care quality by addressing its climate & identifying the external manifestation of its workplace culture (Dastmalchian et al., 2015 & Schneider, 1990).

Many researchers (Karassavidou, Glaveli, &Zafiropoulos, 2011; Dreliozi, 2013; Barahmi et al., 2014; and Fardazar et al., 2015) have successfully measured & identified opportunities for improvement in a healthcare organization supporting an environment for good clinical governance. Some hospitals, including those in Greece & Iran, do not promote a strong clinical governance atmosphere when regions are examined quantitatively (Karassavidou, Glaveli, &Zafiropoulos, 2011; Dreliozi, 2013, Barahmi et al., 2014; and Fardazar et al. 2015). These hospitals are lacking in essential components of clinical governance. Among the areas of improvement are risk management, training, & education.

2.1 Goal Conflict

Individuals are said to experience goal friction to the extent that they believe that some of their various goals are in direct opposition to one another. (Locke et al., 1994). Littlejohns et al. (2017) described a variety of goal conflicts that influence standard settings & healthcare quality assessment. The inability to monitor the quality of care is hindered by regulators' & health departments' divergent health policy objectives. Thus, various forms of goal conflicts arise. When a personal goal is regarded incompatible with an externally imposed goal, i.e., when individuals are given goals that are loftier than their own, goal commitment & performance decrease (Locke et al., 1994 &Yurtkoru, E. S. et al., 2017). Second, performance is hindered when numerous performance aspects compete for an individual's attention (Slocum, 2002). Individuals are thirdly expected to create results within limited time & resources (Slocum, 2002).

Even if more indicators have been created to enhance the clinical quality of care in contemporary healthcare settings, additional benchmarks & assessments are required. The collaborative effort of nurses and other healthcare personnel may be seen from side to side., and other healthcare workers, the incidence of common

healthcare-related infections & bloodstream infections related with central lines has decreased. Goals defined by legislations and requirements ensure that hospitals manage these accidents (Ballard, 2003; Vincent et al., 2008 & Woodward, &Umberger, 2016).   As a pre-condition to enabling hospitals execute clinical governance efficiently, some characteristics include common visions, goals, values and leadership traits (Karassavidou, Glaveli, &Zafiropoulos, 2011). Hence, visions, goals & value are crucial for an organisation. Goal conflict is a crucial component to implement clinical governance efficiently.

2.2 Information Asymmetry

Information asymmetry happens when one party has more or better information than the other, or when one side becomes unaware of information (Akerlof, 1970 & Tsang & Blevins, 2015). In healthcare, decision-makers like the board & senior management must have access to pertinent data in order to make the best choices. Results are likely to influence clinical outcomes. Likewise, when patients provide accurate information, clinicians are often able to make more accurate diagnoses & better management decisions for their ailments (Major, 2019). Major (2019) observed that the existence of two-sided knowledge asymmetry among healthcare organisations& physicians results in an unintended consequence.
In terms of patient safety, hospital board monitoring is crucial because its efficacy is contingent on well-informed members (Millar et al., 2013, Millar et al., 2015 &Mannion et al., 2016). In addition, the board should acquire many forms of information in order to have the proper insight on crucial concerns (Mannion et al., 2016). On a side note, the purpose of information exchange may not always be expressed clearly. Some rules may produce information that fulfills the objectives of specific regulators but not industrial objectives (Quigley, Bisset, & Mills, 2017).

2.3 Risk Aversion

Risk taking, risk appetite or risk aversion is usually examined through gambling & probability tests to determine an individual's risk-taking preference. Risk aversion in corporate governance denotes to agents' or principals' preferences in making decisions based on their understanding. Risk aversion is also characterised as one's preference for guaranteed results over probabilistic ones with an equally predicted value (Mandrik, &Bao, 2005). (Mandrik, &Bao, 2005). It can also be conceptualised as a technique to diminish the willingness to participate in a high-risk activity believed to have an undesired outcome (Lorian, & Grisham, 2011). (Lorian, & Grisham, 2011). For instance, if not executing a procedure as per evidence-based practise will result in damage to patients. Hence, the question in this case is if agents or managers have the inclination to avoid risk or take a higher risk. Consequently, research have demonstrated that a positive association exists among expected value & attractiveness of an alternative, whereas a negative relationship emerges among risk & appeal (Mandrik&Bao, 2005). (Mandrik&Bao, 2005). Therefore, readiness to accept the new technique is bolstered by the allure of executing a procedure that potentially results in superior clinical outcomes.

3.   Research Question and Objective

Based on previous researches this study addressed following question Are there influencing factors that affect clinical governance climate in private hospitals in Malaysia?

3.1 Objective

Attempting to answer the aforementioned questions involves the objective of study is:
To determine the influencing factors on clinical governance climate in private hospitals in Malaysia

Hypothesis

H1: There is a significant negative relationship between goal conflict and clinical governance climate
H2: There is a significant negative relationship between information asymmetry and clinical governance climate
H3: There is a significant negative relationship between risk aversion and clinical governance climate

4.   Research Methodology

After presenting the literature review on the climate of clinical governance, this correlation study intends to examine the relationship between a complete set of parameters and the clinical governance climate of Malaysian private healthcare. To investigate the elements contributing to the clinical governance climate, a quantitative survey methodology is selected based on the Philosophical, Ontological, and Epistemological approaches. The clinical governance framework aims to quantify data for causal link explanation. This investigation uses quantitative research tools and procedures in an explanatory manner.

4.1 Population of Study

The population of this study comprises clinical employees involved in clinical governance in Malaysia. The sample of the population mainly includes executive managers who have an experience in management or are exposed to quality management in private hospitals.

4.2 Data Collection

The researcher contacted the head of the hospitals, the CEOs, or the head of quality via an email or a phone message. Upon approval, a copy of the questionnaire and an online version prepared in Google® Form was also sent to the person in charge. A brief explanation on the purpose of the research and the identified respondents was given to the identified person. The survey questionnaire via the Google® form was allowed to be shared with their colleagues.

4.3 Sample Size

A total of 187 private hospitals were documented in Malaysia in 2016 as reported in KKM Healthfacts (2017)

4.4 Data Analysis

This study's objective is to analyze the link between both the dependent varied clinical governance environment and the independent variables—specifically, goal conflict, risk avoidance, and information asymmetry—in order to draw conclusions about the nature of that relationship. PLS-SEM, which stands for partial least square structural equation modeling, is utilized because it is suitable for determining the multidimensional correlations that exist between observable and predictor variable (Vinzi et al., 2010).SPSS is used for this research to conduct parametric and non-parametric comparison analyses. In addition to enabling a frequency analysis to be done, a normality and outlier test can be conducted to determine the assumption of the data being analyzed. Additionally, it allows a researcher to determine the assumptions of the test (Ong &Puteh 2017).

5. Results

5.1Respondents' Features and Demographic Profiles
The participants' demographic data were collected to explore background factors. Approximately 80% of the respondents were aged 40 and below, and most of them had 20 years or less of 147 Experience. The targeted respondents were doctors, nurses and allied health staff, such as pharmacist, lab technicians, radiographers, radiologists and physiotherapists, and other individuals with clinical background. The gender distribution leaned towards females, and nurses accounted for 70% in the workforce. The demographic factors considered in this study were as follows:

Table: 1 Frequency distributions of demographic characteristics

Variables		N=275; Percentage (%)
Age (year)	<30	110;(40.0)
	30−40	107;(38.9)
	>40	58;(21.1)
Profession	Nurse	118;(42.9)
	Clinical/allied	71;(25.8)
	Management	52;(18.9)
	Doctor	34;(12.4)
Work experience (year)	1−10	158;(57.5)
	11−20	97;(35.3)
	>20	20;(7.3)
Gender	Male	88;(32.0)
	Female	187;(68.0)

5.2 Structural Equation Modelling (SEM)

The structural equation model (SEM) is a mixture of factor analysis and multiple regressions that consists of a series of statistical procedures that allow for complicated interactions between variables that are independent and variables that are dependent. Almost any research issue that involves the direct or indirect measurement of independent and dependent variables can be answered with the help of structural equation modeling (SEM). However, the basic objective of SEM is to verify the validity of a given causative mechanism or a model. This can be thought of as the "testing" of the "validity." Therefore, the SEM is a technique that is used for confirmation. Validating the measurement instrument and matching the structural model are the two steps

that are the primary foci of SEM. The first is completed mostly via the use of confirmatory factor analysis, whilst the second is completed primarily through the utilization of path analysis using latent variables.
The validation of the study's hypothesized causal connection, which is based on the findings presented in Table 2 of the research.

Table: 2 List of hypotheses and relative paths

Hypothesis	Path
H1. There is a significant negative relationship between goal conflict and clinical governance climate	GC------> CGC
H2. There is a significant negative relationship between information asymmetry and clinical governance climate	IA------> CGC
H3. There is a significant negative relationship between risk aversion and clinical governance climate	RA------> CGC

In order to evaluate the hypotheses underlying the investigation, SEM was utilised. In accordance with the conceptual framework of the research, the model included four variables: three independent variables (goal conflict, information asymmetry, and risk aversion), and one dependent variable (clinical governance climate). In order to determine the importance of the presented study hypotheses for the model, a bootstrapping method was utilized as an estimation method. The process of bootstrapping includes taking a random sample from the primary dataset in order to generate fresh samples that have the same size as the primary dataset. This technique not only determines whether or not the dataset can be trusted, but it also evaluates the statistically significant of the coefficients in question and, as a result, the errors associated with the predicted path coefficients (Chin, 1998).
Table 3 displays the bootstrapping findings and p-values for the path utilized in this investigation. The direct impacts (path c') of all three independent variables on clinical governance climate were statistically significant, as shown by bootstrapping. Negative and statistically significant effects of information asymmetry (=0.184, p0.001), risk aversion (=0.246, p0.001), and goal conflict (=0.463, p0.001) on clinical governance atmosphere.

Table: 3 List of hypotheses and relative paths

Path	β	SE	t value	P Values
PATH C'				
IA------> CGC	-0.184	0.052	3.579	<0.001
RA------> CGC	-0.246	0.049	5.052	<0.001
GC------> CGC	-0.463	0.05	9.26	<0.001

7. Findings and Discussion

The variables identified as goal conflict, information asymmetry, and risk aversion. The purpose of developing this conceptual model was to validate the projected consequences that these determinants of clinical governance environment would have. The relationships between these attributes proposed in the model for empirical testing.

Table: 4 Results of Hypothesis testing

Hypothesis	Path	B	p value	Results
H1: There is a significant negative relationship between goal conflict and clinical governance climate	GC------> CGC	-0.501	<0.001	Supported
H2: There is a significant negative relationship between information asymmetry and clinical governance climate	IA------> CGC	-0.244	<0.001	Supported
H3: There is a significant negative relationship between risk aversion and clinical governance climate	RA------> CGC	-0.280	<0.001	Supported

As showed in above table that goal conflict had a significantly negative effect on clinical governance climate. This finding was consistent with the concept of goal conflict, which affects the effectiveness of clinical governance in a hospital (Locke et al. 1994 &Karassavidou, Glaveli, &Zafiropoulos, 2011).The findings of this study mentioned the hypothesis that information asymmetry had a significantly negative effect on clinical governance climate. The existence of information asymmetry reduces the climate supporting clinical governance in an organisation. The private healthcare organisation in Malaysia has demonstrated various situations; for instance, one party has more information than the other, or executive staff with vested interests can lead to undesirable outcomes (Tsang, & Blevins, 2015; Jiang, Lockee, & Fraser, 2012).This study supports the hypothesis that risk aversion has a significantly negative effect on clinical governance climate. This study considers the acceptance level or the perception of risk by employees in terms of decision making within their hospitals (Qualls and Puto 1989 &Mandrik&Bao 2005). The survey question measures the extent of the preference of the clinical staff on more predictable outcomes in their daily decision making.

Conclusion

The clinical governance climate in the Malaysian healthcare context remains unchartered and requires more contributions in theoretical and practical approaches. Providing and maintaining safe care and high quality of care to patients in a private healthcare in this country need a robust system and an effective control measure. Clinical governance may require a framework that may be prescriptive in nature. However, the climate that supports this governance is challenging, and further efforts should be devoted to identifying and implementing clinical governance. As such, healthcare organizations that aim to have an effective clinical governance climate in Malaysia should 200 consider reducing the negative impact of these variables on their organizations. The genuine interest and dedication shown by healthcare facility decision making and policy makers is essential to the realization of the clinical governance environment in Malaysia from the point of view of private hospitals in terms of their efforts to pursue, promote, and execute the climate. As a result and as indicated by this study, only by placing and developing fundamental pre-conditions in these healthcare organizations, such as working relation between management and executive management, setting shared vision and goals, managing and reducing information asymmetry and risk aversion, and considering the readiness for change amongst the staff. Therefore, these can help achieve a well-supported climate for clinical governance in private Malaysian hospitals.

Limitation of Study

The empirical findings that were provided in this article should be viewed in light of certain restrictions as well as the possibility of further research. The few limitations in this study could be addressed in future research. Hospitals were confined to private healthcare centres in specific locations, such as Kuala Lumpur, Seremban, Johor, Melaka and Ipoh. The geographical constraint of reaching out to more private hospitals also limited the study. The limited areas included east, west and northern parts of Malaysia. This study could be replicated in other geographical locations in Malaysia and other countries. Various countries may have different regulations and practices. Nevertheless, patient safety may be the common objective for all healthcare organisations around worldwide.

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